CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: BHPP Site differential and MPPR rules

Rule Number(s):

5101:3-1-60 (Amended), Appendix DD (Amended);

5101:3-4-02.2 (Amended), Appendix A (Removed);

5101:3-4-09 (Rescinded), Appendix A (Rescinded);

5101:3-4-25 (Amended)

Date: September 19, 2013

Rule Type:

- ☐ New
- ☑ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

Rule 5101:3-1-60, titled "Medicaid reimbursement," sets forth payment policies for services furnished by professional providers. This rule is being proposed for amendment, and the changes take effect on December 31, 2013.

Changes: Within the body of the rule, one unnecessary sentence is eliminated. In addition to minor nonsubstantive corrections, several significant changes are made to the appendix:

- For each of more than 1,700 procedures, two separate maximum fees are established. One maximum fee applies when the procedure is performed in a non-facility setting such as a physician's office; the other applies when the procedure is performed in an institutional setting such as a hospital or a skilled nursing facility. These fees are shown in two new columns that have been added to the table.
- Maximum fee amounts for more than 100 genetic procedures are updated. Most of these procedures involve molecular pathology; the fees for these "mopath" procedures are based on allowed payment amounts recently established by the Centers for Medicare & Medicaid Services (CMS).
- Maximum fee amounts for oxygen services are removed and listed instead in the new appendix to revised rule 5101:3-10-13 of the Ohio Administrative Code.
- Pursuant to section 5111.021 of the Ohio Revised Code 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.

Rule 5101:3-4-02.2, titled "Site differential payments and place of service," sets forth provisions under which payment for a procedure or service differs according to the location in which the procedure or service is performed. This rule is being proposed for amendment, and the changes take effect on January 1, 2014.

Changes: A provision is added that allows payment of two different fee amounts; one applies when the procedure is performed in a non-facility setting such as a physician's office, and the other applies when the procedure is performed in an institutional setting such as a hospital or a skilled nursing facility. (This provision, which mirrors Medicare payment policy, compensates physicians for the extra overhead expenses they incur when providing services in non-hospital settings.) The appendix to the rule is removed; the fees are shown instead in Appendix DD to rule 5101:3-1-60. In addition, certain phrases and references in the rule are clarified or corrected.

Rule 5101:3-4-09, titled "Office incentive program," establishes additional payment amounts for certain procedures in order to encourage physicians and clinics to perform

those procedures in non-hospital settings and to compensate physicians for the extra overhead cost involved. The establishment in rule 5101:3-4-02.2 of separate non-facility and facility fees for certain services makes the office incentive program obsolete. So this rule, which includes an appendix, is being proposed for rescission as of January 1, 2014.

Rule 5101:3-4-25, titled "Laboratory and radiology services," sets forth provisions for coverage and payment of laboratory and radiology services performed by physicians and other non-institutional providers. This rule is being proposed for amendment, and the changes take effect on January 1, 2014.

Changes: A payment-reduction provision is added that applies when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date; under this provision, payment is made for the primary procedure at 100% and for each additional procedure at 50%. (This provision mirrors Medicare payment policy.) In addition, certain phrases and abbreviations in the rule are clarified or corrected.

2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

The Ohio Department of Medicaid (ODM) is promulgating these rules under section 5111.02 of the Ohio Revised Code.

3. 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.

Provisions in 42 C.F.R. Part 447 Subpart B require each state Medicaid program to maintain documentation of the amounts it pays for supplies and services and to provide public notice of any significant proposed change in its methods and standards for establishing payment amounts. Changes involving the addition, revision, or discontinuation of Healthcare Common Procedure Coding System (HCPCS) codes are required to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

4. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

These rules do not exceed federal requirements.

5. 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)?

Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the

types of entities that can receive Medicaid payment for these goods and services. They publish payment methodologies or fee schedules for the use of providers and the general public.

Medicaid is proposing changes to these rules for three reasons: (1) to comply with the biennial budget, (2) to bring Medicaid fees more into line with Medicare payment policy, and (3) to compensate certain providers for particular expenses related to the setting in which a service is rendered.

The site-differential payment provision is predicated on the accounting principle that some portion of the expense of performing any procedure (supplies, equipment, rent, utilities, insurance, etc.) is attributable to the facility in which it is performed. When a procedure is performed in an institutional setting such as a hospital, the institution receives separate payment for facility overhead expenses. A practitioner in an office setting, on the other hand, receives no separate facility payment; the practice-related overhead expense must be accounted for in the procedure fee itself. So for certain procedures that can be performed in either a non-facility setting or a facility setting, distinct non-facility and facility fees need to be established.

Medicaid is adopting the multiple-procedure payment-reduction provision for radiology used by Medicare in recognition of the fact that—regardless of setting—there is no appreciable difference in overhead expense whether one procedure is performed or several procedures are performed in a single treatment session. Therefore, when multiple procedures are performed by the same provider for the same person on the same date, payment for overhead expense should be included for only one of the procedures and deducted for the others.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

These rules essentially involve internal operating procedures and place no requirements on providers. Their success, therefore, will be measured by the extent to which operational updates to the Medicaid Information Technology System (MITS) result in the correct payment of claims.

Development of the Regulation

7. **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 proposed changes to the rules were presented as part of the Executive Budget for SFY2014 and SFY2015 and posted on the Office of Health Transformation website at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=3I8MukSy-Uw%3d&tabid=156. Director Greg Moody (Office of Health Transformation) and members of

the Health Transformation team described them on February 14, 2013, in testimony before the House Finance and Appropriations Committee. Director John McCarthy (Ohio Department of Medicaid) presented them in testimony on February 28, 2013, before the Health and Human Services Subcommittee of the House Finance and Appropriations Committee and on April 24, 2013, before the Medicaid Finance Subcommittee of the Senate Finance Committee.

In addition, in order to solicit public comment, the department submitted to the Clearance process the proposed Administrative Code rules resulting from the budget legislation.

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

Neither the proposed site-differential payment provision nor the proposed multiple-procedure payment-reduction provision for radiology was modified in or eliminated from Am. Sub. H.B. 59 during the legislative process. Accordingly, those legislative provisions will be implemented through the administrative rules.

Drafts of those rules were made available to the public through the Clearance process. No comment on the rules was received.

9. 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?

Utilization and expenditure data drawn from ODM's Decision Support System were used in projecting the fiscal impact of the proposed changes.

10. 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?

No alternatives were considered, because multiple-procedure payment-reduction and the establishment of distinct facility and non-facility fees for certain procedures were requirements set forth in the biennial budget.

11. Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

Because these rules place no requirements on providers, the concept of performance-based regulation does not apply.

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

Rules involving Medicaid providers are housed exclusively within division 5101:3 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to which type of provider and item or service; in this instance, there was no duplication.

13. 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.

Both the proposed site-differential and multiple-procedure payment-reduction policies will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the applicable rule. They will therefore be automatically and consistently applied by the department's electronic claim-payment system whenever an appropriate provider submits a claim for an applicable service.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

c. Quantify the expected adverse impact from the regulation.
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.

a. Changes to fees listed in Appendix DD to rule 5101:3-1-60 affect such professional (non-institutional) providers as advanced practice nurses, ambulance providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, home health agencies, independent diagnostic testing facilities, independent laboratories, mammography suppliers, medical suppliers, occupational therapists, optometrists, physical therapists, physicians, physician assistants, podiatrists, portable X-ray suppliers, private duty nurses, psychologists, wheelchair van or ambulette providers, and other providers of limited practitioner services.

The changes to rule 5101:3-4-02.2 affect Medicaid providers of professional services.

The rescission of rule 5101:3-4-09 affects physicians performing certain procedures in office or clinic settings. (The impact is more than offset by the establishment of site-differential payment in rule 5101:3-4-02.2.)

The changes to rule 5101:3-4-25 affect non-hospital providers of radiology services.

b. These rules impose no license fees or fines. Most of the reporting requirements laid out in these rules are essentially billing instructions that enable providers to submit claims successfully. They are not directives to submit a claim but rather descriptions of the information to be included if a provider should submit a claim. Similarly, specifications concerning procedure codes or modifiers provide guidance rather than impose obligation.

c. Any adverse operational impact, either on individual providers or in the aggregate, is attributable to efforts on the part of some providers to update their billing systems in order to maintain compliance with industry standards.

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

None of the changes in these rules requires a provider to do anything. Any effort undertaken by providers to update their billing systems will be the result of business decisions rather than regulatory mandate.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

These rules do not require any compliance action on the part of providers other than to submit claims when they want Medicaid payment.

17. 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 impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a “trading partner”) can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.