



BY THE NUMBERS

A monthly compendium of OHA finance and patient financial services policy and payment alerts

March 2015

ODM Releases Revised Collection & Payment Schedule for 2015 Hospital Franchise Fee and Upper Payment Limit (UPL) Payments

On March 2 the Ohio Department of Medicaid issued an updated regulation governing the 2015 hospital franchise fee program that contained a revised collection schedule. Hospitals now must pay fifty percent of their 2015 franchise fees to ODM on or before April 30 and the remaining fifty percent on or before May 18. In turn, ODM will remit fifty percent of each hospital's inpatient and outpatient UPL payments on or before May 11 and June 4.

OHA previously released preliminary hospital-specific [franchise fee](#) and [UPL](#) schedules for the 2015 program year. These figures have not yet been finalized by ODM, but represent OHA's most recent estimates of the likely fees and UPL payments, by hospital. Additional information is available [here](#).

Ohio Medicaid Moving Forward on 2016 OPPS Design

In addition to major projects on Medicaid Episodes of Care and potentially preventable readmissions (see the [February 2015](#) issue of *By the Numbers* for details), the Ohio Department of Medicaid is also planning a new outpatient prospective payment system, tentatively scheduled to start Jan 1, 2016. ODM, OHA staff and representatives of the OHA Finance and Admitting, Billing & Collection Committees will be meeting semi-monthly through this summer on OPPS design, and OHA is in contact with other states that have adopted a similar system to gain insight from their conversions.

Created by 3M and modeled on Medicare's OPPS, the [Enhanced Ambulatory Patient Classification](#) system includes "EAPGs" for non-Medicare aged patients, and takes into account both the diagnoses and procedures performed during an outpatient encounter. ODM is currently "costing" a rolling three years of paid claims data to help arrive at proposed EAPG weights and hospital-specific base rates (conversion factors), and will soon begin to contrast proposed EAPG payments to what is paid under existing Medicaid outpatient fee schedules.

Several OPPS policies are still under discussion, including payment for facility fees, multiple procedures performed during the same visit, outpatient observation and dental services. OHA is also questioning whether ODM will employ any of the transitional payment and benchmark policies used when it adopted the 3M inpatient APR-DRG-based inpatient PPS in 2013. ODM has not made any promises concerning whether the new OPPS will be installed on a budget neutral basis and OHA will continue the discussion as part of the current 2016/2017 state budget debate.



CMS Drops Seven Medicare National Coverage Determinations

In Transmittal 180 ([CR 9095](#)) the Centers for Medicare & Medicaid Services announced the elimination of seven National Coverage Determinations (NCDs) covering *Tinnitus masking Stereotactic, Cingulotomy as a Means of Psychosurgery, Carotid Sinus Nerve Stimulator, Electroencephalographic (EEG) Monitoring During Open-Heart Surgery, Electron Microscope, Xenon Scan, and Nuclear Radiology Procedure*. The effective date is listed as Dec. 18, 2014, but the implementation date for the transmittal is April 6 to allow Medicare contractors time to identify and remove edits for the former NCDs.

Medicaid Computer Upgrade Accidentally Terminates Some Providers' Enrollment

Late this month the Ohio Department of Medicaid (ODM) informed OHA that ODM installed a system upgrade that resulted in the accidental termination of many Ohio Medicaid providers. Reportedly no hospitals were included in the mix, but hospital-based physicians may be.

ODM states providers can ignore any [termination letter](#) related to Federal exclusions that were generated by this error. In addition, these providers' access to MITS was also affected. ODM states it is hoping this issue was fixed over the weekend but it has not yet received confirmation.

Medicaid Non-Institutional Provider Fee Schedule Updated

In [MMTL 3334-15-04](#) the Ohio Department of Medicaid updates its public rule [5160-1-60](#), including payment policy for non-institutional providers and a link to the Appendix DD reimbursement fee schedule for 2015.

Major changes include:

- Maximum payment amounts for certain procedures, services, or supplies have been reduced to not exceed the corresponding maximum Medicare allowed amounts.
- Medicaid maximum payment amounts for molecular pathology procedures and for the transportation of portable X-ray equipment are increased.
- The professional/technical split indicators for radiology and diagnostic medicine procedures are revised to reflect Medicare payment ratios.
- Initial Medicaid maximum payment amounts are established for adult preventive medicine procedures covered under the Medicaid program.
- Payment information for ASC, laboratory-related services, transportation services, DMEPOS, dentistry services, and eyeglass frames, ocular lenses, and eye prostheses are relocated to separate sections of the appendix.

CMS OPPS Transmittal Adds Instructions on Hospital Billing for Inpatient-Only Procedures and Provider-Based Services

CMS Transmittal 3217 ([CR 9097](#)) updates the Medicare Claims Processing Manual with new instructions on billing inpatient-only procedures delivered in a DRG Window and a modifier for identifying outpatient services furnished in a provider-based facility.



Effective April 1, CMS will allow payment for inpatient-only procedures performed on an outpatient basis up to three days before an inpatient admission. Essentially, CMS is stating the procedures will be deemed to be covered when bundled into the admission.

CMS is also establishing a “PO” HCPCS modifier to be associated with services delivered in a provider-based facility. According to CMS the modifier is to be reported with every HCPCS code for outpatient hospital services furnished in an off-campus provider-based department of a hospital. (See [42 CFR 413.65\(a\)\(2\)](#) for a definition of “campus.”) The modifier should not be reported for remote locations of a hospital, satellite facilities of a hospital, or for services furnished in an emergency department. Reporting is voluntary in CY 2015 and required beginning Jan. 1, 2016.

OIG Recommends Medicare pay SNF rates for CAH swing beds and Reduce Hospital Payments for Routine Outpatient Surgical Procedures

In federal budget news, the Department of Health and Human Services’ Office of Inspector General (HHS OIG) recommended this month that the Centers for Medicare & Medicaid Services reduce swing-bed reimbursement rates at critical access hospitals (CAHs) from 101% of reasonable cost to the daily rates paid under the skilled nursing facility prospective payment system. The [OIG report](#) estimates Medicare could have saved \$4.1 billion between 2005 and 2010 if CAHs were paid for swing-bed services using SNF PPS rates.

CMS disagreed, saying the OIG finding “*overestimates savings by failing to incorporate important factors such as the level of care needed by swing-bed patients, transportation fees to alternative facilities, and the use of point-to-point mileage distances instead of road miles.*” CMS also expressed concern with the methodology used to determine the findings on availability of skilled nursing services at nearby alternative facilities and the calculation of cost savings.

The HHS OIG also repeated its call for Medicare to pay hospitals the same as it pays ambulatory surgery centers for “low-risk” outpatient procedures, saving \$15 billion over five years and between \$2 billion and \$4 billion in reduced beneficiary copayments. The recommendation is included in the [OIG's annual list](#) of the top 25 recommendations that HHS has not carried out.

CMS states the recommendation could raise “circularity concerns” because ASC rates are based on a conversion factor from the hospital outpatient prospective payment system. Lowering those outpatient rates could affect the surgical center rates and create a kind of downward spiral. CMS also said the inspector general's report fails to offer clinical criteria to distinguish which patients could be treated in ASCs rather than hospital outpatient settings.

Among other recommendations in the report, OIG urges the CMS to review the claims of clinicians whose Medicare payments exceed a certain amount to help identify possible improper payments. About 2% of clinicians, the report notes, were responsible for nearly 25% of all Part B payments between 2008 and 2011.



Significant Reforms of the Medicaid Behavioral Health Benefit Proposed

The Ohio Departments of Medicaid and Mental Health and Addiction Services this month proposed three key reforms that reportedly will focus on Medicaid patients with high-end needs and bend the cost curve in the long run:

- **Transition to managed behavioral healthcare to improve care coordination and outcomes.** Final decisions have not been made as to the requirements for and type of care management that will be used. Examples of models used by other states include the use of a specialty behavioral health plan, use of the state's main MCO plans, or a hybrid approach.
- **Update billing codes and service definitions to align with national standards and identify specific service activities.** Mental health pharmacological management and AoD medical/somatic services are being targeted for the first phase update.
- **[Budget neutral] redesign of the behavioral health benefit that aligns services according to a person's acuity level and need.** This will include the addition of several new services based on proven models, such as Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), high-fidelity wraparound, peer services, supportive employment, and residential services for substance use treatment. Also, Community Psychiatric Supportive Treatment (CPST), case management, and health home services will be disaggregated to allow specific components to be aligned with a person's acuity level and need.

Directors McCarthy and Plouck were joined by Director Greg Moody, of the Governor's Office for Health Transformation at a meeting held March 13, seeking stakeholder input on the transition to managed behavioral health care. OHA will provide feedback on three managed care models under consideration.

Volunteer for July Medicare ICD-10 End-to-End Testing; Forms Due 4/17

From July 20 through 24, 2015, a third sample group of providers will have an opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors and the Common Electronic Data Interchange (CEDI) contractor. Approximately 850 volunteers will be selected to participate. CMS will select a broad cross-section of provider, claim, and submitter types. Testers who are participating in the January and April end-to-end testing are able to test again in July without re-applying.

Volunteer forms are available on your [MAC](#) website and are due April 17. If selected, testers must be able to submit future-dated claims and valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) to be used on test claims.

For more information go to [MLN Matters® Article #MM8867](#), "ICD-10 Limited End-to-End Testing with Submitters for 2015," [MLN Matters Special Edition Article #SE1435](#), "FAQs – ICD-10 End-to-End Testing" and [MLN Matters Special Edition Article #SE1409](#), "Medicare FFS ICD-10 Testing Approach"



Reminder to Submit AHA Annual Hospital Survey

All Ohio hospitals are encouraged to complete the American Hospital Association Annual Survey of Hospitals by March 31. Materials and instructions needed to complete the survey were sent to hospital CEOs in February. Healthcare leaders, policy makers and researchers use the data to describe and understand the operations of U.S. Hospitals and the AHA Annual Survey of Hospitals has become the definitive source for aggregate hospital data and trend analysis.

This year, participants can complete the survey online, which allows the user to receive real-time reports with benchmarks and analysis tools, grant access to multiple users within the hospital, and retrieve historical reference data as well as instant data verification as information is entered. OHA is partnering with AHA to achieve the highest possible survey completion rate. For questions about completing the survey, contact AHA at surveysupport@healthforum.com, or Berna Bell at OHA, bernab@ohanet.org.

Just the Facts

- The Medicare FFY 2014 hospital cost report [form](#), [instructions](#) and [electronic specifications](#) are out. Updates are included in **red** and cover cost reporting periods ending on or after Oct. 1, 2014.
- Ohio BWC's March 2015 edition of the Provider e-News is available [here](#). ODM's fifth billing guidance document for ICD-10 implementation was posted to [ODM's ICD-10 webpage](#) and is located under the *ICD-10 TIPS (Billing Guidance)* section. The fifth *ICD-10 TIPS* focuses on [Inpatient Hospital Interim Billing](#).
- Ohio Medicaid's fifth *ICD-10 TIPS* was posted to its [webpage](#), under the *ICD-10 TIPS (Billing Guidance)* section. This edition focuses on [Inpatient Hospital Interim Billing](#).

Hold the Dates

- **OHA Annual Meeting** is scheduled **June 8 – 10** at the Hilton Easton in Columbus, with two days of **Finance Track** educational programming. The annual HCAP/HFF/UPL membership session is scheduled June 9th, as is the *Finance and Legal Affairs Luncheon*, with a special session on the next round of HHS Office of Civil Rights HIPAA Audits.
- **Medicare 101 and Medicare Cost Reporting Fundamentals**, an expanded Medicare two-day 101 educational seminar includes a Cost Report session on day two. Produced in cooperation with the Florida Hospital Association and Plante Moran, the popular program is **Aug. 19 & 20**. Attendees will be able to register for either or both sessions.
- **Medicare & Medicaid in 2016** (aka the "Larry & Larry Show") is scheduled **Oct. 6**.

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