Outpatient Facility Reimbursement

Presented by the

Employees Group Insurance Department

Oct. 28, 2015

Background

- Outpatient reimbursement was last reviewed in 2008
- Surgical codes (CPT 10000-69999) and covered revenue codes are reimbursed using a percentage of billed charges
  — Urban: 60 percent of billed charges
  — Rural: 70 percent of billed charges
- Most remaining codes have established Allowable Fees ranging from 125 percent to 300 percent of Medicare

Background

- No lesser of billed charges of Allowable Fees on a line or claim level
- No multiple procedure discounting
- The Department of Corrections (DOC) and HealthChoice use the same reimbursement methodology

Objectives and Analysis

- Primary Objective
  - Evaluate whether EGID payment levels for outpatient hospital services are in alignment with common industry practices
    - No changes in methodology for injectables, per diem or commonly-billed dialysis codes
- Analytical Steps
  - Retained external consulting services to assist in data analysis and identifying reimbursement options that are consistent with industry practices
  - Reviewed EGID's utilization, reimbursement levels and historical cost trends
    - Outpatient cost increases are disproportionate to utilization and case mix changes
    - Over 50 percent of outpatient reimbursement is at a percentage of billed charges

Objectives and Analysis

- Analytical Steps
  - Assessed current EGID reimbursement levels in the context of:
    - Commercial payer ranges
    - Actual EGID line item (procedure level) versus case level Allowable Fees
    - Medicare payment levels and policies
      - Under Medicare’s Outpatient Prospective Payment System (OPPS), certain charges are “packaged” and not reimbursed at the line item level
      - Medicare discounts secondary and tertiary procedures at 50 percent

Task Force Process

- Established an outpatient task force and presented the following proposed reimbursement changes in December 2014
  - CPT 10000-69999:
    - 170 percent urban/180 percent rural of Medicare (National Addendum B amounts)
    - Discontinued payment of packaged services (as indicated by Medicare status indicators)
  - C-Codes that are not packaged
    - 170 percent urban/180 percent rural of Medicare
  - Continue with no multiple procedure discount
  - No changes to 7xxxx and 9xxxx series codes
  - Continue with urban/rural differential
  - No outlier payment

Task Force Process

- Most common task-force feedback:
  - Establish tiers similar to the inpatient tiers
  - Continue reimbursement for implants and high-cost drugs (revenue codes 274 through 279 and 636)
    - Cost plus approach, or
    - Percent of billed charges approach with annual cap on chargemaster increases
  - Establish fee schedule with inflation factor rather than tying rates to Medicare
  - Establish different markups over Medicare for different service lines, i.e., higher markups for higher cost services such as orthopedics
  - Larger urban/rural differential
  - Exclude Critical Access and Sole Community Hospitals from methodology and continue to pay a percentage of billed charges
  - Phase in Medicare percentages over three years

Task Force Process

- In order to be responsive to the task forces concerns, EGID and its consultant conducted additional data analyses and benchmarking
  - July 2015 – a revised proposal incorporated many of the task forces recommendations
- Remaining task force concerns
  - Reductions are too large
    - EGID response
      - Shifting from a charge-based reimbursement approach to a fee-schedule approach will have a larger impact on facilities that have the highest charges
      - Analysis sought to balance the impact as much as possible, but the ability to do so for facilities with high charges was limited

Task Force Process

- Remaining task force concerns
  - The fully phased-in rates will be among the lowest compared to other Oklahoma commercial payers
    - EGID response
      - Analysis indicates that aggregate reimbursement under the revised proposal will be within close range of market levels

Task Force Process

- Remaining task force concerns
  - The proposal does not account for high-cost devices, drugs or specialty services that some facilities provide
    - EGID response
      - Medicare OPPS is based on resource costs and accounts for high-cost devices and drugs within the Ambulatory Payment Classification rates which are reviewed annually
      - EGID will follow most of Medicare’s policy regarding packaging and payments; however, select implant-related revenue codes will continue to be reimbursed at a percentage of billed charges
      - Medicare uses multiple-procedure discounting (MPD); EGID proposal does not include MPD which would result in additional reductions
      - Vast majority of outpatient services billed to EGID are routine surgical procedures

Task Force Process

- Some facilities are calculating a different financial impact than the EGID models
  - EGID response
    - Facilities may be calculating the impact using different assumption regarding inflation, Medicare rate increases and/or their anticipated chargemaster increases
    - Facilities may have misunderstood the pro forma fee schedule that was provided during the task force process; many codes that are currently allowed at 60 percent/70 percent will remain that way when indicated by the status designation of BR, i.e., G0378
    - Detailed claim examples provided during the task force process focused only on changes in Allowable Fees for those codes where there was a proposed methodology change
- Special thanks to task force members for their time and consideration

Revised Proposal

- Establish tiers similar to inpatient tiers
  - Tier 1 – Network urban facilities with greater than 300 beds
  - Tier 2 – All other urban and non-Network facilities
  - Tier 3 – Critical Access Hospitals, Sole Community Hospitals, Indian, Military and VA facilities
  - Tier 4 – All other Network rural facilities
    - For inpatient, Tier 4 remains frozen until Tier 2 base rate exceeds Tier 4, which is estimated to occur in 2023. At that time, both inpatient and outpatient Tier 4 will be moved to Tier 2
- Phase-in changes over the next three years
  - April 1, 2016
  - April 1, 2017
  - April 1, 2018

Revised Proposal

- Code ranges allowed as a tier-specific percentage of Medicare:
  - Surgery and other procedures within 10000 – 69999 that are not packaged by Medicare
  - Cardiovascular and other procedures within 92900 – 93999 that are not packaged by Medicare
  - HCPCS “C” codes that are not packaged by Medicare

Tier	April 1, 2016	April 1, 2017	April 1, 2018
1	220%	205%	180%
2	210%	195%	170%
3	230%	215%	200%
4	220%	205%	190%

Revised Proposal

- Revenue codes
  - Covered revenue codes that are currently allowed at 60 percent/70 percent of billed charges, generally Medicare packaged revenue codes, will initially be allowed at a reduced percentage of billed charges and then will be phased out

Tier	April 1, 2016	April 1, 2017	April 1, 2018
All	25%	10%	No Payment

  - Covered implants will be allowed at the CPT/HCPCS Allowable Fee, or if no CPT/HCPCS code exists, then revenue codes 275, 276, 278, and 279 will be allowed at 30 percent/35 percent of billed charges

Tier	April 1, 2016	April 1, 2017	April 1, 2018
1	30%	30%	30%
2	30%	30%	30%
3	35%	35%	35%
4	35%	35%	35%

Revised Proposal

- No phase in for colonoscopy services; allowables will begin at fully phased-in levels effective April 1, 2016
  - CPT/HCPCS codes

Tier	April 1, 2016	April 1, 2017	April 1, 2018
1	180%	180%	180%
2	170%	170%	170%
3	200%	200%	200%
4	190%	190%	190%

  - Revenue codes associated with colonoscopy procedures currently allowed at 60 percent/70 percent will initially be allowed at reduced percentages of billed charges and then they will be phased out

Tier	April 1, 2016	April 1, 2017	April 1, 2018
All	25%	10%	No Payment

Revised Proposal

- As additional procedures are identified for HealthChoice Select, they will go to fully phased-in reimbursement levels effective with the next quarterly fee schedule update with appropriate notification
- No methodology changes to 7xxxx, 8xxxx and 9xxxx series codes except where noted earlier for code range 92900-93999
- No changes to injectables, dialysis and per diem
- No multiple procedure discount
- No lesser of billed charges of Allowable Fee on a line or claim level
- Clinical edits will still apply
- Plan provisions and limitations for non-covered services will still apply

Revised Proposal

- Timing of fee schedule updates:
  - April 1, 2016: Comprehensive updates based on the Jan. 1, 2016 National Addendum B amounts
  - July 1, 2016, Oct. 1, 2016, and Jan. 1, 2017: Updates for adds, changes and deletes
  - April 1, 2017: Comprehensive updates based on the Jan. 1, 2017 National Addendum B amounts
  - July 1, 2017, Oct. 1, 2017, and Jan. 1 2018: Updates for adds, changes and deletes
  - April 1, 2018: Comprehensive updates based on the Jan. 1, 2018, National Addendum B amounts

Impact of Proposed Changes

- While most hospitals will experience an increase at the line (procedure) level, they may experience overall reductions in case level payments
  — Primarily due to phase out of codes considered packaged by Medicare
- Greater impact for hospitals with relatively high charges
- Fully phased-in payment levels will result in a per case payment within range of Oklahoma commercial payer levels

Timeline

Item	Date
Public Hearing	Oct. 28, 2015
Public Hearing Written Comments Due	Nov. 13, 2015
Final Recommendations Posted to Website	Dec. 11, 2015
Implementation of First Phase	April 1, 2016
Implementation of Second Phase	April 1, 2017
Implementation of Third Phase	April 1, 2018