CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Health Home Eligibility and Rate

Rule Number(s): 5160-27-02 Amended, 5160-27-05 Amended

Date: 7/10/2015

Rule Type:

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- ☐ Rescinded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

   5160-27-02: This rule sets forth the Medicaid coverage and limitation policies for community mental health services including eligibility policy for the health home program. These services are administered by the Ohio Department of Mental Health and Addiction Services. The proposed change is in (A)(7)(b). This is a Medicaid rule therefore the Ohio Department of Medicaid (ODM) is responsible for this amendment.

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5160-27-05: This rule sets forth the reimbursement policies for Medicaid covered community mental health services including the health home program. These services are administered by the Ohio Department of Mental Health and Addiction Services. The proposed change is in (H)(3). This is a Medicaid rule, therefore ODM is responsible for this amendment.

These rules are being proposed for amendment to implement policy directives resulting from the redesign of Medicaid behavioral health services, a joint collaboration between ODM, the Ohio Department of Mental Health and Addiction Services, and the Governor's Office of Health Transformation. The proposed revisions would continue the current enrollee eligibility and provider reimbursement policies for phase one of the health home program which was set to expire on July 1, 2015. These proposed revisions are currently in place as a result of an emergency filing of this rule.

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

   Ohio Revised Code section 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. The regulation describes a set of Medicaid covered services that are deemed "optional" by the Center for Medicare and Medicaid Services (CMS). Regulations in the two rules were developed by ODM and are permitted by CMS. Compliance with the regulations stated in these two rules permit the State to receive matching federal payments for those services covered in the rules.

   5160-27-02: The requirement that a health home provider disenroll a member, who requests disenrollment, within three business days was implemented to ensure that the provider carry out the wishes of the member as soon as reasonably possible. For the protection of the member and provider, a note must be made in the member's record to reflect the request and that it was carried out.
   A second provider requirement that health home services be documented to establish medical necessity is to ensure that the health home member receives only those services that are necessary and beneficial to the member, and a review of such documentation can indicate what services have been rendered. Such documentation is a reflection of good medical practice.

5160-27-05: The requirement that a [mental health provider] agency maintain a fee schedule of charges ensures that each agency has documentation of the fees and charges that will be used to bill Medicaid. This ensures regularity in billing practices and facilitates review of claims to ensure program integrity.

The proposed amendments to the two rules do not impact any of the provider regulations described above and no new regulations are created.

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

   The State has chosen to include, in the Medicaid program, the mental health services and health home services stated in the rule. The rules describe and codify mental health services, health home eligibility criteria and Medicaid reimbursement for these services. All requirements and regulations described in the two rules as well as the proposed amendments, which would only impact the health home program, are permitted by 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)?**

   5101-27-02: By having this rule the State is able to provide coverage of the mental health services described to make them available to Medicaid recipients. This regulation states the Medicaid coverage and limitation policies for community mental health services and eligibility policy for health home services received by eligible Medicaid consumers.

   5101-27-05: The purpose of this regulation is to state the Medicaid reimbursement policies for community mental health and health home services received by eligible Medicaid consumers. This rule ensures that Medicaid providers, including health home providers, will be reimbursed appropriately.

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

   The successful output/outcome is determined by the appropriateness and accuracy of the Medicaid payments made to community mental health and health home providers for services rendered to eligible Medicaid consumers.

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.

5101-27-02: The initial coverage and limitation rule was developed several years ago with input from, at that time, the Department of Mental Health (now Ohio Department of Mental Health and Addiction Services (OhioMHAS)).

5101-27-05: The initial provider reimbursement rule was developed several years ago with input from, at that time, the Ohio Department of Mental Health (now OhioMHAS).

As described in both rules, revisions in health home eligibility and reimbursement policy, which were implemented July 1, 2014, were impacted by input from OhioMHAS, the participating six health home providers, and interested provider and consumer advocacy groups. The Centers for Medicare and Medicaid Services approved the policies. Staff from ODM Legal and the Bureau of Health Plan Policy also provided a review. These discussions took place during 2014.

The proposed amendments are a result of discussions between ODM, OhioMHAS, and the Governor's Office of Health Transformation. The amendments would continue the eligibility and reimbursement policies that were a result of the stakeholder discussions described above.

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

5101-27-02: For the July 1, 2014 revisions, health home providers as well as provider and consumer advocacy groups expressed a desire for those health home enrollees impacted (members not meeting the new eligibility criteria) to be able to continue receiving services from the health home in which they were currently enrolled. This would result in a continuity of services that all parties saw as beneficial.

5101-27-05: For the July 1, 2014 revisions, discussions were held between ODM and OhioMHAS with the six health home providers to formulate a new reimbursement policy (ten percent payment reduction). Five of the six impacted providers stated that the resulting reimbursement policy was a very reasonable compromise and would allow them to concentrate on achieving the desired clinical and financial outcomes that all parties were seeking.

Discussions between ODM, OhioMHAS, and the Governor's Office of Health Transformation led to the proposed policy amendments to continue the eligibility and reimbursement policies beyond the proposed termination date of July 1, 2015.

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?**

   The use of scientific data is not applicable to the requirements of either rule.

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?**

    These rules describe the health home member eligibility and provider reimbursement policies and as such, the Agency does not consider alternative regulations appropriate.

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.**

    The Agency did not consider a performance-based regulation, because the nature of the regulations described in these two rules do not lend thenselves to a performance based standard.

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

    The Agency performed a review of the Ohio Administrative Code. Regulations regarding provider reimbursement of Medicaid covered mental health and health home services exist only in Division 5160-27 of the Administrative Code. Further, under Ohio Revised Code Sections 5162.022 and 5162.03, the Ohio Department of Medicaid is the single state agency to supervise the administration of the Medicaid program, and its regulations governing Medicaid are binding on other agencies that administer components of the Medicaid program. No agency may establish, by rule or otherwise, a policy governing Medicaid that is inconsistent with a Medicaid policy established, in rule or otherwise, by the medical assistance director.

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 Agency has communicated to Medicaid providers and other stakeholders the health home eligibility and provider reimbursement policies stated in the rule. The regulation resulting from the proposed amendment will be communicated by Medicaid transmittal letter to relevant Medicaid providers. As enrollee eligibility and provider reimbursement is impacted, the Agency will ensure that the computerized Medicaid payment system will distribute provider payments appropriately. As the proposed amendment continues health home enrollee eligibility and provider reimbursement policy currently in place, no new actions will be required.

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;

The two rules impact community mental health providers and health home providers certified by the Ohio Department of Mental Health and Addiction Services and provide the services described in these rules. The proposed amendments to the rules impact only the six health home providers that have voluntarily chosen to participate in phase one of the health home program which operates in five counties.

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

5101-27-02: The rule sets Medicaid coverage and limitation policies for community mental health services as well as eligibility policy for the health home program. The coverage and limitation policies do, as described in previous responses, require providers to perform specific actions in certain circumstances. No fees or fines are involved but rather a cost of compliance to fulfill the requirement which involves documentation.

The proposed amendment does not create an impact nor affect the provider requirements currently stated in the rule.

5101-27-05: The rule sets reimbursement policy for mental health provider agencies and health home providers. The rule requires, as described in previous responses, providers to maintain a fee schedule. No fees or fines are imposed, only a one-time cost of compliance to develop the fee schedule.

On July 1, 2014 a ten percent reduction in health home provider's reimbursement was implemented. At that time five of the six impacted providers signed a letter supporting the payment reduction, recognizing the need for payment reform in the health home program.

The proposed amendment does not create an impact nor affect the provider requirements currently stated in the rule. The amendment continues the current ten percent reimbursement reduction plan for the six health home providers.

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.

5101-27-02: The impact of the three days disenrollment requirement will vary from provider to provider, depending on the number of member disenrollments. Financial impact should be slight and only a few minutes to complete the disenrollment process. Likewise the health home service documentation requirement should not require financial outlay but just a few minutes to make some notes.

5101-27-05: The impact of maintaining a fee schedule should not have any financial impact and only a small amount of time would be required to develop the schedule. The impact of the July 1, 2014 ten percent payment reduction for health home providers varies by provider based on health home enrollment, therefore impact estimates are difficult to make.

The proposed amendments to the two rules do not create any new impact and therefore no new costs to providers.

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

Regulatory language in these rules state the Medicaid member eligibility and provider reimbursement policies for the health home program. The rules inform providers which services they can receive Medicaid payment for and what they need to do to receive payment. This ensures that Medicaid providers, including health home providers, abide by coverage and eligibility policies and agree to reimbursement policies set by the federal government

and ODM. The proposed amendments to the rules do not create new regulations but rather continue, past the current termination date of July 1, 2015, the eligibility and reimbursement policies currently in effect.

Regulatory Flexibility

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

No. By voluntarily participating in the Medicaid program, mental health provider agencies and health home providers agree to abide by federal and state Medicaid program rules and regulations including these two rules which set health home eligibility and reimbursement policies.

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 does not apply as neither of the two rules apply a fine or penalty for non-compliance of provider requirements.

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

Medicaid providers in need of technical assistance can contact Medicaid Provider Assistance at 1-800-686-1516.