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):

Amendment of Ohio Administrative Code Rule 5160-26-05

Rule Number(s): Rule 5160-26-05 – rescind/new

Date of Submission for CSI Review: 9/17/2024

Public Comment Period End Date: 9/24/2024

Rule Type/Number of Rules:

New/1 rules
No Change/____ rules (FYR? ___)
Amended/____ rules (FYR? ___)
Rescinded/1 rules (FYR? No___)

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.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   In Ohio, approximately 90% of Medicaid recipients receive their Medicaid services through the managed care delivery system. Managed care organizations (MCOs) are health insurance companies licensed by the Ohio Department of Insurance and have a provider agreement (contract) with the Ohio Department of Medicaid (ODM) to provide coordinated health care to Medicaid beneficiaries. The rules in Ohio Administrative Code (OAC) Chapter 5160-26 govern the Managed care program. There are seven MCOs in Ohio, each with a network of health care professionals.

   OAC rule 5160-26-05, entitled "Managed Care: Provider Network and Contracting Requirements "establishes the provider contract specifications processes for the Managed care program. A rescind will be proposed to remove provider contract provisions and related references throughout this rule, and house them in the Medicaid Addendum (ODM10235). Because more than half of the language in the existing rule is being modified, ODM will be proposing that the current rule 5160-26-05 be rescinded and replaced with a new rule of the same number and subject.

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.**

   Revised Code Section 5167.02 authorizes ODM to adopt these rules, and 5162.02, 5164.02, 5167.02, 5167.03, and 5167.10 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 MCOs; instead they require state Medicaid agencies to ensure MCO compliance with federal standards. The rules ensure MCO compliance with federal regulation and are 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)?**

   OAC rule 5160-26-05 is necessary for various reasons. Federal regulations require state Medicaid agencies to ensure MCO compliance with federal standards, therefore this rule ensures ODM compliance with federal regulations governing Medicaid managed care programs. The public purpose of this regulation is to:

   - Ensure MCOs provide or arrange for the delivery of covered health care services either through the use of employees or through contracts with network providers of health care services.
   - Ensure all of the MCOs activities and obligations are performed in accordance with agency 5160 of the Administrative Code, as applicable, the MCOs provider agreement or contract with ODM, and all applicable federal, state, and local regulations.

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 Medicaid Managed Care provider agreement. 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 MCOs listed below were provided the draft rule electronically on 02/23/2024.
- UnitedHealthcare Community Plan of Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- CareSource Ohio, Inc.
- Amerihealth Caritas Ohio
- Community Insurance Company d/b/a Anthem Blue Cross & Blue Shield
- Humana of Ohio
- Buckeye Community Health Plan
- Gainwell

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

ODM did not receive any feedback from the stakeholders listed above. However, ODM did send an accompanied ODM form in tandem, related to this rule modification and received feedback from one plan. Based on the feedback ODM made modifications to the form to address the concerns and recirculated 4/16/2024 to 4/23/2024 to above stakeholders and received no further concerns.

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 these rules or the measurable outcomes of the rules.

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.*

No alternative regulations were discussed during the updating of OAC rule 5160-26-05. The specific provisions within the regulations in OAC rule 5160-26-05 are necessary to ensure that provider contract specifications can be included in the Medicaid Addendum (ODM10235), to allow for ODM to update the Medicaid Addendum without requiring updates to be made to the rule to reflect the changes. The rescind to be proposed for OAC rule 5160-26-05 is to implement more than 50% of the content to the MCO provider network and contracting requirement rule, therefore requiring a rescind and proposed new rule.

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

    ODM has reviewed its rules and regulations in the Ohio Revised Code and Ohio Administrative Code and confirmed that the requirements found in 5160-26-05 are not duplicated elsewhere.

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 MCOs of the final rule changes via email notification. Additionally, per the MCO provider agreement, MCOs are required to subscribe to the appropriate distribution lists for notification of all ODM OAC clearances, BIAs, and filings affecting managed care program requirements including RuleWatch Ohio and the CSIO eNotification System. ODM will ensure MCOs 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 Medicaid Managed Care Organizations in the State of Ohio (Community Insurance Company d/b/a Anthem Blue Cross & Blue Shield, Amerihealth Caritas Ohio, Buckeye Community Health Plan, CareSource Ohio, Humana of Ohio, Molina Healthcare of Ohio, and UnitedHealthcare Community Plan of Ohio).

    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 5160-26-05 establishes the managed care provider network and contracting requirement processes. This rule requires the following expenditures or reports of information as a condition of compliance:

    - All provider contracts must be written in accordance with the parameters established in OAC 5160-26-05;
    - All provider contracts shall be made available to ODM by the MCOs upon request;
    - MCO network providers are required to maintain an active, valid Medicaid provider agreement as set forth in OAC 5160-1-17.2;
    - When utilizing an out of network provider, the MCO must establish a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of the medicaid addendum (ODM 10235).

- The MCO must notify ODM of any addition to or deletion from its provider network on an ongoing basis within the time restrictions specified in OAC 5160-26-05;
- The MCO must submit other evidence related to its provider contracts at the direction of ODM, as specified in OAC 5160-26-05;
- The MCO shall notify ODM in writing of provider contract expirations, nonrenewals, or terminations as specified in 5160-26-05;
- ODM may require the MCO to notify members or providers of the expiration, nonrenewal, or termination of other provider contracts that may adversely impact the MCO's membership;
- In the event that the MCO's medicaid managed care program participation in a service area is terminated, the MCO must provide written notification to its affected contracted providers as specified in 5160-26-05;
- The MCO must give affected providers written notice of the reasons it declines to include them in its network.

MCOs are paid a per member per month amount. ODM must pay MCOs 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 MCOs 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.

All rates and actuarial methods can be found on the ODM website in Appendix M of the Medicaid Managed Care provider agreement. Through the administrative component of the capitation rate paid to the MCOs by ODM, MCOs will be compensated for the cost of the reporting and notice requirements found in these rules. For CY 2021, the administrative component of the managed care capitation rate varies by program/population and ranges from 3.0% to 6.0% for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates.

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).*

Not Applicable.

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

MCOs are aware of federal requirements for covered services prior to seeking and signing contracts with the state. More importantly, without the requirements outlined OAC 5160-26-03, 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 MCO'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?

These rules do 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?

MCOs may contact ODM directly through their assigned Contract Administrator. Network Providers may contact ODM through the Provider Hotline at 800-324-8680.

TO BE RESCINDED

5160-26-05 **Managed care: provider network and contracting requirements.**

(A) Provider contracts.

(1) A managed care entity (MCE) must provide or arrange for the delivery of covered health care services described in rule 5160-26-03 of the Administrative Code either through the use of employees or through contracts with network providers of health care services ("providers"). All provider contracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6 (October 1, 2021). The MCE's execution of a provider contract does not terminate the MCE's legal responsibility to the Ohio department of medicaid (ODM) to ensure all of the MCE's activities and obligations are performed in accordance with agency 5160 of the Administrative Code, as applicable, the MCE's provider agreement or contract with ODM, and all applicable federal, state, and local regulations.

(2) The MCE shall make all provider contracts available to ODM upon request.

(3) Provider contracts may not include language that conflicts with the specifications identified in paragraphs (C) and (D) of this rule.

(4) MCE network providers have to maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.

(5) When utilizing an out of network provider, the MCE must establish a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph (D) of this rule. For medicaid-covered non-emergency hospital services outlined in rule 5160-26-03 of the Administrative Code, the compensation amount is identified in rule 5160-26-11 of the Administrative Code.

(B) Notification.

(1) Notwithstanding paragraph (D)(13) of this rule, the MCE must notify ODM of any addition to or deletion from its provider network on an ongoing basis, and must follow the time restrictions contained in this paragraph unless the explanation of extenuating circumstances is accepted by ODM.

(2) At the direction of ODM, the MCE must submit evidence of the following:

(a) A copy of the provider's current licensure;

(b) Copies of written agreements with the provider, including but not limited to provider contracts, amendments, and the medicaid addendum as specified in paragraph (D) of this rule;

(c) Notification to ODM of any hospital provider contract for which a date of termination is specified; and

(d) The provider's medicaid provider number and provider reporting number, if applicable.

(3) The MCE shall notify ODM in writing of the expiration, nonrenewal, or termination of any provider contract at least fifty-five calendar days prior to the expiration, nonrenewal, or termination of the provider contract in a manner and format directed by ODM. If the MCE receives less than fifty-five calendar days' notice from the provider, the MCE must inform ODM in writing within one working day of becoming aware of this information.

(4) If the provider contract is for a hospital:

(a) Forty-five calendar days prior to the effective date of the expiration, nonrenewal or termination of the hospital's provider contract, the MCO shall notify in writing all providers who have admitting privileges at the hospital of the impending expiration, nonrenewal, or termination of the provider contract and the last date the hospital will provide services to members under the MCO provider contract. If the MCO receives less than forty-five calendar days' notice from the hospital, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the provider contract.

(b) Forty-five calendar days prior to the effective date of the expiration, nonrenewal, or termination of the hospital's provider contract, the MCO shall notify in writing all members in the service area, or in an area authorized by ODM, of the impending expiration, nonrenewal, or termination of the hospital's provider contract. If the MCO receives less than forty-five calendar days' notice from the hospital provider, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the provider contract.

(c) The MCO shall submit a template for member and provider notifications to ODM along with the MCO's notification to ODM of the impending

expiration, nonrenewal, or termination of the hospital's provider contract. The notifications shall comply with the following:

(i) The form and content of the member notice must be prior-approved by ODM and contain an ODM designated toll-free telephone number members can call for information and assistance.

(ii) The form and content of the provider notice must be prior-approved by ODM.

(d) ODM may require the MCO to notify additional members or providers if the impending expiration, nonrenewal, or termination of the hospital's provider contract adversely impacts additional members or providers.

(5) If the provider contract is for a primary care provider (PCP):

(a) The MCO shall include the number of members that will be affected by the change in the notice to ODM; and

(b) The MCO shall notify in writing all members who use or are assigned to the provider as a PCP at least forty-five calendar days prior to the effective date of the change. If the MCO receives less than forty-five calendar days prior notice from the PCP, the MCO shall issue the notification within one working day of the MCO becoming aware of the expiration, nonrenewal, or termination of PCP's provider contract. The form of the notice and its content must be prior-approved by ODM and must contain, at a minimum, all of the following information:

(i) The PCP's name and last date the PCP is available to provide care to the MCO's members;

(ii) Information regarding how members can select a different PCP; and

(iii) An MCO telephone number members can call for further information or assistance.

(6) ODM may require the MCE to notify members or providers of the expiration, nonrenewal, or termination of other provider contracts that may adversely impact the MCE's members.

(7) In order to ensure availability of services and qualifications of providers, ODM may require submission of documentation in accordance with paragraph (B) of this rule regardless of whether the MCE contracts directly for services or does so through another entity.

(8) In the event that the MCE's medicaid managed care program participation in a service area is terminated, the MCE must provide written notification to its affected contracted providers at least forty-five calendar days prior to the termination date, unless otherwise specified by ODM.

(C) Provider qualifications.

(1) The MCE must ensure that none of its employees or contracted providers are sanctioned or excluded from providing medicaid or medicare services. The MCE shall use available resources for identifying sanctioned providers, at least monthly, including, but not limited to, the following:

(a) The federal office of inspector general provider exclusion list;

(b) The ODM excluded provider web page; and

(c) The discipline pages of the applicable state boards that license providers or an alternative data resource, such as the national practitioner databank, that is as complete and accurate as the discipline pages of the applicable state boards.

(2) The MCE may not discriminate with regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If the MCE declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision. This paragraph may not be construed to:

(a) Require the MCE to contract with providers beyond the number necessary to meet the needs of its members as described in the MCE's provider agreement or contract with ODM;

(b) Preclude the MCE from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(c) Preclude the MCE from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

(3) The MCE must have written policies and procedures for the selection and retention of providers that prohibit discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(4) The MCE will accept ODM credentialing of ODM-enrolled providers and will not conduct any further credentialing activities for those providers.

(D) Provider contract specifications.

All provider contracts, including single case agreements, must include a medicaid addendum that has been approved by ODM. The medicaid addendum must include the following elements, appropriate to the service being rendered, as specified by ODM:

(1) An agreement by the provider to comply with the applicable provisions for record keeping and auditing in accordance with Chapter 5160-26 of the Administrative Code.

(2) Specification of the medicaid population and service areas, pursuant to the MCE's provider agreement or contract with ODM.

(3) Specification of the health care services to be provided.

(4) Specification that the provider contract is governed by, and construed in accordance with all applicable laws, regulations, and contractual obligations of the MCE and:

(a) ODM shall notify the MCE and the MCE shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCE;

(b) The provider contract shall be automatically amended to conform to such changes without the necessity for written execution; and

(c) The MCE shall notify the provider of all applicable contractual obligations.

(5) Specification of the beginning date and expiration date of the contract, or an automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination.

(6) Specification of the procedures to be employed upon the ending, nonrenewal, or termination of the contract, including an agreement by the provider to promptly supply all records necessary for the settlement of outstanding medical claims.

(7) Full disclosure of the method and amount of compensation or other consideration to be received by the provider from the MCE.

(8) An agreement not to discriminate in the delivery of services based on the member's race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services.

(9) An agreement by the provider to not hold liable ODM or members in the event that the MCE cannot or will not pay for services performed by the provider pursuant to the contract with the exception that:

(a) Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be reimbursed by ODM in the event of MCE insolvency.

(b) The provider may bill the member when the MCE has denied prior authorization or referral for services and the conditions described in rule 5160-1-13.1 of the Administrative Code are met.

(10) An agreement by the provider that with the exception of any member co-payments the MCE has elected to implement in accordance with rule 5160-26-12 of the Administrative Code, the MCE's payment constitutes payment in full for any covered service and the provider will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit nursing facilities or home and community-based services waiver providers from collecting patient liability payments from members as specified in rules 5160:1-6-07 and 5160:1-6-07.1 of the Administrative Code or FQHCs and RHCs from submitting claims for supplemental payments to ODM as specified in Chapter 5160-28 of the Administrative Code. Additionally, the MCE and the provider agree to the following:

(a) The MCE shall notify the provider whether the MCE has elected to implement any member co-payments and if, applicable, the circumstances in which member co-payment amounts will be imposed in accordance with rule 5160-26-12 of the Administrative Code; and

(b) The provider agrees that member notifications regarding any applicable co-payment amounts must be carried out in accordance with rule 5160-26-12 of the Administrative Code.

(11) A specification that the provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the contract, and that provider and all employees of the provider have not been excluded from participating in federally funded health care programs.

(12) An agreement that ODM administered home and community based services (HCBS) waiver providers are currently enrolled as ODM providers with an active status in accordance with agency 5160 of the Administrative Code, and all other providers are either currently enrolled as ODM providers and meet the qualifications specified in paragraph (C) of this rule, or they are in the process of enrolling as ODM providers;

(13) A stipulation that the MCE will give the provider at least sixty-days' prior notice in writing for the nonrenewal or termination of the contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the contract be terminated sooner or when the contract is temporary in accordance with 42 C.F.R. 438.602 (October 1, 2021) and the provider fails to enroll as an ODM provider within one hundred twenty days.

(14) A stipulation that the provider may nonrenew or terminate the contract if one of the following occurs:

(a) The provider gives the MCE at least sixty days prior notice in writing for the nonrenewal or termination of the contract, or the termination of any services for which the provider is contracted. The effective date for any nonrenewal or termination of the contract, or termination of any contracted service must be the last day of the month.

(b) ODM has proposed action to terminate, nonrenew, deny or amend the MCO's provider agreement in accordance with rule 5160-26-10 of the Administrative Code, regardless of whether this action is appealed. The provider's termination or nonrenewal written notice must be received by the MCE within fifteen working days prior to the end of the month in which the provider is proposing termination or nonrenewal. If the notice is not received by this date, the provider must agree to extend the termination or nonrenewal date to the last day of the subsequent month.

(15) The provider's agreement to serve members through the last day the contract is in effect.

(16) The provider's agreement to make the medical records for medicaid eligible individuals available for transfer to new providers at no cost to the individual.

(17) A specification that all laboratory testing sites providing services to members must have either a current clinical laboratory improvement amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or certificate of registration along with a CLIA identification number.

(18) A requirement securing cooperation with the MCO's quality assessment and performance improvement (QAPI) program in all its provider contracts and employment agreements for physician and nonphysician providers.

(19) An agreement by the provider and MCE that:

(a) The MCE shall disseminate written policies in accordance with the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2022) and section 5162.15 of the Revised Code, regarding the reporting of false claims and whistleblower protections for employees who make such a report, and including the MCE's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(b) The provider agrees to abide by the MCE's written policies related to the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2022) and section 5162.15 of the Revised Code, including the MCE's policies and procedures for detecting and preventing fraud, waste, and abuse.

(20) A specification that hospitals and other providers must allow the MCE access to all member medical records for a period of not less than ten years from the date of service or until any audit initiated within the ten year period is completed and allow access to all record-keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in rule 5160-26-06 of the Administrative Code.

(21) A specification, appearing above the signature(s) on the signature page in all PCP contracts, stating the maximum number of MCO members that each PCP can serve at each practice site for that MCO.

(22) A specification that the provider must cooperate with the ODM external quality reviews required by 42 C.F.R. 438.358 (October 1, 2021) and on-site audits as deemed necessary based on ODM's periodic analysis of financial, utilization, provider network and other information.

(23) A specification that the provider must be bound by the same standards of confidentiality that apply to ODM and the state of Ohio as described in rule 5160-1-32 of the Administrative Code, including standards for unauthorized uses of or disclosures of protected health information (PHI).

(24) A specification that any third party administrator (TPA) must include the elements of paragraph (D) of this rule in its contracts and ensure that its contracted providers will forward information to ODM as requested.

(25) A specification that home health providers must meet the eligible provider requirements specified in Chapter 5160-12 of the Administrative Code and comply with the requirements for home care dependent adults as specified in section 121.36 of the Revised Code.

(26) A specification that PCPs must participate in the care coordination requirements outlined in rule 5160-26-03.1 of the Administrative Code.

(27) A specification that the provider in providing health care services to members must identify and where necessary arrange, pursuant to the mutually agreed upon policies and procedures between the MCE and provider, for the following at no cost to the member;

(a) Sign language services; and

(b) Oral interpretation and oral translation services.

(28) A specification that the MCE agrees to fulfill the provider's responsibility to issue notice of the member's right to request a state hearing whenever the provider bills a member due to the MCE's denial of payment of a service, as specified in rules 5160-26-08.4 and 5160-58-08.4 of the Administrative Code, utilizing the procedures and forms as specified in Chapter 5101:6-2 of the Administrative Code.

(29) The provider's agreement to contact the twenty-four-hour post-stabilization services phone line designated by the MCE to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.

(30) A specification that the MCE may not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

(a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the member needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment versus non-treatment; and

(d) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(31) A stipulation that the provider must not identify the addressee as a medicaid recipient on the outside of the envelope when contacting members by mail.

(32) An agreement by the provider that members will not be billed for missed appointments.

(33) An agreement that in the performance of the contract or in the hiring of any employees for the performance of services under the contract, the provider shall not by reason of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the contract relates.

(34) An agreement by the provider that it shall not in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the contract on account of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry.

(35) Notwithstanding paragraphs (D)(13) and (D)(14) of this rule, in the event of a hospital's proposed nonrenewal or termination of a hospital contract, an agreement by the contracted hospital to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the contract and the last date the hospital will provide services to members under the MCE contract. The contracted hospital must send this notice to the providers with admitting privileges at least forty-five calendar days prior to the effective date of the nonrenewal or termination of the hospital contract. If the contracted hospital issues less than forty-five days prior notice to the MCE, the notice to providers with admitting privileges must be sent within one working day of the contracted hospital issuing notice of nonrenewal or termination of the contract.

(36) An agreement by the provider to supply, upon request, the business transaction information required under 42 C.F.R. 455.105 (October 1, 2021).

(37) An agreement by the provider to release to the MCO, ODM or ODM designee any information necessary for the MCE to perform any of its obligations under

the ODM provider agreement, including but not limited to compliance with reporting and quality assurance requirements.

(38) An agreement by the provider that its applicable facilities and records will be open to inspection by the MCE, ODM, or ODM's designee, or other entities as specified in rule 5160-26-06 of the Administrative Code.

(E) In lieu of including a medicaid addendum as required by paragraph (D) of this rule, an MCE may permit a TPA that assists in the administration of health care services including pharmaceutical, dental, vision and behavioral health services on behalf of the MCE's members, to include elements in paragraphs (D)(1) to (D)(38) of this rule in contracts with entities that provide for the direct provision of health care services to its members. The MCE must receive written evidence that the TPA complied with this paragraph and has informed the entities of the obligation to provide health care services to the MCE's members.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	null
Rule Amplifies:	null

DRAFT - NOT FOR FILING

5160-26-05 Managed care: provider network and contracting requirements.

(A) Provider contracts.

(1) A managed care entity (MCE) must provide or arrange for the delivery of covered health care services described in rule 5160-26-03 of the Administrative Code either through the use of employees or through contracts with network providers of health care services ("providers"). All provider contracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6 (October 1, 2021). The MCE's execution of a provider contract does not terminate the MCE's legal responsibility to the Ohio department of medicaid (ODM) to ensure all of the MCE's activities and obligations are performed in accordance with agency 5160 of the Administrative Code, as applicable, the MCE's provider agreement or contract with ODM, and all applicable federal, state, and local regulations.

(2) The MCE will make all provider contracts available to ODM upon request.

(3) Provider contracts may not include language that conflicts with the specifications identified in paragraph (C) of this rule.

(4) MCE network providers have to maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.

(5) When utilizing an out of network provider, the MCE must establish a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of the medicaid addendum (ODM 10235). For medicaid-covered non-emergency hospital services outlined in rule 5160-26-03 of the Administrative Code, the compensation amount is identified in rule 5160-26-11 of the Administrative Code.

(B) Notification.

(1) Notwithstanding applicable provisions outlined in the medicaid addendum (ODM 10235), the MCE must notify ODM of any addition to or deletion from its provider network on an ongoing basis and must follow the time restrictions contained in this paragraph unless an explanation of extenuating circumstances is accepted by ODM.

(2) At the direction of ODM, the MCE must submit evidence of the following:

(a) A copy of the provider's current licensure;

(b) Copies of written agreements with the provider, including but not limited to provider contracts, amendments, and the medicaid addendum as specified in paragraph (D) of this rule;

(c) Notification to ODM of any hospital provider contract for which a date of termination is specified; and

(d) The provider's medicaid provider identification number.

(3) The MCE will notify ODM in writing of the expiration, nonrenewal, or termination of any provider contract at least fifty-five calendar days prior to the expiration, nonrenewal, or termination of the provider contract in a manner and format directed by ODM. If the MCE receives less than fifty-five calendar days' notice from the provider, the MCE must inform ODM in writing within one working day of becoming aware of this information.

(4) If the provider contract is for a hospital:

(a) Forty-five calendar days prior to the effective date of the expiration, nonrenewal or termination of the hospital's provider contract, the MCE shall notify in writing all providers who have admitting privileges at the hospital of the impending expiration, nonrenewal, or termination of the provider contract and the last date the hospital will provide services to members under the MCE provider contract. If the MCE receives less than forty-five calendar days' notice from the hospital, the MCE shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the provider contract.

(b) Forty-five calendar days prior to the effective date of the expiration, nonrenewal, or termination of the hospital's provider contract, the MCE shall notify in writing all members in the service area, or in an area authorized by ODM, of the impending expiration, nonrenewal, or termination of the hospital's provider contract. If the MCE receives less than forty-five calendar days' notice from the hospital provider, the MCE shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the provider contract.

(c) The MCE shall submit a template for member and provider notifications to ODM along with the MCE's notification to ODM of the impending expiration, nonrenewal, or termination of the hospital's provider contract. The notifications shall comply with the following:

(i) The form and content of the member notice have to be prior-approved by ODM and contain an ODM designated toll-free telephone number members can call for information and assistance.

(ii) The form and content of the provider notice have to be prior-approved by ODM.

(d) ODM may require the MCE to notify additional members or providers if the impending expiration, nonrenewal, or termination of the hospital's provider contract adversely impacts additional members or providers.

(5) If the provider contract is for a primary care provider (PCP):

(a) The MCE will include the number of members that will be affected by the change in the notice to ODM; and

(b) The MCE will notify in writing all members who use or are assigned to the provider as a PCP at least forty-five calendar days prior to the effective date of the change. If the MCE receives less than forty-five calendar days prior notice from the PCP, the MCE will issue the notification within one working day of the MCE becoming aware of the expiration, nonrenewal, or termination of PCP's provider contract. The form of the notice and its content have to be prior-approved by ODM and must contain, at a minimum, all of the following information:

(i) The PCP's name and last date the PCP is available to provide care to the MCE's members;

(ii) Information regarding how members can select a different PCP; and

(iii) An MCE telephone number members can call for further information or assistance.

(6) ODM may require the MCE to notify members or providers of the expiration, nonrenewal, or termination of other provider contracts that may adversely impact the MCE's members.

(7) In order to ensure availability of services and qualifications of providers, ODM may require submission of documentation in accordance with paragraph (B) of this rule regardless of whether the MCE contracts directly for services or does so through another entity.

(8) In the event that the MCE's medicaid managed care program participation in a service area is terminated, the MCE must provide written notification to its affected contracted providers at least forty-five calendar days prior to the termination date, unless otherwise specified by ODM.

(C) Provider qualifications.

(1) The MCE must ensure that none of its employees or contracted providers are sanctioned or excluded from providing medicaid or medicare services. The MCE shall use available resources for identifying sanctioned or excluded providers, at least monthly, including, but not limited to, the following:

(a) The federal office of inspector general provider exclusion list;

(b) The ODM excluded provider web page; and

(c) The discipline pages of the applicable state boards that license providers or an alternative data resource, such as the national practitioner databank, that is as complete and accurate as the discipline pages of the applicable state boards.

(2) The MCE may not discriminate with regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If the MCE declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision. This paragraph may not be construed to:

(a) Require the MCE to contract with providers beyond the number necessary to meet the needs of its members as described in the MCE's provider agreement or contract with ODM;

(b) Preclude the MCE from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(c) Preclude the MCE from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

(3) The MCE must have written policies and procedures for the selection and retention of providers that prohibit discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(4) The MCE will accept ODM credentialing of ODM-enrolled providers and will not conduct any further credentialing activities for those providers.

(D) Provider contract specifications.

All provider contracts, including single case agreements, must include a medicaid addendum that has been approved by ODM. A template for the medicaid addendum (ODM 10235) is available on the department's website at medicaid.ohio.gov.