CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: ASC Reimbursement

Rule Number(s): 5160-22-01 (Amended)

Date: 8/7/18

Rule Type:

- ☐ New
- X 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- ☐ Rescinded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.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   This rule sets forth the definition of an ambulatory surgery center (ASC), how an ASC can become an eligible Medicaid provider, covered and non-covered surgical procedures allowed in an ASC, and the ASC reimbursement methodology. Dental service reimbursement is being added so that any dental service that groups to EAPG codes 00350 through 00372, will be reimbursed a flat rate of $953.60. This flat rate payment is also subject to discounting factors assigned by the EAPG grouper.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

The amended rule also removes references to Administrative Code rules, that have either been rescinded or are no longer needed as a reference, throughout paragraph (E). In paragraph (A)(5) the list of percentages was updated and in (A)(9) a spelling mistake was corrected. In paragraphs (C), (C)(1), (E)(1)(a) and (E)(2)(a) the term 'facility' was struck as it is redundant and was not used consistently throughout the rule. The line stating ASCs must bill in accordance with 5160-1-19 of the Administrative Code was struck from paragraph (E) and moved to paragraph (B), to make it clear it applies to all services billed, not just the services listed in paragraph (E). In paragraphs (F)(1)(a) and (F)(2)(a) the language "Additional payments for" was changed to "Payments for covered" for clarity. In paragraph (E)(1)(c), (E)(2)(c) and (E)(3)(c), for simplicity, the language "product of paragraphs (D)(2)(a), (D)(2)(b) and (D)(2(d)" was updated to "result of paragraph (D)(2)(d)" . In paragraph (E)(1)(a), (E)(2)(a) and (E)(3)(a), the language "in addition to the facility fee" was struck for clarity.

The adverse impacts of this rule are part of preexisting content of the rule.

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.**

   ASC services are not one of the category of services that are federally mandated by the federal government to be covered under the Medicaid program. However, ODM has determined it to be cost effective and beneficial to the Medicaid program to cover procedures in the ASC setting. The only requirement to be a Medicaid ASC provider is a valid Medicare agreement, the Medicare conditions and requirements to be an ASC provider are defined in 42 CFR 416 subpart B.

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, the prior authorization requirement for certain services, and the reimbursement methodology for the covered services.

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 claims are properly paid under the updated reimbursement methodology.

Development of the Regulation

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

   ODM solicited input from the Ohio Association of Ambulatory Surgery Centers (OAASC) about adding dental services.

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

   OAASC was supportive of ODM adding coverage and reimbursement for dental 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?**

   ASCs payments use the same relative weights and a percentage of the statewide average outpatient base rate and cost to charge ratio. ODM used four years of outpatient claims data to set the EAPG relative weights and base rates. The new ASC dental flat rate is set at 80% of the statewide average outpatient hospital flat rate, like the ASC base rate and cost to charge ratio. 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 EAPG reimbursement methodology has only been in place since 8/1/2017 so it does not make sense to explore alternatives to the reimbursement methodology.

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 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 updates to the reimbursement methodology in Rule 5160-22-01 will be implemented on January 1, 2019. A Medicaid Transmittal Letter will be posted that will describe the changes for the ASCs.

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;**

       This rule impacts 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**

       This 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. These requirements are currently part of the rule and the proposed changes will not impact these requirements.

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

       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). After obtaining an agreement with CMS, there are no more fees for ASCs to obtain a Medicaid provider agreement. However, there is a small time impact, upwards of an hour, to fill out and submit an application to become a Medicaid provider. There is no expected adverse impact on existing ASC providers as they already meet the requirements.

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

    The Agency determined that the regulatory intent justifies the adverse impact to the ASCs because a Medicaid Provider Agreement is required for participation in the Medicaid

program and there must be some standards for participation in the Medicaid program. By using the same standards as Medicare and requiring ASCs to have a valid agreement with CMS causes the least impact to providers and eliminates multiple certification processes and fees.

Regulatory Flexibility

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

No, ODM 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.

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 OAC rule 5160-22-01 to Hospital_policy@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

DRAFT - NOT FOR FILING

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

Effective for dates of service on or after the effective date of this rule, 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 "International Classification of Diseases" diagnosis codes, 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~~or repeated ancillary services designated by default EAPG settings or both. 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) "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.

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

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

(9) "Diagnosis code" is the "International Classification of Diseases" codes as ~~indentified~~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) "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. 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.

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

(13) "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) ASC providers must bill in accordance with rule 5160-1-19 of the Administrative Code. 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~~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) Services covered in an ASC are listed on the department's web site http://www.medicaid.ohio.gov/.

(3) 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

(2) The payment for a paid line on the claim is calculated as follows, except as described in paragraph (E) or (F) of this rule:

(a) The ASC EAPG base rate times;

(b) The EAPG relative weight for which the service was assigned by the EAPG grouper, rounded to the nearest whole cent;

(c) For EAPGs 00134 and 00149, the result of paragraph (D)(2)(b) of this rule multiplied by one hundred ten per cent, rounded to the nearest whole cent,

(d) The result of paragraphs (D)(2)(a) and (D)(2)(b) of this rule, or, for EAPGs 00134 and 00149, (D)(2)(a) to (D)(2)(c), times applicable discounting factor(s) as defined in paragraph (A)(5) of this rule, rounded to the nearest whole cent.

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

An ASC may be reimbursed in addition to the facility fee for covered 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.

(c) Laboratory services will be reimbursed the lesser of billed charges or the result of paragraph ~~product of paragraphs (D)(2)(a), (D)(2)(b) and~~ (D)(2)(d) of this rule.

(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.

(c) Radiological services will be reimbursed the lesser of billed charges or the result of paragraph ~~product of paragraphs (D)(2)(a), (D)(2)(b) and~~ (D)(2)(d) of this rule.

(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.

(c) Diagnostic and therapeutic services will be reimbursed the result of paragraph ~~product of paragraphs (D)(2)(a), (D)(2)(b) and~~ (D)(2)(d) of this rule.

(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.

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

(1) Pharmaceuticals.

(a) ~~Additional payments~~Payments for covered 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 (F)(1)(b) and (F)(1)(c) 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~~Payments for covered 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~~Payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.~~.~~

(3) Dental Services

(a) Payments for covered dental services may be made for all line items grouping to EAPG code 00350, 00351, 00352, 00353, 00354, 00355, 00356, 00357, 00358, 00359, 00360, 00361, 00362, 00363, 00364, 00365, 00366, 00367, 00368, 00369, 00370, 00371, or 00372.

(b) Reimbursement for dental services will be nine-hundred fifty-three dollars and sixty cents.

(c) Payments for dental services will be made in accordance with the discounting factors as determined by the EAPG grouper.