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

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<tr>
<th>Tier</th>
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<tr>
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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.

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<tr>
<td>All</td>
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- 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.

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Revised Proposal

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

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- 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

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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
  - 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

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<th>Item</th>
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<tr>
<td>Public Hearing</td>
<td>Oct. 28, 2015</td>
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<tr>
<td>Public Hearing Written Comments Due</td>
<td>Nov. 13, 2015</td>
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<tr>
<td>Final Recommendations Posted to Website</td>
<td>Dec. 11, 2015</td>
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<td>Implementation of First Phase</td>
<td>April 1, 2016</td>
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<td>Implementation of Second Phase</td>
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<tr>
<td>Implementation of Third Phase</td>
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