Ohio | Common Sense Initiative

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Business Impact Analysis

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

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

Presumptive eligibility medical coverage and the Qualified Entities that may determine the eligibility.

Rule Number(s): 5160:1-2-13

Date of Submission for CSI Review: TBD

Public Comment Period End Date: TBD

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/__1__ rules (FYR? _YES__)

Rescinded/____ rules (FYR?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.

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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.

   This rule describes the criteria for Medicaid presumptive eligibility determinations. Medicaid presumptive eligibility provides a time-limited benefit that allows applicants to receive needed healthcare while awaiting a full determination of Medicaid eligibility.

   Medicaid presumptive eligibility determinations can be performed by healthcare providers or other agencies who have elected to participate in the presumptive eligibility program. These providers and other agencies are called Qualified Entities. Current Qualified Entities include hospitals, federally qualified health centers (FQHCs), FQHC look-alikes, local health departments, WIC clinics, the Ohio Department of Rehabilitation and Correction (DRC), or other entities as designated by the director.

   This rule is being amended, as requested by the Centers for Medicare & Medicaid Services (CMS), to remove the Ohio Department of Medicaid (ODM) as a Qualified Entity and to remove language which allows a hospital to determine presumptive eligibility for a long-term care individual. Hospitals will continue to make presumptive eligibility determinations for Modified Adjusted Gross Income (MAGI) Medicaid individuals. These provisions were added in response to the COVID-19 public health emergency (PHE) and are being removed as they are no longer applicable to presumptive eligibility determinations.

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.**

   R.C. 5163.02 is the statutory authority to adopt the rule. R.C. 5163.01 and R.C. 5163.101 amplifies the authority to adopt the rule.

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.

   The regulation implements a federal requirement under Section 1902(a)(47) of the Social Security Act to include hospitals as a Qualified Entity that can make Medicaid presumptive eligibility determinations. Additionally, this regulation implements a state option as set forth in Sections 1920 and 1920A of the Social Security Act to allow other agencies to determine Medicaid presumptive eligibility.

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

   This rule exists to comply with R.C. 5163.10 and R.C. 5163.101 which require the Ohio Department of Medicaid (ODM) to implement the state's option to allow Qualified Entities to determine Medicaid presumptive eligibility and send notices of approval or denial.

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 purpose of this regulation is to allow applicants to receive immediate healthcare while awaiting a full determination of Medicaid eligibility and to describe the criteria for Medicaid presumptive eligibility that must be determined by the Qualified Entities. Additionally, this regulation describes the notice of approval or denial that must be sent by the Qualified Entity to the individual being determined for Medicaid presumptive eligibility.

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

   The successful output/outcome is measured by the accuracy of the Medicaid presumptive eligibility determinations performed by the Qualified Entities who have elected to participate in the presumptive eligibility program. The accuracy is ensured by regular reviews conducted ODM.

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. This rule is not being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931.

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.

   A copy of the draft rule was sent via e-mail to the following stakeholders on February 4, 2021: Ohio Health Care Association, Leading Age Ohio, Ohio Job and Family Services Directors Association, Ohio Department of Job and Family Services (ODJFS) Office of Family Assistance, ODJFS Office of Legal and Acquisition Services, Hamilton County Department of Job and Family Services (CDJFS), Cuyahoga CDJFS, Greene CDJFS, Fairfield CDJFS, Summit CDJFS, Stark CDJFS, Mahoning CDJFS, Hickman and Lowder Co. L.P.A, Schraff Thomas Law, The Law Offices of Burke and Pecquet, Sitterley Law, and O'Diam and Stecker Law Group, Inc., Legal Aid Society of Greater Cincinnati, and Ohio State Legal Services Association.

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

    No concerns were expressed by the contacted stakeholders.

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?**

    The use of scientific data is not applicable to the requirements of this 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?**
Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.

ODM did not consider regulatory alternatives. This rule is necessary to communicate the criteria for Medicaid presumptive eligibility determinations and the responsibility of the healthcare providers or other agencies who choose to enroll as Qualified Entities to provide a notice of the Medicaid presumptive eligibility approval or denial. In addition to this regulation, ODM has developed materials with further guidance to assist Qualified Entities with determining Medicaid presumptive eligibility.

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

ODM performed a review of the Ohio Administrative Code. Regulations regarding Medicaid presumptive eligibility determinations and Qualified Entity responsibilities exist only in Divisions 5160 and 5160:1 of the Administrative Code. Further, under R.C. 5162.022 and R.C. 5162.03, ODM is the single state agency that supervises the administration of the Medicaid program, and its regulations governing Medicaid are binding on other agencies that administer components of the Medicaid program. No other agency may establish, by rule or otherwise, a policy governing Medicaid that is inconsistent with an established ODM regulation.

14. 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 final rule as adopted by ODM will be made available to all stakeholders and to the general public on the Register of Ohio website.

The regulations set forth in this rule are already in place and will continue to be implemented as they are today. Qualified Entities have access to technical assistance and training material on the ODM website. Additionally, ODM will ensure the accuracy of Medicaid presumptive eligibility determinations completed by Qualified Entities by performing regular reviews.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:

a. Identify the scope of the impacted business community, and

The segment of the business community impacted by this regulation are certain medical providers who have agreements in place with ODM and have chosen to participate in the presumptive eligibility program as a Qualified Entity.

b. Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).

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.

It is estimated that Qualified Entities will spend less than 5 minutes per individual to determine Medicaid presumptive eligibility, enroll the individual through the web portal, and send a notice of approval or denial. The time estimates were obtained upon implementation of a prior version of this rule from both the ODM staff directly involved in the training process and from employees of Qualified Entities. Since the process has not changed, these estimates still accurately measure the time spent to determine the adverse impact produced by this regulation.

An average of 50 Medicaid presumptive eligibility determinations are made monthly by each Qualified Entity, for an estimated processing time of 250 minutes. If the Qualified Entity is a hospital, the determination and sending of the approval or denial notice would normally be made by a Financial Clerk/Counselor. According to the Bureau of Labor Statistics, a Financial Clerk/Counselor in Ohio has a median hourly wage of $20.06. Therefore, the monthly average costs for a hospital that is a Qualified Entity to determine Medicaid presumptive eligibility and send notices is approximately $84. The cost will vary based on each Qualified Entity, but is anticipated to remain minimal.

16. **Are there any proposed changes to the rules that will <u>reduce</u> a regulatory burden imposed on the business community? Please identify.** ***(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).***

    There are no proposed changes to the rule that will reduce a regulatory burden imposed on the business community.

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

    ODM determined the regulatory intent justified the adverse impact to the regulated business community because this rule allows Qualified Entities to determine Medicaid presumptive eligibility for individuals to gain immediate healthcare coverage, therefore assuring the provider of receiving payment for the services it has rendered.

Regulatory Flexibility

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

No. There are no exemptions or alternative means of compliance that are permissible per federal regulations.

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 is not applicable since there are no monetary fines or penalties associated with non-compliance.

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

Qualified Entities in need of technical assistance may contact Medicaid Provider Assistance at 1-800-686-1516 or the Presumptive Eligibility Support Team at pequestions@medicaid.ohio.gov

Resources, including training materials for Qualified Entities, may be found on the ODM website at: https://medicaid.ohio.gov/resources-for-providers/billing/presumptive-eligibility-training/presumptive-eligibility-training

DRAFT - NOT FOR FILING

5160:1-2-13 Medicaid: presumptive eligibility.

(A) This rule describes the conditions under which an individual may receive time-limited medical assistance as a result of an initial, simplified determination of eligibility based on the individual's self-declared statements.

(B) Eligibility criteria for presumptive coverage.

(1) Except as set forth in paragraph (B)(2) of this rule, an individual is eligible for presumptive coverage ~~if~~ when the individual:

(a) Is a resident of the state of Ohio; and

(b) Is a U.S. citizen or has an immigration status as defined in rule 5160:1-2-12 of the Administrative Code that allows for medicaid eligibility; and

(c) Meets the non-financial eligibility criteria for a group set out in rule 5160:1-4-02, 5160:1-4-03, 5160:1-4-04, or 5160:1-4-05 of the Administrative Code, except that a simplified household composition will be determined, comprised of the individual and, if living in the home:

(i) The individual's spouse; and

(ii) The individual's children under age nineteen; and

(iii) ~~If~~ When the individual is under age nineteen:

(a) The individual's parents; and

(b) The individual's siblings under the age of nineteen.

(d) Has gross family income, for the individual's family size, of no more than the eligibility limit set out for the relevant eligibility group in rule 5160:1-4-02, 5160:1-4-03, 5160:1-4-04, or 5160:1-4-05 of the Administrative Code.

(2) Limitations. An individual is ineligible for a subsequent presumptive coverage period for twelve months beginning on the date of a presumptive coverage determination, except that a woman may receive presumptive coverage based on pregnancy once during each pregnancy.

(C) Duration and scope of presumptive coverage.

(1) Presumptive coverage begins on the date an individual is determined to be presumptively eligible. No retroactive coverage may be provided as a result of a presumptive eligibility determination.

(2) Presumptive coverage ends on the earlier of (and includes):

(a) The date the administrative agency determines the individual is eligible or ineligible for ongoing medical assistance pursuant to rule 5160:1-2-01 of the Administrative Code; or

(b) ~~If~~ When an application for ongoing medical assistance for the individual has not been filed, the last day of the month following the month in which the individual was determined to be presumptively eligible.

(3) Services for individuals found presumptively eligible on the basis of pregnancy are restricted to

ambulatory prenatal care.

(D) State agency responsibilities. The Ohio department of medicaid (ODM) is responsible for training and monitoring each qualified entity (QE) in accordance with rule 5160-1-17.12 of the Administrative Code.

(E) QE responsibilities.

(1) ~~If~~ When the QE is ~~ODM or~~ a county department of job and family services (CDJFS) office:

(a) No later than twenty-four hours after receipt of a signed and dated full application for medical assistance on behalf of an individual, the CDJFS must determine, based on the individual's self-declared information, whether the individual is eligible for presumptive coverage under this rule.

(b) ~~If~~ When an individual is eligible for presumptive coverage, ~~ODM or~~ the CDJFS must:

(i) Approve presumptive coverage for the individual; and

(ii) Provide a notice issued from the electronic eligibility system to inform the individual:

(a) That presumptive coverage was approved; and

(b) That failure to cooperate with the eligibility determination process set forth in rule 5160:1-2-01 of the Administrative Code will result in a denial of medical assistance, which will trigger the discontinuance of presumptive coverage.

(c) ~~If~~ When an individual is not eligible for presumptive coverage, ~~ODM or~~ the CDJFS must inform the individual that eligibility for medical assistance will be determined within forty-five days.

(d) Whether or not an individual is eligible for presumptive coverage, ~~ODM or~~ the CDJFS must determine whether the individual is eligible for ongoing medical assistance pursuant to rule 5160:1-2-01 of the Administrative Code.

(2) ~~If~~ When the QE is a hospital, the Ohio department of rehabilitation and correction (DRC), the Ohio department of youth services (DYS), a federally qualified health center (FQHC), an FQHC look-alike, a local health department, a special supplemental nutrition program for women, infants, and children (WIC) clinic, or other entity as designated by the director as defined in rule 5160:1-1-01 of the Administrative Code:

(a) Upon request, determine whether the individual is presumptively eligible under this rule. Such determination shall not be delegated to a third party, but shall be completed by the QE.

(b) Accept self-declaration of the presumptive eligibility criteria unless contradictory information is provided to or maintained by the QE.

(c) ~~If~~ When the individual is presumptively eligible:

(i) Approve presumptive coverage for the individual using the electronic eligibility system designated by ODM ; and

(ii) Provide a notice issued from the electronic eligibility system to the individual at the time of determination which indicates that presumptive coverage was approved and which includes:

(a) The presumptive eligibility determination date; and

(b) The basis for presumptive eligibility; and

(c) The individual's name, date of birth, and address; and

(d) The individual's medicaid ~~information technology system (MITS)~~ billing number; and

(e) A reminder that the individual must apply for ongoing medical assistance no later than the last day of the month following the month of approval.

(iii) Upon request, assist the individual with completing an application for ongoing medical assistance.

(d) ~~If~~ When the individual is not presumptively eligible, inform the individual that there may be other categories of medical assistance available and that he or she should apply for a full determination of eligibility for medical assistance.

~~(3) If the QE is a hospital, in addition to the eligibility criteria identified in paragraph (B)(1) of this rule, the hospital may also make presumptive eligibility determinations for the group set out in rule 5160:1-6-03.1 of the Administrative Code.~~

(F) Denial of presumptive coverage is not grounds for a state hearing under division 5101:6 of the Administrative Code.