Outpatient Prospective Payment in MS

Change from Cost Based to Fee Schedule Payment Model Based on Medicare OPPS

Hospital Information Meeting 7/11/2012

Government Healthcare Solutions

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Contents

1. Background
2. Effective dates
3. Payment calculation and hierarchy
4. Similarities to Medicare
5. Differences from Medicare
6. Simulation

Payment policy decisions remain subject to change before implementation.

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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.	

3

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BACKGROUND

Medicare Outpatient Prospective Payment

- Outpatient Prospective Payment System (OPPS)
- Based on Ambulatory Payment Classification (APC) groups
- In 2000 OPPS consisted of 451 groups of APCs. Today there are 851
- Uses hospital specific conversion factors adjusted for work areas
- The status indicator provides information on the type of service represented by the APC
- Anesthesia, some medications, supplies, and operating and recovery room services are packaged under one APC payment rate
- Outlier adjustments in addition to the APC payment
- Uses Outpatient Code Editor software to identify errors and assign APCs

4

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BACKGROUND

Current MS Payment Method

- 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

5

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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

6

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EFFECTIVE DATES

Two Phases Toward Implementation

- DOM has reevaluated the DDD from 2008 to reflect current policy
- Decision to move forward with Phase 1 implementation of fee schedule September 1, 2012
- Phase 2 implementation of status indicators and status "T" discounting December 10, 2012
- State plan amendment is being filed
- Administrative rules filed
- Provider education (e.g., FAQ document, WebEx training sessions)
  - Tentative dates for provider WebEx
    - September 6-7, 2012
    - December 6-7, 2012

7

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PAYMENT CALCULATION AND HIERARCHY

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					

8

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PAYMENT CALCULATION AND HIERARCHY

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.

SIMILARITIES TO MEDICARE

Parallels to Medicare

- No CPT or HCPCS codes required for revenue codes 025X, 027X, 037X or 071X
- Payment driven by status indicator of CPT/HCPCS code
- Certain revenue codes will not be allowed when provided by a hospital outpatient department (i.e. ambulance, take home supplies)
- Revenue code 0636 physician administered drugs will require specific CPT/HCPCS codes
- Status indicator “T” will be subject to discounting – first service at 100%, all others at 50%

DIFFERENCES FROM MEDICARE

MS Division of Medicaid Policy

- Physician administered drugs will require a valid NDC
- Outpatient claims will go through NCCI edits
- No outlier payments will be made
- Low level ER visits will be subject to a limit of 6 for adults
- Policy concerning codes requiring prior authorization will not change
- Hospitals will be paid the lower of the calculated allowed amount and the billed charge, with the comparison done at the claim level (not line level)
- All services provided by the same hospital to the same patient on the same day must be billed on the same claim except therapies
- 5% assessment will still apply

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OUTPATIENT PAYMENT SIMULATION

Criteria for Simulation

- Data is based on 6 months of claims
  - June 2011 – November 2011
- 1.8 million lines of service
  - 1.4 million had both a revenue code and a procedure code
- 19% of lines had no CPT/HCPCS codes
- Many claims had invalid revenue codes for hospital outpatient services
  - i.e. 110-room and board, 171-nursery level I
- 30,786 lines where the codes were discontinued, not covered by policy or were services that should have been inpatient only

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OUTPATIENT PAYMENT SIMULATION

Examples of New Fees

CPT Code	Description	Average Allowed Charge-Old Method	MS APC Rate
99285	Emergency dept visit	$412.03	$258.61
70553	Mri brain w/o & w/dye	$515.98	$427.81
85025	Complete cbc w/auto diff wbc	$9.96	$9.92
70450	Ct head/brain w/o dye	$129.56	$153.74
96372	Ther/proph/diag inj sc/im	$46.10	$27.86
93306	Tte w/doppler complete	$439.55	$314.67
33233	Removal of pm generator	$521.85	$1,218.31
99283	Emergency dept visit	$147.27	$108.97

For Further Information

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