CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: BHPP Utilization Review – 5160-2-07.12, 07.13, 40

Rule Number(s): 5160-2-07.12, 5160-2-07.13, 5160-2-40

Date: October 9, 2015

Rule Type:

- ☐ New
- ☐ Amended
- X 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- ☐ Rescinded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.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 5160-2-07.12 sets forth the process for requesting reconsideration after a utilization review of inpatient or outpatient hospital services by the Department or its medical review entity. The rule is being proposed for amendment as a result of five-year rule review. The

proposed changes include updating references to outdated administrative code throughout the rule, and adding language to permit the Department or the medical review entity to issue notice of an incomplete request for reconsideration and gives the provider two business days to submit the missing documentation. Language was also rearranged for improved readability.

Rule 5160-2-07.13 sets forth the nature and timelines of utilization reviews conducted on inpatient and outpatient hospital services by the Department or it contracted medical review entity as required by 42 C.F.R. 456.3, effective October 1, 2013. The rule is being proposed for amendment as a result of five-year rule review. The proposed changes include updating language to state that utilization reviews will be conducted in accordance with section 5164.57 of the Ohio Revised Code and updating the sample size requirement of retrospective reviews. In addition, language was added regarding recovery of payments for professional services that are associated with a recouped hospital payment that is not eligible for resubmission due to the results of a utilization review.

Rule 5160-2-40, sets forth the guidelines and process of the pre-certification review program for inpatient hospital services. The rule is being submitted as a result of five-year rule review. There are no changes to this rule.

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

   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?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes. As the state Medicaid agency, the Department is required by 42 C.F.R. 456.3 to implement a utilization control program that implements the following: safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of services provided; provides for the control of the utilization of all services provided under the plan in accordance with 42 C.F.R. 456 Subpart B; and provides for the control of the utilization of inpatient services in accordance with Subparts C through I.

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

   The federal regulation does not specifically delineate how utilization control is to operate. The rules in this packet merely put a process around implementing the generally stated federal requirements.

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)?**

The public purpose for these rules is to safeguard Medicaid resources against unnecessary or inappropriate use of Medicaid services and excess payments, assure beneficiary access to quality hospital services and to ensure that hospitals and managed care plans will be informed of Medicaid policy regarding utilization control.

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

   The federally mandated utilization review program is not new, and the measurable outcome in financial terms is the recovery of state Medicaid payments for unsupported hospital services of approximately $30 million annually.

Development of the Regulation

7. **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.

   On 8/27/2015, the Department initiated conversation with the Ohio Hospital Association (OHA) to seek comments regarding the proposed changes. Conversations between the Department and OHA will continue as OHA is a large stakeholder group as it represents the majority of hospitals throughout the State. As of 9/18/2015, OHA has not provided comments regarding the proposed changes to the rules.

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

   The draft regulations were sent to OHA however, no comments were received.

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 did not consider alternative regulations as the rules were a result of a federal mandate.

11. **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.

No, the Department did not specifically consider a performance-based regulation as the utilization control process is quite complicated and descriptive rules are required to implement the process.

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

The Department reviewed the regulations cited within the rules and reduced duplication when possible by referring readers to existing rules. Ohio Administrative Code (OAC) rule 5160-2-07.12 is the only rule that gives hospitals reconsideration rights for determinations made as a result of utilization review. OAC rule 5160-2-07.13 is the only regulation that implements a utilization review program on hospitals. OAC rule 5160-2-40 is the only rule that address pre-certification for the delivery of services in a less cost-effective setting due to individual circumstances such as medical necessity and severity of illness.

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 hospital utilization review program is not a new program. The Department of Medicaid contracts with an independent medical review entity to perform utilization review of Medicaid inpatient services regardless of the payment methodology used for reimbursement of those services.

OAC rule 5160-2-07.13 clearly indicates for the reviewing entity the areas to be reviewed, the sources of review materials and the time period for review. As supported by section 5164.57 of the Revised Code, this regulation permits the Department to review and recover any overpayment made to a Medicaid provider during the five-year period immediately following the end of the state fiscal year in which the overpayment was made, or the one-year period immediately following the date the Department receives from the Centers for Medicare and Medicaid Services a completed and audited Medicare cost report that applies to the state fiscal year in which the overpayment was made. To minimize the burden on a specific set of providers or line of business and protect the interests of Ohio tax payers, Ohio Medicaid's independent review entity selects a stratified, random sample of admissions for review from several different categories, including: transfers, readmissions, claims for which outlier payments were made, admissions with short lengths of stay, DRG assignment, and high cost claims.

For all admissions selected, medical records and physician attestation are reviewed along with the diagnostic and procedural information on the claim to determine appropriateness of coding, medical necessity, medical appropriateness of discharge, and quality of care rendered. Outpatient hospitals are also reviewed to determine whether the care or services were medically necessary.

In cases where the care is found to be medically necessary and appropriate, but the coding is incorrect, providers are allowed to resubmit their claims with correct coding. Additionally, providers may contest determinations made during utilization review. The process for doing so is also outlined in Ohio Administrative Code to ensure consistency across providers.

OAC rule 5160-2-07.12 outlines the process for Departmental reconsideration regarding decisions made during utilization review.

OAC rule 5160-2-40 describes the Department's policy regarding requests to perform procedures traditionally provided in an outpatient hospital setting in the more expensive inpatient hospital setting. All providers who believe that an inpatient rather than outpatient setting is more clinically appropriate, are required to submit a pre-certification request along with documentation demonstrating the medical necessity of performing the procedure in the more expensive hospital setting.

The procedures requiring pre-certification are published by the Department or its designee, and nationally recognized protocols for diagnostic and therapeutic care based on severity of illness and intensity of services are used as standards of medical practice by the Department in determining appropriateness of service setting. The Department notifies all hospital providers of these standards and any changes to them.

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;

This regulation impacts all hospitals enrolled as Ohio Medicaid providers.

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

The utilization review program is not a new program. We have indicated an adverse impact on hospitals since hospitals must submit additional information to support the payments they have received from the Medicaid program. Documentation related to pre-certification, utilization review, and requests for reconsideration includes medical records and other supporting documentation. Therefore, the submission of additional information may increase staff time.

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.**

If the provider submits a request for reconsideration as allowed by rule 5160-2-07.12, there may be cost of compliance associated with submitting the patient's medical record and other information supportive of the provider's position. It is difficult to estimate a dollar amount due to the inability to predict the volume of requests for reconsideration and due to provider differences in business practices. Since providers are not required to submit a request for reconsideration, any cost associated with the reconsideration request is not a true cost of compliance as it is a choice by the provider to request reconsideration.

Through an ad hoc survey conducted by OHA to its members to determine average cost of compliance to produce medical records when requested by the Department's medical review entity, it was determined that on average, a hospital spends $83.81 to produce a medical record for utilization review. Every month, approximately 1,500 medical records are reviewed, which results in an estimated annual cost of compliance of $1.5 million to the industry. This cost of compliance could become negligible due to the fact that any increased provision of documentation will be offset by good clinical practice associated with a complete clinical record. This review should also result in improved health outcomes for Medicaid beneficiaries.

Though providers incur an estimated annual cost of compliance of $1.5 million, providers received $911.4 million in inpatient fee-for-service hospital payments and $324.3 million in outpatient fee-for-service hospital payments in state fiscal year 2015.

Pre-certification review is intended to limit procedures from being conducted in costly settings when medically unnecessary. The process of demonstrating the medical necessity and appropriateness of performing a procedure in a less cost effective setting requires the electronic submission of documentation. There may be a cost of compliance associated with this reporting of information. However, that cost cannot be predicted due to the variability in the conditions necessitating performing procedures in more costly settings and the variability in record keeping and office management processes.

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

Medical providers keep medical records as part of good medical practice. The regulatory intent and fiscal responsibility of ensuring medical necessity and appropriateness of the provision of services and hospital admissions offsets any cost associated with the provision of medical records to the Department or its medical review entity.

Though there is a cost of compliance to providers to produce medical records for utilization review, the Department is able to recoup $32 million annually due to providers' incorrect submission of claims.

Regulatory Flexibility

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

No. This regulation is a federal mandate. Documentation of medical necessity and clinical appropriateness can be obtained from existing medical records.

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?

There are no fines or penalties associated with the implementation of these rules.

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

Smaller hospitals may be part of the random sample selected for review. The Department's medical review entity, Permedion, may assist the hospital by conducting an on-site medical record review. The Permedion website can be accessed by providers at www.hmspermedion.com. Providers may also email questions or concerns to Ohio Department of Medicaid at Hospital_Policy@medicaid.ohio.gov or submit a constituent inquiry at http://medicaid.ohio.gov/CONTACT.aspx.