Rule Summary and Fiscal Analysis (Part A)

Department of Job and Family Services
Agency Name

Division of Medical Assistance | **Nancy Van Kirk**
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5101:3-1-60 | **AMENDMENT**
Rule Number | 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, 5111.02, 5111.021**

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

This rule was emergency filed by the department for an effective date January 1, 2009 in response to healthcare common procedure coding system (HCPCS) changes introduced for 2009 by the American Medical Association (AMA) in order to maintain consistency with industry standards, which the department is required to do under the Health Insurance Portability and Accountability Act (HIPAA), pursuant to 45 CFR 162.1000 and 45 CFR 162.1002. This rule is being proposed for regular filing to follow the emergency filing.

This rule is also being filed to incorporate recent reimbursement changes to specific

durable medical equipment (DME) and injection codes contained within this rule.

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 is being amended to incorporate the 2009 healthcare common procedure coding system (HCPCS) code set. This involves adding and pricing new codes, deleting obsolete or discontinued codes, and revising the definitions and reimbursement amounts for other codes. Some of the coding changes require amendments to existing policy on coverage.

This rule is being amended to decrease the reimbursement amounts for certain durable medical equipment codes for which the medicaid rate would have been in excess of the comparable medicare rate as of January 1, 2009. Thirty-six of these codes are for wheelchair components, five are for oxygen items and one each is for a humidifier and bed side rails. The average rate reduction over the affected DME codes is approximately ten percent, of which approximately five percent is attributable to aligning the medicaid rate with that of medicare and five percent is attributable to a cost savings initiative.

Corrections were also made to vaccine codes 90696, 90681, and 90698 in order to codify the reimbursement amount allowed for these codes, which became effective November 13, 2008 in rule 5101:3-4-12.

This rule is being amended to increase the reimbursement rate for vaccine code 90378 (Respiratory synctial virus immune globulin IM 50 mg), an adjustment that is necessary to assure access to this vaccine for medicaid-eligible children.

Finally, this rule is being amended to update the reimbursement rates for drugs administered in a provider setting (J-codes) using the Centers for Medicare and Medicaid Services most recent Average Sales Price (ASP) listing. Because ASP is based on the average price charged by manufacturers of the product, the reimbursement amount for any individual code may have increased or decreased.

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 ORC 121.71 to 121.74 pursuant to ORC 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:

The appendix of this rule was revised to accomodate a stakeholder request to increase the proposed maximum allowable reimbursement rate for healthcare common procedure coding system (HCPCS) codes K0734 and K0735.

The revised filing reduces the original estimated savings for the agency for the current biennium by approximately $5,000. As a result, RSFA 13 and RSFA 15 were changed as follows: In RSFA 13, the total net amount of reduction in expenditures was changed from $775,000 to $770,000 (the net amount of reduction in expenditures for durable medical equipment (DME) was changed from $545,000 to $540,000). In RSFA 15, the reduction in expenditures for the 43 DME codes was changed from $545,000 to $540,000.

12. 119.032 Rule Review Date: **11/1/2010**

(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.

$770,000

The department estimates that the agency would decrease expenditures by $770,000 for the remainder of the current biennium. This figure reflects approximately $230,000 in savings from changes made as a result in the reimbursement for specific injection codes and $540,000 from the durable medical equipment (DME) program.

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

Not Applicable

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:

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal. The reimbursement amounts for 43 durable medical equipment (DME) codes is being reduced by an average of approximately ten percent, of which approximately five percent is attributable to aligning the medicaid rate with that of medicare and five percent is attributable to a cost savings initiative. The department estimates there will be a reduction in expenditures of $540,000 through the remainder of the biennium as a result of these decreased reimbursement amounts. The fiscal impact on any specific provider cannot be ascertained as it depends on the business model employed and the number of times the affected codes are billed. There is no additional cost of compliance associated with the correction of the reimbursement amounts for the three vaccine codes because although the rates were inadvertantly not listed in 5101:3-1-60, they were correctly entered into the payment system in conjunction with the filing of the immunization rule 5101:3-4-12 in November, 2008. There is no cost of compliance associated with the increase in the reimbursement rate for vaccine code 90378 (Respiratory synctial virus immune globulin IM 50 mg). The reimbursement rates for drugs administered in a provider setting (J-codes) is being adjusted using the Centers for Medicare and Medicaid Services most recent Average Sales Price (ASP) listing. Overall, the department estimates there will be a reduction in expenditures of $230,000 through the remainder of the biennium as a

result of the ASP pricing adjustment. The fiscal impact on any specific provider cannot be ascertained because ASP is based on the average price charged by manufacturers of the product and the reimbursement amount for any individual code may have increased or decreased.

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**

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
No	**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.

   The department is proposing changes to rules which involve incorporation of the 2009 HCPCS code set, a decrease in the reimbursement rates for 43 durable medical equipment codes, a decrease in the reimbursement rates for drugs administered in a provider setting (J-codes), an increase in the reimbursement rate for one vaccine code, and clarifications to the reimbursement rates for three other vaccine codes.

   Counties, townships or municipal corporations may operate as providers of medical services reimbursed under the medicaid program. These provider types typically include health departments, ambulatory clinics and durable medical equipment providers.

   All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

   The department is unable to determine the cost of compliance and fiscal impact of the proposed reimbursement changes on these provider types because the impact is provider specific and dependent upon the business model used and the number of times each of the affected procedure codes are billed.

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.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

The reimbursement amounts for specific durable medical equipment (DME) codes for which the Ohio rate would have been in excess of the comparable medicare rate as of January 1, 2009 have been reduced. Thirty-six of these codes are for wheel chair components, five are for oxygen items and one each is for a humidifier and bed side rails. The average rate reduction over the DME codes is approximately ten percent, of which five percent is attributable to aligning the medicaid rate with that of medicare and five percent is attributable to a cost-savings initiative.

The maximum payment amounts for drugs administered in a provider setting have been updated using the Centers for Medicare and Medicaid Services most recent Average Sales Price (ASP) listing. ASP is based on the average price charged by the manufacturer or manufacturers of the drug product, so the maximum payment for an individual code may have increased or decreased based on market conditions.

(a) Personnel Costs

The department is unable to determine the impact on personnel costs as a result of the proposed adjustment to the reimbursement rates identified. However, to the extent that a county, township or municipal corporation that is also a medicaid provider chooses to reduce or expand the portion of their business associated with the provision of medicaid services to medicaid consumers, there could be a corresponding reduction or expansion in the amount of staffing required which, other things being equal, would translate into increased or reduced personnel costs for the enterprise. The actual amount of any such increase or reduction in personnel costs would be provider-specific and cannot be quantified by the department.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

(b) New Equipment or Other Capital Costs

The department is unable to determine the impact on equipment/capital costs as a result of the proposed adjustment to the reimbursement rates identified. However, to the extent that a county, township or municipal corporation that is also a medicaid provider chooses to reduce or expand the portion of their business associated with the provision of medicaid services to medicaid consumers, there could be a corresponding reduction or expansion in the amount of equipment/capital required which, other things being equal, would translate into increased or reduced equipment/capital costs for the enterprise. The actual amount of any such increase or reduction in equipment/capital costs would be provider-specific and cannot be quantified by the department.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

(c) Operating Costs

The department is unable to determine the impact on operating costs as a result of the proposed adjustment to the reimbursement rates identified. However, to the extent that a county, township or municipal corporation that is also a medicaid provider chooses to reduce or expand the portion of their business associated with the provision of medicaid services to medicaid consumers, there could be a corresponding reduction or expansion in the amount of operating costs required which, other things being equal, would translate into increased or reduced operating costs for the enterprise. The actual amount of any such increase or reduction in operating costs would be provider-specific and cannot be quantified by the department.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

(d) Any Indirect Central Service Costs

The department is unable to determine the impact on indirect costs as a result of the proposed adjustment to the reimbursement rates identified. However, to the extent that a county, township or municipal corporation that is also a

medicaid provider chooses to reduce or expand the portion of their business associated with the provision of medicaid services to medicaid consumers, there could be a corresponding reduction or expansion in the amount of indirect costs required which, other things being equal, would translate into increased or reduced indirect costs for the enterprise. The actual amount of any such increase or reduction in indirect costs would be provider-specific and cannot be quantified by the department.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

(e) Other Costs

The department is unable to determine the impact on other costs as a result of the proposed adjustment to the reimbursement rates identified. However, to the extent that a county, township or municipal corporation that is also a medicaid provider chooses to reduce or expand the portion of their business associated with the provision of medicaid services to medicaid consumers, there could be a corresponding reduction or expansion in the amount of other costs required which, other things being equal, would translate into increased or reduced other costs for the enterprise. The actual amount of any such increase or reduction in other costs would be provider-specific and cannot be quantified by the department.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

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.

There are no new requirements imposed on counties, townships or municipal corporations. However, medicaid providers will be receiving decreased reimbursement for identified durable medical equipment and injections codes, conversely some injection codes are receiving an increase in reimbursement. To the extent that a county, township or municipal corporation that is also a medicaid provider chooses to reduce or expand their medicaid services, there could be a corresponding change in their revenues and expenses. The actual amount of any such expansions or reductions in revenues would be provider-specific and cannot be quantified by the department.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.

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

To the extent that a county, township or municipal corporation that is also a medicaid provider chooses to reduce or expand the portion of their business associated with the provision of medicaid services to medicaid consumers, there could be a corresponding positive or negative impact on economic development in that county, township or municipality. More generally, it is estimated revenues will decrease by $3.1 million for the entire state of Ohio annually for the medicaid services identified in the filing of this rule provided by medicaid providers. The actual amount of any such increase or decrease in economic development which might occur as a result of the proposed rule change is specific to individual counties, townships and municipalities and cannot be quantified by the department.

All payers will require providers to utilize the 2009 HCPCS code set when billing for services rendered on and after January 1, 2009. Any cost associated with the annual update of HCPCS codes is expected to be minimal.