DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

HIPAA Billing Code and Reimbursement Update – Outpatient Hospital (SPA 17-K)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective on or after January 1, 2017, SPA 17-K will clarify the updating process for the outpatient hospital reimbursement methodology that was implemented on July 1, 2016 under SPA 16-0016 (which is still under review by CMS). This SPA is being implemented pursuant to section 17b-239 of the 2016 supplement to the Connecticut General Statutes, as amended by section 87 of Public Act 16-3 of the May 2016 Special Session. Specifically, DSS will implement APC updates annually effective each January 1st. This update includes updating the wage index and the cost to charge ratios used in the outlier calculations, as well as revising Connecticut Medical Assistance Program's (CMAP's) Addendum B to incorporate the 2017 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Any changes in coding that affect reimbursement are being priced using a comparable methodology to other codes in the same or similar category. The majority of codes being added and deleted will follow the Outpatient Prospective Payment System (OPPS) methodology and will be reimbursed based off the Ambulatory Payment Classification (APC) payment as described in CMAP's Addendum B, which is published at this link: http://www.ctdssmap.com, then click on "Hospital Modernization".

In addition to those changes, effective on or after January 1, 2017, code J1942- Injection, aripiprazole lauroxil, 1 mg, is being added to the behavioral health clinic fee schedule, which applies both to outpatient hospital behavioral health clinics and also to freestanding behavioral health clinics. This SPA adds the code for outpatient hospital behavioral health clinics (and SPA 17-I is adding the same code for freestanding behavioral health clinics). Fee schedules are published at this link: http://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download."

Fiscal Information

Due to the lack of detailed data currently available, the fiscal impact not yet possible to quantify at this time. However, it is expected that this SPA will result in only a minimal change to annual aggregate expenditures.

Information on Obtaining SPA Language and Submission of Comments

The proposed SPA is posted on the DSS website at this link: http://www.ct.gov/dss. Go to "Publications" and then "Updates". The proposed SPA may also be obtained at any DSS field office or the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: ginny.mahoney@ct.gov or write to: Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799). Please reference "SPA 17-K: HIPAA Billing Code and Reimbursement Update – Outpatient Hospital".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than January 11, 2017.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES–OTHER TYPES OF CARE

(2) (a) Outpatient hospital services –

Effective for dates of service on or after July 1, 2016, the Connecticut Medical Assistance Program (CMAP) Outpatient Prospective Payment System (OPPS) reimbursement methodology described in this section applies to all outpatient hospital services, except for publicly operated outpatient hospital psychiatric services as described further below in the outpatient hospital section of Attachment 4.19-B. Within CMAP OPPS, an Ambulatory Payment Classification (APC) reimbursement methodology shall apply to all outpatient services except as otherwise provided in CMAP Addendum B, as explained below. Except as otherwise noted in the plan, state-developed fee schedules and rate methods are the same for both governmental and private providers.

Definitions

1. "APC" or "Ambulatory Payment Classification" means the classification of clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources and serves as one of the methods of payment under CMAP OPPS.
2. "APC conversion factor" means a set dollar amount determined by the department that is used as the basis for calculating the payment for outpatient hospital services based on the APC payment methodology.
3. "APC grouper" means the program that assigns each service on an outpatient claim an APC if appropriate, as well as assigning a status indicator that specifies if and how the provider will be reimbursed for a service.
4. "APC relative weight" means the relative value assigned to each APC and is the same as Medicare's weight.
5. "CMAP Addendum B" means the Connecticut Medical Assistance Program's document that lists HCPCS codes and describes payment information regarding outpatient hospital services.
6. "CMAP's Outpatient Prospective Payment System" or "OPPS" means the department's outpatient prospective payment system for outpatient hospital services as described in this section, which is the department's prospectively-determined payment system for outpatient hospital services that are reimbursed using APCs, the applicable fee schedule or such other prospective payment methodology as established by the department as described in CMAP Addendum B.
7. "Wage index" means the index published by CMS pursuant to 42 USC 1395ww(d)(3)(E) but not including any adjustments for geographic reclassification of hospitals to other labor market areas.

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Overall Payment Methodology

1. Outpatient hospital services are provided pursuant to 42 CFR 440.20(a).
2. No inflation, inflationary factor, or any other automatic increase is included in any reimbursement for outpatient hospital services. Reimbursement is solely based upon the methodology described below.
3. Reimbursement for outpatient hospital services and other services prior to inpatient hospital admission.
   a. Except as provided in subdivision b. of this subsection, reimbursement for inpatient hospital services includes payment for all outpatient hospital services provided by the hospital or another hospital that is an affiliated hospital at any location, including the hospital's main campus and any satellite location, on the date of admission and the two days prior to the date of admission, which shall not be separately reimbursed by the department and shall be billed as part of the inpatient hospital stay.
   b. The department pays a hospital or an affiliated hospital separately for the following services provided on the date of admission but before the actual admission and the two days prior to the date of admission: Any service clinically unrelated to the admission, maintenance renal dialysis, physical therapy, occupational therapy, speech and language pathology services, audiology services, routine psychotherapy, electroconvulsive therapy (except if the electroconvulsive therapy causes the admission), psychological testing, neuropsychological testing, intermediate care programs and any other category of service specifically designated on the outpatient hospital fee schedule referenced below.

4. The department shall pay hospitals for providing outpatient hospital services using CMAP OPPS. As determined and designated by the department, services are paid using one or more of the following methodologies and in accordance with the department's fee schedules and payment rules as defined in CMAP Addendum B, which is posted to www.ctdssmap.com:
   a. APC payment based on Medicare's system as modified for CMAP, as detailed below;
   b. A fee on the department's fee schedule for outpatient hospitals, which has been updated as of July 1, 2016 and is posted to www.ctdssmap.com;
   c. A fee on one of the department's fee schedules other than the outpatient hospital fee schedule. For each service that is paid using a fee schedule, CMAP Addendum B specifies the applicable fee schedule, which is updated as of the effective date listed in the applicable section of Attachment 4.19-B and is also posted to www.ctdssmap.com; or
   d. Other prospective payment as included in CMAP Addendum B.

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Payment Rate and Limitations for Hospitals Reimbursed Using APCs

The CMAP APC system is based on Medicare's Addendum B (OPPS payment by HCPCS code as modified and reflected in CMAP Addendum B), Addendum A (list of APCs) and Addendum D1 (list of payment status indicators) and uses Medicare's APC grouper software. Effective July 1, 2016, APC IOCE Version 17.1 will be used. When Medicare issues subsequent APC IOCE versions, the CMAP APC system will adopt such version with the same effective date as Medicare. In order to implement each such new version, the department will update Addendum B in accordance with such version and in conformance with the existing methodology and policy as reflected in the current version of CMAP Addendum B, including any new or deleted codes that were included by Medicare.

CMAP Addendum B also includes a column entitled "Payment Type" that indicates whether an item is reimbursable based on the APC methodology, the applicable fee schedule or other prospective payment methodology.

1. Effective for services provided on or after July 1, 2016, for applicable services as specified in CMAP Addendum B, the department pays for outpatient hospital services on a fully prospective per service basis using an APC payment methodology in accordance with this section.

2. The statewide conversion factor established by the department is $82.25 for general acute care children's hospitals and $71.76 for all other hospitals.

3. The conversion factor is adjusted for the hospital's wage index based on the original Medicare assignment. Medicare reclassifications of the geographic wage index will not be recognized. The wage index is applied to 60% of the conversion factor and is updated annually effective January 1st of each year.

4. Hospitals located outside of Connecticut shall be paid the statewide conversion factor of $71.76, with no adjustment for the wage index for services reimbursed using APCs, except that if a hospital requests to have the conversion factor adjusted for the hospital's actual wage index, the department may grant such request on a case-by-case basis if the department determines that such adjustment is necessary to ensure access to medically necessary services for a beneficiary. For services reimbursed using a non-APC methodology, hospitals located outside of Connecticut shall be reimbursed in the same manner as hospitals located in Connecticut. However, if the department determines that a service is not available in Connecticut, the department may negotiate payment rates and conditions with such provider, up to, but not exceeding, the provider's usual and customary charges.

5. Observation Services. Observation services shall include not less than eight hours but not greater than forty-eight hours of continuous care. Observation services are reimbursed using APCs. The hospital may bill for ancillary services related to observation only if such services are ordered during the observation stay.

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6. The APC service payment is calculated as follows:
   a. The relative weight for the assigned APC is multiplied by the wage-adjusted APC conversion factor and by the units of service.
   b. The resulting amount from a. may be multiplied by a discount factor when applicable.
   c. An outpatient service may qualify for an outlier payment. To qualify as an outlier, the cost of the service (defined as covered charges multiplied by the overall hospital-specific cost-to-charge ratio updated annually effective January 1st of each year from the Medicare cost report two years prior, i.e. 2015 cost reports for 2017 ratios), must exceed both of the following thresholds:
      i. The multiple threshold. This is defined as the APC payment amount multiplied by 1.75, to be adjusted in accordance with any applicable Medicare adjustments.
      ii. The fixed-dollar threshold. This is defined as the APC payment plus the fixed dollar threshold of $2,900 for dates of service from July 1, 2016 through December 31, 2016. Effective for dates of service on or after January 1, 2017, the fixed dollar amount shall be the same as the Medicare amount, which will be adjusted annually in accordance with Medicare adjustments.

   The outlier payment is calculated as 50% of the amount by which the hospital's cost of the service exceeds the multiple threshold amount.

   When calculating costs, the cost of an APC service that is packaged and not separately payable, is allocated to the APC payable services on the claim proportionately, based on each line's APC payable amount.

Services Reimbursed Separately from APC

1. The department shall not pay a hospital for any service identified as not payable in CMAP Addendum B.

2. The department separately reimburses a hospital using a non-APC payment as designated in CMAP Addendum B for the following:
   a. All services designated for separate non-APC payment in CMAP Addendum B, including: physical therapy, occupational therapy, speech and language pathology services, behavioral health services, vaccine administration, mammograms, and any other service designated for separate non-APC payment in CMAP Addendum B.

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b. Practitioners' Professional Services. Except as otherwise provided in paragraph c. immediately below regarding behavioral health services, physicians, nurse practitioners, physician assistants, dentists, nurse-midwives and podiatrists, each as defined in section 5 or 6, as applicable, of Attachment 3.1-A of the Medicaid State Plan, are required to bill separately for professional services and will be reimbursed in the manner provided for such provider in section 5 or 6, as applicable, of Attachment 4.19-B of the Medicaid State Plan.

c. Behavioral Health Services. Except as otherwise provided in this paragraph, behavioral health outpatient hospital services are reimbursed based on the clinic and outpatient behavioral health fee schedule as detailed within the behavioral health clinic methodology in section 9 of Attachment 4.19-B of the Medicaid State Plan. This fee schedule includes higher reimbursement for some services at hospitals that meet the enhanced care clinic (ECC) provider qualifications described below. Unlike medical services, most of the behavioral health services are all-inclusive payments that include payment for both the hospital's facility services and also the practitioners' professional services).

The only professional services that are reimbursed separately from the payment to the hospital for behavioral health outpatient hospital services are: (1) emergency department evaluation provided by a licensed clinical social worker, psychiatrist, psychiatric nurse practitioner / advanced practice registered nurse (APRN), or psychologist (each as defined in section 5 or 6, as applicable, of Attachment 3.1-A of the Medicaid State Plan), and (2) the professional component of electroshock treatment billed by psychiatrists or psychiatric nurse practitioners / APRNs. Those practitioners will be paid for such professional services in the manner provided for each applicable type of practitioner in section 5 or 6, as applicable, of Attachment 4.19-B.

d. Laboratory services provided to hospital non-patients are reimbursed in accordance with section 3 of Attachment 4.19-B.

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Outpatient Hospital Behavioral Health Enhanced Care Clinics (ECCs)

There are higher fees for outpatient hospital behavioral health services that meet special access and quality standards as enhanced care clinics (ECCs), as noted in the hospital-specific schedule for each hospital that has an ECC. ECCs must accept all (100%) telephonic and walk-in referrals that present during business hours. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine. A clinician must evaluate a client who presents at the clinic with an emergent condition within two (2) hours. Clients that undergo telephonic or walk-in screening and are determined to be in urgent need of services must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days of the screening. Clients that undergo telephonic or walk-in screening and are determined to have routine needs must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within 14 calendar days of the screening. ECCs must have at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. ECCs that have a valid Letter of Agreement with the department that holds them accountable to the quality standards and access standards receive the enhanced rate for all routine outpatient services provided. The state monitors the access standards on a routine basis and provides access standards reports to the providers on a quarterly basis. The state has established a process for providers to submit corrective action plans (CAPs) if they do not meet the access standards for any reason except an increase in volume in excess of 20% compared to the same quarter of the previous year. ECCs must electronically register appointments made with the Administrative Services Organization (ASO). This process allows for an automated process to track access standards for routine cases. The state also utilizes a mystery shopper process to track access standards. In addition, the state performs on-site chart reviews to determine if providers are in compliance with quality standards and the urgent and emergent access standards. As a result of the on-site reviews, CAPs will be required from providers who do not meet quality or access standards. Fees for services provided to individuals 18 years of age and over are 95% of the published fee for ECCs.

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Supplemental Reimbursement to Publicly Operated General Acute Care Hospitals for Providing Outpatient Hospital Services

Supplemental payments shall be made to the publicly owned and operated hospital in the amount of $8.2 million for the state fiscal year ending June 30, 2017. The payments shall be made quarterly.