Rule Summary and Fiscal Analysis
Part A - General Questions

Rule Number: 5160-22-01

Rule Type: Amendment

Rule Title/Tagline: Ambulatory surgery center (ASC) services: provider eligibility, coverage, and reimbursement.

Agency Name: Ohio Department of Medicaid

Division:

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I. Rule Summary

1. **Is this a five year rule review?** No

    A. **What is the rule's five year review date?** 8/1/2022

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 5164.02

5. **What statute(s) does the rule implement or amplify?** 5162.03, 5164.02

6. **What are the reasons for proposing the rule?**

    The proposed amendments to this rule are intended to align with the continued reform and modernization of the outpatient reimbursement methodology. In order to facilitate the move to Enhanced Ambulatory Patient Grouping (EAPG) version 3.14 from version 3.9, the Department will recalibrate relative weights used to calculate Ambulatory Surgery Center (ASC) reimbursement. The amendments also update the methodology used to determine ASC base rates, which include adjusting payments to ASCs that focus on eye procedures in order to prevent an un-intended cut in Medicaid payments to these ASCs.

7. Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.

Rule 5160-22-01 sets forth provider eligibility, coverage, and reimbursement methodology for ASCs, subject to the EAPG system prospective payment methodology.

The following changes are proposed for the ASC EAPG payment methodology:

Paragraph (A)(11) of this rule will be changed so that the EAPG base rates for ASCs will be calculated as ninety per cent of the statewide average outpatient hospital EAPG base rate.

Paragraph(D)(2) will be changed so that: payments for EAPGs 00134 and 00149 will no longer receive enhanced payments; payments for EAPG 00233 will be multiplied by one hundred forty five per cent; and, payments for EAPG 00485 will be multiplied by two hundred thirty three per cent.

Paragraphs (F)(2) and (F)(3) will be changed so that EAPG codes are no longer specified when describing items which may be paid outside of EAPG.

8. Does the rule incorporate material by reference? Yes

9. If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.

This rule incorporates one or more references to 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 pursuant to RC 121.75(A)(1)(d).

This rule incorporates one or more references to the Ohio Revised Code. This question is not applicable to any incorporation by reference to another ORC rule because such reference is exempt from compliance pursuant to RC 121.75(A)(1)(a).

The rule incorporates one or more references to the pharmaceutical fee schedule and non-institutional maximum payment schedule. These documents are generally available to persons affected by this rule on the Ohio Department of Medicaid website at http://www.medicaid.ohio.gov/ and are exempt from compliance pursuant to RC 121.75(B)(6).

10. If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.

Not Applicable

II. Fiscal Analysis

11. Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.

This will increase expenditures.

$1,960,561

The amendment of this rule will result in the increase of $1,960,561 in reimbursements to the ambulatory surgery centers as a result of payment enhancements for cataract procedures and corneal tissue processing.

12. What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?

In order to obtain a valid agreement with CMS to provide ASC services in the Medicare program there is an estimated $3000-$5000 fee for accreditation (Source: The American Association for Accreditation of Ambulatory Surgery Facilities). There is a minimal time impact of about one hour (and de minimis associated cost) to fill out and submit an application for the agreement with CMS. After obtaining an agreement with CMS, there are no more fees for ASCs to obtain a Medicaid provider agreement. However, there is also a minimal time impact of about one hour (and de minimis associated cost) to fill out and submit an application to become a Medicaid provider. There is no expected adverse impact on existing ASC providers as they already meet the requirements. In regards to requesting prior authorization for services provided in a ASC, the Department estimates that for those services which would require prior authorization, that the ASC staff would spend about one hour to gather the information and complete authorization form on the web site. Of the 5,800 procedure codes covered in the ASC setting only 258 are flagged as requiring prior authorization.

13. Does the rule increase local government costs? (If yes, you must complete an RSFA Part B). No

14. Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C). No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    This rule does not impose a regulation fee.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** Yes

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** Yes

    The rule requires the ASC to maintain a Medicaid provider agreement. In order for an ASC to become a Medicaid provider, the ASC must first have a valid agreement with the Centers for Medicare and Medicaid Services (CMS) to provide services in the medicare program.

    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

    This rule requires ASCs to request prior authorization in order to receive reimbursement for certain services. The services that require prior authorization are listed on the department's website, http://www.medicaid.ohio.gov. They are generally cosmetic or experimental, therefore ODM requires these to be authorized in advance to ensure they are appropriate and medically necessary.

    D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No