Outpatient Prospective Payment in MS Phase 1 Provider Training

Implementation 9/1/12

Provider Training Material will be updated for Phase 2

Government Healthcare Solutions

Introductions

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Questions

Please feel free to send questions via the WebEx during this session.

We will attempt to provide answers where possible at the end of the session.

Contents

1. Background
2. Effective Dates
3. What is OPPS?
4. Payment calculation and hierarchy
5. Key policy decisions

Payment policy decisions remain subject to change before implementation.

BACKGROUND

Current MS Payment Method

- FY 07 $247 million
- FY 11 $264 million
- Method
  - Claims are paid based on a cost-to-charge ratio (CCR) that is the lesser of the hospital-specific Medicare cost-to-charge ratio using the original cost report, or 75% of charges
  - After the final cost report is received from the Medicare contractor, the cost-to-charge ratio is recalculated and claims history is adjusted
  - For lab and imaging services, payment is made on a fee-for-service basis, with no cost settlement
- Concerns
  - Hospitals that control costs are penalized
  - Audit concerns over Medicare cost reports
  - No transparency into what is being purchased
  - Very different payments for similar care

BACKGROUND

Outpatient Payment Methods Nationwide

How Medicaid Pays for Hospital Outpatient Care

November 2011

Ambulatory Payment Classification (APC)
IA, MI, MN, MT, NM*, RI*, VT, WA, WY

* APC based fee schedule

States that base their payment methods on Medicare's approach typically follow Medicare in using a fee schedule for lab services, an RBRBS-based fee schedule for therapy services, and APCs for all other services. States vary in how closely they follow the Medicare APC logic. Some (e.g., MT) very closely follow the Medicare model while others (e.g., RI) may not adopt Medicare payment policies such as conditional packaging and composite APCs.

Enhanced Ambulatory Patient Groups (EAPGs)
MA, MD, NY

Enhanced APGs are a software product developed and owned by 3M Health Information Systems. MA and MD use APGs indirectly to measure hospital casemix in setting payment rates. NY calculates payment for each claim based directly on APGs.

Primarily Other Fee Schedule
AL, AR, AZ, CA, HI, IL*, IN, KS, OH, OK, PA, SC, WV

*Moving to EAPGs

This group of states covers a wide range of approaches, with more emphasis on fee schedules than on cost reimbursement. Nevertheless, some fee schedule states may use cost reimbursement for selected services while cost-reimbursement states typically use fee schedules for lab services and sometimes other types of care. Fee-schedule states may have developed their own fees or have based their payment methods on other approaches, such as Medicare's previous method for ambulatory surgical centers.

Primarily Cost Reimbursement
AK, CO, CT, DC, DE, FL, GA, ID, KY, LA, ME, MO, MS**, NC, ND**, NE, NH*, NJ, NV, OR, SD, TN, TX*, UT, VA*, WI

* Moving to EAPGs ** Moving to APCs

In a typical cost reimbursement method, Medicaid makes an interim payment for each claim based on a percentage of billed charges. Final payment is calculated after a cost settlement process that typically occurs one to three years after the service is provided. Although a state's payment method may be primarily cost reimbursement, states typically use fee schedules to pay for lab services and, depending on the state, may also use fee schedules for imaging services or other types of care.

Notes:

1. Updates and corrections are welcome. Please contact Connie Courts at connie.courts@xerox.com or 859-623-6118.
2. Sources: Individual states, Xerox State Healthcare LLC, 3M Health Information Systems.
3. Xerox State Healthcare LLC does not have a financial interest in any APC, APG or other outpatient grouping algorithm.

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BACKGROUND

Development of Outpatient Payment Method

- 2005: Assessment of options
  - Evaluation report delivered 9/6/2005
- 2008: Detailed design of payment method
  - Detailed design report delivered 6/24/2008
- 2012: Legislature directed DOM to implement

EFFECTIVE DATES

Two Phases Toward Implementation

- Phase 1 implementation September 1, 2012
  - Fee schedule
- Phase 2 implementation December 10, 2012
  - Discounting
- Fee schedule and revenue code list will be published
- Provider education (e.g., FAQ document, WebEx training sessions)
  - September 6 and 7, 2012
  - December 6 and 7, 2012
- Special WebEx for CAH, Children's and Cancer Centers
  - August 22, 2012

WHAT IS OPPS?

Outpatient Prospective Payment System

Based on Medicare's payment system

- Line level payment method – essentially a fee schedule
  - APC (Ambulatory Payment Classifications)
  - Medicare Fee
  - Medicaid Fee

General

- APCs are groups made up of CPT/HCPCS codes that share common types of service or common types of delivery of service
- Weights are assigned to the APC based on the degree of difficulty of the service and of the cost of the service
- Many APC weights also include a calculation for nursing services, supplies and drugs that are commonly performed at the same time as the principal service-this is why many supplies, drugs and administration of injection codes have a “N” or bundled status indicator

OPPS Claims Should Paint a Picture

- Every service performed should be coded
- Where did the patient come into the facility?
  - ER, clinic, direct admit?
- What happened to the patient?
  - Surgery?
  - Clinic visit?
  - Treatment room?
- What resources were used by the facility?
  - Supplies?
  - Pharmaceuticals?
  - Blood products?
- The claim should tell the story of what happened to the patient

APC Status Indicators (SI)

- Status Indicators tell you how the line was priced
  - A, B & M – Miscellaneous codes paid by Medicaid fee (i.e. lab, therapies, vaccinations)
  - C – Inpatient only services
  - D – Discontinued codes
  - E – Non-covered code
  - G & K – Drugs & biologicals paid by Medicare fee
  - N – Service is bundled into an APC (If all your codes are N on your claim, your claim will pay at zero)
  - R – Blood products
  - S – Significant procedure paid by APC that the multiple procedure discount DOES NOT apply to
  - T – Significant procedure paid by APC that the multiple procedure discount DOES apply to (will be implemented 12/10/2012 as part of Phase 2)
  - U – Brachytherapy
  - V – Medical visits in the clinic, critical care or emergency department (includes codes for direct admits)
  - X – Ancillary services paid by their own APC

Conversion Factor

- MS Medicaid will use the Jackson area conversion factor as it represents the average
- National weights will be used

Wage Area	Wage Index	GAF	40% Unaffected by Wage Area	60% Affected by Wage Area	Conversion Factor
Rural MS	0.7586	0.8276	$ 28.01	$ 31.87	$ 59.87
Pascagoula, MS	0.7733	0.8386	$ 28.01	$ 32.49	$ 60.49
Hattiesburg, MS	0.8119	0.8670	$ 28.01	$ 34.11	$ 62.11
Jackson, MS	**0.8154**	**0.8696**	**$ 28.01**	**$ 34.25**	**$ 62.26**
Gulfport-Biloxi, MS	0.8428	0.8895	$ 28.01	$ 35.41	$ 63.41
Memphis, TN-MS-AR	0.9202	0.9446	$ 28.01	$ 38.66	$ 66.66
Note: The national Medicare APC conversion factor is $70.016					

Hierarchy of Payment

1. If there is a Medicare APC assigned to the code, the fee will be the Mississippi Medicaid conversion factor times the national APC weight times 90% times units (when applicable)
2. If there is not an APC assigned and a Medicare fee is available, the fee will be 90% of the Medicare fee times the units
3. If there is not an APC assigned nor a Medicare fee, the fee will be the Mississippi Medicaid fee time the units (when applicable). If a technical component or site-of-service differential are appropriate that fee will apply, otherwise the general Mississippi Medicaid fee will apply.

KEY POLICY DECISIONS

Phase 1

- The only hospitals exempt from OPPS are Indian Health Services
- Conversion Factor – Jackson area used
- Charge cap – paid the lower of the allowed amount or the billed charges at claim level
- Revenue codes – functionality to disallowed certain revenue codes (i.e. inpatient)
  - Some revenue codes will not require CPT/HCPCS codes
  - If no code present line will price at $0.00
- Physician administered drugs will require a valid NDC
- Outpatient claims will go through NCCI edits
- Existing policy for service limits and units will apply
- 5% assessment will still apply

KEY POLICY DECISIONS

Phase 1

- Blood unit limits for inpatient and outpatient will no longer apply
- Observation – paid a per hour rate for minimum of 8 and maximum of 23 hours
  - G0379 will be set at N for bundled and paid at $0.00
- There will no longer be limitations for adults for outpatient hospital emergency department visits
  - CPT 99282 will pay APC 604 (lowest level clinic visit APC) instead of APC 613
- Policy concerning codes requiring prior authorization will not change
- All services provided by the same hospital to the same patient on the same day must be billed on the same claim except therapies

Important Points to Note

- Date Bundling
  - All services provided by the same hospital to the same patient on the same day must be billed on the same claim except therapies
  - For observation services this means that all hours of observation must be included on a single line – even the hours that take place after midnight
  - Therapies (speech, physical and occupational) may be span billed
- National Drug Codes (NDC) codes MUST be present for rebateable drug codes
- National Correct Coding Initiative (NCCI) edits will apply
  - Rules are posted at https://msmedicaid.acs-inc.com/all_late_breaking_news.pdf

KEY POLICY DECISIONS

Phase 2

- Discounting will apply to codes with a “T” status indicator
  - 1st line billed will be paid at 100% of APC
  - Additional lines will be paid at 50% of APC
  - Make sure you bill your highest priced service first
- Two fees for observation in Phase 2
  - Claims with 99284, 99285 or 99291 present on the claim will pay the Medicaid rate of $43.09 for 8-23 hours
  - Other observation lines will be paid APC 8002 for minimum of 8 and maximum of 23 hours
- Some procedure codes must be billed with specific revenue codes
  - Rev Code 0636 for specific pharmacy codes
  - Rev Code 068X (trauma team activation) with G0390

Coding Impact

Overall Totals

MS Phase 1 Outpatient - Summary By Lines		
Metric	**Value**	**% of Lines**
Total claims	408,132	
Total lines	1,863,304	
Lines--average lines per claim	5	
All Lines--% with procedure code		81.0%
Revenue code not allowed	1,836	0.1%
Procedure code required - not present	67,475	3.6%
Procedure code not present- not required	294,205	15.8%
Bundled lines	149,714	8.0%
All other lines	1,350,074	72.5%
Total Lines	**1,863,304**	**100.0%**
Notes:		
1. Data is from June 2011 through November 2011		

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Questions?

For Further Information

- For technical questions about the payment method: **Debra Stipcich**, Project Director, Payment Method Development, Xerox State Healthcare Solutions, LLC (debra.stipcich@xerox.com, 406-457-9587).

- For questions about Medicaid policy: **Zeddie R. Parker**, Accountant/Auditor VI, Professional, Division of Medicaid (Zeddie.Parker@medicaid.ms.gov, 601-359-6021).


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