CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Physician Services

Rule Number(s):

5160-4-01 (to be rescinded), 5160-4-01 (new)

Date: April 7, 2017

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- ☑ Rescinded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.

   Existing rule 5160-4-01, "Physicians and other eligible providers of physician services," sets forth coverage and payment policies for services that may be rendered by "eligible providers of physician services," which are defined as (1) physicians, (2) professional medical groups, (3) ambulatory health care clinics, (4) federally qualified health centers, (5) outpatient health facilities, and (6) rural health clinics. This rule is rescinded and replaced by new rule 5160-4-01.

   New rule 5160-4-01, "Physician services," addresses only services provided by physicians, following the convention established by the Centers for Medicare and Medicaid Services (CMS) that only physicians can be providers of physician services. Reference to "eligible providers of physician services" is omitted from this rule; provisions governing non-physician providers of medical, surgical, radiological, and imaging services are set forth in other rules in agency 5160 of the Ohio Administrative Code. Other unnecessary or redundant references have also been removed. The modifications made to the rule, however, represent no change in policy.

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

   Section 5164.02 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.

   No.

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

   These payment policies are not required by federal law, but they do fall within the federal authority granted to the states in the administration of the Medicaid program.

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 formulas or schedules for the use of providers and the general public.

The administrative rule for physician services performs these functions, and no alternative is readily apparent.

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

   The success of this rule change 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.

   On 10/26/2016, rule drafts were sent to the Medicaid managed care plans. On 10/25/2016, drafts were sent to 20 provider associations.

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

   One clarifying question (concerning how the rules addressed services provided by physician assistants) was submitted by a provider association, and a response was provided. No other comment 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?**

   No data were needed.

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?**

    These rules involve the coverage of and payment for physician services. Whatever the policy may be, the form of the rule is the same; no alternative is readily apparent.

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.**

    The concept of performance-based regulation does not apply to these services.

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 agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. These rules have been reviewed by legal services and policy staff members to prevent 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.

The policies set forth in these rules will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the new rule. They therefore will be applied by the Department's electronic claim-payment system automatically and consistently whenever an appropriate provider submits a claim for an applicable service.

In accordance with standard Medicaid practice, policy changes will be communicated through the issuance of a public hearing notice and the publication of a transmittal letter.

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 affect physicians and non-physician providers of medical, surgical, radiological, and imaging services.

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

Paragraph (C)(1)(a) of existing rule 5160-4-01 and paragraph (A)(1) of new rule 5160-4-01 make Medicaid payment contingent upon a provider's current enrollment in the Ohio Medicaid program.

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.

Provider enrollment is a basic Medicaid requirement. Medicaid can make direct payment only to providers enrolled in the program. Costs associated with enrollment cannot be attributed to rule 5160-4-01.

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

Medicaid can make direct payment only to providers enrolled in the program.

Regulatory Flexibility

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

The requirements set forth in these rules are applied uniformly; no exception is made on the basis of an entity's size.

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.

Policy questions may be directed via e-mail to the Non-Institutional Policy section of ODM's policy bureau at noninstitutional_policy@medicaid.ohio.gov.

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

TO BE RESCINDED

5160-4-01 Physicians and other eligible providers of physician services.

(A) The following definitions and clarifications apply to division 5101:3 of the Administrative Code:

(1) "Physician" is an individual currently licensed under the laws of Ohio or of another state to practice as a doctor of medicine and surgery or as a doctor of osteopathic medicine and surgery. An unlicensed individual who is authorized to practice under the laws of the state in which the services are performed is not a physician, even if the person holds a staff or faculty appointment.

(2) "Provider-based physician" is a physician who has entered into an employment agreement, contract, or other legally binding arrangement with a site-based provider entity such as a hospital, clinic (either fee-for-service or cost-based), or long-term care facility and is consequently under the fiscal, administrative, and professional control of that provider entity. Interns, residents, and fellows are not physicians. Services provided by interns, residents, and fellows are treated as hospital services.

(3) Physicians may form or enter into a professional medical group in accordance with the provisions set forth in rule 5101:3-1-17 of the Administrative Code. A professional medical group may submit claims for physician services performed by its member physicians.

(B) The following Ohio medicaid providers are eligible providers of physician services:

(1) A physician;

(2) A professional medical group;

(3) An ambulatory health care clinic, which is defined in Chapter 5101:3-13 of the Administrative Code;

(4) A federally qualified health center, which is defined in Chapter 5101:3-28 of the Administrative Code;

(5) An outpatient health facility, which is defined in Chapter 5101:3-29 of the

Administrative Code;

(6) A rural health clinic, which is defined in Chapter 5101:3-16 of the Administrative Code; and,

(7) For the sole purpose of demonstrating eligibility for incentive payments made in accordance with Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. No. 111-5) and the regulations published at 42 C.F.R. Part 495 (July 28, 2010), an optometrist operating within the appropriate scope of practice defined in section 4725.01 of the Revised Code.

(C) Reimbursement for providers of physician services is subject to the following provisions:

(1) A provider of physician services may be reimbursed for providing covered services only if two conditions are met:

(a) The provider of physician services is currently enrolled as a medicaid provider; and

(b) The services are rendered to medicaid-eligible Ohio recipients in a state in which the provider is licensed or authorized to practice.

(2) Professional services rendered by a provider-based physician directly to or for the benefit of an individual patient are separately reimbursable only if the following requirements are met:

(a) The physician is separately enrolled as an Ohio medicaid provider;

(b) The physician personally rendered the services to the individual patient;

(c) The services contribute directly to the diagnosis or treatment of the individual patient;

(d) The services ordinarily require performance by a physician;

(e) In the case of anesthesiology, laboratory, or radiology services, the additional requirements set forth in rules 5101:3-4-21 and 5101:3-4-25 of the Administrative Code are met; and

(f) The expenses associated with the provision of the professional services are

excluded from the cost report of the site-based provider entity.

(3) Facility-related services rendered by a provider-based physician that are of benefit to patients in general (e.g., teaching; research; administration; supervision of professional or technical personnel, residents, interns, or fellows; or service on provider committees) are reimbursable only to the employing or contracting provider.

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, 5164.70
Prior Effective Dates:	04/07/1977, 10/01/1983 (Emer), 12/29/1983, 09/01/1989, 03/26/2001, 09/01/2005, 10/25/2008, 08/02/2011, 12/02/2011 (Emer), 03/02/2012

5160-4-01 **Physician services.**

(A) Payment may be made for a covered service rendered by a physician only if the following conditions are met:

(1) The physician is currently enrolled as an Ohio medicaid provider;

(2) The service is rendered to a medicaid-eligible Ohio recipient in a state in which the physician is licensed or authorized to practice; and

(3) The service is within the scope of practice of the physician's specialty.

(B) Separate payment may be made for covered professional services rendered by a physician employed by or under contract with a facility such as a hospital or long-term care facility (i.e., a "facility-based" physician) only if the following additional conditions are met:

(1) The services contribute directly to the diagnosis or treatment of an individual patient;

(2) Any applicable requirements set forth in agency 5160 of the Administrative Code are satisfied; and

(3) The expenses associated with the provision of the professional services are excluded from the cost report of the facility.

(C) In addition to professional services, a facility-based physician often performs other services that are of benefit to patients in general (e.g., teaching; research; administration; supervision of professional or technical personnel, residents, interns, or fellows; or service on provider committees). Payment for such services may be made only to the employing or contracting provider.

(D) For the sole purpose of demonstrating eligibility for incentive payments made in accordance with Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. No. 111-5), codified at 42 U.S.C. 1396b (February 1, 2017), and with the regulations published at 42 C.F.R. Part 495 (October 1, 2016), an optometrist operating within the appropriate scope of practice defined in section 4725.01 of the Revised Code is considered to be a physician.

Replaces: 5160-4-01

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:	5164.02
Prior Effective Dates:	04/07/1977, 10/01/1983 (Emer), 12/29/1983, 09/01/1989, 03/26/2001, 09/01/2005, 10/25/2008, 08/02/2011, 12/02/2011 (Emer), 03/02/2012