MEMORANDUM

TO: Tommi Potter, Ohio Department of Medicaid

FROM: Travis Butchello, Regulatory Policy Advocate

DATE: April 17, 2017

RE: **CSI Review – Ambulatory Surgery Center - Enhanced Ambulatory Patient Group Reimbursement Methodology (OAC 5160-22-01)**

On behalf of Lt. Governor Mary Taylor, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Agency as provided for in ORC 107.54.

Analysis

The proposed rule package submitted by the Ohio Department of Medicaid (ODM) consists of one amended rule[1]. The rule package was submitted to the CSI Office on March 24, 2017 and the comment period was held open through March 31, 2017.

Ohio Administrative Code (OAC) 5160-22-01 sets forth the definition of an ambulatory surgery center (ASC) and applicable terms, how an ASC can become an eligible Medicaid provider, services covered as part of the ASC facility payment, and the new Enhanced Ambulatory Patient Group (EAPG) reimbursement methodology. Under the new methodology, services provided by the EAPG are grouped together based upon similar costs and utilization of similar materials. Each EAPG is given a relative weight which reflects the relative costs imposed by that EAPG for the services they provide. The reimbursement rate is calculated based upon the provider's base rate and the EAPG relative weight calculation. In addition, ASC's will also be required to request prior

[1] OAC 5160-22-01 is being amended to the extent that the Legislative Service Commission requires the Ohio Department of Medicaid to rescind the rule and replace it with a new rule of the same rule number.

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authorization for certain codes that pertain to the new services they choose to provide and post applicable codes to the Department's website.

ODM states in the BIA that the purpose of the rule is to set forth requirements for an ambulatory surgery center to become a Medicaid provider and establish the new EAPG reimbursement methodology. The rule also requires prior authorization because with the implementation of the EAPG reimbursement method, ODM is expanding covered services and needs the prior authorization process to ensure the services are appropriate.

ODM consulted the Ohio Association of Ambulatory Surgery Centers (OAASC) as part of its early stakeholder outreach process. During the process, ODM spoke with numerous ASC's regarding its proposed rule changes at the 2016 ASC conference. Stakeholders expressed concerns regarding billing forms that ODM proposed to change. Per discussions with OAASC, ODM was made aware that a new form for billing would impose a large burden in terms of training and changing overall billing practices. In response to the stakeholders, ODM decided to retain the same form process.

The ASCs also requested ODM update the payment methodology for the proposed expanded service. In response, ODM expanded services for ASC's by 2,257 additional codes and also included the new EAPG calculation which will increase the accuracy and amount ASCs will be reimbursed for the new services. No comments were submitted during the CSI public comment period.

ODM explains in the BIA that the rules adversely impact all ASCs who currently are or desire to be an Ohio Medicaid provider. The impacts include the requirement that all ASCs have a valid agreement with the Center for Medicaid Services (CMS) and execute an Ohio Medicaid Provider Agreement. Further, the rule requires ASCs to obtain prior authorization for some services under the new reimbursement methodology. In order to obtain an agreement with CMS, ASCs will have to pay an estimated $3,000-$5,000 fee for accreditation. However, if the ASC is already a Medicaid provider, there will be no additional adverse impact under the proposed rule because they already meet the requirements.

In addition, under the new EAPPG reimbursement methodology, the task of obtaining prior authorization with the new coded services may take additional administrative time to report. The amount of time and cost added will be determined by how many of the new services a particular ASC wishes to adopt. In their submitted BIA, ODM determined the regulatory intent justifies the adverse impact because the existence of a uniform provider agreement will help eliminate multiple certification processes and fees. In regards to the prior authorization impact, the BIA contends that the adverse effect is justified because while ASCs may have to spend more time requesting authorization for certain services, they will also have the opportunity to provide additional services that were not previously qualified for reimbursement. Lastly, ODM contends that ASCs ability to bill more codes will increase payment to ASCs and hopefully mitigate any adverse impact the regulations have.

Based on review of the draft rules and the BIA, the CSI Office finds that the purpose of the rules is justified.

Recommendations

For the reasons explained above, the CSI office does not have any recommendations regarding this rule package.

Conclusion

Based on the above comments, the CSI Office concludes that the Ohio Department of Medicaid should proceed with the formal filing of this rule package with the Joint Committee on Agency Rule Review.

Cc: Emily Kaylor, Director of Regulatory Policy