CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: Medicaid General Reimbursement Updates

Rule Number(s): 5160-1-05.1: Payment for Medicare Part C cost sharing

Date: 3/5/14

Rule Type:

- ☐ New
- ☐ Amended
- ✓ 5-Year Review
- ☐ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. Please briefly describe the draft regulation in plain language.

This rule describes the reimbursement methodology used by ODM to pay the cost sharing charges for medical services for individuals dually enrolled in Medicaid and a Medicare Part C plan. The rule requires the provider, if they receive payment for Part C crossover claims, to maintain documentation related to the Part C plan's remittance advice, and any capitation arrangement with a Part C plan and the cost sharing requirements therein.

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2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

ORC 5164.02

3. **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?**

Yes. The State has an approved state plan amendment that authorizes the State to pay Medicare cost sharing in accordance with a lesser methodology. This methodology is authorized under Section 1902 (n) of the Social Security Act.

The provision that requires the provider to keep information to support the Part C crossover claim, including the remittance advice from the Part C plan, implements another general Medicaid rule, 5160-1-17.2, and the federal requirement that providers who are furnishing services to Medicaid beneficiaries enter into a provider agreement with the state agency.

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

The provision that requires documentation for capitation arrangements between providers who submit claims for Part C crossovers to Medicaid and the Part C plan is not specifically mentioned under federal law. However, this requirement is necessary in order for ODM to ensure program integrity. The only recourse the State has to ensure the accuracy of claims payment is to require the provider to keep the documentation on file, so, in cases where there are questions, ODM can validate the appropriateness of the crossover payment.

5. **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)?**

Both provisions that require the billing provider to keep on file documentation supporting the accuracy of the crossover claim paid by ODM is intended to enhance program integrity in the Medicaid program by allowing ODM the opportunity to validate the appropriateness of a paid Part C crossover claim.

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

ODM monitors all spending associated with Medicare crossovers, and, through this monitoring, ODM could identify suspicious behavior for Part C crossovers that would require a review of the provider's records.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**

All providers and the public had opportunities to review and comment on the rule during ODM's 2-week clearance process.

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

The Department received no input from stakeholders during its public clearance process.

9. **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?**

Not applicable

10. **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 Department considered relying on another rule (OAC 5160-1-27) that describes the documents a provider may be required to show as a part of a provider's records review but determined that, due to the uniqueness of the situation between a provider who submits a Part C crossover claim for a service rendered as part of a capitation arrangement, the more detailed and specific regulation was necessary.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.**

No. The only way to verify the appropriateness of a very specific payment for services delivered via a capitation arrangement between a Medicaid provider and a Part C Medicare Advantage Plan is to look at the cost sharing requirements between the two parties under such an arrangement.

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

The rule was reviewed by policy and legal staff for ODM.

13. **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.**

The reimbursement methodology described in this rule has been used to price Part C crossover claims since 2004. This methodology is currently applied to all providers who submit Part C crossover claims, and the documentation provision is also currently applied across the program.

Adverse Impact to Business

14. 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;

All Medicaid providers who submit Part C crossover claims for medical services rendered to a dually enrolled individual are positively impacted by the rule.

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

Any documentation that exists is assumed to already exist as a part of whatever capitation contract the providers may have with a Part C Medicare Advantage Plan.

c. Quantify the expected adverse impact from the regulation.

There are no expected adverse impacts from this rule. Providers who bill Part C crossover claims to the Department and are in a capitation arrangement can receive a distinct benefit because the provider will not have a Medicare paid amount on the submitted claim and, therefore, will always receive a positive payment from ODM.

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

ODM believes there are currently no adverse impacts from this rule. However, any potentially adverse impacts are more than offset by the Medicaid payment for Medicare cost sharing obligations.

Regulatory Flexibility

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

No providers are exempt from compliance with this rule. All providers in a capitation arrangement with a Part C plan and who submit Part C crossover claims to Medicaid receive the benefit of a positive payment by ODM. Such providers are also required to keep the capitation arrangement documentation on file, something ODM assumes happens regardless of whether or not the provider is rendering services and billing the Department.

17. 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 on providers.

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

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.