CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: BHPP ASC EAPG

Rule Number(s): 5160-22-01 (Rescinded); 5160-22-01 (New)

Date: 3/23/17

Rule Type:

- X New
- ☐ Amended
- ☐ 5-Year Review
- X Rescinded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.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**

   Rule 5160-22-01 (Rescinded) sets forth the definition of an ambulatory surgery center (ASC), how an ASC can become an eligible Medicaid provider and how an ASC will be reimbursed. This rule is being rescinded.

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Rule 5160-22-01 (NEW) sets forth the definition of an ambulatory surgery center (ASC), how an ASC can become an eligible Medicaid provider, the services covered as part of the ASC facility payment, and the new Enhanced Ambulatory Patient Group (EAPG) reimbursement methodology. 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 material. 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. This rule also adds a new provision that requires ASCs to request prior authorization for certain codes.

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

   Section 5164.02 of the Revised Code authorizes the Agency to adopt these rules.

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?**

   No, the regulation does not implement a federal requirement.

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

   Although ASCs are a mandatory service under the Medicaid program, neither federal law nor federal regulation dictates the eligibility requirements or manner of reimbursement. In this rule ODM describes the certification/licensure requirements, which services Medicaid covers for ASCs and the new EAPG methodology under which those services are reimbursed. This rule also implements a new requirement that ASCs request prior authorization for certain services.

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)?**

   The purpose of this rule is to set forth the requirements for an ambulatory surgery center (ASC) to become a Medicaid provider, the services that are covered and the new EAPG reimbursement methodology. The new EAPG methodology is necessary to update the outdated ASC payment policies. The new requirement for prior authorization is necessary because with the implementation of EAPG, ODM is also expanding the services covered and reimbursable for ASCs. Since some services, are cosmetic or experimental, ODM requires these to be authorized in advance to ensure they are appropriate and medically necessary.

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

The measurable outcomes of this regulation are that ASC providers are able to successfully obtain prior authorization and ASC claims are properly paid under the new EAPG methodology.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**

   Discussions and trainings with Ohio Association of Ambulatory Surgery Centers (OAASC), began in the spring of 2015. ODM presented an overview of the changes and solicited feedback from ASCs on the proposed changes, at the annual OAASC conference, on September 16th, 2016. ODM held a training on 3M's EAPG system, led by Dave Fee, a representative from 3M, on January 24th, 2017.

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

   Initially ODM was going to change billing requirements to require ASCs to begin billing on the UB-04 form instead of the CMS-1500 form on which they currently bill ODM. Per discussions with OAASC, ODM was informed that this would be a large burden, in terms of training and overhauling their billing practices, in addition it would be different than how they bill most other insurances companies. Therefore, ODM decided to continue allowing ASCs to bill on the CMS-1500.

   OAASC shared a cost study they performed to demonstrate total ASC costs for orthopedic procedures to the Bureau of Workers Compensation. This cost study will be taken into consideration when evaluating the sufficiency of ASC rates.

   The ASCs requested when ODM updated the payment methodology to expand the services ODM will cover for ASCs. ODM took this into consideration and will expand covered services for ASC's by approximately 2,257 additional codes. These expanded services will expand access to care for consumers since ASC will be able to perform more procedures and consumers won't be limited to outpatient hospitals to receive those services.

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?**

   ODM used four years of outpatient claims data to set the EAPG relative weights and base rates used in the outpatient payment calculation. ASCs payments will be based off of the same relative weights and a percentage of the statewide average outpatient base rate. Basing the ASC rates on this data creates more appropriate payments for the services ASCs provide.

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?**

None. The new EAPG reimbursement methodology is already being implemented for outpatient hospitals, since ODM was looking to update the outdated ASC payment methodology and it was ODMs intention to pay them similarly to an outpatient hospital, it would not make sense to develop a new reimbursement methodology. Also since ODM is expanding coverage to additional services which might be cosmetic or experimental it is necessary to require ASC providers to request prior authorizations to ensure the services being provided are appropriate and medically necessary. By expanding the covered services, consumers have better access to care, since they won't be limited to the outpatient hospital setting to receive those services.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.**

    No. Medicare's regulations set forth in 42 C.F.R. 416 already require quality assessment and performance improvement standards for ASCs to be accredited.

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

    Medicaid rules were reviewed by Ohio Department of Medicaid staff, including legal and legislative staff. Ohio Administrative Code rule 5160-22-01 is the only regulation that defines how ambulatory surgery centers can participate in the Medicaid program and how they are reimbursed.

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.**

    The new EAPG reimbursement methodology and prior authorization requirement in Rule 5160-22-01 will be implemented on July 1, 2017. To ensure the implementation is consistent and predictable, we will be training the ASCs in the new prior authorization requirements.

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;**

       These rules impact all Ambulatory Surgery Centers who are or want to be an Ohio Medicaid provider.

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

       The rescinded rule requires ambulatory surgery centers to have a valid agreement with CMS to provide ASC services in the Medicare program and execute an Ohio Medicaid Provider Agreement.

The new rule requires ambulatory surgery centers to have a valid agreement with CMS to provide ASC services in the Medicare program and execute an Ohio Medicaid Provider Agreement. The new rule also requires ASCs to request prior authorization for certain services under the new EAPG reimbursement methodology.

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.

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. How much additional time depend 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 any additional time from them. 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 to 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).

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

Requiring ASC to have a valid agreement with CMS is necessary because there must be some standards for participation in the Medicaid program. Using the same standards as Medicare causes the least impact to providers and eliminates multiple certification processes and fees. A Medicaid Provider Agreement is required for participation in the Medicaid program.

ODM determined that the new prior authorization regulation was necessary to ensure that certain services that ASCs will now be allowed to bill are appropriate and medically necessary. The new prior authorization requirement is only being implemented since ODM is expanding coverage of services that ASC providers can provide to Medicaid consumers. This means that while ASCs might have to spend additional time requesting authorization on certain services, they are also able to provide and be reimbursed for many more services. ODM believes the adverse impact due to the new prior authorization requirement is greatly outweighed by the benefits from the new EAPG reimbursement methodology which will result in increased payments to ASCs.

Regulatory Flexibility

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

No, we cannot make an exception for small providers. Requiring ASCs to have a valid agreement with CMS to provide ASC services in the Medicare program ensures that ASCs are providing safe and quality care to Medicaid consumers. A Medicaid Provider Agreement is required for participation in the Medicaid program. Requiring ASCs to request prior authorizations for certain services ensures that the services being provided are appropriate and medically necessary for Medicaid consumers.

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?

There are no penalties or fines associated with this rule.

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

ASCs may email questions regarding rule 5160-22-01 to EAPG@medicaid.ohio.gov

Providers needing enrollment assistance may contact ODM provider services at http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx or hospital services at Hospital_policy@medicaid.ohio.gov

5160-22-01 **Ambulatory surgery center (ASC) services: provider eligibility, coverage, and reimbursement.**

Effective for dates of service on or after July 1, 2017, eligible ambulatory surgery centers as defined in paragraphs (A)(1) and (B) of this rule are subject to the enhanced ambulatory patient grouping system (EAPG) and prospective payment methodology utilized by the Ohio department of medicaid as described in this rule.

(A) Definitions.

(1) An "ambulatory surgery center (ASC)" is any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

(2) "Enhanced ambulatory patient grouping (EAPG)" is a group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-10 diagnosis, CPT code set and healthcare common procedure coding system (HCPCS) procedure codes.

(3) "EAPG grouper" is the software provided by 3M Health Information Systems to group outpatient claims based on services performed and resource intensity.

(4) "Default EAPG settings" are the default EAPG grouper options in 3M's core grouping software for each EAPG grouper version.

(5) "Discounting factor" is a factor applicable for multiple significant procedures and/or repeated ancillary services designated by default EAPG settings. The appropriate percentage (fifty or one hundred per cent) will be applied to the highest weighted of the multiple procedures or ancillary services payment group.

(a) "Full payment" is the EAPG payment with no applicable discounting factor.

(b) "Consolidation factor" is a factor of zero per cent applicable for services designated with a same procedure consolidation flag or clinical procedure consolidation flag by the EAPG grouper under default EAPG settings.

(c) "Packaging factor" is a factor of zero per cent applicable for services designated with a packaging flag by the EAPG grouper under default EAPG settings.

(6) "EAPG base rate" is the dollar value that shall be multiplied by the final EAPG

weight for each EAPG on a claim to determine the total allowable medicaid payment for a visit.

(7) "ASC invoice" is a bill submitted in accordance with chapter 5160-1 of the Administrative Code, to the department for services rendered to one eligible medicaid beneficiary on one or more date(s) of service. For an invoice encompassing more than one date of service, each date will be processed separately as an individual claim.

(8) "ASC claim" encompasses the ASC services rendered to one eligible medicaid beneficiary on one date of service at an ASC facility.

(9) "Procedure code" is the current procedural terminology (CPT) codes and healthcare common procedure coding system (HCPCS) as identified in rule 5160-1-19 of the Administrative Code.

(10) "Relative weight" is a factor specific to each EAPG that represents that EAPG's relative cost compared to an average case. The relative weights for EAPGs are calculated as described in paragraph (F) of rule 5160-2-75 of the Administrative Code.

(11) "ASC facility services" are items and services furnished by an ASC in connection with a covered ASC surgical procedure.

(12) "ASC Cost-to-charge ratio" is eighty per cent of the statewide average outpatient cost-to-charge ratio as calculated in rule 5160-2-22 of the Administrative Code.

(B) Eligible ASC providers.

(1) All ASCs that have a valid agreement with the centers for medicare and medicaid services (CMS) to provide services in the medicare program are eligible to become medicaid providers upon execution of the "Ohio Medicaid Provider Agreement".

(2) The department will reimburse an ASC for properly submitted claims for facility services furnished in connection with covered surgical procedures when the services are provided by an eligible ASC provider to an eligible medicaid recipient. Reimbursement for covered ASC facility services will be paid in accordance with paragraph (D) of this rule.

(C) Covered ASC facility services.

(1) Facility services include but are not limited to:

(a) Nursing, technician, and related services;

(b) Use of the ASC facilities;

(c) Drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of the surgical procedure;

(d) Diagnostic or therapeutic services or items directly related to the provisions of a surgical procedure;

(e) Administrative, record keeping, and housekeeping items and services;

(f) Materials for anesthesia;

(g) Intraocular lenses; and

(h) Supervision of the services of an anesthetist by the operating surgeon.

(2) Prior Authorization (PA) will be required for certain surgical CPT codes. The services that require PA are listed on the department's web site, http://www.medicaid.ohio.gov/, in accordance with section 5160.34 of the Revised Code.

(D) EAPG payment formula.

(1) Total EAPG payment is the sum across all paid line items on an ASC claim, of the product of (E)(1)(a) through (E)(1)(c) of this rule, rounded to the nearest whole cent:

(a) ASC EAPG base rate;

(b) EAPG relative weight for which the service was assigned by the EAPG grouper;

(c) Applicable discounting factor(s) as defined in paragraph (A)(5) of this rule.

(2) The EAPG base rate for ASCs is eighty per cent of the statewide average outpatient hospital EAPG base rate. Hospital EAPG base rates are calculated as described in paragraph (D) of rule 5160-2-75 of the Administrative Code.

(3) Sources for inputs in the payment formula are described in paragraph (C) of rule 5160-2-75 of the Administrative Code.

(E) Items which may be paid outside of EAPG.

(1) Pharmaceuticals.

(a) Additional payments for pharmaceuticals will be made in accordance with the discounting factors as determined by the EAPG grouper. If no consolidation or packaging factors are assigned then the pharmaceutical line is separately payable and will pay according to paragraph (E)(1)(b) of this rule.

(b) Reimbursement for separately payable covered pharmaceuticals shall be the lesser of billed charges or the payment amounts in the provider administered pharmaceutical fee schedule as published on the department's web site, http://medicaid.ohio.gov/, at the rate in effect on the date of service.

(c) If a J-code or Q-Code, that is covered for ASC facilities and separately payable, is listed as "by report" in the provider-administered pharmaceutical fee schedule, the line will be multiplied by sixty per cent of the ASC cost-to-charge ratio.

(2) Durable medical equipment (DME).

(a) Additional payments for DME may be made for all line items grouping to EAPG code 01001, 01002, 01003, 01004, 01005, 01006, 01007, 01008, 01009, 01010, 01011, 01012, 01013, 01014, 01015, 01016, 01017, 01018, 01019, or 01020.

(b) Reimbursement for DME shall be the lesser of billed charges or the payment amounts in the medicaid non-institutional maximum payment schedule as published on the department's web site, http://medicaid.ohio.gov/, at the rate in effect on the date of service.

(c) Additional payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.

(3) Corneal Tissue.

(a) Reimbursement for acquisition of corneal tissue, procedure code V2785, shall be the lesser of billed charges or the payment amount in the medicaid non-institutional maximum payment schedule.

Replaces: 5160-22-01

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	3/20/84, 1/14/88, 2/17/91, 12/29/95 (Emer.), 5/21/96, 1/1/04, 5/10/07, 7/1/09, 4/15/15, 8/1/16

TO BE RESCINDED

5160-22-01 **Ambulatory surgery center (ASC) services: provider eligibility, coverage, and reimbursement.**

(A) Eligible ASC providers.

(1) An "ambulatory surgery center (ASC)" is any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

(2) All ASCs that have a valid agreement with the centers for medicare and medicaid services (CMS) to provide services in the medicare program are eligible to become medicaid providers upon execution of the "Ohio Medicaid Provider Agreement".

(3) The department will reimburse an ASC for facility services furnished in connection with covered surgical procedures when the services are provided by an eligible ASC provider to an eligible medicaid recipient. Reimbursement for covered ASC facility services will be paid in accordance with paragraph (E) of this rule.

(B) Covered ASC surgical procedures.

(1) "Covered ASC surgical procedures" are procedures designated in appendix DD to rule 5160-1-60 of the Administrative Code.

(2) Covered ASC procedures shall be listed under the column headings "Current ASC Group" and "Previous ASC Group" in appendix DD to rule 5160-1-60 of the Administrative Code and classified into nine surgical groups.

(3) The inclusion of any procedure as a covered ASC surgical procedure determines that reimbursement for facility services may be paid to an ASC and does not preclude its coverage in an inpatient or outpatient hospital setting.

(C) Noncovered ASC surgical procedures.

A facility fee is not reimbursable to an ASC for the following procedures:

(1) Surgical procedures not designated as covered ASC surgical procedures in

appendix DD to rule 5160-1-60 of the Administrative Code; and

(2) Surgical procedures, regardless of their designation in appendix DD to rule 5160-1-60 of the Administrative Code, that are not covered services as described in either rule 5160-2-03 or rule 5160-4-28 of the Administrative Code.

(D) Covered ASC facility services.

"ASC facility services" are items and services furnished by an ASC in connection with a covered ASC surgical procedure. Facility services include but are not limited to:

(1) Nursing, technician, and related services;

(2) Use of the ASC facilities;

(3) Drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of the surgical procedure;

(4) Diagnostic or therapeutic services or items directly related to the provisions of a surgical procedure;

(5) Administrative, record keeping, and housekeeping items and services;

(6) Materials for anesthesia;

(7) Intraocular lenses; and

(8) Supervision of the services of an anesthetist by the operating surgeon.

(E) Payment for facility services.

(1) Payment for facility services is based on a reimbursement rate for each surgical group classification, referred to as the surgical group rate, as determined by the department.

(2) Maximum reimbursement for facility services furnished with a covered surgical procedure will be the provider's billed charges or one hundred per cent of the surgical group rate as specified in paragraph (E) of rule 5160-1-60 of the Administrative Code, whichever is less.

(3) When more than one covered procedure is performed in a single operative session, payment for facility services will be based on one hundred per cent of the highest paying surgical group rate to which one of the covered procedure codes is assigned and fifty per cent of the next highest paying or identical surgical group rate to which one of the covered procedure codes is assigned for the secondary procedure. Any subsequent procedures will be reimbursed zero per cent of the surgical group rate.

(F) Payment for laboratory services, radiological services, and diagnostic and therapeutic procedures.

An ASC may be reimbursed in addition to the facility fee for laboratory procedures, radiological procedures, and diagnostic and therapeutic procedures provided in connection with a covered ASC surgical procedure. To be reimbursed for these services, ASC providers must bill in accordance with rule 5160-1-19 of the Administrative Code.

(1) Payment for laboratory services.

(a) An ASC facility may be reimbursed in addition to the facility payment for covered laboratory services they actually performed as long as the services are provided and billed in accordance with Chapter 5160-11 of the Administrative Code.

(b) An ASC may not bill separately for the professional component of an anatomical pathology procedure.

(2) Payment for radiological services.

(a) An ASC facility may be reimbursed in addition to the facility payment for covered radiological services they actually performed as long as the services are provided and billed in accordance with rule 5160-4-25 of the Administrative Code.

(b) An ASC may not bill the department for the professional component separately.

(3) Payment for diagnostic and therapeutic procedures.

(a) An ASC may be reimbursed in addition to the facility fee for the provision of diagnostic and therapeutic services when provided and billed in

accordance with rules 5160-4-11, 5160-4-16, 5160-4-17 and 5160-4-18 of the Administrative Code.

(b) An ASC may not bill separately for the professional component of a diagnostic and therapeutic procedure.

(4) An ASC may also be reimbursed for laboratory, radiology and diagnostic and therapeutic services actually performed in the ASC in conjunction with covered services not eligible for an ASC facility payment.

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