Common Sense Initiative

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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): Managed Care TPL and Recovery Rule Update - MC

Rule Number(s): 5160-26-09.1

Date of Submission for CSI Review: 5/7/2024

Public Comment Period End Date: 5/14/2024

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Rescinded/_____ rules (FYR?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.**

   OAC rule 5160-26-09.1, entitled "Managed care: third party liability and recovery", sets forth the coordination of benefits and third-party liability (TPL) requirements for managed care entities (MCEs). This rule is applicable to Managed Care Organizations (MCOs), the Single Pharmacy Benefit Manager (SPBM), the MyCare Ohio Plans (MCOPs), and the OhioRISE plan (collectively known as "MCEs"). The rule is being proposed for amendment to revise references to MCO and children with medical handicaps where applicable and remove ODM form revision dates for clarity.

3. **Please list the Ohio statute(s) that authorizes 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 Sections 5167.02, 5167.03, 5167.10, and 5167.32 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 CFR 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 implements a federal requirement, but 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 MCEs; instead, they require state Medicaid agencies to ensure MCE compliance with federal standards. The rule is consistent with federal managed care requirements outlined in 42 CFR 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)?**

   Federal regulations require state Medicaid agencies to ensure MCE compliance with federal standards, therefore these rules ensure ODM compliance with federal regulations governing Medicaid managed care programs. The public purpose of this regulation is to ensure that when a Medicaid recipient has third party insurance including Medicare, Medicaid resources are the last to be used as payment for covered services. This helps to preserve Medicaid funding.

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 and the SPBM contract. 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, MyCare Ohio Plans, Aetna OhioRISE, and Single Pharmacy Benefit Manager (i.e., the MCEs) listed below were provided with the draft rules on 2/24/24 and were given until 3/7/24 to comment.3/7/24 to comment.

- UnitedHealthcare Community Plan of Ohio, Inc.
- Humana Health Plan of Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- AmeriHealth Caritas Ohio, Inc.
- Anthem Blue Cross and Blue Shield
- CareSource Ohio, Inc.
- Buckeye Community Health Plan
- Aetna Better Health of Ohio
- Gainwell Technologies
- Aetna OhioRISE

The rule was shared with the MCEs except OhioRISE on 2/29/2024 and were given until 3/7/2024 to comment. The rule was shared with OhioRISE on 3/21/2024 and they were given until 3/28/20204 to comment.

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

No input was provided by the 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?**

No scientific data was used to develop this rule or the measurable outcomes 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?**
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.
The amendment to this rule includes general updates to keep the rules current. The rule itself is needed to codify the regulations required of ODM by CMS.

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

All Medicaid regulations governing MCEs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid managed care program, and the rules and regulations found in the rules in Chapter 5160-26 are not duplicated elsewhere in Agency 5160.

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.**

ODM will notify the MCEs of the final rule changes via email notification. Additionally, per the MCE provider agreements, MCEs are required to subscribe to the appropriate distribution lists for notification of all OAC rule clearances, BIAs, and filings with the Joint Committee on Agency Rule Review via RuleWatch Ohio and the CSIO eNotification System. ODM will ensure MCEs are made aware of any future rule changes via established communication processes.

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**

    This rule impacts the SPBM (Gainwell Technologies), MCOs in the State of Ohio (UnitedHealthcare Community Plan of Ohio, Humana Health Plan of Ohio, Molina Healthcare of Ohio, AmeriHealth Caritas Ohio, Anthem Blue Cross and Blue Shield, Buckeye Community Health Plan, and CareSource Ohio), MyCare Ohio plans in the State of Ohio (Aetna Better Health Ohio, Buckeye Community Health Plan, CareSource Ohio, Molina Healthcare of Ohio, and UnitedHealthcare Community Plan of Ohio), and the OhioRISE plan (Aetna OhioRISE).

    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.

    OAC rule 5160-26-09.1 requires MCEs to report information to ODM and service providers. MCEs must notify ODM of requests related to tort action using specific ODM forms.

MCEs are paid a per member per month amount. ODM must pay MCEs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.4, 42 CFR 438.5, and CMS's Medicaid Managed Care Rate Development Guide. ODM's actuary will develop capitation rates for the MCEs that 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.

Through the administrative component of the capitation rate paid to MCEs by ODM, MCEs will be compensated for the cost of the requirements found in these rules. For CY 2023, the administrative component of the managed care capitation rate varies by program/population and ranges from 4.0% to 6.5% for MCOs and from 3.0% to 6.0% for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates. For MCOs, all rates and actuarial methods will be found in Appendix M ("Rate Methodology") of the Medicaid Managed Care provider agreement. For MCOPs, all rates and actuarial methods can be found in Appendix E of the MyCare Ohio provider agreement. The SPBM is paid a monthly administrative fee. Through this administrative fee, the SPBM will be compensated for the costs of the requirements found in these rules.

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).***
    No.

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

    MCEs are aware of federal requirements for covered services prior to seeking and signing contracts with the state. More importantly, without the requirements outlined in this OAC rule, 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 MCE'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?**

    The rule does not impose any monetary fines or penalties for first-time paperwork violations for small businesses as outlined in ORC section 119.14.

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

    While there are no small businesses negatively impacted by the rule, MCEs may contact ODM directly through their assigned Contract Administrator if they have questions about compliance with this regulation.

DRAFT - NOT FOR FILING

5160-26-09.1 Managed care: third party liability and recovery.

(A) Tort.

(1) Pursuant to sections 5160.37 and 5160.38 of the Revised Code, the Ohio department of medicaid (ODM) maintains all rights of recovery (tort) against the liability of any third party payer (TPP) for the cost of medical services.

(2) A managed care entity (MCE) is prohibited from accepting any settlement, compromise, judgment, award, or recovery of any action or claim by a member.

(3) The MCE must notify ODM and/or its designated entity within fourteen calendar days of all requests for the release of financial and medical records to a member or the member's representative pursuant to the filing of a tort action. Notification must be made via the "Notification of Third Party (tort) Request For Release" form (ODM 03245~~, rev. 7/2014~~) or a method determined by the ODM designated entity, provided ODM approved the designated entity's method and notified the MCE.

(4) The MCE must submit a summary of financial information to ODM and/or its designated entity within thirty calendar days of receiving an original authorization to release a financial claim statement letter from ODM pursuant to a tort action. The MCE must use the "Tort Summary Statement" form (ODM 03246~~, rev. 7/2014~~) or a method determined by the ODM designated entity, provided ODM has approved the designated entity's method and notified the MCE. Upon request, the MCE must provide ODM and/or its designated entity with true copies of medical claims.

(B) Fraud, waste, and abuse recovery. ODM assigns to the ~~managed care organization (MCO)~~MCE its rights of recovery against any TPP for costs due to provider fraud, waste, or abuse as defined in rule 5160-26-01 of the Administrative Code related to each member during periods of enrollment in the ~~MCO~~MCE. In instances when the ~~MCO~~MCE fails to properly report suspected fraud, waste, or abuse, before the suspected fraud, waste, or abuse is identified by the state of Ohio, any portion of the fraud, waste, or abuse recovered by the state shall be retained by the state.

(C) Coordination of benefits.

(1) ODM assigns its right to third party resources (coordination of benefits) to the ~~MCO~~MCE for services rendered to each member during periods of enrollment. ODM reserves the right to identify, pursue, and retain any recovery of third party resources assigned to the ~~MCO~~MCE but not collected by the ~~MCO~~MCE after one year from date of claim payment.

(2) Except as specified in paragraph (C)(3) of this rule, the MCE must act to provide coordination of benefits if a member has third party resources available for the payment of medical expenses for medically necessary medicaid-covered services. Such expenses will be paid in accordance with this rule and sections 5160.37 and 5160.38 of the Revised Code.

(3) Children that have been legally placed in the custody of an Ohio county public children's services agency (PCSA) or related entity are excluded from third party liability cooperation and are exempt from post-payment recovery unless it is confirmed that the child will not be put at risk for doing so (e.g. medical support order).

(4) The MCE is the payer of last resort when a member has third party resources available for payment of medical expenses for medicaid-covered services, except:

(a) The MCE pays after any TPP including medicare but before:

(i) Resources provided through the ~~children with medical handicaps~~ program for children and youth with special health care needs under sections 3701.021 to 3701.0210 of the Revised Code.

(ii) Resources that are exempt from primary payer status under federal medicaid law, 42 U.S.C. 1396 (as in effect July 1, 2022).

(iii) Resources provided through the state sponsored program awarding reparations to victims of crime, as set forth in sections 2743.51 to 2743.72 of the Revised Code.

(b) The ~~MCO~~MCE pays first for preventive pediatric services before seeking reimbursement from any liable third party.

(5) The MCE will take reasonable measures to ascertain and verify any third party resources available to a member. When the MCE denies a claim due to third party liability (TPL), the MCE must timely share, on the explanation of payment sent to providers, available information regarding the third party resources for the purposes of coordination of benefits, including:

(a) Insurance company name;

(b) Insurance company billing address for claims;

(c) Member's group number;

(d) Member's policy number; and

(e) Policy holder name.

(6) The MCE must require providers who are submitting TPL claims to the MCE to request information regarding third party benefits from the member or his/her authorized representative. If the member or the member's authorized representative specifies that the member has no third party benefits, or the provider is unable to determine that the member has third party benefits, the MCE must permit the provider to submit a claim to the MCE. If, as a result of requesting the information, the provider determines that third party liability exists, the MCE must allow the provider to submit a claim for reimbursement if he/she first takes reasonable measures to obtain third party payment as set forth in paragraph (C)(7) of this rule.

(7) The MCE must require providers to take reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing the MCE. The MCE must permit providers who have taken reasonable measures to obtain all third party payments, but who have not received payment from a TPP or received partial payment, to submit a claim to the MCE requesting reimbursement for rendered services.

(a) The MCE must process claims when the provider has complied with one or more of the following reasonable measures:

(i) The provider first submits a claim to the TPP for the rendered services and does not receive a

remittance advice or other communication from the TPP within ninety days after the submission date. The MCE may require providers to document the claim and date of the claim submission to the TPP.

(ii) The provider has retained and/or submitted one of the following types of documentation indicating a valid reason for non-payment for the services not related to provider error:

(a) Documentation from the TPP;

(b) Documentation from the TPP's automated eligibility and claim verification system;

(c) Documentation from the TPP's member benefits reference guide/manual; or

(d) Any other documentation from the TPP showing there is no third party benefit coverage for the rendered services.

(iii) The provider submitted a claim to the TPP and received a partial payment along with a remittance advice documenting the allocation of the charges.

(b) Valid reasons for non-payment from a TPP to the provider for a third party benefit claim include, but are not limited to:

(i) The service is not covered under the member's third party benefits.

(ii) The member does not have third party benefits through the TPP for the date of service.

(iii) All of the provider's billed charges or the TPP's approved rate was applied, in whole or in part, to the member's third party benefit deductible amount, coinsurance and/or co-payment for the TPP. The provider may then submit a secondary claim to the MCE showing the appropriate amount received from the TPP.

(iv) The member has not met any required waiting periods, or residency requirements for his/her third party benefits, or was non-compliant with the TPP's requirements in order to maintain coverage.

(v) The member is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.

(vi) The member has reached the lifetime benefit maximum for the medical service or third party benefits being billed to the TPP.

(vii) The TPP is disputing or contesting its liability to pay the claim or cover the service.

(8) If the provider receives payment from the TPP after the MCE has made payment, the MCE must require the provider to repay the MCE any amount overpaid by the MCE. The MCE must not allow the provider to reimburse any overpaid amounts to the member.

(9) The MCE must make available to providers information on how to submit a claim that will have a zero paid amount in the third party field on the claim.

(10) The MCE payment for third party claims will not exceed the MCE allowed amount for the service, less all third party payments for the service.

(11) The MCE's timely filing limits for provider claims shall be at least ninety days from the date of the remittance advice that indicates adjudication or adjustment of the third party claim by the TPP.

(12) The MCE must ensure that providers do not hold liable or bill members in the event that the MCE cannot or will not pay for covered services unless all of the specifications set forth in rule 5160-26-05 and rule 5160-26-11 of the Administrative Code are met. The provider may not collect and/or bill the member for any difference between the MCE's payment and the provider's charge or request the member to share in the cost through a deductible, coinsurance, co-payment, or other similar charge, other than MCE co-payments.

(D) The MCE is required to submit information regarding members with third party coverage as directed by ODM.