STATE OF CONNECTICUT HOSPITAL PAYMENT MODERNIZATION

TRANSITION TO OUTPATIENT HOSPITAL AMBULATORY PAYMENT CLASSIFICATION

July 9, 2015

Janet Flynn, Mercer
James Matthisen, Mercer
Sarah Yahna, Mercer
Amy Perry, Myers and Stauffer
Scott Simerly, Myers and Stauffer

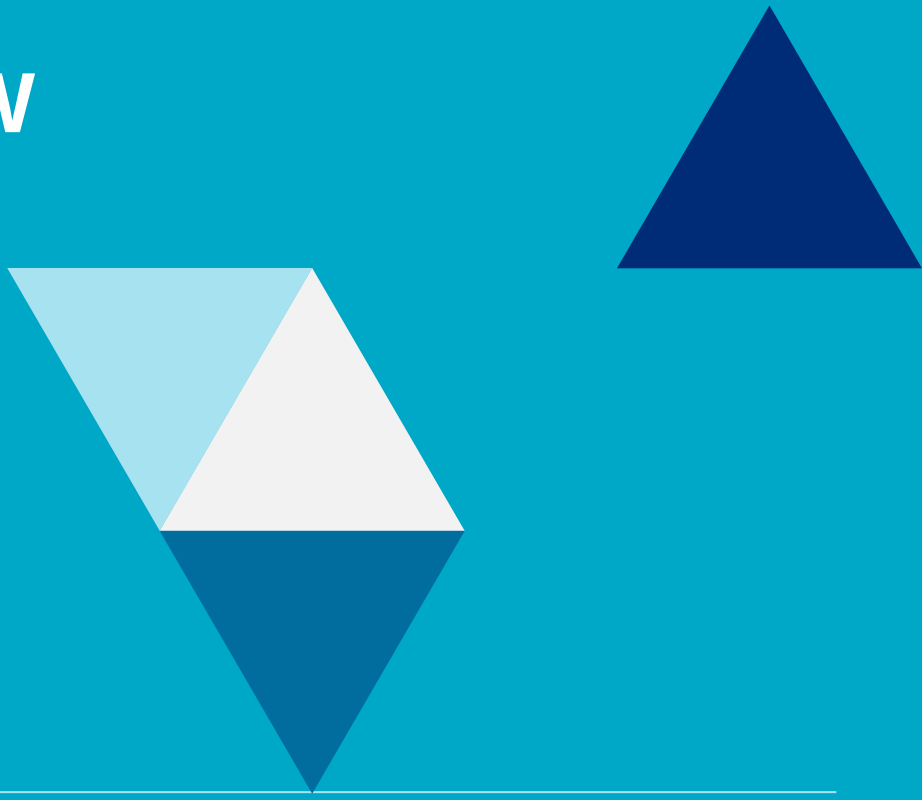
Hartford, CT

AGENDA

- Welcome and Introduction.
- Project Overview.
- Payment Design and Policies.
- Claims Analysis.
- Next Steps.
- Questions and Answers.

INTRODUCTION

PROJECT OVERVIEW



PROJECT OVERVIEW
CONTEXT REVIEW

- Hospital Payment Modernization (HPM).
- Phase II Focus — Outpatient.
- Payment Design and Policies.
- Data Modeling.
- Beginning work on Fiscal Impact Model — but not yet “Developing Rates”.

PROJECT OVERVIEW
LAST MEETING "NEXT STEPS"

Additional Data Analysis

- Three month claims sample.
- Assign Ambulatory Payment Classifications (APCs).
- Claims data quality.
- Billing and coding improvements.

Payment Design and Policies

- Inventory current payment structure.
- Identify proposed payment structure.

PROJECT OVERVIEW
YOU ASKED ABOUT…

- Focus on method of payment, not level of payment.
- Follow Medicare payment policy.
- Use enough data/testing process.
- Routine system updates.
- Meetings.

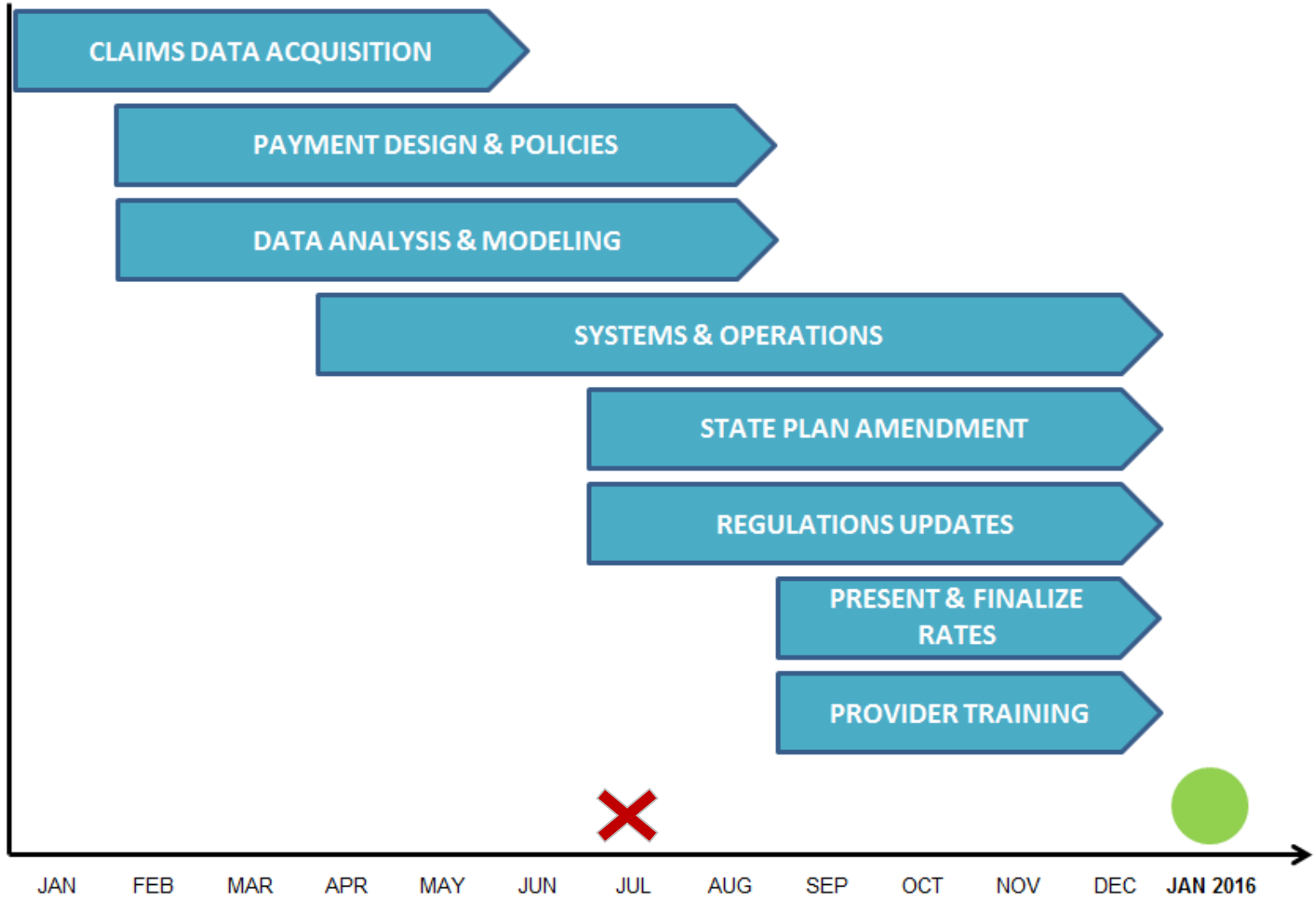
PROJECT OVERVIEW
PROJECT PLAN OVERVIEW

Task	Timeframe
Claims Data Acquisition	
3-month Data Sample	Q1
Full Data File	Q2
Payment Design and Policies	
Identify Policy Exclusions	Q1–Q2
Identify Exceptions to Medicare Policies	Q1–Q2
Document Payment Approaches	Q2–Q3
Data Modeling	
Initial Claims Analysis	Q1–Q2
Full Claims Analysis	Q2–Q3
Costing of Claims	Q3
Modeling and Fiscal Impact	Q3

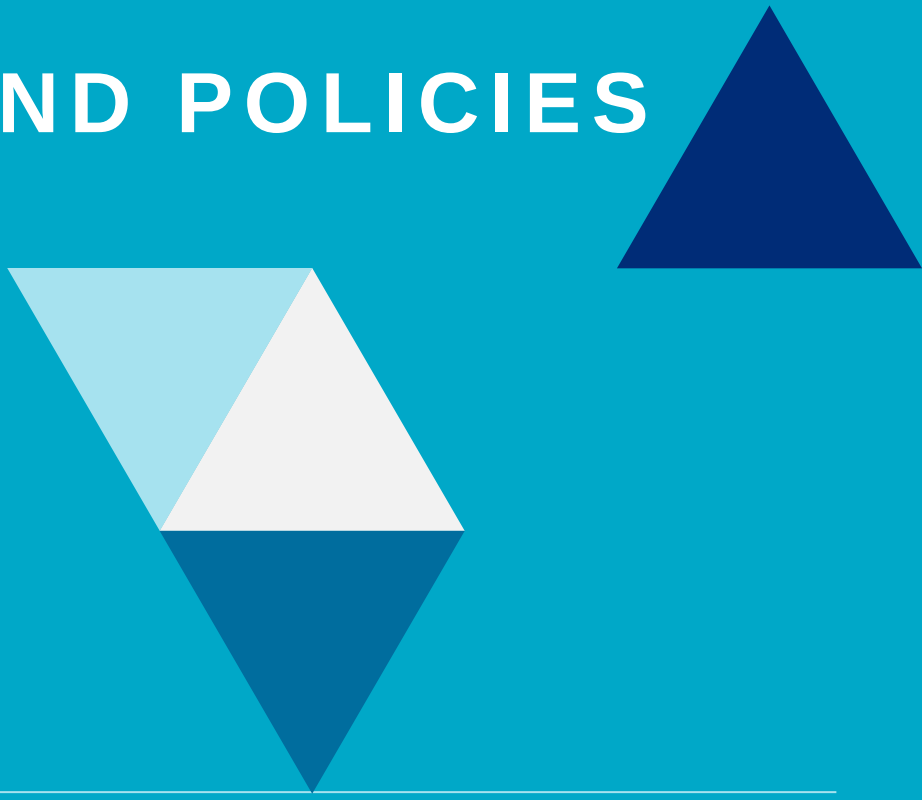
PROJECT OVERVIEW
PROJECT PLAN OVERVIEW (CONT'D)

Task	Timeframe
Peer Review	Q1–Q4
Target Development	Q2–Q3
Regulations and State Plan Amendment	Q3–Q4+
Communication Plan	
Hospital Meeting #1 (web conference)	April 9
Hospital Meeting #2 (onsite at DSS)	July 9
Hospital Meeting #3	Q3
Additional Hospital Meetings	TBD
Systems and Operations	
Document APC Business Requirements	Q2–Q3
Support Medicaid Management Information System (MMIS) Implementation	Q3–Q4

PROJECT OVERVIEW
TIMELINE REVIEW

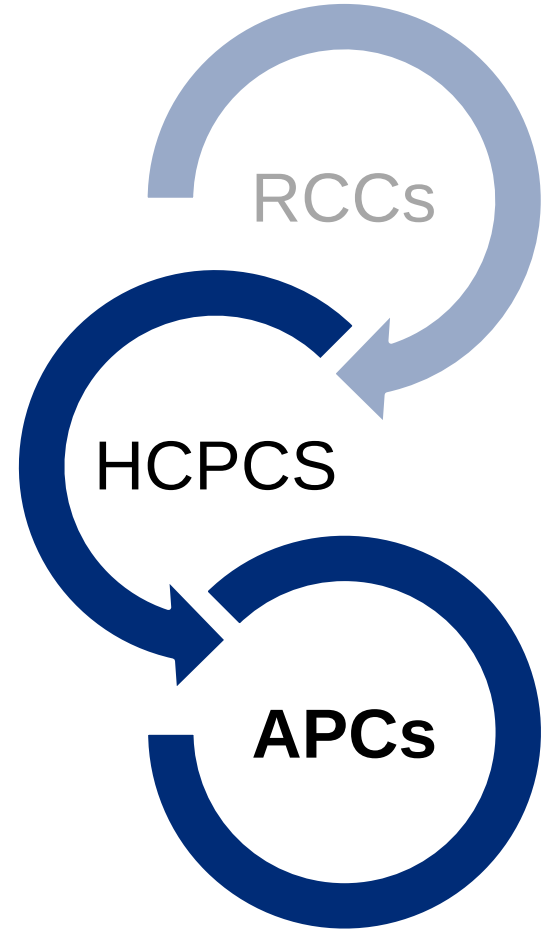


PAYMENT DESIGN AND POLICIES



PAYMENT DESIGN AND POLICIES
SHIFT TO PROCEDURE CODES

- Revenue center codes (RCCs) are currently the primary source of payment determination:
  - Cost to charge ratios.
  - Fixed fee.
- RCCs will be utilized for:
  - Processing policy exclusions.
  - Assigning applicable edits.
- Procedure codes will be the primary source of payment determination under APC methodology.
- Procedure codes will be used to perform system audits of services.



PAYMENT DESIGN AND POLICIES
APC POLICY EXCLUSIONS

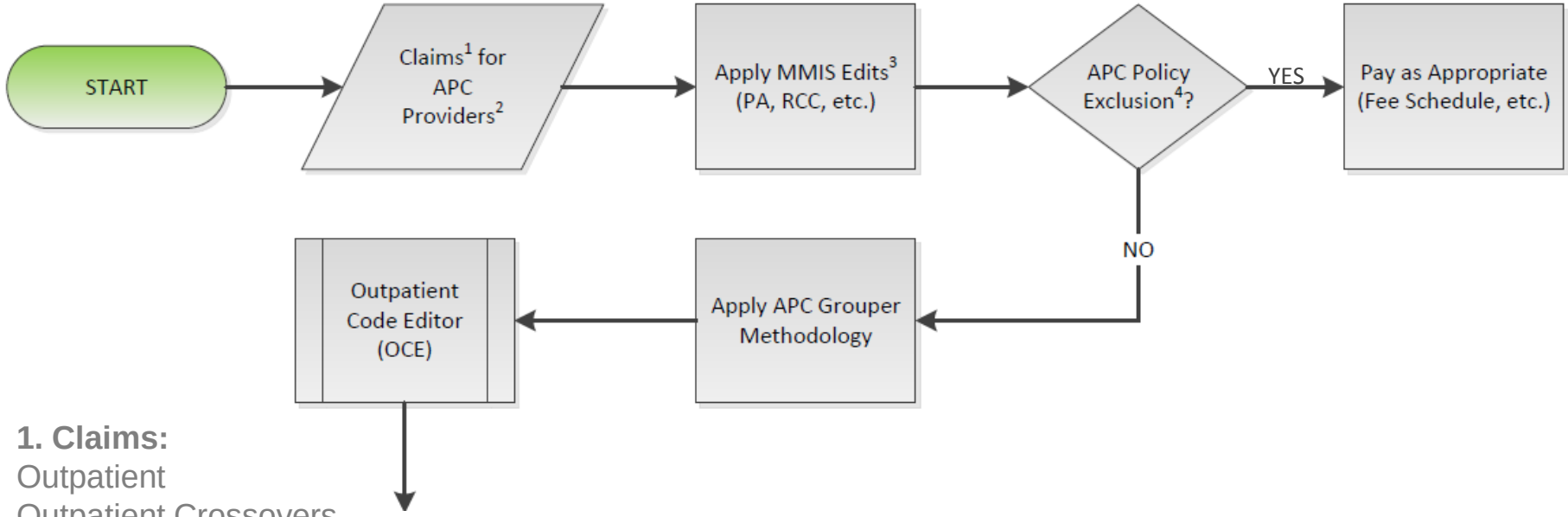
- Line items that will not be run through the APC grouper and will continue to be paid as they are currently.
- Line items will be identified by RCC.
- APC policy exclusions include:

RCC	Description
42x	Physical Therapy
43x	Occupational Therapy
44x	Speech Therapy
771	Vaccine Administration
905, 906	Intensive Outpatient Program (IOP)
907	Extended Day
913	Partial Hospitalization (PHP)

PAYMENT DESIGN AND POLICIES
PROFESSIONAL SERVICES

- Policy shift under new outpatient prospective payment system (OPPS):
  - Currently billed on outpatient claim (UB-04 or 837I).
  - Under new OPPS, must be billed on professional claim (CMS-1500 or 837P).
- Most professional services are currently billed in RCCs 960 and above, designated specifically for professional services.
- Some professional services are currently bundled:
  - RCC 456 (Emergency Room/Urgent Care).
  - RCC 51x (Clinic).
- Under new OPPS:
  - RCCs 960 and above will deny.
  - Hospitals will bill for facility portion using appropriate procedure codes.
  - Professional services must be billed on professional claim.

PAYMENT DESIGN AND POLICIES
APC CLAIM WORKFLOW — PART 1



1. Claims:
Outpatient
Outpatient Crossovers

2. APC Providers:
General Outpatient Hospital (specialty 007)
Chronic Disease Outpatient Hospital (specialty 007)
Psychiatric Outpatient Hospital (specialty 008)

3. MMIS Edits include:
Deny payment for Professional Services (RCC 960+)

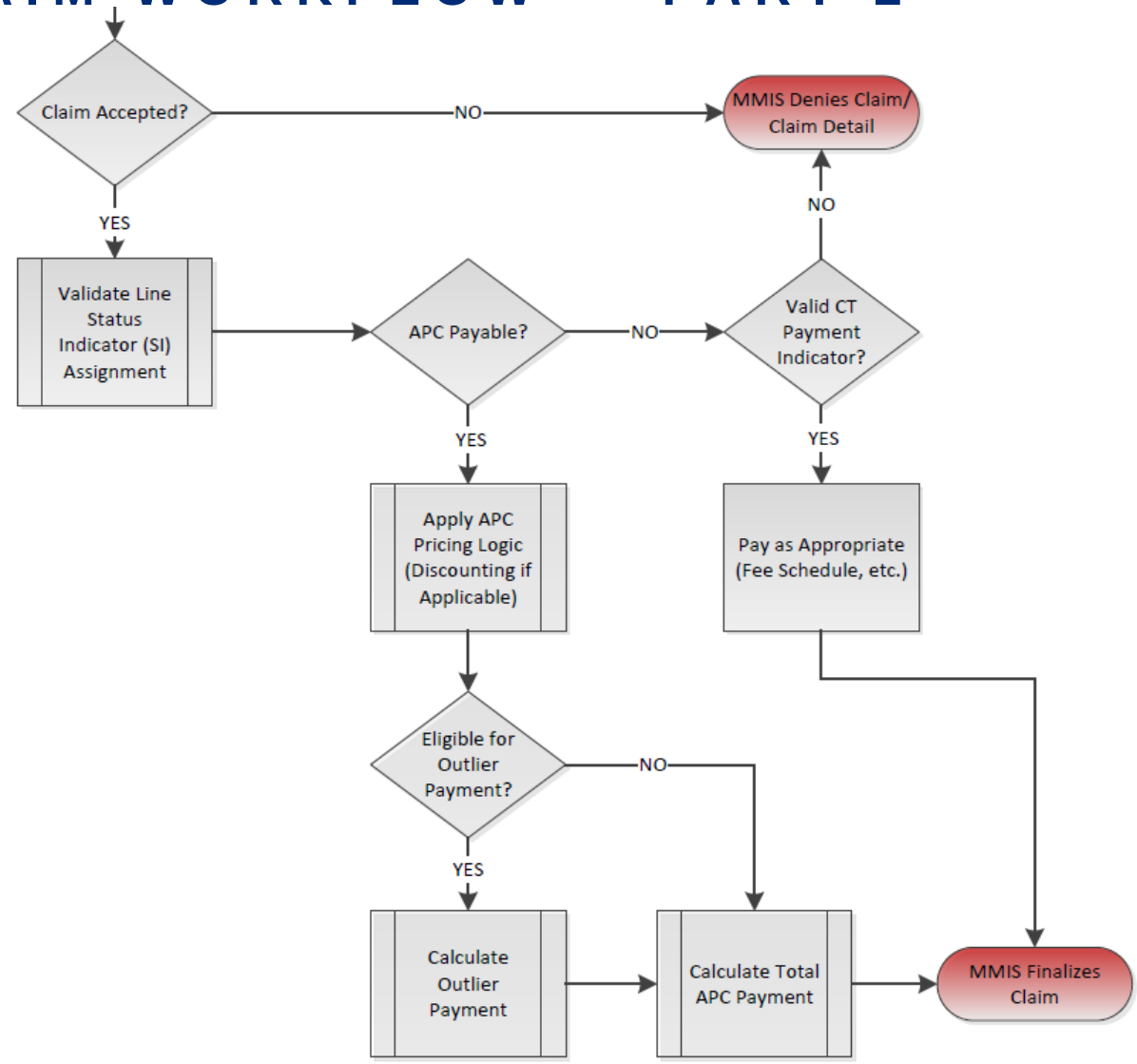
4. APC Policy Exclusions include:
Physical Therapy (RCC 42x)
Occupational Therapy (RCC 43x)
Speech Therapy (RCC 44x)
Vaccine Administration (RCC 771)
Intensive Outpatient Program (RCC 905, 906)
Extended Day (RCC 907)
Partial Hospitalization (RCC 913)

PAYMENT DESIGN AND POLICIES
APC STATUS INDICATORS

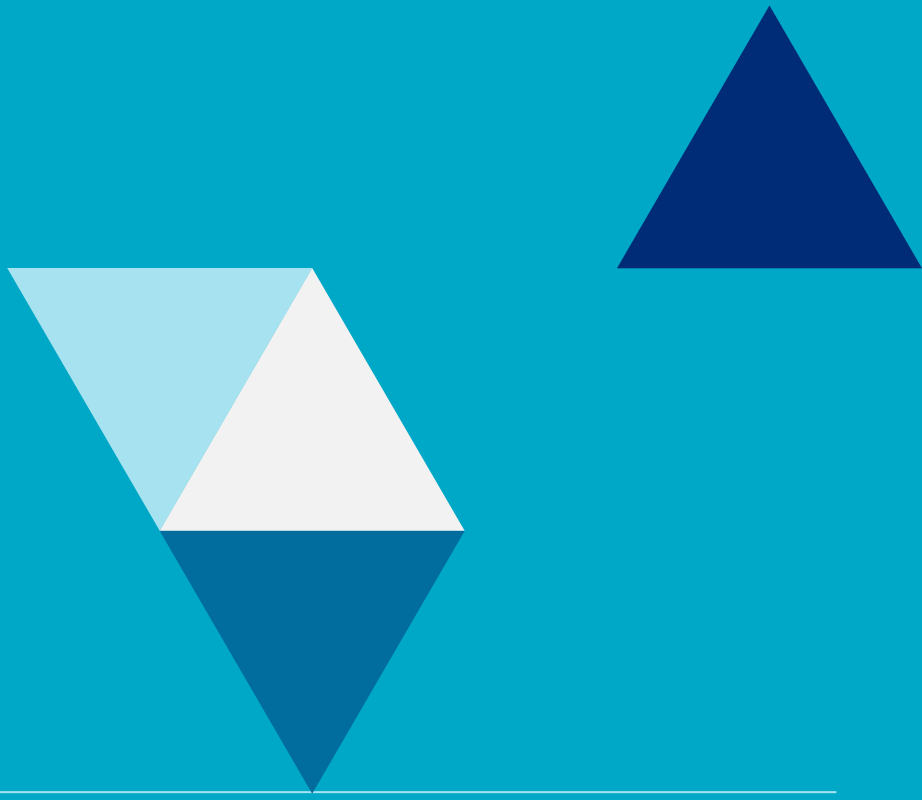
- The APC grouper assigns a status indicator to each line item detail.
- Most status indicators (SI) are assigned by procedure code to identify how the line item detail will be paid under the OPPS.
- There are four possible outcomes for each line item detail:

APC Payable		Not APC Payable	
1. APC Paid	**2. Packaged**	**3. CT Paid**	**4. CT Denied**
Line item details are paid based on the APC assigned.	Line item details may be zero paid. The payment for these services is often included in an APC payment on the claim for another detail.	Line item details are paid based on Connecticut (CT) policy (e.g., other fee schedule payment).	Line item details are denied based on CT policy.
G,H,R,S,T,U,V,X	J1,K,N,Q1,Q2,Q3	A,B,C,E,F,K,L,M,P,W,Y,Z	

PAYMENT DESIGN AND POLICIES
APC CLAIM WORKFLOW — PART 2



CLAIMS ANALYSIS



CLAIMS ANALYSIS
DATA OVERVIEW

- Claims universe:
  - Outpatient claims data.
  - Dates of service (DOS) from May 1, 2014 through December 31, 2014.
  - Approximately 1.25 million outpatient claims.
  - Approximately 5.8 million detail lines.
  - Approximately $420 million in total payments.
- Process:
  - Flagged APC providers.
  - Removed APC policy exclusions.
  - Grouped claims using APC grouper.
  - Reviewed edit codes assigned by integrated outpatient code editor.
  - Identified significant billing and coding issues.

CLAIMS ANALYSIS
RESULTS

- Claims not grouped by APC grouper (rejected):
  - Approximately 50% of claims rejected initially.
  - Less than 1% of claims do not have a reasonable coding fix.
- Summarized by OCE edit code.
- Fixes:
  - Data fixes: How to handle data for modeling.
  - Billing fixes: How to ensure claims are not rejected under APC methodology.

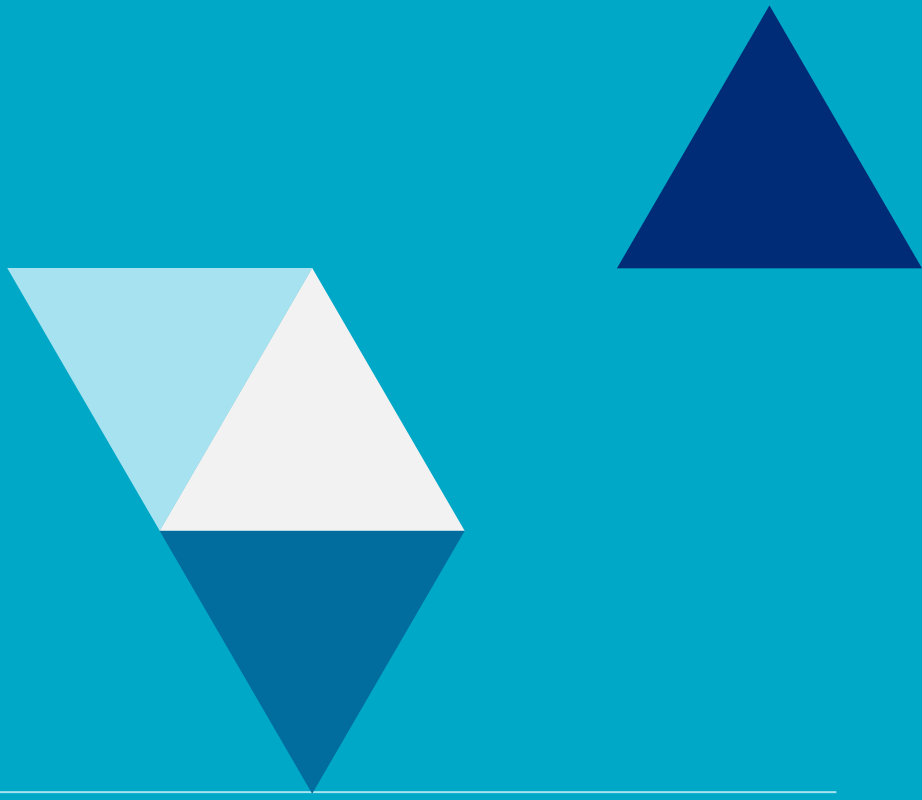
CLAIMS ANALYSIS EXAMPLES

Edit Code	Issue	Data Fix	Billing Fix
0020	For the same DOS, a HCPCS code pair has been reported that should not be reported together.	Remove line item detail with ‘code 2' of the code pair.	Follow Medicare billing requirements related to NCCI limitations.
0021	Clinic or emergency department (ED) visit, without modifier 25, on the same date of service as a significant procedure.	Add modifier 25 to all line items and send the modified claim to the grouper.	Follow Medicare billing requirements related to modifiers for Evaluation and Management codes.
0027	Only incidental services reported.	Add modifier L1 to all line items and send the modified claim to the grouper.	Follow Medicare billing requirements, specifically modifier L1 for laboratory services when appropriate.
0062	HCPCS is valid, but not reportable for services paid under the OPPS.	Replace incorrect codes with the correct codes.	Follow Medicare billing requirements for ED, clinic, and observation visits in an outpatient setting.
0071	Procedure requiring use of a device reported, but appropriate device code not reported.	Remove entire claim from data modeling.	Follow Medicare billing requirements related to devices and their use.

CLAIMS ANALYSIS
BILLING REQUIREMENTS

- Follow Medicare billing requirements:
  - Professional services must be billed on professional claim (CMS-1500 or 837P).
  - Appropriate modifiers must be included on claim.
  - Current codes must be utilized to ensure proper payment.
- Exceptions include:
  - Revenue center codes identified as policy exclusions, for example vaccine administration, IOP, and PHP.
  - Services that Medicare pays via another payment system, for example mammograms and some lab tests.
  - Services not covered by Medicare but covered by Medicaid, for example family planning services or hearing aids.
- Billing requirements for exceptions to Medicare will be forthcoming.

NEXT STEPS



NEXT STEPS

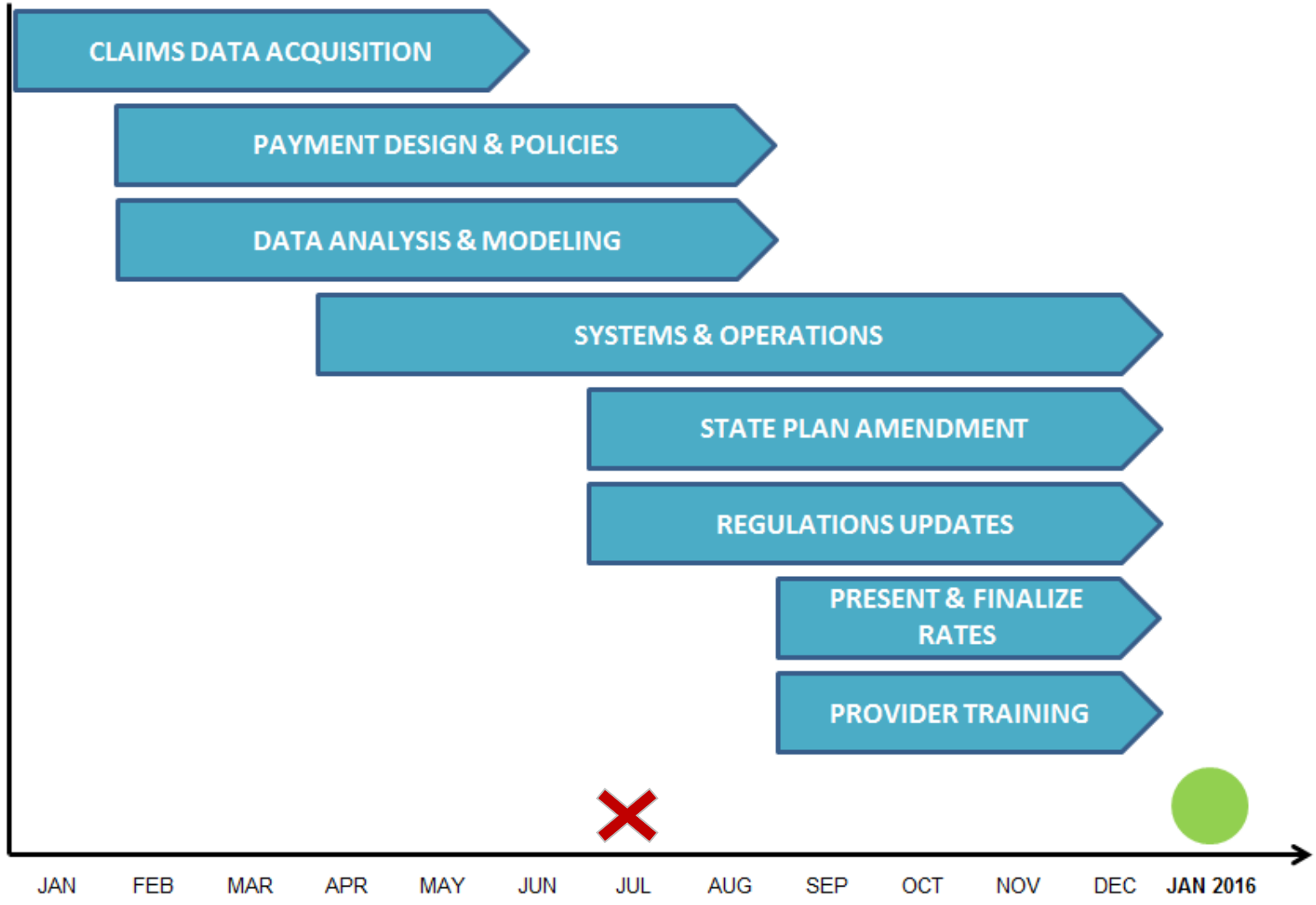
Data Modeling

- Perform costing of claims.
- Model claims payments.
- Develop fiscal impact model.

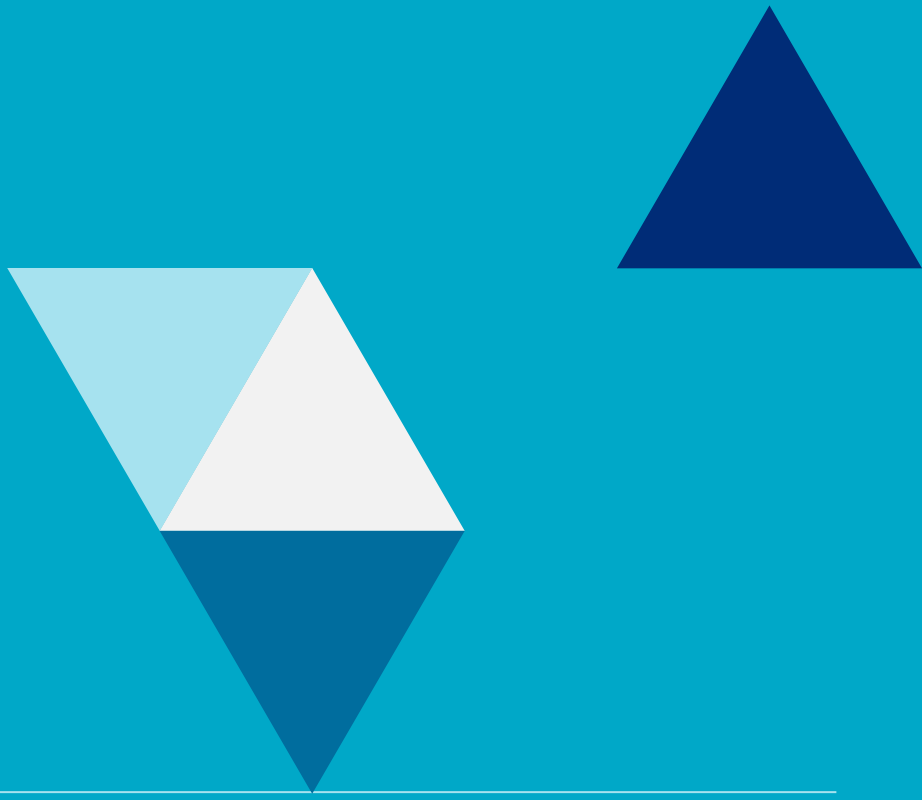
Payment Design and Policies

- Document payment approaches.
- Write issue papers.
- Identify exceptions to Medicare billing requirements.

NEXT STEPS
TIMELINE REVIEW

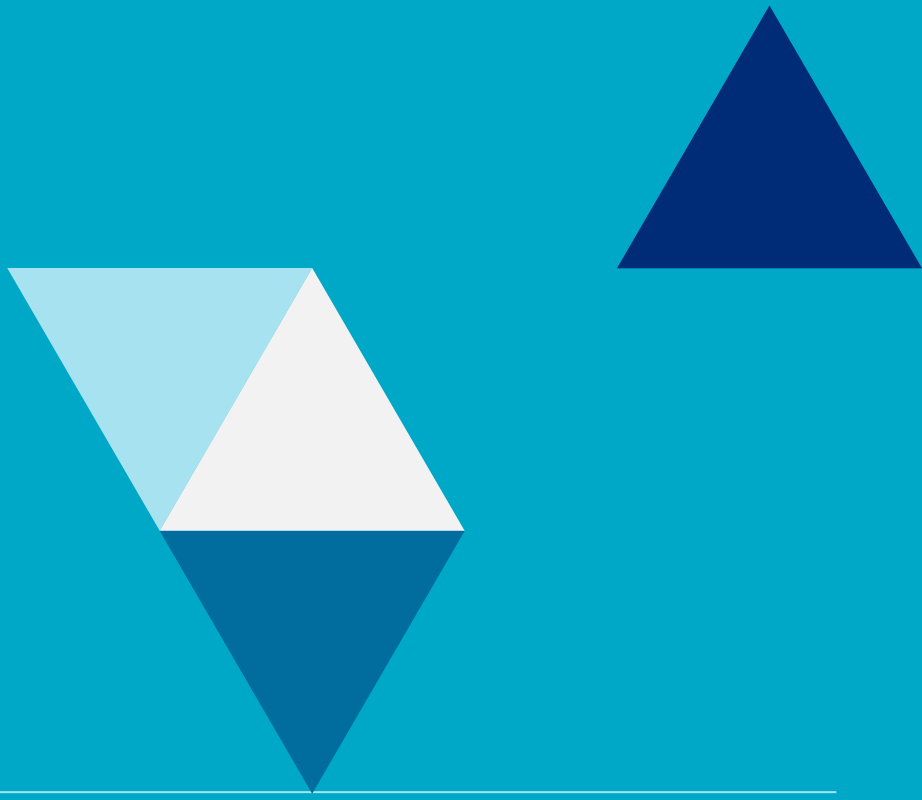


QUESTIONS?



Please address any additional questions in writing to:

Kate McEvoy
DSS Medicaid Director
55 Farmington Avenue
Hartford, CT 06105



RESOURCES

Connecticut Department of Social Services Reimbursement Modernization:

http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256

Connecticut Medical Assistance Program:

www.ctdssmap.com

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