Rule Summary and Fiscal Analysis (Part A)

Ohio Department of Medicaid
Agency Name

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5160-22-01 — Rule Number
NEW — TYPE of rule filing

Rule Title/Tag Line — **Ambulatory surgery center (ASC) services: provider eligibility, coverage, and reimbursement.**

RULE SUMMARY

1. Is the rule being filed for five year review (FYR)? **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: **5164.02**

5. Statute(s) the rule, as filed, amplifies or implements: **5162.03, 5164.02**

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

This is a new rule being filed to replace the rule with the current ASC reimbursement methodology and describe the new Enhanced Ambulatory Patient Group (EAPG) reimbursement methodology.

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 the definition of an ambulatory surgery center (ASC) and related concepts, how an ASC can become an eligible Medicaid provider, and describes the covered ASC services. The rule describes the new Enhanced Ambulatory Patient Group (EAPG) reimbursement methodology, as well as add a new provision requiring prior authorization for certain CPT codes.It sets forth the requirements for reimbursement for laboratory services, radiological services, and diagnostic and therapeutic procedures, specifies items that may be paid outside of EAPGs and specifies EAPGs paid at an enhanced rate. Under this new reimbursement methodology, each service on a claim is grouped to an EAPG. An EAPG groups together services that are similar in nature, have similar costs and utilizes similar resources. For each EAPG a relative weight is developed, which reflects the relativity of the costs for the services in that EAPG. Reimbursement for a service is the product of the provider#s base rate and the EAPG#s relative weight, then any discounting, consolidation or packaging is taken into account.

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 (OAC). 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:

Paragraph (D)(1) was updated to remove "of the product of (D)(1)(a) through (D)(1)(c) of this rule, rounded to the nearest whole cent:".

Paragraph (D)(2) was added to include "The payment for a paid line on the claim is calculated as follows, except as described in paragraphs (E) or (F) of this rule:"

Paragraph (D)(1)(a), (D)(1)(b) and (D)(1)(c) became renumbered paragraphs (D)(2)(a), (D)(2)(b) and (D)(2)(d) respectively.

Paragraph (D)(2)(a) was updated to include "times"

Paragraph (D)(2)(b) was updated to include "rounded to the nearest whole cent"

Paragraph (D)(2)(c) was added and describes enhanced payments for certain EAPGs

Paragraph (D)(2)(d) was updated to include "The result of (D)(2)(a) and (D)(2)(b) or, for EAPGs 00134 and 00149, (D)(2)(a) through (D)(2)(c), times" and "rounded to the nearest whole cent"

Paragraphs (E)(1)(c), (E)(2)(c) and (E)(3)(c) were updated to change the paragraph references to "(D)(2)(a), (D)(2)(b) and (D)(2)(d)".

12. Five Year Review (FYR) 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 have no impact on revenues or expenditures.

$0

This rule will increase expenditures to ASCs by $16.3 million for the current biennium. However, due to the expansion of codes covered for ASCs and the

increased rates, the department also expects services to shift from the Outpatient setting to the ASC setting. This shift of services would increase revenue to the ASCs but decrease expenditures to the department as a whole because ASCs are a more cost efficient setting.

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

ALI 600-525

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:

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). However, as long as a valid agreement with CMS is maintained, there is no additional adverse impact in order to become a Medicaid provider. There is no expected adverse impact on existing ASC providers as they already meet the requirements.

Under the new EAPG reimbursement methodology, Ohio is expanding the coverage of services that ASC's can perform for Medicaid consumers by approximately 2,257 new codes. Because some of these services might be cosmetic or experimental in nature, the ASCs will be required to request prior authorization on certain codes to ensure they are appropriate and medically necessary. The new prior authorization requirement might require additional time from the ASC providers in order to submit the prior authorizations. How much additional time depends on the types of services the ASCs are providing. Some might not be providing any services that require prior authorization, in which case this new requirement will not cause them to spend any additional time. Other ASCs that choose to provide many services that require prior authorization may need to devote multiple hours a week to requesting prior authorizations.

Completing a PA request takes between five and thirty minutes of provider staff time. This estimate is based on the professional experience of ODM staff members and on figures reported by other Medicaid providers. The wage cost depends on who performs the task. The median statewide hourly wage for a billing clerk, according to Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services, is $16.10; for a medical equipment repairer, it is $24.23; for a higher-level manager, it is $36.32. With an additional 30% for fringe benefits, submitting a PA request costs between $1.75 (five minutes at $20.93 per hour) and $23.61 (thirty minutes at $47.22 per hour).

16. Does this rule have a fiscal effect on school districts, counties, townships, or municipal corporations? **No**

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? **Yes**

> 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. The ASC is also required to have a valid Medicaid provider agreement with the department.

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**

> Under the new EAPG reimbursement methodology, Ohio is expanding the coverage of services that ASC's can perform for medicaid consumers by approximately 2,257 new codes. This rule requires ASCs to request prior authorization in order to receive reimbursement for certain services that will now be covered under the new EAPG reimbursement methodology. The services that require prior authorization are described in rule 5160-2-02 of the Ohio Administrative Code. They are generally cosmetic or experimental, therefore ODM requires these to be authorized in advance to ensure they are appropriate and medically necessary.