Rule Summary and Fiscal Analysis (Part A)

Department of Job and Family Services
Agency Name

Division of Medical Assistance | **Mike Lynch**
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5101:3-1-60 Rule Number

NEW TYPE of rule filing

Rule Title/Tag Line **Medicaid reimbursement.**

RULE SUMMARY

1. Is the rule being filed consistent with the requirements of the RC 119.032 review? **No**

2. Are you proposing this rule as a result of recent legislation? **No**

3. Statute prescribing the procedure in accordance with the agency is required to adopt the rule: **119.03**

4. Statute(s) authorizing agency to adopt the rule: **5111.02**

5. Statute(s) the rule, as filed, amplifies or implements: **5111.01, 5111.0112, 5111.02, 5111.021**

6. State the reason(s) for proposing (i.e., why are you filing,) this rule:

This rule is being proposed to update policy related to the administration of the Medicaid program. It replaces a rescinded rule of the same number and title.

7. If the rule is an AMENDMENT, then summarize the changes and the content of the proposed rule; If the rule type is RESCISSION, NEW or NO CHANGE,

then summarize the content of the rule:

This rule sets forth reimbursement policies for services furnished by professional providers. The text of the rule is being reorganized, streamlined, and clarified; a new provision states explicitly that reimbursement limits may be set on the basis of the characteristics of an individual procedure, service, or supply or the relationships between procedures, services, or supplies.

The appendix to the rule is being amended in several ways:

* Typographical errors are corrected, new HCPCS codes are added, obsolete Healthcare Common Procedure Coding System (HCPCS) codes are discontinued, coverage is started for some previously noncovered HCPCS codes, adjustments are made to the professional/technical split of certain current HCPCS codes, and code descriptions are revised.

* The 'Visit' column, whose sole function has been to display an indicator for 12 blood-related procedures that may be separately reimbursable on the day of surgery, is being discontinued; this provision will now be addressed in the body of rule 5101:3-4-06.

* Pursuant to RC 5111.021 and paragraph (D) of this rule, the maximum fees for certain procedures, services, or supplies are reduced so that they do not exceed the corresponding maximum Medicare allowed amounts.

* Long sections of outdated items (such as old models of spectacle frames and lenses) are collapsed into single entries.

* Entries for vaccines and other provider-administered pharmaceuticals (represented, for example, by CPT codes in the range from 90476 to 90749, Current Procedural Terminology (CPT) codes in the range from 90281 to 90399, or HCPCS codes beginning with the letter J) are removed from this appendix and replaced with a reference to new rule 5101:3-4-12.

8. If the rule incorporates a text or other material by reference and the agency claims the incorporation by reference is exempt from compliance with sections 121.71 to 121.74 of the Revised Code because the text or other material is **generally available** to persons who reasonably can be expected to be affected by the rule, provide an explanation of how the text or other material is generally available to those persons:

This rule incorporates one or more references to another rule or rules of the Ohio Administrative Code. This question is not applicable to any incorporation by reference to another OAC rule because such reference is exempt from compliance with RC 121.71 to 121.74 pursuant to RC 121.76(A)(3).

9. If the rule incorporates a text or other material by reference, and it was **infeasible** for the agency to file the text or other material electronically, provide an explanation of why filing the text or other material electronically was infeasible:

Not Applicable

10. If the rule is being **rescinded** and incorporates a text or other material by reference, and it was **infeasible** for the agency to file the text or other material, provide an explanation of why filing the text or other material was infeasible:

Not Applicable.

11. If **revising** or **refiling** this rule, identify changes made from the previously filed version of this rule; if none, please state so. If applicable, indicate each specific paragraph of the rule that has been modified:

Not Applicable.

12. 119.032 Rule Review Date:

(If the rule is not exempt and you answered NO to question No. 1, provide the scheduled review date. If you answered YES to No. 1, the review date for this rule is the filing date.)

NOTE: If the rule is not exempt at the time of final filing, two dates are required: the current review date plus a date not to exceed 5 years from the effective date for Amended rules or a date not to exceed 5 years from the review date for No Change rules.

FISCAL ANALYSIS

13. Estimate the total amount by which *this proposed rule* would **increase /decrease** either **revenues /expenditures** for the agency during the current biennium (in dollars): Explain the net impact of the proposed changes to the budget of your agency/department.

This will decrease expenditures.

$12 million

The adoption of this rule will decrease expenditures during the current biennium by approximately $12 million.

14. Identify the appropriation (by line item etc.) that authorizes each expenditure necessitated by the proposed rule:

600525

15. Provide a summary of the estimated cost of compliance with the rule to all directly affected persons. When appropriate, please include the source for your information/estimated costs, e.g. industry, CFR, internal/agency:

When this rule is implemented, Medicaid maximum fees for covered immunizations, injections and infusions, and provider-administered pharmaceuticals will be removed from Appendix DD to this rule. The methodology for establishing those maximum fees will instead be spelled out in rule 5101:3-4-12. A listing of covered services and items will be published on the Fees Schedules and Rates page of the Ohio Medicaid web site, at http://jfs.ohio.gov/ohp/bhpp/FeeSchdRates.stm (or its successor). The change will enable the Office of Medical Assistance (OMA) to update codes and fees for these services and items more quickly and efficiently, but the bases for the fee amounts will remain the same. Moving these codes from a rule appendix to a web page should not result in a cost of compliance to Medicaid providers.

Changes to the appendix of this rule include the addition of new Healthcare Common Procedure Coding System (HCPCS) codes, the discontinuation of obsolete HCPCS codes, the initiation of coverage for some previously noncovered HCPCS codes, adjustments to the professional/technical split of certain current HCPCS codes, and the revision of some HCPCS code descriptions. HCPCS is a standardized coding system that must be used by both providers of medical services and payers for medical services -- such as Medicare, Medicaid, and private insurance carriers -- to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA). This coding system is updated at least once a year, and often quarterly, by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These updates must be reflected in OMA rules, and providers of medical services must use updated codes in order to maintain their compliance with HIPAA. Any costs incurred by providers in connection with HCPCS updates would result from the HIPAA mandate and not from any requirement imposed by OMA. Indeed, OMA expects that Medicaid providers routinely incorporate HCPCS updates as part of their standard business practices.

Other changes to the appendix of this rule reduce the maximum fee for some services to no more than the amount allowed by Medicare. These reductions are being made in compliance with R.C. 5111.021, which provides that Medicaid reimbursement may not exceed the reimbursement level for the same service under Medicare.

16. Does this rule have a fiscal effect on school districts, counties, townships, or municipal corporations? **Yes**

You must complete Part B of the Rule Summary and Fiscal Analysis in order to comply with Am. Sub. S.B. 33 of the 120th General Assembly.

17. Does this rule deal with environmental protection or contain a component dealing with environmental protection as defined in R. C. 121.39? **No**

S.B. 2 (129th General Assembly) Questions

18. Has this rule been filed with the Common Sense Initiative Office pursuant to R.C. 121.82? **Yes**

19. Specific to this rule, answer the following:

A.) Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business? **No**

B.) Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms? **No**

C.) Does this rule require specific expenditures or the report of information as a condition of compliance? **Yes**

> Providers are required to submit claims in order to receive Medicaid reimbursement. On each claim, a provider reports many pieces of information, such as the identity of the person served, the services provided, related diagnoses, the date of service, and the place of service.
>
> Rule 5101:3-1-60 also has particular reporting requirements: (1) When a recipient has third-party coverage (e.g., by a private insurance company), a provider is required to report service information to the third-party payer in the form of a claim. (2) The "billed amount" reported on a Medicaid claim must be a provider's usual and customary charge.

Rule Summary and Fiscal Analysis (Part B)

1. Does the Proposed rule have a fiscal effect on any of the following?

(a) School Districts	(b) Counties	(c) Townships	(d) Municipal Corporations
Yes	**Yes**	**Yes**	**Yes**

2. Please provide an estimate in dollars of the cost of compliance with the proposed rule for school districts, counties, townships, or municipal corporations. If you are unable to provide an estimate in dollars, please provide a written explanation of why it is not possible to provide such an estimate.

To the extent that it is also a school district, county, township, or municipal corporation, a Medicaid provider could be affected by the proposed rule.

When this rule is implemented, Medicaid maximum fees for covered immunizations, injections and infusions, and provider-administered pharmaceuticals will be removed from Appendix DD to this rule. The methodology for establishing those maximum fees will instead be spelled out in rule 5101:3-4-12. A listing of covered services and items will be published on the Fees Schedules and Rates page of the Ohio Medicaid web site, at http://jfs.ohio.gov/ohp/bhpp/FeeSchdRates.stm (or its successor). The change will enable the Office of Medical Assistance (OMA) to update codes and fees for these services and items more quickly and efficiently, but the bases for the fee amounts will remain the same. Moving these codes from a rule appendix to a web page should not result in a cost of compliance to Medicaid providers.

Changes to the appendix of this rule include the addition of new Healthcare Common Procedure Coding System (HCPCS) codes, the discontinuation of obsolete HCPCS codes, the initiation of coverage for some previously noncovered HCPCS codes, adjustments to the professional/technical split of certain current HCPCS codes, and the revision of some HCPCS code descriptions. HCPCS is a standardized coding system that must be used by both providers of medical services and payers for medical services -- such as Medicare, Medicaid, and private insurance carriers -- to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA). This coding system is updated at least once a year, and often quarterly, by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These updates must be reflected in OMA rules, and providers of medical services must use updated codes in order to maintain their compliance with HIPAA. Any costs incurred by providers in connection with HCPCS updates would result from the HIPAA mandate and not from any requirement imposed by OMA. Indeed, OMA expects that Medicaid

providers routinely incorporate HCPCS updates as part of their standard business practices.

Other changes to the appendix of this rule reduce the maximum fee for some services to no more than the amount allowed by Medicare. These reductions are being made in compliance with R.C. 5111.021, which provides that Medicaid reimbursement may not exceed the reimbursement level for the same service under Medicare.

3. If the proposed rule is the result of a federal requirement, does the proposed rule exceed the scope and intent of the federal requirement? **No**

4. If the proposed rule exceeds the minimum necessary federal requirement, please provide an estimate of, and justification for, the excess costs that exceed the cost of the federal requirement. In particular, please provide an estimate of the excess costs that exceed the cost of the federal requirement for (a) school districts, (b) counties, (c) townships, and (d) municipal corporations.

Not Applicable.

5. Please provide a comprehensive cost estimate for the proposed rule that includes the procedure and method used for calculating the cost of compliance. This comprehensive cost estimate should identify all of the major cost categories including, but not limited to, (a) personnel costs, (b) new equipment or other capital costs, (c) operating costs, and (d) any indirect central service costs.

The comprehensive cost estimates are provided in the following sections.

(a) Personnel Costs

OMA does not expect that the proposed rule will result in any increase in personnel costs to Medicaid providers.

(b) New Equipment or Other Capital Costs

OMA does not expect that the proposed rule will result in any increase in new equipment or other capital costs to Medicaid providers.

(c) Operating Costs

OMA does not expect that the proposed rule will result in any increase in

operating costs to Medicaid providers.

(d) Any Indirect Central Service Costs

OMA does not expect that the proposed rule will result in any increase in indirect central service costs to Medicaid providers.

(e) Other Costs

Other changes to the appendix of this rule reduce the maximum fee for some services to no more than the amount allowed by Medicare. These reductions are being made in compliance with R.C. 5111.021, which provides that Medicaid reimbursement may not exceed the reimbursement level for the same service under Medicare. The fiscal impact of these obligatory reductions will be provider-specific, based on the provider's current business model for service delivery. Therefore, OMA cannot calculate a comprehensive cost estimate.

6. Please provide a written explanation of the agency's and the local government's ability to pay for the new requirements imposed by the proposed rule.

Any reductions in Medicaid reimbursement occurring as a result of this rule will be based on reimbursement levels paid by Medicare. Such reductions are required by R.C. 5111.021, which provides that Medicaid reimbursement may not exceed the reimbursement level for the same service under Medicare. To the extent that affected Medicaid providers are also providers under the Medicare program, they will be accustomed to the payment rates paid by Medicare and should have adjusted their budgets accordingly. As a general matter, Medicaid is known to pay less than Medicare, so there should be no expectation that Medicaid rates will be higher. For these reasons, OMA expects that the affected agencies and local governments will be able to adjust to the reduction in Medicaid reimbursement for some services.

7. Please provide a statement on the proposed rule's impact on economic development.

There is no discernible impact on economic development as a result of this proposed rule.