

A New Hospital Outpatient Payment Method for MO HealthNet

Frequently Asked Questions

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Please note that details of the payment method shown in this document remain subject to change before the implementation date. If so, an update will be available on the MO HealthNet Division's website.

The MO HealthNet Division (MHD) will move to a new method of paying for hospital outpatient services using a simplified fee schedule based on Medicare's Ambulatory Payment Classifications (APCs). Our goal is to implement a new method that is sustainable, rewards efficiency, increases fairness and transparency, reduces administrative burden, and improves purchasing clarity.

This document provides answers to some common questions about the new method. We invite additional questions.

OVERVIEW QUESTIONS

1. When will the new method be implemented?

The target date is July 1, 2021.

2. What change is being made?

The MO HealthNet Division will change the current payment method, which is reimbursement at a percent of the hospital's billed charges for most services and payment from a fee schedule for certain services (laboratory, radiology, some surgical procedures). The outpatient simplified fee schedule (OSFS) is based on, but not identical to Medicare APCs and fee schedules. The new method uses this fee schedule for all outpatient services.

3. What providers and services will be affected by the new payment method?

The OSFS will apply to all hospitals enrolled in the MO HealthNet program. Payment to physicians will not be affected.

4. How does the current payment method work?

The MO HealthNet Division's current outpatient hospital payment method is primarily based on an outpatient payment percent of the hospital's billed charges. The current method also utilizes a fee schedule for certain services (laboratory, radiology, some surgical procedures, and telehealth originating site).

The prospective outpatient payment percentage for Missouri hospitals is calculated using the MHD overall outpatient cost-to-charge ratio from each hospital's fourth, fifth, and sixth prior base year cost reports regressed to the current state fiscal year. For out-of-state hospitals, the prospective outpatient payment percentage is either the projected statewide average outpatient payment percentage or if the hospital elected to have its outpatient payment percentage set on its cost reports then the outpatient payment percentage is calculated the same as Missouri hospitals.

5. Why change to the new payment method?

MHD's goals for the new outpatient hospital payment method include:

- **Implement a sustainable payment method.** MHD needs a payment methodology that can be sustained over time, with adaptations as appropriate to promote access to quality care and reduce unnecessary expenditures.
- **Reward efficiency.** The current charge-based method lacks appropriate incentives for hospitals to reduce the cost of care. Under the new method, hospitals will receive a designated fee for each service. If a hospital improves efficiency, it will benefit from savings.
- **Increase fairness.** Today, different hospitals are paid very different amounts for the same or very similar care to similar patients, as payment is based on the charges submitted. With the new fee schedule methodology, hospitals will be paid the same for the same service as the payment is based on the procedure code being billed.
- **Ensure simplicity.** The current method, involving a cost report process to set the outpatient percent and unique billing requirements for payment, is burdensome for both MHD and providers. The new method is a fee schedule concept with limited use of complex pricing logic, designed for administrative ease.
- **Improve purchasing clarity.** It is currently very difficult to understand how much MHD is paying for specific types of outpatient services. MHD wishes to align its payment methodology with prevailing methodologies used by Medicare, other Medicaid programs and private payers, improving purchasing clarity.

COMPONENTS OF THE NEW PAYMENT METHOD

6. What is the basic approach?

The basic approach is simply a fee schedule, based on Medicare's APCs and fee schedules. Hospitals will be paid according to the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure code listed on the claim.

If a claim line has a procedure code and the service is considered covered, then the payment for that line will equal the fee times the billed units, up to the maximum units allowed. Payment will be the lower of the provider's charge or the payment as calculated under the OSFS Payment Methodology.

The outpatient simplified fee schedule (OSFS) method is similar but not identical to the APC-based method currently in use by Medicare. The differences reflect both the fact that Medicare payment policy is not always appropriate for Medicaid and MHD's goal is to avoid some of the complexities of the Medicare method.

7. How does the OSFS methodology work?

Fees for outpatient hospital services covered by the MO HealthNet program will be determined by the CPT/HCPCS code at the line level and the following hierarchy:

- The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS Addendum B will be used to calculate the fee for the service.
- If there is no APC relative weight or APC payment rate established in the Medicare OPPS Addendum B for the procedure, a fee will be calculated using other Medicare fee schedules applicable to the outpatient hospital service and setting (e.g., Physician Fee Schedule, Clinical Laboratory Fee Schedule, Durable Medical Equipment, Prosthetic, Orthotic, and Supply Fee Schedule).
- For any remaining outpatient hospital services covered by the program, MO HealthNet fee schedules applicable to the service will be used or a fee will be calculated.

Federally-deemed critical access hospitals (CAHs) and nominal charge hospitals will receive a policy adjustor of an additional percent applied to the OSFS fee for each billed procedure code covered by MHD: forty percent (40%) for CAHs and twenty-five percent (25%) for nominal charge hospitals. Payment will be the lower of the provider's charge or the payment as calculated under the OSFS Payment Methodology.

8. How will the APC-based fees be calculated?

APC-based fees will be calculated using the Medicare OPPS Addendum B effective as of January 1 of each year as updated by Medicare. The fee is calculated using the APC relative weight times the Missouri conversion factor. The Missouri conversion factor is the single statewide conversion factor used to determine the APC-based fees, using a formula based on Medicare OPPS.

The formula consists of: sixty percent (60%) of the APC conversion factor multiplied by St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment. The resulting amount is then multiplied by ninety percent (90%) to derive the OSFS fee.

For APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee.

9. How does the simplified fee schedule compare with Medicare?

- **Coverage policies.** Both Medicare and Medicaid cover a very wide range of hospital outpatient services. However, there are a few instances where coverage policy differs between the two payers. For CPT/HCPCS not priced or not covered by Medicare, MHD will determine coverage and develop fees as needed. MO HealthNet coverage policies will continue to apply under the new method.
- **Payment levels.** MHD will set the payment level at 90% of the Medicare fee.
- **Special treatment for some hospital types.** Medicare has special payment provisions for children's hospitals, cancer hospitals, rural hospitals, and critical access hospitals. MHD will use the same payment method for all hospitals. Federally-deemed critical access hospitals will receive a policy adjustor of an additional forty percent (40%) for each billed procedure; nominal charge hospitals will receive an additional twenty-five percent (25%) for each billed procedure code.
- **Integrated Outpatient Code Editor (I/OCE).** MHD will not use the Medicare I/OCE. However, claims will continue to be subject to standard edits (e.g., eligibility, enrolled provider, timely filing) and other edits (e.g., covered services, maximum service units).
- **Discounting.** Medicare discounts payment for multiple significant procedures and in the presence of some modifiers. Discounting logic will not be applied under the new method.
- **Packaged services.** Some services will be "bundled" or packaged; that is, the fee will be zero because payment is considered packaged into the payment for other services on the claim. Packaging will apply to any services considered always packaged under Medicare's APC methodology.
- **Conditional packaging.** Under Medicare, some procedure codes are sometimes paid and sometimes packaged, depending on what other codes are submitted on the claim. Conditional packaging will not be used.
- **Composite APCs and Comprehensive APCs (C-APCs).** Medicare uses composite APCs to make packaged payments for certain services. Implementation of these pricing techniques are complex and, for several APCs, geared specifically to the Medicare program. Composite APC and C-APC logic will not be used under the new method.
- **Modifier pricing.** Modifiers that will continue to be required include EP to indicate EPSDT and SL for administration of VFC-covered vaccines.
- **Quality reporting.** Medicare reduces payments to hospitals that do not report outpatient quality data. MHD has no similar program.

CODING, BILLING AND EDITING

10. What billing and coding practices will be important for hospitals to follow?

There are several billing requirements that will become increasingly more important under the new payment method.

- **Procedure code billing.** Payment will be based on the procedure code billed by the hospital at the line-level of the outpatient claim.

- **Procedure code units.** Procedure codes will pay the fee times the number of units billed, unless the billed units exceed the allowed units. Hospitals are asked to pay attention to billed units, which must be appropriate for the specific CPT/HCPCS code description. Special attention should be paid to therapy and observation codes.
- **Same-day billing.** Hospitals are expected to bill all services provided on the same day to the same patient on the same claim.
- **Span date billing.** The requirements for span date billing (multiple dates of service on a single claim) have not changed. Hospitals may continue to bill multiple dates of service on one claim listing each specific date of service at the line level.
- **Visit levels.** In billing for emergency room and clinic visits (e.g., 99281-99285), hospitals are expected to follow the same guidelines as they do for Medicare. Similarly, for clinic visits (e.g., 99202-99205 and 99211-99215), hospitals should bill G0463 Hospital outpatient clinic visit.
- **National Correct Coding Initiative (NCCI).** NCCI is an initiative of the Centers for Medicare and Medicaid Services to ensure that CPT/HCPCS codes are billed in appropriate combinations. NCCI edits associated with procedures and modifiers will continue to be applied under the new method.
- **Dental services.** With the new payment method, MO HealthNet will accept certain Current Dental Terminology© (CDT) codes (also known as D-codes) for dental services on the hospital claim form. These D-codes will be identified on the OSFS and priced by MHD for payment in the outpatient hospital setting.
- **Observation care.** Continue to report observation using HCPCS G0378 (Hospital observation services, per hour). Report the number of hours in the “units” field. One hour equals one unit of service.
- **Dialysis.** The technical component of dialysis provided in hospital-based dialysis clinics may be billed on the institutional claim using procedure code 90999 (Dialysis procedure).
- **Telehealth.** Hospitals may continue to bill for distant site services provided in their facilities. With the new payment method, the distant site service must be reported on the institutional claim form with the CPT/HCPCS for the service and modifier GT (Interactive telecommunication). Hospitals should not bill a separate line with zero billed charges.

11. Will hospitals have to buy software to submit claims under the simplified fee schedule payment method?

No. Providers do not have to buy software to submit claims under the new payment method.

12. Will commercial APC software be applicable to the new payment method?

Commercially available APC software is intended for use in submitting and analyzing Medicare claims. Because of the differences between Medicare and Medicaid, the software will not be completely accurate in emulating MO HealthNet’s OSFS payment method.

13. What changes, if any, will be made to MO HealthNet’s prior authorization policy?

The change in payment method has no impact on MHD prior authorization policy.

14. Will National Drug Codes (NDC) be required?

Yes. Current edits to require NDC codes will continue to be in place.

OTHER QUESTIONS

15. Will hospitals still have to submit cost reports?

Yes.

16. Will OSFS payments be subject to cost settlement after cost reports have been submitted?

No.

FOR FURTHER INFORMATION

17. What assistance will be available to help hospitals plan for the new payment method?

- *FAQ:* MHD will provide updates to these questions and answers on a periodic basis.
- *Quick Tips:* A Quick Tips document summarizing billing information in the FAQs will be made available prior to implementation.
- *Fee Schedule:* The Outpatient Simplified Fee Schedule will be made available when finalized.
- *Webinars/workshops:* MHD will provide webinars/workshops to providers.

18. Who can I contact for more information?

Nanci M. Nikodym, Assistant Deputy Director, Clinical Services, MHD

Email: Nanci.M.Nikodym@dss.mo.gov

Jamie Purnell, Clinical Services Manager, MHD

Email: Jamie.Purnell@dss.mo.gov

Christina Jenks, Director of Hospital Policy and Reimbursement, Hospital Reimbursement Unit, MHD

Email: Christina.Jenks@dss.mo.gov

Melissa Massman, Hospital Policy and Reimbursement Manager, Hospital Reimbursement Unit, MHD

Email: Melissa.Massman@dss.mo.gov