Ohio | Common Sense Initiative

**Mike DeWine**, Governor
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# Business Impact Analysis

**Agency, Board, or Commission Name:** Ohio Department of Medicaid

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**Regulation/Package Title (a general description of the rules' substantive content):** Medicaid Managed Care Program: eligibility and enrollment

**Rule Number(s): 5160-26-02**

**The date of Submission for CSI Review: October 8, 2020**

**Public Comment Period End Date: October 15, 2020**

**Rule Type/Number of Rules:**

**New/___rules**

**Amended/ 1 rules (FYR? Yes)**

**No Change/____rules (FYR?____)**

**Rescinded/ rules (FYR?____)**

**The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.**

## Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   **Which adverse impact(s) to businesses has the agency determined the rule(s) create?**

   **The rule(s):**

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

## Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   ***Please include the key provisions of the regulation as well as any proposed amendments.***

   In Ohio, approximately 90% of Medicaid recipients receive their Medicaid services through a Managed Care Organization (MCO) or MyCare Ohio Plan (MCOP). MCOs/MCOPs are health insurance companies licensed by the Ohio Department of Insurance and have a provider agreement (contract) with the Ohio Department of Medicaid (ODM) to provide coordinated health care to Medicaid beneficiaries. There are six MCOs/MCOPs in Ohio, each with a network of health care professionals. The rules outlined in Chapter 5160-26 of the Administrative Code set forth the requirements of MCOs and the Ohio Medicaid managed care program.

   **OAC rule 5160-26-02, entitled "Managed health care program: eligibility and enrollment,"** sets forth the eligibility criteria for individuals who are then enrolled in the managed care program and the enrollment process. This rule is being proposed for amendment to clarify policy related to the administration of the managed care program. Changes to the rule include: In paragraph (B)(5), added several enrollment exclusion categories per current process. In paragraph (C)(2) removed language requiring MCOs to report the birth of a newborn to a mother enrolled in managed care because this requirement exists in the managed care plan provider agreement. Other technical edits were made throughout.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Revised Code Section 5167.02 authorizes ODM to adopt the rule, and 5164.02, 5167.02, 5167.03, and 5167.10 amplify that authority.

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
***If yes, please briefly explain the source and substance of the federal requirement.***

   Yes. 42 C.F.R. Part 438 imposes comprehensive requirements on the state regarding Medicaid managed care programs, however the proposed changes to the rule are not related to changes to federal regulation.

5. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   Federal regulations do not impose requirements directly on MCOs; instead they require state Medicaid agencies to ensure MCO compliance with federal standards. The rules are consistent with federal managed care requirements outlined in 42 C.F.R Part 438 that require the state to implement policies and regulations as the state deems necessary and appropriate.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of this regulation is to outline the eligibility and enrollment criteria for managed care.

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   ODM monitors compliance with the regulation through reporting requirements established within the managed care provider agreements. Successful outcomes are measured through a finding of compliance with these standards as determined by monitoring and oversight.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
***If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.***

   No.

## Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
***If applicable, please include the date and medium by which the stakeholders were initially contacted.***

   The Medicaid Managed Care Organizations were provided the draft rules electronically on July 14, 2020. And were given until July 27, 2020 to comment.

   **Managed Care Organizations**

- Buckeye Health Plan
- CareSource
- Molina Healthcare of Ohio
- Paramount Advantage
- UnitedHealthcare Community Plan of Ohio

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

    As a result of MCO outreach, no concerns were expressed. Therefore, no changes were made to the rules.

11. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

    No scientific data was used to develop this rule or the measurable outcomes of the rule as it is not applicable to the function of the rule.

12. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    The amendments to the rule include general updates to keep the rule current, clarification related to managed care enrollment and to implement minor changes to the managed care program. The regulations are set forth in this rule for enforcement purposes.

13. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    A performance-based regulation would not be appropriate because ODM is required to comply with detailed federal requirements set forth in 42 CFR Part 438. MCO performance requirements are outlined in the Medicaid Managed Care Plan Contracts available online at: https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans

14. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    All Medicaid regulations governing MCOs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid program. And the regulations in Chapter 5160-26 are not duplicated elsewhere.

15. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

ODM will notify the MCOs of the final rule via email notification. Additionally, per the provider agreement, MCOs are required to subscribe to the appropriate distribution lists for notification of all OAC rule clearances and BIAs, and final published rules via RuleWatch Ohio.

## Adverse Impact to Business

16. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

a. **Identify the scope of the impacted business community; and**

This rule impacts MCOs in the State of Ohio including: Buckeye Health Plan, CareSource, Molina Healthcare of Ohio, Paramount Advantage, and UnitedHealthcare Community Plan of Ohio.

b. **Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and**

This rule requires the MCOs to notify ODM of an infant born to a mother enrolled in an MCO. This requirement is being removed from the rule as it is duplicative of requirements found elsewhere.

c. **Quantify the expected adverse impact from the regulation.**
***The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.***

Managed care plans (MCOs) are paid per member per month. ODM must pay MCOs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.6(c) and CMS's "2019/2020 Managed Care Rate Setting Consultation Guide." Ohio Medicaid capitation rates are "actuarially sound" for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. Costs include but are not limited to expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government mandated assessments, fees, and taxes.

All rates and actuarial methods can be found on the ODM website in Appendix E of the Medicaid Managed Care provider agreement. Through the administrative component of the capitation rate paid to the MCOs by ODM, MCOs will be compensated for the cost of the requirements found in this rule. For CY 2020, the administrative component of the capitation rate varies by program/population and ranges from 3.00% to 6.50% of the effective rate for MCOs. Note that these amounts exclude care management and risk margin included in the capitation rates.

17. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

    The MCOs were aware of federal requirements for covered services prior to seeking and signing contracts with the state. More importantly, without the requirement, the State would be out of compliance with federal regulations.

## Regulatory Flexibility

18. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

    The requirements of this rule must be applied uniformly, and no exception is made based on an MCO's size.

19. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    This rule imposes no sanctions.

20. **What resources are available to assist small businesses with compliance of the regulation?**

    While there are no small businesses negatively impacted by this rule, the managed care organizations may contact ODM directly through their assigned Contract Administrator.

# ***DRAFT - NOT FOR FILING***

**5160-26-02 Managed health care program: eligibility and enrollment.**

(A) This rule does not apply to "MyCare Ohio" plans as defined in rule 5160-58-01 of the Administrative Code. The eligibility and enrollment provisions for "MyCare Ohio" plans are described in rule 5160-58-02 of the Administrative Code.

(B) Eligibility for managed care ~~plan~~organization ~~(MCP)~~(MCO) enrollment.

(1) Except as specified in paragraphs (B)(3) to (B)(5) of this rule, in mandatory service areas as permitted by 42 C.F.R. 438.52 ~~(October 1, 2018)~~(October 1, 2020), an individual must be enrolled in an ~~MCP~~MCO if he or she has been determined medicaid eligible in accordance with division 5160:1 of the Administrative Code.

(2) ~~MCP~~MCO enrollment is mandatory for the following individuals:

(a) Children receiving Title IV-E federal foster care maintenance;

(b) Children receiving Title IV-E adoption assistance:

(c) Children in foster care or other out-of-home placement; and

(d) Children receiving services through the Ohio department of health's bureau for children with medical handicaps (BCMH) or any other family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act, 42 U.S.C. 701(a)(1)(D) (as in effect January 1, ~~2019~~2021) and is defined by the state in terms of either program participation or special health care needs.

(3) Medicaid eligible individuals may voluntarily choose to enroll in an ~~MCP~~MCO if they are:

(a) Indians who are members of federally recognized tribes; ~~or~~

(b) Individuals diagnosed with a developmental disability who have a level of care that meets the criteria specified in rule ~~5123:2-8-01~~5123-8-01 of the Administrative Code and receive services through a ~~1915(c)~~ home and community based services (HCBS) waiver administered by the Ohio department of developmental disabilities (DODD)~~.~~;

(4) Except for individuals receiving medicaid in the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (as in effect January 1, 2021),~~2019)~~ and individuals who meet criteria in paragraph (B)(3)(b) of this rule~~,~~ medicaid eligible individuals ~~described in paragraph (B)(1) of this rule~~ are excluded from ~~MCP~~MCO enrollment if they: ~~meet any of the following criteria:~~

(a) ~~Residing~~ Reside in a nursing facility; or

(b) ~~Receiving~~Receive medicaid services through a medicaid waiver component, as defined in section 5166.02 of the Revised Code.

(5) The following individuals are excluded from ~~MCP~~MCO enrollment.

(a) Inmates of public institutions as defined in 42 C.F.R. 435.1010 ~~(October 1, 2018)~~(October 1, 2020) unless otherwise specified by ~~the Ohio department of medicaid (ODM)~~ODM;

(b) Dually eligible individuals enrolled in both the medicaid and medicare programs;

(c) Individuals receiving services in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or a developmental center as defined in rule 5123-9-30 of the Administrative Code; ~~and~~

(d) Individuals enrolled in the program of all-inclusive care for the elderly (PACE)~~.~~;

(e) Individuals who are determined to be presumptively eligible and receive temporary, time-limited medical assistance as described in rule 5160:1-2-13 of the Administrative Code;

(f) Individuals who receive alien emergency medical assistance in accordance with rule 5160:1-5-06 of the Administrative Code;

(g) Individuals who receive refugee medical assistance in accordance with rule 5160:1-5-05 of the Administrative Code; and

(h) Non-citizen victims of trafficking as set forth in rule 5160-1-5-08 of the Administrative Code.

(6) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for other non-medicaid benefits to which he or she may be entitled.

(C) Enrollment in an ~~MCP~~MCO.

~~(1)~~ (1) ~~The following applies to enrollment in an MCP:~~

~~(a)~~ (1) The ~~MCP~~MCO must accept eligible individuals without regard to race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services. The ~~MCP~~MCO will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.3(d) ~~(October 1, 2018).~~(October 1, 2020).

~~(b)~~ (2) The ~~MCP~~MCO must accept eligible individuals who request ~~MCP~~MCO enrollment without restriction.

~~(c)~~ (3) If an ~~MCP~~MCO member loses managed care eligibility and is disenrolled from the ~~MCP~~MCO, and subsequently regains eligibility, his or her enrollment in the same ~~MCP~~MCO may be reinstated back to the date eligibility was regained in accordance with procedures established by ODM.

~~(d)~~ (4) ODM shall confirm the eligible individual's ~~MCP~~MCO enrollment via the ODM-produced Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 834 daily and monthly enrollment files of new members, continuing members and terminating members.

~~(e)~~ (5) The ~~MCP~~MCO shall not be required to provide coverage until ~~MCP~~MCO enrollment is confirmed via

the ODM-produced HIPAA compliant 834 daily or monthly enrollment files except as provided in paragraph ~~(C)(2)~~ (C)(6) of this rule or upon mutual agreement between ODM and the ~~MCP~~MCO.

~~(2)~~ (6) ~~Newborn notification and enrollment~~.Infants born to mothers enrolled in an MCO are enrolled in an MCO from their date of birth through at least the end of the month of the child's first birthday, or until such time that the MCO is notified of the child's disenrollment via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files.

~~(a)~~ (a) ~~The MCP must notify ODM's designee, as directed by ODM, of the birth of any newborn whose mother is enrolled in an MCP.~~

~~(b)~~ (b) ~~Infants born to mothers enrolled in an MCP are enrolled in an MCP from their date of birth through at least the end of the month of the child's first birthday, or until such time that the MCP is notified of the child's disenrollment via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files.~~

(D) Commencement of coverage.

(1) Coverage of ~~MCP~~MCO members will be effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily and monthly enrollment files to the ~~MCP~~MCO, except as specified in paragraph ~~(C)(2)~~(C)(6) of this rule.

(2) When an eligible individual is admitted to an inpatient facility prior to the effective date of ~~MCP~~MCO enrollment and remains in an inpatient facility on the enrollment effective date, the following responsibilities apply:

(a) The admitting medicaid payer, either fee-for-service or the admitting ~~MCP~~MCO, is responsible for all inpatient facility charges, pursuant to rule 5160-2-07.11 of the Administrative Code, through the date of discharge.

(b) The enrolling ~~MCP~~MCO is responsible for all other medically necessary medicaid covered services including professional services related to the inpatient stay, beginning on the enrollment effective date.