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REPORT ON WORKERS' COMPENSATION REIMBURSEMENT METHODOLOGIES

State of Minnesota

Minnesota Department of Labor and Industry

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CGI Federal Inc. 1001 Lakeside Avenue, Suite 800, Cleveland, Ohio 44114
Tel. 216-687-1480 / Fax. 216-687-6738
www.cgi.com

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EXECUTIVE SUMMARY

The Minnesota Department of Labor and Industry (MN-DLI) engaged CGI Federal, Inc. to identify, summarize, and report on reimbursement methodologies employed for other State Workers' Compensation agencies, Medicare, Medicaid, and group health insurers. This report presents the strengths and weaknesses of the reimbursement systems to enable MN-DLI to assess the direction that is needed in order to manage future health care expenditures for the workers' compensation program. This study focuses on the methods used by workers' compensation and Medicaid programs for the targeted states. The states included in this analysis include California, Florida, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Nebraska, North Carolina, North Dakota, Tennessee, Washington, Wisconsin, and Wyoming.

The goal for any health care reimbursement system is to pay providers for appropriately delivered services at a price level that is reasonable for resources expended for the service without disrupting patient access to care and quality of care. Additionally, the reimbursement system should incentivize health care providers to deliver the appropriate services in order to treat the patient. The administration and operation of the reimbursement system need to be considered before moving forward with implementation.

This study's focus is on the payment for health care services. We discuss in many sections the vulnerability that is created when reimbursement is based on provider charge and is not managed via a fee schedule or case-based payment. While a fee schedule is a step towards managing the expense vulnerability, a case based payment system further extends the effort in closing that part of the system vulnerability. Even when fee schedule or case based systems are put into place, annual system maintenance and fee updates are necessary for the system to keep pace and maintain any system successes achieved.

The service areas of focus are the following:

- Inpatient Hospital Services
- Outpatient Hospital Surgical Services
- Small Hospitals defined as less than 100 beds
- Ambulatory Surgery Centers
- Anesthesia Services (both Provider and Facility-based)
- Surgical Implants

CGI identified that a variety of reimbursement methodologies are used to pay providers for the targeted services by CMS for Medicare and the various state payers for Workers' Compensation and Medicaid beneficiaries. It is important to note that throughout the

research, providers of healthcare services are reimbursed under separate systems via separate claims. The primary providers reviewed in this study are hospitals and physician providers, specifically anesthesiology providers.

The table below summarizes the methodologies by targeted service:

Study Area	Workers' Compensation	Medicaid	Medicare
Inpatient Hospital	60% PPS 33% POC/Cost	86% PPS 0% POC/Cost	PPS
Outpatient Hospital	27% APC 27% POC 20% Fee Schedule	27% APC 0% POC 27% Fee Schedule 47% EAPG	OPPS based on APC
Small Hospital	67% No special treatment	27% No special treatment	Cost-based
Ambulatory Surgery Center (ASC)	40% Medicare ASC 27% POC/Chg 20% Fee Schedule	20% Medicare ASC 7% POC 47% Old Medicare ASC Groups	APCs for ASCs
Anesthesia Providers	87% RVU	87% RVU	RVU
Surgical Implants	13% POC/Chg 40% No Separate Pmt 47% Invoice plus 0% Fee Schedule	0% POC/Chg 33% No Separate Pmt 27% Invoice plus 27% Fee Schedule	No separate payment
Key: PPS – Prospective payment system POC – Percent-of-Charge APC – Ambulatory Patient Classification EAPG – Enhanced Ambulatory Patient Groups RVU – Relative Value Units			

While the exact reimbursement systems vary across the different agencies and targeted services, there is a clear trend toward prospectively set amounts such as fee amounts for services as opposed to reimbursement based on than charges or a percentage of charges. Reimbursement based on charges is difficult to predict and makes it more difficult to manage medical inflation since the providers of care set the charges for services. As an example, according to the Workers' Compensation Research Institute (WCRI) Hospital Cost Index January 2012 report, states with no fee schedules or some other prospective payment system incurred higher costs than those with reimbursement systems based on a percent of charges.

When considering a modification to a workers' compensation reimbursement system with regard to medical payments, it is important to model the proposed reimbursement system and payment policies using historical utilization data to understand payment

variances that might exist by provider and service, as well as identify opportunities to better match reimbursement with the resources needed to treat workers' compensation claims.

The structure of the reimbursement systems reviewed for this study range from simple to very complex. Regardless of the primary payment mechanism, the associated policies and procedures that are implemented by the payer agency also affect payment. Payment policies and procedures such as prior authorization, visit limits, and case management impact total expenditures by the system as they can control utilization. That is to say, the effectiveness of a payment system is not defined purely by the primary payment mechanism but rather, by all approaches taken to cost control.

Prospective payment systems have the flexibility to direct and manage reimbursements as necessary and a carefully designed system can properly incentivize providers to provide appropriate care. It is important to note that payment systems are aligned to the provider of service. Hospital and other facility based services such as those provided by an ambulatory surgery center are reimbursed separately from physician services even though the physician played a role in delivering the service. Facility charges are almost always considered separate from physician and allied professional charges even if the physician is an employee of the hospital.

Following are the recommendations from the findings of this report:

Inpatient Hospital Reimbursement

CGI recommends that MN-DLI assess the implementation of workers' compensation based on the Medicare MS-DRG system. The method should apply to all hospital suppliers of inpatient hospital care (i.e. acute care, critical access, small hospitals). The per-case reimbursement method employed by MS-DRGs encourages the responsible resource utilization since unnecessary services are not incentivized for delivery by the reimbursement system. MS-DRGs are widely used and understood in the health care marketplace. The MS-DRG system could be implemented as straight Medicare or some level of customization is possible. The customization does not involve the MS-DRG assignment itself but rather the supporting payment policies, provider payment rates, and possibly the MS-DRGs that are included or excluded from coverage. The policies and pricing levels chosen must coincide with the MN-DLI goals for the payment levels.

Outpatient Hospital Reimbursement

Although the initial request was for the reimbursement of outpatient hospital surgical services, none of the payment systems found in use specifically carve-out surgical services as a separate system. Typically surgical services are but one part of the entire

reimbursement program. All outpatient hospital services should be reimbursed under some sort of predetermined payment system. Two systems are recommended for consideration: Medicare Ambulatory Patient Classification (APCs) and 3M Enhanced Ambulatory Patient Groups (EAPG). Both of these systems have merit for consideration and the ultimate selection may be based on the cost to implement, ability to influence services rendered, along with the MN-DLI policy goals for outpatient hospital reimbursement. Of the two, the Medicare APC system is more widely known but the 3M EAPG system is gaining in popularity specifically in State Medicaid programs. One possible explanation for the EAPG system popularity in Medicaid is the system's ability to accommodate all services rendered to all populations. That is to say, the EAPG system is not geared toward Medicare reimbursement policy which may be of benefit to workers' compensation. If widespread familiarity is more important, then the Medicare APC system represents an important first step towards pre-determining prices paid for outpatient hospital care. Given that the system is geared towards Medicare benefit coverage, a review must be conducted and coverage gaps need to be addressed for payment. Many commercial payers and State Medicaid agencies have adapted the Medicare APC system to fit their needs.

Small Hospital Reimbursement

The research shows that small hospitals are not exempt from prospectively set reimbursement systems. Small hospital reimbursement usually follows the payment system for the setting of the delivery of care. That is, no different treatment from the primary inpatient hospital reimbursement and the same is true for outpatient hospital reimbursement. CGI recommends that small hospitals be blended into any new inpatient or outpatient hospital reimbursement changes. Options exist with regard to creating an add-on payment in addition to the prospective payment system but this is a matter of policy.

Ambulatory Surgical Centers (ASC)

ASC reimbursement in this report is centered on the facility reimbursement for services rendered and not the physician component. Even when the ASC facility is physician owned, two separate claims are submitted and reimbursed under separate systems. This is true for Medicare, Medicaid, and commercial payers. CGI's review of the workers' compensation system payments for the comparative states reveals separate reimbursement is made to the facility and to the physician. CGI's recommendation is to follow the Medicare ASC reimbursement methodology. The Medicare ASC payment system is well recognized by the marketplace and although the incentive to provide more services exists, at least prices paid are determined before the services are delivered. This methodology applies to those ASCs that are certified as such by Medicare. As with inpatient and outpatient hospital reimbursement based on a

Medicare method, a review of the covered procedures is needed to identify any differences in benefit coverage. Where gaps exist, supplemental fee amounts need to be created for the identified service. Since the Medicare ASC reimbursement system is largely a fee schedule, the facilitation of the fee payment should be minimal once the level of reimbursement is created. MN-DLI could set reimbursement at the Medicare price or at a percentage above Medicare. Again, determining reimbursement levels are a matter of policy.

Anesthesia

Anesthesia services reviewed are with regard to the physician or related certified nurse anesthetist. Eighty-seven percent (87%) of the states reviewed for both workers' compensation and Medicaid use the Medicare RVU methodology. CGI recommends that MN-DLI implement a system based on the Medicare RVU methodology. The basic components of anesthesiology reimbursement are: service weight (RVU), service units (time), conversion factor (dollar per unit), modifier (for reduced services). The conversion factor is the primary consideration when developing the system as most implementations of the Medicare RVU method for anesthesiology only vary on the conversion factor. Virtually all state workers' compensation and Medicaid agencies have created their own conversion factor and have left the remainder of the billing policies and reimbursement the same as Medicare.

Surgical Implants

Surgical implant reimbursement varies from no separate treatment from the reimbursement setting for which the patient was classified to invoice cost plus some percentage to a fee schedule defined by HCPCS code. The charge submitted by providers for surgical implants has seen tremendous growth in both terms of usage and charge levels. Reimbursement systems based on a percentage of charge or an overall cost-to-charge ratio that is factored on the provider charge leaves the payer vulnerable to the same price inflation. CGI recommends that reimbursement for surgical implants be blended into any new prospectively based payment system as the cost of the item would be included in the surgical procedure. If a prospective payment system is not put into place for inpatient, outpatient, and ASC facility settings, then CGI recommends reimbursement for surgical implants be made at invoice cost. The decision to reimburse for any percentage above invoice cost would be a matter of policy. There are many ways to communicate the invoice cost on the claim form. A key policy would be the ability for the payer to audit the actual manufacturer invoice as needed.

REPORT METHODOLOGY

The research methods used in this report constitute a “meta-analysis” of available information. No primary research was performed as part of this effort. The resources used were:

- Internet searches of credible sources such as Rand, URAC, Robert Wood Johnson Foundation
- Review of state Medicaid and Worker’s Compensation websites for reimbursement regulations and methods.
- Phone and email contact with Medicaid and Worker’s Compensation offices.
- CGI Federal clients for group health industry feedback

Sources are cited throughout the report and a full bibliography is provided in Appendix B.

ACRONYMS

A review of U.S. health care system and the associated reimbursement methods reveals extensive use of acronyms. The following list of acronyms will appear throughout this report.

APC – Ambulatory Patient Classification as used by Medicare and is used interchangeably with OPSS by many authors. APC's refers to a subset of services that are reimbursed for hospital outpatient claims.

AP-DRG – All Patient DRGs as created by 3M that was created to reflect services consumed on an inpatient basis for the general population.

APR-DRG – All Patient Refined DRGs as created by 3M that was created to reflect services consumed on an inpatient basis for the general population. This grouper contains variables to reflect the severity and mortality of the inpatient case.

ASC – Ambulatory Surgery Center's represent those that are certified by Medicare as an ASC and may be either free-standing or a sub-part unit of a hospital campus. ASC's typically perform elective, non-intense surgical procedures that may safely be done outside of a hospital.

CAH – Critical Access Hospitals; hospitals certified by Medicare as CAH are 25 beds and under.

CMS – Centers for Medicare and Medicaid, also referred to as Medicare

DRG – Diagnosis Related Groups is a generic term used to describe an inpatient classification system based on DRGs. It could represent any one of the many different DRG grouper systems available.

EAPG – Enhanced Ambulatory Patient Groups. A patient classification system developed by 3M for use in analyzing and reimbursing hospital outpatient visits.

IPPS – Inpatient Prospective Payment System as used by Medicare is a DRG-based system for reimbursing short-term acute care inpatient claims. Used interchangeably with MS-DRG.

OPPS – Outpatient Prospective Payment System as used by Medicare to reimburse for hospitals for outpatient care. Used interchangeably with Ambulatory Patient Groups (APC).

MS-DRG – Medicare Severity Diagnosis Related Groups is the current DRG grouper name used by Medicare and many Medicaid and commercial payers. It is a classification system based on patients with similar clinical presentations and resource utilization.

POC – percent of charge that could represent either a discount from charges or a cost-to-charge ratio. In either case, the percentage is typically multiplied by the claim charges to arrive at the claim reimbursement.

RVU – Relative value unit which represents a weight value. Used most often for physician based reimbursement.

WC – workers' compensation

DETAILED REPORT

INTRODUCTION

CGI Federal Inc. was engaged by Minnesota Department of Labor and Industry to conduct an analysis of current reimbursement methodologies for selected state workers' compensation and Medicaid agencies. Details for the Centers for Medicare and Medicaid (CMS) are also reviewed. The purpose of this study is to identify the reimbursement methods used, identify and discuss the merits of the various reimbursement methods, and provide information with regard to cost containment strategies, results of reimbursement method reforms, and the current initiatives with regard to new and innovative reimbursement changes being tested.

Fifteen states were selected for comparison based on their various reimbursement methodologies, geographic locations, and workers' compensation health care expenditure trends. They are California, Florida, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Nebraska, North Carolina, North Dakota, Tennessee, Washington, Wisconsin and Wyoming. The table below identifies the health care expenditures trends, if the state is a neighbor and the state's region and includes comments on workers' compensation reimbursement methodologies.

State Matrix Approved for Study			
State	Health Care Expenditure Trends	Neighbor State/Region	WC Related Brief
California	Normal Fluctuations	No/West	Has instituted various cost containment strategies in recent years with mixed results.
Florida	Normal Fluctuations	No/South	Employs similar cost containment strategies as MN.
Illinois	Increasing	No/Midwest	Employs similar cost containment strategies as MN yet struggles with cost containment. Also has achieved recent legislative changes.
Iowa	Normal Fluctuations/Increasing	Yes/Midwest	No fee schedules but does use some cost containment strategies.
Louisiana	Stable	No/South	Cost containment strategies vary from that of MN yet state continues to have relatively stable medical payments albeit, high medical payments.
Maryland	Normal Fluctuations	No/East	Achieves low cost per claim over time.
Massachusetts	Increasing	No/East	Relatively low medical payments per claim but has seen recent increasing cost trends.

State Matrix Approved for Study			
Michigan	Increasing	No/Midwest	High utilization of prospective payment system methods.
Nebraska	Normal Fluctuations	Yes/Midwest	High utilization of prospective payment system methods.
North Carolina	Increasing	No/South	Hospital expense increasing at a more rapid pace.
North Dakota	Increasing	Yes/Midwest	Neighboring state.
Tennessee	Normal Fluctuations	No/South	Has implemented prospective payment systems in the past 5 years.
Washington	Normal Fluctuations	No/West	Has implemented wide variety of payment systems in the past 5 or so years.
Wisconsin	Increasing	Yes/Midwest	Good value propositions for workers and their employers. Fees from providers are regulated.
Wyoming	Unknown	No/West	Wyoming is one of four monopolistic states where employers can purchase insurance only through the state worker's compensation fund.

Notes: The above states represent a cross-section across the U.S. The states suggested for inclusion in this study:

- Represent a variety of medical claims payment systems
- Range from no legislation for payment to high utilization of payment systems
- Represent a range of healthcare cost trends
- A couple of the states recently were successful in achieving legislative change in establishing new payment systems

This report covers each of the following main study areas:

- Inpatient Hospital – services provided by a hospital to inpatients; does not include physician reimbursement provided to the inpatient of the hospital
- Outpatient Hospital – Surgical Services – services provided by a hospital to an outpatient; does not include physician reimbursement provided to the outpatient of the hospital
- Small Hospitals – less than 100 beds; reimbursement for the hospital services only
- Ambulatory Surgery Centers – reimbursement for the facility services only and does not include the physician reimbursement which is separate.
- Anesthesia – Provider and Non-Facility Based for the physician or nurse anesthetist services.
- Surgical Implants – items for which are surgically implanted.

Within each study area, the following sub-sections are provided:

- Current reimbursement methodology for Minnesota workers' compensation
- Current reimbursement methodology for workers' compensation for each of the study states – in alphabetic order
- Current reimbursement methodology for Medicare
- Current reimbursement methodology for Medicaid for each of the study states – in alphabetic order

INPATIENT HOSPITAL

This section describes the reimbursement methodologies found for inpatient hospital payment for workers' compensation agencies, Medicare, and Medicaid. These descriptions are intended to provide a high level overview of how payments are made and how payment rates may vary across providers of inpatient hospital care. Sufficient detail is presented for the reader to differentiate the various payment methods and policies employed by each state agency included.

The order of the payment program review is as follows:

- Minnesota WC
- WC methods by each study state in alphabetical order
- Medicare Reimbursement
- Medicaid Reimbursement

Reimbursement for inpatient hospital is only for the hospital portion of services rendered as physician services provided to an inpatient are made under a separate reimbursement system.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA WORKERS' COMPENSATION – INPATIENT HOSPITAL

Minnesota Worker's Compensation current payment methodology provides that hospital inpatient services are reimbursed as a percentage of charges depending on hospital size (number of beds). Reimbursement for inpatient services for hospital's with more than 100 licensed beds is limited to the lower of 85% of the facility's usual and customary charge, 85% of the prevailing charge, or the facility's actual charge. Hospitals with 100 or fewer licensed beds are reimbursed at 100% of the hospital's usual and customary charge, unless the commissioner or compensation judge determines the charge is unreasonably excessive.

CURRENT WORKERS' COMPENSATION REIMBURSEMENT METHODOLOGY FOR COMPARATIVE STATES – INPATIENT HOSPITAL

California. Inpatient hospital workers' compensation reimbursement in California is aligned directly with CMS Inpatient Prospective Payment System (IPPS). California's regulations identify that MS-DRGs are used along with the Medicare DRG weight. A hospital specific composite rate is used and multiplied by a factor of 1.2 times the DRG weight to determine the payment before outlier consideration. Provisions for transfers and capital payments are recognized in the same manner as Medicare. The outlier policy deviates from Medicare in that implantable devices are excluded from outlier cost

and payment determination. The MS-DRGs cited for exclusion from outlier are: 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473. Implantable devices are separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost, net of discounts and rebates, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid. Sole community hospitals are reimbursed in the same manner as Medicare in that they may choose to receive the higher of the current composite rate or the hospital specific composite rate base rate from a specific year, inflated to current. In summary, California follows Medicare IPPS in policy, weights but develops its own composite (base) rate and excludes implantable devices from the cost outlier payment.

Florida. Florida updated its inpatient reimbursement in 2004 to a per diem based system. The per diem does not include reimbursement for patients receiving implantable devices or the instrumentation to support the implantation. Providers receive 60% above the invoice cost, net of any discounts showing on the invoice and they receive 20% above the invoice cost if the supporting instrumentation also appears on the invoice. The appropriate charges must appear on the claim for implants and be communicated by revenue code 0278. Separate documentation (i.e. invoice) must be submitted to support the charges. Electronically submitted charges must be communicated in the Remarks section of the electronic transaction and the supporting documentation must be submitted within 30 days of request by the department if such a request is made. The system provides for a stop loss however, implants are excluded from stop loss calculations. Reimbursement is set at 75% of charges if the claim exceeds \$51,400 in total charges excluding implants.

Illinois. As of January 1, 2012, Illinois workers compensation altered its inpatient reimbursement to recognize regions within the state. Illinois has been using MS-DRGs since 2009. The system presently divides the state into 14 regions based on county. The MS-DRG grouper is used across the state but reimbursement by MS-DRG will vary from a case perspective (MS-DRG weight multiplied by the provider base rate) to a percent-of-charge (POC). The POC is used when a region's case load is below 9 in order to set the case payment. When an MS-DRG case payment is calculated, the final case payment is the lower of the provider charge or the computed case payment. Implants are carved out and paid at "invoice plus" amount. Outliers are recognized when the claim charges, excluding carve-outs, exceeds 2.857 times the fee schedule amount. Payment for an outlier shall be the sum of: 1) the assigned fee schedule amount, plus 2) 53.2% of the charges that exceed the fee schedule amount, plus 3) 125% of the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges for implants, plus 4) 65% of charge for the non-implantable carve-out revenue codes.

Iowa. Iowa does not have a fee schedule for inpatient hospital claims. Claims are reimbursed at charges.

Louisiana. According to the Louisiana publication Title 40, section 2505: “Reimbursement for inpatient hospital services will be limited to the lesser of covered billed charges or the per diem amount. The per diem rate assigned to the Standard Metropolitan Statistical Area in which the services are rendered will be applied to inpatient days by type of service, either medical or surgical. The reimbursement amount will be reduced by charges for non-covered items and services”.

Maryland. Maryland uses the All Patient Refined DRG (APR-DRG) grouper and regulates prices paid for inpatient hospital care regardless of who the payer is. The State of Maryland operates under a waiver that was granted back in 1977 when Medicare and Medicaid were cost based systems. Since Maryland operates under a waiver, the Health Services Cost Review Commission (HSCRC) establishes the policies and payment levels to hospitals for all payers.

Massachusetts. Division of Health Care Finance and Policy (Division) has been granted the authority to establish rates of payment for hospitals and health care providers providing services covered by insurers and other purchasers. The Division’s rates and rules will prevail unless the provider and insurer enter into a separate contract. Each hospital has a specific Payment on Account Factor (PAF) for each rate year and the PAF is multiplied by charges to determine reimbursement.

Michigan. Michigan WC has established payment for inpatient hospital care based on a cost-to-charge ratio. Each hospital is assigned a cost factor expressed as a percentage that is multiplied by the covered claims charges to arrive at the claim payment. Michigan has also established a “prompt pay” incentive for carriers of WC insurance in that if a clean claim is submitted to the carrier and the carrier fails to promptly pay the claim in 30 days, the carrier is required to remit an extra percentage of the payment to the provider.

Nebraska. Nebraska WC uses Medicare’s MS-DRG grouper and weights. Nebraska has created a schedule that applies to the 20 largest facilities in the state and each facility has its own schedule based on a calculated “Workers’ Compensation Factor” or base rate. Only DRGs that make up the most frequent workers’ compensation discharges from the previous reporting year are included. For inpatient cases that are billed as trauma as identified by clinical coding on the claim, a separate base rate has been created for each of the 20 hospitals. For DRGs not included in the schedule and for all other hospitals a percent of charges regulation based on tier levels applies.

North Carolina. Inpatient hospital stays are reimbursed according to a DRG fee schedule that duplicates the State Health Plan contract accounts. However, in

instances where the calculated DRG payment fall below charges or the DRG payment exceeds charges, end caps are imposed. Thus, while following a DRG reimbursement schedule, reimbursement shall be no less than a lower bound percentage of charge and no higher than the billed charges. The current lower bound is 75% of charge. This system essentially reimburses inpatient claims at 75% of charge. There are several revenue codes that are excluded from charges before the calculation is conducted.

North Dakota. Inpatient acute and acute psychiatric services are reimbursed by Medicare's MS-DRG. A North Dakota Workforce Safety and Insurance (WSI) specific rate (conversion factor) is computed using the information published each year in the federal Register and is effective for the following calendar year. WSI uses Medicare's operating and capital base rates. The WSI adjusted operating base rate is 92% of the 2008 Medicare national operating amount adjusted annually by the Medicare market basket and the capital portion is recognized at 8% of the 2008 Medicare amount adjusted annually. WSI does not reimburse for disproportionate share, medical education, or other Medicare pass-through amounts. Outlier claims are recognized and paid at 80% of the costs that exceed a fixed-loss threshold plus the DRG amount. The transfer methodology used by Medicare is also recognized.

Tennessee. Inpatient hospital claims for WC are reimbursed based on a per diem methodology. Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual charges, the PPO or other contracted amount, or the maximum amount allowed under the inpatient hospital fee schedule. Acute care hospitals are reimbursed based on either a medical per diem or a surgical per diem. The per diem is higher for the first seven (7) days of the stay and is reduced for the remaining days. A higher trauma per diem is also used.

The following items are reimbursed in addition to the per diem:

- Durable Medical Equipment
- Orthotics and prosthetics
- Implants
- Ambulance
- Take Medications and Supplies
- Radiology
- Laboratory services

A stop-loss provision is provided when the claim charge exceeds the calculated payment by \$15,000. Items not reimbursed under the per diem amount are excluded from the stop loss calculation in terms of charges and payments. Reimbursement for charges in excess of the stop-loss threshold is paid at 80% of charges.

Washington. Inpatient prices are regulated with an alternate percent-of-charge, per diem, or All Patient DRG (AP-DRG) based methodology and these rates vary by hospital. If there is a relative weight assigned to an AP-DRG then the reimbursement is equal to the relative weight multiplied by the hospital's base rate. If there is no relative weight established then reimbursement is per diem. If there is no relative weight and no per diem, a hospital specific cost-to-charge ratio is applied to the billed charges. Washington uses the following payment policies for inpatient claims:

- Transfer cases are paid a DRG per diem up to the full DRG amount.
- Low outlier cases are those where the costs of a case are less than a specified DRG threshold. The case is then paid at the percent-of-charge amount.
- High outlier cases are those where the costs of a case are more than a specified DRG threshold. The case is then paid the DRG case amount plus 100% of the costs that exceed the threshold.

Wisconsin. Wisconsin does not issue a specific inpatient fee schedule for workers' compensation. Each employer in the state is required to provide workers' compensation insurance via an independent insurance provider or through a third party administrator if the employer is approved to be self-insured. Fees from providers are regulated and must be reasonable. Reasonable charges are defined as data provided by a department approved database and the billed service fee must not be more than 1.4 standard deviations from the mean of the service from the approved database.

Wyoming. Inpatient reimbursement is set at the usual and customary amount. Inpatient hospital room rates are paid upon an annual survey conducted by the Division. Charges for hospital room rates for inpatients are reimbursed at 100 percent of the annual room rate survey from each hospital for semi-private and intensive care units. Other charges are reimbursed accordingly to rules listed or usual and customary if not directly listed.

CURRENT REIMBURSEMENT METHODOLOGY FOR MEDICARE – INPATIENT HOSPITAL

The CMS Medicare payment for acute care hospital inpatient stays is based on the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group known as the Medicare Severity Diagnosis Related Group (MS-DRG). Each MS-DRG is assigned a weight that reflects the average resources used to treat Medicare patients for that MS-DRG relative to all MS-DRGs. The weights are based on the national average of hospital costs and are updated annually.

CMS determines the national payment rate that is applied to the MS-DRG weight. The national payment rate is further parsed into a separate rate based on the wage index in which the provider is located and whether the hospital has submitted its quality reporting information. The national base rate is then adjusted to the individual provider. Adjustments to the national rate include a wage adjustment, cost of living adjustment, disproportionate share (DSH), and indirect medical education (IME). Not all providers will qualify for each adjustment and the adjustment is specific to a provider and in some cases represents a significant portion of the provider's reimbursement. The provider base rate is then multiplied by the DRG relative weight. CMS also funds capital improvements via a capital payment adjustment. The capital amount is also adjusted for DSH and IME as appropriate. Capital payments are made as a way to partially fund hospital physical plant improvements.

Additional payment provisions apply to a patient case level. These include:

- Outlier – for extraordinarily costly cases. This payment provides for an additional payment to cover some of the costs for the particular case. Transfer cases qualify for outliers.
- Transfer – for patients who transfer to another facility in less time than is expected for the DRG.
- New technology – Annually CMS assesses what, if any, new technologies may qualify for an additional offsetting cost-based payment. Specific claim coding criteria will be published in the Federal Register Final Rule that will indicate to Medicare claims processors that a new technology was supplied to the patient.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA MEDICAID AND OTHER STATE MEDICAID AGENCIES – INPATIENT HOSPITAL

Medicaid Background

According to the Centers for Medicare and Medicaid (CMS) website (cms.gov), the Medicaid program was enacted in 1965 through amendments to the Social Security Act. Medicaid is a health and long-term care coverage program that is jointly financed by states and the federal government. Each state establishes and administers its own Medicaid program and determines the type, amount, duration, and scope of services covered within broad federal guidelines. States must cover certain mandatory benefits and may choose to provide other optional benefits.

Federal law also requires states to cover certain mandatory eligibility groups, including qualified parents, children, and pregnant women with low income, as well as older adults and people with disabilities with low income. States have the flexibility to cover

other optional eligibility groups and set eligibility criteria within the federal standards. State plans must ensure that unnecessary utilization is safeguarded against and assure that payments are sufficiently set to ensure access to care is available to recipients in any geographic area.

It is important to note as we describe the payment methods employed by each state, that significant differences in the population of covered lives are very different from worker's compensation. One major difference is the coverage of children. Their consumption of healthcare services is very different from that of the working population. Many of the payment systems described below may include significant coverage for children that would not be necessary in the worker's compensation arena.

Most states have established both a fee-for-service program and managed-care. The regulations and methods described in this document represent the fee-for-service program as administered by each state. Each managed-care contractor will define their own payment methods and beyond the scope of this document. The table below identifies the reimbursement methodologies used by all states:

How Medicaid Pays for Hospital Inpatient Care	
Per Stay → CMS-DRGs	Per Stay – AP or Tricare DRGs
CO*, IA, IL, KS**, KY, MN, OH, SC, UT, VT, WV** *Moving to APR-DRGs ** Moving to MS-DRGs	DC, GA, IN, NE, NJ, VA, WA
Per Stay → MS-DRGs	Per Stay – Other
MI, NC, NH, OK, OR, SD, TX*, WI *Moving to APR-DRGs	DE, MA*, NV, WY *Case-mix adjustment based on APR-DRGs
Per Stay – APR-DRGs	Per Diem
MT, ND, NY, PA, RI	AK, AZ, CA, FL*, HI, LA, MO, MS *Moving to a DRG system in FY2013
Cost Reimbursement	Other
AL, AR, CT, ID, ME	MD – Regulated charges with adjustment based on APR-DRGs TN – Completely managed care with varying methods employed by the MCO's
<p>1. CMS-DRGs=CMS Diagnosis Related Groups (used by Medicare until 10/1/07); MS-DRGs = Medicare Severity DRGs (used by Medicare since 10/1/07); AP-DRG=All Patient DRGs; APR-DRGs – All Patient Refined DRGs; Tricare DRGs = DRGs used by the military health care system</p> <p>2. Source: http://www.chcs.org/usr_doc/Sound_Medicaid_Purchasing_FINAL.pdf with updates by CGI Federal.</p>	

Each state Medicaid agency reimbursement for inpatient hospital care is discussed below.

Minnesota. Minnesota Medicaid uses the CMS-DRG system for inpatient hospital discharges. Inpatient services must be prior authorized. Following are key reimbursement policies:

- Hospital Acquired Conditions – MN Medicaid will not pay for hospital acquired conditions.
- Day outliers – for stays that extent beyond the established threshold for the DRG of the patient, additional payment beyond the standard DRG payment will be made at 70% of the allowable cost for regular cases and 90% for neonatal and burn cases.
- Transfers – cases qualifying as a transfer case will be paid on a per diem basis not to exceed the DRG payment.
- Hospital rates include an operating and property payment, which include disproportionate share funding. Hospital rates are calculated based on each individual hospital. Small hospitals receive a 15% - 20% increase in their calculated base rate.

California. Medi-Cal has instituted contracted rates, called the Selective Provider Contracting Program (SPCP), for select acute care hospitals for inpatient care and many hospitals are still non-contracted and paid under the former rates and regulations. Medi-Cal has an extensive treatment authorization request (TAR) in place and even contracted hospitals may provide non-contracted services for which a TAR would be needed for reimbursement. Contract arrangements range from a per diem to a per discharge type system.

For Medi-Cal non-contracted hospitals, the final reimbursement payable for inpatient services provided during a hospital's fiscal period is referred to as the peer grouping inpatient reimbursement limitation (PIRL), which is the lesser of the hospital's (1) customary charges, (2) 90% of the audited allowable costs in accordance with Medicare standards and principles of cost-based reimbursement, (3) an all-inclusive rate per discharge limitation (ARPD), or (4) peer grouping rate per discharge limitation (PGRPDL).

Florida. Florida Medicaid reimburses inpatient stays on a per diem basis. Florida specifies annual limits in terms of days whereby enrollees less than 21 years of age have unlimited inpatient days and enrollees 21 years and older have an annual limit of 45 days. Special considerations may be extended to the 21 and older group on an emergency basis.

Florida Medicaid will be moving to a DRG based reimbursement system in FY2013. The details are still being worked out.

Illinois. Inpatient payments include two methods of reimbursement: per diem and diagnosis related groups (DRGs). Under the per diem methodology, hospitals receive a flat rate for each day of inpatient services provided. Per diem reimbursed hospitals include: University of Illinois at Chicago hospital, Cook County hospital, rehabilitation hospitals, psychiatric hospitals, children's hospitals, long-term stay hospitals and certain rural hospitals.

The Illinois DRG reimbursement system is based on the Version 12 Medicare DRGs which CMS used in 1995. A few DRGs have been created to accommodate neonates and represent a custom modification to the grouper. The department does adjust payments for exceptionally long stays or exceptionally high costs. The department also pays hospitals for the capital costs associated with the Medicaid inpatient stay.

Some procedures normally provided in the outpatient setting of a hospital will be reimbursed by the department in the inpatient setting in limited circumstances. Providing these services in an inpatient setting will also require a justification and reimbursement is subject to prepayment review.

Additional hospital add-on payments include:

- **Disproportionate Share Hospitals (DSH):** The disproportionate share hospital program, as described in Illinois Administrative Code, Section 148.120, allows the department to provide additional payments to qualifying hospitals for services vital to Medicaid clients.
- **Medicaid High Volume Adjustments (MHVA) to DSH Hospitals:** MHVA payments, as described in Illinois Administrative Code, Section 148.120, consist of adjustments made to disproportionate share hospitals (DSH), excluding those operated by Cook County and the University of Illinois at Chicago.
- **Critical Hospital Adjustment Payment (CHAP) Programs:** This program described in Illinois Administrative Code, Section 148.295, has four separate categories in which a hospital can qualify for additional Medicaid payments: trauma, rehabilitation, direct and rural hospitals. Supplemental CHAP payments are made to hospitals that meet requirements defined in the Illinois Administrative Code, Section 148.296.
- **Pediatric Outpatient Adjustment Payments:** This payment defined in the Illinois Administrative Code, Section 148.297, rewards hospitals that devote resources to providing outpatient services to a high percentage of Medicaid-eligible children.

- **County Trauma Center Adjustment Program:** Under this program, separate from the CHAP Program, all Level I and Level II Illinois trauma centers can receive additional Medicaid payments. The program is funded by fines for traffic citations.

Iowa. Medicaid reimbursement for inpatient hospital care is based on prospective payment per discharge according to DRG. The current grouper is the CMS v24 version. The DRG weights are recalibrated once every 3 years. The current DRG payment is established through a base-year rate (2007) to which an annual legislative index may be applied on July 1 of each year.

The provider base rate is a blend of hospital-specific and statewide average costs reported by each hospital, for the routine and ancillary base and capital cost components, per Medicaid discharge. Direct medical education, indirect medical education, and disproportionate share payments are made directly from the graduate Medical Education and Disproportionate Share Fund. They are not added to the reimbursement for claims.

The following payment policies are used:

- Short stay outliers – inpatient stays that are at or below the short stay threshold for the DRG are reimbursed on a DRG per diem.
- Long stay outliers – inpatient stays that exceed the high trim day are reimbursed the base DRG payment for the days below the threshold and 60% of the DRG per diem for days exceeding the threshold.
- Cost outliers - Cases qualify as cost outliers when costs of service (not including any add-on amounts for direct or indirect medical education or for disproportionate-share costs) exceed the cost threshold. This cost threshold is the greater of:
 - Two times the statewide average DRG payment for that case, or
 - The hospital's individual DRG payment for that case plus \$16,000.

Louisiana. Louisiana classifies hospitals into three groups each with its own reimbursement rates:

- State-owned (reimbursed cost),
- Small rural, or
- Non-small/rural, non-state.

Reimbursement for non-small rural/non-state hospitals for inpatient acute care is a prospective per diem rate. All non-small rural/non-state hospitals enrolled in Louisiana

Medicaid are classified as one of the following five peer groups, or as a specialty hospital:

- **Peer Group 1 – Major Teaching Hospitals** Qualifying hospitals will receive not less than 80% of the current peer group rate
- **Peer Group 2 – Minor Teaching Hospitals** Qualifying hospitals will receive not less than 103% of the current peer group rate
- **Peer Group 3 – Non-Teaching Hospitals with less than 58 beds** Qualifying hospitals will receive not less than 103% of the current peer group rate
- **Peer Group 4 – Non-Teaching Hospitals with 59 to 138 beds** Qualifying hospitals will receive not less than 122% of the current peer group rate
- **Peer Group 5 – Non-Teaching Hospitals with more than 138 beds** Qualifying hospitals will receive not less than 103% of the current peer group rate

Maryland. Maryland regulates rates for all hospitals. All hospitals must bill and all payers must pay based on a list of approved payment rates for service-specific and departmental units. The aggregate payments to urban hospitals are capped by an average per case rate based on All Patient Refined-Diagnosis Related Groups (APR-DRGs V28). Approved rates also are set for outpatient visits in the same manner. Volume that exceeds the baseline year is reimbursed at 85 percent of the approved case rate. Hospitals return the other 15 percent through an aggregate downward adjustment to the following year's rate. Rural hospitals are constrained by a cap on total annual revenue.

Massachusetts. MassHealth uses a Standard Payment per Adjusted Discharge (SPAD) rate per discharge. This rate is based on hospital reported costs and a blend of:

- Statewide average payment amount per discharge adjusted by an efficiency standard and then for wage area differences, hospital-specific case mix and an operating cost inflation factor;
- A per discharge payment for hospital-specific expenses for malpractice insurance and organ acquisition
- A per discharge payment amount for capital cost, adjusted by hospital-specific case mix and by a capital inflation factor.

The case mix is measured by the APR-DRG v26 grouper and Massachusetts cost-based weights. Transfer payments are made on a per diem basis up to the full SPAD and outliers are recognized as well although only for patients under the age of 21. Payment will not be made for a claim should a "never" event occur.

Michigan. Michigan Medicaid follows the Medicare MS-DRG grouper but uses its own DRG weights. Transplant DRGs are carved-out and paid at a percentage of charge. Michigan provides for a capital add-on payment. Additional payment policies include:

- Low day outlier where the payment is the lesser of charges, the hospital's cost-to-charge ratio (CCR) time charges (case cost), or the DRG payment.
- Long stay outlier payment is a day outlier formula where the payment is the DRG payment plus 60% of the DRG per diem.
- Cost outlier where the case cost (CCR time charges) exceeds either two times the DRG payment or \$35,000. The provider receives the DRG payment plus 85% of the amount that costs exceeds the threshold.
- A transfer payment is made for cases where the patient is transferred to another acute care hospital. The payment is a DRG per diem up to the full DRG amount. Transfer cases are eligible for outlier payments.

Nebraska. Nebraska Department of Health and Human Services (NHHS) moved to the AP-DRG grouper on October 1, 2009. NHHS formerly used the CMS version 24 DRG grouper. Payments under the AP-DRG method include the following costs: operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio. The AP-DRG system payment levels may not exceed what would be paid for the same case under Medicare. The hospital payment rates are peer group based. Following is a description of the six peer groups:

- Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
- Other Urban Acute Care Hospitals: Hospitals that have been re-designated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
- Rural Acute Care Hospitals: All other acute care hospitals;
- Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
- Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
- Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Not all DRGs are paid via the peer group base rate. When the DRG weights are established, some will qualify as low volume or unstable DRGs. Payments for the low-volume and unstable DRGs are based on the sum of:

- The Cost-to-Charge Ratio (CCR) Payment amount; and
- When applicable - Direct Medical Education Cost Payment

The following payment policies are employed by NHHS:

- Prior-authorization for surgical procedures.
- Prior-authorization for select expensive drugs.
- Payment reduction for hospital acquired conditions where Medicaid is secondary to Medicare.
- Outlier payment for high cost cases. Case costs must exceed the sum of the regular DRG payment plus a fixed-loss amount (threshold). Payment will be the regular DRG payment plus 80% of the amount of costs that exceed the threshold. Costs are calculated by the Medicare cost-to-charge ratio per hospital.
- Transplant cases are paid via a cost-to-charge ratio.
- Payment for rehabilitation is made on a per-diem basis regardless of the type of hospital providing the service.

North Carolina. The North Carolina Division of Medical Assistance (NC DMA) reimburses hospitals for inpatient care using two separate pricing methods:

- Medicare Severity Diagnosis Related Groups (MS-DRG) with custom weights
- Per Diem

The DRG payment method is for general acute care hospitals and excludes DRGs for inpatient psychiatric and rehabilitation DRGs. The following payment policies are employed:

- Disproportionate Share Hospital (DSH) payments are made to qualifying hospitals
- Outlier payments are permitted when costs for allowed revenue codes exceeds either a cost outlier threshold or a day outlier threshold. The outlier payment is 75% of the amount that costs exceed the threshold. If the claim qualifies for both cost and day outlier payments, both will be calculated, and the greater of the two payments will be applied to the DRG allowable. Day outlier payments are an additional payment made for an exceptionally long length of stay for children under age six (6) at disproportionate share hospitals and children under age one (1) at hospitals that are not disproportionate share facilities.

- Transfer payments are made when a patient is transferred to another acute care facility. The payment is a DRG per diem. Final payment is either the calculated DRG per diem up to the full DRG amount.

The following are reimbursed by per diem:

- inpatient psychiatric and rehabilitation services
- skilled nursing facility/intermediate care facility care in acute care facilities
- swing-bed hospital units
- state-operated hospitals
- inpatient psychiatric or substance abuse DRGs 424-437
- inpatient rehabilitation DRG 462

North Dakota. North Dakota Medicaid in 2012 made the transition from CMS-DRGs to APR-DRGs for payment to in-state hospitals, excluding long-term care, psychiatric, and rehabilitation hospitals or distinct part units. This grouper change was made to better accommodate the Medicaid population. The base rate for providers is based on peer groups. Payment to psychiatric and rehabilitation hospitals or distinct part units is based on a per diem payment. Inpatient services provided by a long-term care hospital and all outpatient services are paid based on a percentage of charges.

Payment to out of state hospitals is based on a percentage of charges and is payable if the patient has obtained prior approval from North Dakota for out of state referral. Prior authorization is not required for true emergencies or for United States hospitals located within 50 miles of the North Dakota border but are required for all other inpatient stays.

Tennessee. Tennessee's TennCare program is 100% managed care whereby all enrollees in this Medicaid program receive care through a managed care organization (MCO). There are three primary carriers of TennCare: BlueCare by Blue Cross Blue Shield of Tennessee, Amerigroup of Norfolk, Virginia, and Americhoice, a subsidiary of United Healthcare. Each MCO has created network agreements with providers and payment methods will vary. TennCare retains oversight of how the MCOs operate and will dictate certain policies for which each MCO must comply. TennCare uses a "medical home" where each enrollee is matched to a primary care physician who provides and coordinates the care.

BlueCare manages inpatient care by using CMS-DRGs which is not what is currently used by Medicare as they have moved up to the severity adjusted grouper MS-DRGs. BlueCare employs payment policies for transfers and outliers.

Washington. The Washington State Health Care Authority (WA HCA) uses the AP-DRG grouper for fee-for-service enrollees. Within the inpatient payment system, transplants are reimbursed at a percentage of charge. For DRGs that are low volume, a

per diem is used instead of a case weight. Different per diems are set for medical, surgical, neonate and burn cases. WA HCA payment policies include transfers and outliers for costly cases. High cost outlier cases must exceed two thresholds:

- Fixed loss threshold \$50,000, and
- 175% time the original DRG payment

High cost outlier payments represent an additional payment for the costs that exceed the threshold and vary by service. Burn and neonatal cases receive a higher percentage of the outlier costs than do regular cases.

WA HCA also provides additional payments for qualifying trauma cases at certified trauma hospitals. A scoring system has been established to determine if a case qualifies for the trauma payment.

Wisconsin. Wisconsin Medicaid and Badgercare Plus use CMS MS-DRGs for inpatient hospital payment but with some exceptions:

- Neonatal DRGs are based on the AP-DRG grouper to better differentiate services used by this population.
- Select transplant DRGs are customized as well.
- The DRG weights are specific to the distribution of Medicaid resource utilization and where utilization is not sufficient, the Medicare weight is used.
- DRGs for AIDS, brain injury, and long term ventilator services are carved out the DRG system and reimbursed on a per diem basis.

Wisconsin determines a unique "hospital-specific DRG base rate" for each hospital. This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. This rate also includes an amount for capital costs and, for qualifying hospitals, additional amounts for serving a disproportionate share of low-income persons, for direct and indirect costs of a medical education program, or for the hospital being located in a rural area. Payment to a hospital for the stay is determined by multiplying the hospital's specific DRG base rate by the weight assigned to the DRG into which the stay is classified by the grouper.

The following payment policies are used:

- A "cost outlier" payment is made when the cost of providing a service exceeds a pre-determined "trimpoint". Trim points are hospital specific based on a formula that differentiates between hospitals over/under 100 beds and a different trim point is used for critical access hospitals. A length-of-stay outlier payment is available upon a hospital's request for children under six years of age in disproportionate share hospitals and for children under age one in all hospitals.

The outlier payment varies by provider type and ranges from 77% of excess costs for most hospitals and 100% of excess costs for critical access hospitals.

- In total for a given state fiscal year, the total amount of DRG payments plus DSH may not exceed charges for the same time period.

Wyoming. Wyoming Medicaid pays for inpatient hospital services using three different approaches, depending upon the type of service:

- Level of care prospective rate per discharge – Used to pay for general inpatient acute care services.
- Prospective per diem rate – Used to pay for rehabilitation services provided with a ventilator and a separate per diem rate to pay for services provided without a ventilator.
- Payment of 55 percent of billed charges – Used to pay for transplant services.
- Letters of agreement – Used for specialty services not otherwise obtainable in Wyoming.

Level of Care (LOC) Methodology

In the LOC system, Medicaid pays a prospective payment amount per discharge. Each discharge is classified into a LOC based on diagnosis codes, procedures or revenue codes that hospitals report on the inpatient claim. For the purposes of LOC payment, participating hospitals are all in-state hospitals that are enrolled as Medicaid providers as well as out-of state hospitals enrolled as Medicaid providers that received a specified level of Medicaid payments. In SFY 2010, Medicaid rebased the inpatient level of care system using more recent cost and claims data to better categorize services and to calculate new payment rates. The LOCs in the rebased system are:

- Rehabilitation with ventilator
- Rehabilitation
- Maternity (medical)
- Maternity (surgical)
- Neonatal intensive care unit
- Intensive care, critical care and burn units
- Surgery
- Psychiatric care
- Newborn nursery
- Routine care

The LOC payment rates are different depending on the following peer groups:

- Teaching Hospital
- Critical Access Hospital

- Hospitals with < 90 beds
- Hospitals >= 90 beds

The LOC rates are lower at the Critical Access Hospitals and hospitals with less than 90 beds.

Disproportionate Share Hospital (DSH) Payments

Medicaid makes additional payments to hospitals that serve a disproportionate number of low-income patients. These DSH payments are required by federal law and are capped according to state-specific allotments. Beginning with the FFY 2009 DSH payments, Medicaid determined the amount of DSH payment to each qualifying hospital based on its unreimbursed Medicaid costs, i.e., the Medicaid payment deficit. As part of the Affordable Care Act, DSH allotments are expected to start decreasing beginning in 2014. This section of the Affordable Care Act will not affect the mechanism the state uses to distribute or pay the DSH dollars; it will only alter the amount allocated.

Qualified Rate Adjustment (QRA) Payments

Medicaid also supplements qualified inpatient hospital providers with QRA payments. Medicaid paid 20 hospitals a total \$4.8 million in inpatient hospital QRA payments during SFY 2011 (federal and state share). Qualifying hospitals, i.e., Wyoming non-state government owned or operated hospitals with unreimbursed Medicaid costs, provide the state share of the QRA payment, and the State then distributes the corresponding federal matching Medicaid funds as well as the state share to the participating hospitals.

OUTPATIENT HOSPITAL – SURGICAL SERVICES

This section describes the reimbursement methodologies found for outpatient hospital payment for workers' compensation agencies, Medicare, and Medicaid. These descriptions are intended to provide a high level overview of how payments are made and how payment rates may vary across providers of outpatient hospital care. There is not sufficient detail contained within this report to completely define an outpatient reimbursement program but rather enough detail is presented for the reader to differentiate the various payment methods and policies employed by each study state agency. The information presented is not limited to surgical services but rather a description of the outpatient hospital method in general. Typically, surgical services are not carved out explicitly of the overall payment method but rather are a subset of the entire outpatient hospital reimbursement system. The order of the payment program review is as follows:

- Minnesota WC
- WC methods by each study state in alphabetical order
- Medicare Reimbursement
- Medicaid Reimbursement

The context of outpatient hospital service payment is centered on the payment to the facility only. Physician reimbursement is typically separate from the hospital payment.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA WORKER'S COMPENSATION - OUTPATIENT HOSPITALS

Minnesota worker's compensation reimburses outpatient hospital services for hospitals with 100 or more beds at 85% of the usual and customary or prevailing charges or the actual charge from the provider for services not found in the relative value fee schedule, otherwise, the fee schedule amount is used unless the provider charge is lower. For hospitals with fewer than 100 beds, the reimbursement is 100% of the provider's usual and customary charges unless a compensation judge determines the charges are excessive.

CURRENT WORKER'S COMPENSATION REIMBURSEMENT METHODOLOGY FOR THE 15 COMPARATIVE STATES – OUTPATIENT HOSPITAL

California. California has adopted the CMS hospital outpatient prospective payment system (HOPPS) in 2004 with a few exceptions as noted below:

- The HOPPS – APC conversion factor is custom to California but recognizes the Medicare market basket for annual increases.

- For benefit policy differences, California directs payment to an existing fee schedule.
- For procedures on the inpatient only procedure list, California will permit prior-authorization on a case-by-case basis at a pre-negotiated fee.
- Out-of-state hospitals are excluded from this methodology.
- Hospitals may elect to be paid an outlier should a claim qualify or the hospital can elect to not receive an outlier payment but instead receive a multiplier above the standard APC payment on all services. The multiplier varies by APC status indicator code.
- Items with an APC status code indicator of “H” are excluded from the outlier methodology as are drugs and biologicals that have a separate APC.
- Devices are also excluded from the outlier methodology.

Florida. Hospital charges for services and supplies provided on an outpatient basis are reimbursed at 75% of usual and customary charges. Exceptions include scheduled outpatient surgery which is reimbursed at 60% of usual and customary charges. The following are paid as nonhospital providers under the Maximum Reimbursement Allowances (MRA) system: physical, occupational and speech therapies, scheduled non-emergency radiology and clinical laboratory services, observation status. Observation status may be used up to 23 hours.

For outpatient hospital services, a line item rate is paid. A line item rate applies one time to each covered outpatient revenue center code billed, regardless of the charges.

Reimbursement for outpatient laboratory and pathology services is the lesser of the amount charged or a technical fee. These services are identified by a 5-digit code that must accompany laboratory and pathology revenue codes 0300 through 0314.

Illinois. The hospital outpatient surgical facility (HOSF) fee schedule is per procedure by HCPCS code. No fees submitted from a hospital for outpatient services are subject to the professional services or HCPCS fee schedules. The schedule includes radiology, pathology and laboratory, physical medicine and rehabilitation, as well as scheduled surgical services performed in a hospital outpatient setting that were not performed during an emergency room encounter or inpatient hospital admission. The radiology, pathology and laboratory, and physical medicine, and rehabilitation schedules are applied to the number of units on the form UB-04. Each component provides the maximum medical fee schedule amount for that component. Not all services on the HOSF are paid via a fee. Some items are scheduled to pay at a percent-of-charge (POC). Professional revenue lines and implants are carved out and paid at a POC.

Iowa. Iowa worker's compensation reimburses claims at charges.

Louisiana. Outpatient hospital services are reimbursed at covered charges less a 10% discount. Even if the patient is in a hospital bed at midnight but was admitted as an outpatient, the claim will be paid under the outpatient rates. However, if the patient remains in a bed for a second consecutive day, the claim will be considered to be an inpatient claim and reimbursed under the applicable per diem rate.

Maryland. Maryland converted to Enhanced Ambulatory Patient Groups (EAPG) in 2008 for hospital outpatient services. Since Maryland operates under a waiver, the Health Services Cost Review Commission (HSCRC) establishes the policies and payment levels to hospitals for all payers.

Massachusetts. The hospital outpatient regulations for Massachusetts vary by service type and location.

- Rehabilitation and restorative services provided by a hospital are reimbursed on a CPT fee schedule.
- The following services: emergency department, observation, and ambulatory surgery that are not approved by Medicare to be performed in an ASC and any other services incidental to the visit are reimbursed by applying the hospital's Payment Adjustment Factor (PAF) to the charges for service.

Michigan. Michigan WC has established payment for inpatient hospital care as a cost-to-charge ratio. Michigan has also established a "prompt pay" incentive for carriers of WC insurance in that if a clean claim is submitted to the carrier and the carrier fails to promptly pay the claim in 30 days, the carrier is required to remit an extra percentage of the payment to the provider.

Nebraska. Reimbursement is percent of charges based and varies by a tier level by which each hospital is assigned. The following apply with regard to Tier reimbursement:

- **Tier I:** Hospitals and licensed ambulatory surgical centers located in or within 15 miles of a Nebraska city of the metropolitan class or primary class and all hospitals and ambulatory centers located outside the boundaries of the State of Nebraska shall be Tier I facilities. The fee under this schedule for a Tier I facility shall be 85 percent of billed charges.
- **Tier II:** Hospitals with 51 or more licensed beds and not classified under Tier I and licensed ambulatory surgical centers located in or within 15 miles of a Nebraska city of the First Class shall be Tier II facilities. The fee under this schedule for a Tier II facility shall be 92.5 percent of billed charges.
- **Tier III:** Hospitals with 50 licensed beds or less and not classified under Tier I, all critical access hospitals, and licensed ambulatory surgical centers not classified

under Tier I or Tier II shall be Tier III facilities. The fee under this schedule for a Tier III facility shall be 96 percent of billed charges.

North Carolina. Reimbursement is set at 79% of charges for all hospitals except critical access hospitals which are reimbursed at 87% of charges.

North Dakota. The Medicare OPPS payment system serves as a backbone for North Dakota WC, but with several notable exceptions:

- For outpatient hospital services that Medicare pays on a fee schedule basis, payment is based on the appropriate WSI fee schedule amount in force at the time the service is rendered.
- Services that are identified by Medicare as paid at cost are reimbursed at invoice amount plus 20%.
- There is not a provision for outliers.
- Ancillary services (APC Status Indicator (SI) = X), Non pass-through items (APC SI = H), and drugs/biological (APC SI = G) are paid lesser of the calculated fee or charge.
- New codes for which the Medicare payment has not yet been established are reimbursed at 85% of charges.

North Dakota does follow the inpatient procedure code list and requires these services to be performed and billed as inpatients. The conversion factor is set at 165% of the Medicare amount and is updated annually.

Tennessee. The Medicare OPPS payment system serves as a backbone for Tennessee WC, but with several notable exceptions:

- The wage index adjustment is not considered.
- The final payment is the lesser of the calculated fee or charges at a claim level.
- For unlisted fee schedule items, the payment is 80% of charge.
- The technical component for radiology when done in hospital outpatient setting are paid at 150% of Medicare, but may only be broken out when the Medicare APC code does not include it.
- Outlier payments are not supported.
- Laboratory/pathology codes are reimbursed at 200% of Medicare.

Washington. Washington HCA generally follows Medicare APCs. The inpatient procedure list is not followed. Services falling in this category are paid at a percentage of charges. Some inpatient procedures require prior authorization.

Wisconsin. Wisconsin does not issue a specific outpatient fee schedule. Each employer in the state is required to provide worker's compensation insurance via an

independent insurance provider or through a third part administrator if the employer is approved to be self-insured. Fees from providers are regulated and must be reasonable. Reasonable charges are defined as data provided by a department approved database and the billed service fee must not be more than 1.4 standard deviations from the mean of the service from the approved database.

Wyoming. Fees for surgical centers other than for injections – prices are regulated with a per procedure methodology. Services are paid per the listed rates. Reimbursement amounts are all inclusive unless otherwise specifically noted. Providers may note specific bill(s) with a written request for an audit to elect payment under the hospital fee schedule. Rates are calculated using the Relative Values for Physician (RVP), as published by Optum/Insight (Ingenix, Inc.) with Wyoming specific conversion factor.

CURRENT REIMBURSEMENT METHODOLOGY FOR MEDICARE – OUTPATIENT HOSPITAL

The Medicare Outpatient Prospective Payment System (OPPS) has been in place since 2000. It is a blend of fee schedule services (e.g. laboratory, physical/occupational/speech therapy) and items paid via the Ambulatory Patient Classification (APC) system. The APC system employs a “grouper” that performs both the editing of claims for proper coding and application of pricing variables for use by the pricer. The grouper is known as the Integrated Outpatient Code Editor (IOCE). The OPPS does not apply to critical access hospitals, children’s hospitals, cancer hospitals and VA hospitals. Although these providers are reimbursed in the interim based on the OPPS, they are ultimately reimbursed based on costs.

Several payment policies are used:

- Multiple procedure discounting – when select surgical procedures are performed on the same day at the same provider, the highest paying procedure is reimbursed at 100% while all other surgical procedures are discounted by 50% of the APC payment.
- Wage index adjustments – geographic adjustments for wage index variances are included.
- Packaging – packaging for APCs follows two concepts: select CPT codes for which payment is never made but included in the weight for other services, or the collapsing of select CPT codes if they appear together on the same claim for the same date of service. The latter concept is called composite APCs.
- Outlier payments – outlier payments are made when two different thresholds are exceeded in terms of the service cost. The outlier determination is made on a service by service level and not at the claim level.

- Extensive editing – the IOCE performs extensive editing of the claim to ensure the claim is coded correctly with regard to CPT/HCPCS coding guidelines and select Medicare site of service requirements (e.g. inpatient procedures).

The IOCE and the APC configuration are maintained by 3M on behalf of CMS.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA MEDICAID AND OTHER STATE MEDICAID AGENCIES – OUTPATIENT HOSPITAL

The following table describes the various payment methods found for all State Medicaid agencies and not just those detailed in this report. The chart shows that about half of the states employ some sort of prospectively based system whereby the fee for the service is known and set to a maximum amount and the other half of the states still base their reimbursement on a cost-to-charge ratio.

How Medicaid Pays for Hospital Outpatient Care	
<p>Ambulatory Patient Classification (APC) IA, MI, MN, MT, NM, RI, VT, WA, WY</p>	<p>Ambulatory Patient Groups (APGs) MA, MD, NY</p>
<p>Primarily Other Fee Schedule AL, AR, AZ, CA, HI, IL, IN, KS, OH, OK, PA, SC, WV</p>	<p>Primarily Cost Reimbursement AK, CO, CT, DC, DE, FL, GA, ID, KY, LA, ME, MO, MS, NC, ND, NE, NH*, NJ, NV, OR, SD, TX, UT, VA, WI* *Moving to EAPGs</p>
<p>100% Managed Care TN – Managed Care Companies will vary in reimbursement methods</p>	

1. Source: http://www.chcs.org/usr_doc/Sound_Medicaid_Purchasing_FINAL.pdf with updates by CGI Federal.

Minnesota. Minnesota Medicaid follows CMS APC system for hospital outpatient claims payment but does have several notable exceptions:

- MN does not adjust for the wage index.
- Outlier payments are not systematically applied.
- Partial hospitalization and day treatment are carved-out.
- Community Mental Health Centers and free-standing ASCs are carved-out.

For facility services which are performed in an outpatient hospital or an ambulatory surgical center, the rate shall be the lower of the provider's submitted charge or the standard flat rate under Medicare reimbursement methods for facility services provided

by ambulatory surgical centers. The standard flat rate shall be the rate based on Medicare costs reported by ambulatory surgical centers for the calendar year in legislation governing maximum payment rates.

California. Fee for service, state may negotiate all-inclusive per visit rates with certain hospitals. Many services need to be prior authorized and extensive billing guidelines have been published. Medi-Cal uses custom HCPCS codes for select services.

Florida. Outpatient services are reimbursed on a line item basis for services rendered under allowable revenue codes regardless of charges. Radiology and laboratory services are reimbursed at the lesser of the technical fee or charges. Reimbursement ceilings are established prospectively for each county in Florida. For purposes of establishing reimbursement ceilings, each hospital within the state are classified as general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings are established for and applied to general hospitals. Rural and specialized psychiatric hospitals are excluded from the calculation and application of the outpatient reimbursement ceilings. Statutory teaching, specialized, CHEP hospitals, and those hospitals defined in Section V.A. 9 through 14 are included in the calculation but are exempt from the application of the outpatient reimbursement ceilings.

Illinois. Illinois Medicaid reimburses hospital outpatient services based on a fee schedule that is organized by CPT and map to one of five payment groups. Each payment group has differing levels of payment. Illinois publishes a list of modifiers that are valid and describe how a modifier will affect payment. A cost outlier payment is available for expensive drugs and devices. A list of eligible drugs and devices is maintained and many require prior authorization. The payment is a function of the provider cost for the claim, a threshold established by multiplying the highest paying procedure times a factor of four (4) with the resulting payment being 80% of the cost, threshold difference.

Iowa. Iowa Medicaid implemented the ambulatory payment classification (APC) methodology for outpatient services in acute care hospitals on October 1, 2008. The outpatient hospital payments are based on Medicare's Outpatient Prospective Payment System (OPPS) APC's and relative weights and are updated annually effective January 1st using the most current calendar update as published by Centers for Medicare & Medicaid Services (CMS).

Except for services provided by critical-access hospitals, outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

- Any specific rate or methodology established in the state plan for the particular service, that is, carved-out services such as behavioral health.
- The OPPTS Ambulatory Payment Classification (APC) established rates.
- Medicaid fee schedule.

The Iowa APC system establishes a unique provider base rate based on costs. Additionally, the system also provides for outlier payments on an individual APC basis if the cost of the service exceeds a multiplier and fixed-loss threshold. The marginal cost payment is 50% of the costs exceeding the multiplier threshold. This is similar to Medicare APCs but the fixed-loss amount may vary from Medicare.

Louisiana. There are six different outpatient hospital fee schedules posted on the Louisiana Medicaid website that vary based on provider type:

Provider Type	Lab	Office/OP Visits	Surgical	Rehab	Other OP Hospital
ASC Rural & State	Lower of billed charges, state max or current Medicare	Lower of billed charges, state max or 70% of the Medicare APC payment	Lower of billed charges, Medicaid HCPCS ASC fee	Fee schedule (Medicare based)	Not applicable
ASC Non-rural & Non-state					Not applicable
Hospital OP Services (non-ASC)					69.71% of costs
Sole Community (non ASC)					
State Hospital (non ASC)	100% of Medicare				100% of cost
Small Rural (non ASC)		110% of allowed cost	100% of allowed cost	110% of allowed cost	110% of allowed cost

As shown above, Louisiana Medicaid employs a variety of mechanisms to reimburse hospital providers for outpatient hospital services.

Maryland. Maryland places constraints on payment to hospitals for outpatient visits, but does not regulate payment for physician services. Enhanced Ambulatory Patient Groups (EAPGs) v3.5 is being used for the year 2012 and contains custom weights based on Maryland Medicaid data and some supplemental data when needed. Outlier payments are made for claims with costly drugs and supplies.

Massachusetts. MassHealth uses the 3M Enhanced Ambulatory Patient Groups (EAPG) grouper to reimburse for Medicaid services. The EAPG system functions similarly to a DRG system in that it groups cases into a single payment for services received in an outpatient setting rather than inpatient. MassHealth has carved out non-surgical lab services from the system and reimburses those on a fee schedule.

EAPG weights are custom to MassHealth and are based on hospital reported costs. The payment is referred to a Payment Amount per Episode (PAPE). This methodology does permit the use of an outlier payment. Additionally, payment will not be made should a “never” event occur.

Michigan. Michigan Medicaid follows Medicare’s OPPTS for outpatient hospital services. For services that Medicaid covers that Medicare does not, Michigan maintains a list of “wrap around” codes that represent a fee schedule for these benefit policy differences. Certain services like physical, occupational and speech therapies have an annual visit cap.

The conversion factor is a percent of the Medicare rate called a reduction factor. The wage index adjustment is not recognized.

Nebraska. For services provided on or after July 1, 2011, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

- Seventy-five (75) percent of the cost-to-charges ratio from the hospital's latest Medicare cost report; multiplied by
- The hospitals submitted charges.

North Carolina. North Carolina Department of Medical Assistance (DMA) payment for outpatient services and Indian Health Hospitals are reimbursed as Ratio of Cost to Charge (RCC). The RCC is calculated by comparing year-end cost of operation to the year-end charges paid Medicaid. DMA assigns an RCC yearly to each facility. Covered hospital outpatient services (with the exception of lab services) are paid at 80% of the hospital’s RCC. Lab services are reimbursed via a fee schedule. Generally, out-of-state providers are reimbursed in the same manner as in-state providers.

North Dakota. North Dakota Medicaid uses a mixed method for hospital outpatient reimbursement. For surgical procedures that may be done in the hospital or ASC, the ASC fee table applies. Hospitals must bill the procedure under the 360-369 and 490-499 revenue codes. Additional payments are made for lab and radiology services in support of the procedure. All other services are reimbursed at 100% of cost. North Dakota Medicaid also employs extensive use of therapy visit limits on an annual basis.

Tennessee. Tennessee’s TennCare program is 100% managed care whereby all enrollees in this Medicaid program receive care through a managed care organization (MCO). There are three primary carriers of TennCare: BlueCare by Blue Cross Blue Shield of Tennessee, Amerigroup of Norfolk, Virginia, and Americhoice, a subsidiary of United Healthcare. Each MCO has created network agreements with providers and payment methods will vary. TennCare retains oversight of how the MCOs operate and

will dictate certain policies for which each MCO must comply. With regard to BlueCare, reimbursement for outpatient care is under a mix of fee schedule and case rates. Details for Amerigroup and Americhoice were not able to be obtained.

Washington. Payments for outpatient hospital services under the Medicaid fee-for-service program are made using an outpatient prospective payment system (OPPS) for most services. The Medicaid Purchasing Administration (MPA) OPPS methodology uses an Ambulatory Patient Classification (APC) approach, modeled after the method developed by CMS to pay for Medicare outpatient hospital services. Under the OPPS, outpatient hospital services reported in outpatient claims submitted to MPA for payment purposes are assigned to APC classifications, and payment is determined based on those APC assignments and other factors. Similar to the inpatient DRG methodology described above, APC payments are generally made by multiplying a hospital's conversion factor by the relative weight applicable to the assigned APCs, adjusted by the budget target adjuster. The budget target adjuster is an MPA-established component of the APC payment calculation applied to all payable APCs to allow MPA to reach and not exceed the established budget target. Under the APC payment approach, some ancillary services (subordinate or secondary) are packaged for payment with a primary service (a process also commonly referred to as "bundling"). In these instances, MPA makes no separate payments for these ancillary services. The ancillary services that are packaged are dependent upon the revenue code assigned to the procedure, the status indicator assigned to the procedure, the status indicator assigned to other procedures in the same claim, and the combinations of procedures that appear on the same claim. For purposes of packaging payments, MPA generally follows the same rules that CMS uses for Medicare payment.

Wisconsin. Hospitals located in the State of Wisconsin are reimbursed for outpatient services for Medicaid enrollees at an interim rate per visit with a subsequent retrospective final settlement. The settlement takes into account the costs incurred by the hospital during its cost-reporting period, which generally is the hospital's fiscal year. Reimbursed costs under the retrospective settlement are limited to a prospectively established ceiling amount. The ceiling amount is a prospective, hospital-specific rate per outpatient visit that is based on a hospital's historical cost and adjusted to stay within the State's available funding for hospital services. For hospitals not located in the State and for border hospitals, reimbursement is at a percentage of charges. Physical, speech, and occupational therapy provided in a hospital setting are reimbursed on the professional fee schedule and are excluded from the cost based limit.

Beginning January 1, 2013, Wisconsin Medicaid will begin using 3M's Enhanced Ambulatory Patient Groups (EAPGs) for hospital outpatient reimbursement.

Wyoming. Wyoming Medicaid follows the Medicare OPPS based on APCs for outpatient hospital services. Benefit differences are recognized in terms of what is covered for a Medicaid population versus the Medicare population and these different services are paid via fee schedule. The benefit differences are for select services (selected DME, selected vaccines and immunization, selected radiology and mammography screening and diagnostic mammography and therapies, laboratory services, corneal tissue services, new medical devices covered under Medicare's transitional pass-through payments, and dental and bone marrow transplant services) from the APC methodology and pays for them using a separate Wyoming Medicaid fee schedule.

The APC weights are custom to the Wyoming Medicaid utilization and are updated annually. Three conversion factors are used:

- General acute care
- Children's hospital
- Critical Access Hospital

Wyoming limits the number of outpatient hospital visits annually to 12 for enrollees over the age of 21 but does not limit the number of visits for younger enrollees.

SMALL HOSPITALS (LESS THAN 100 BEDS)

For the purposes of this study, small hospitals are defined as those hospitals having less than 100 beds. This section describes the reimbursement methodologies found for small hospitals reimbursement for workers' compensation agencies, Medicare, and Medicaid. These descriptions are intended to provide a high level overview of how payments are made and how payment rates may vary across small providers. There is not sufficient detail contained within this report to completely define a reimbursement program for small hospitals but rather enough detail is presented for the reader to differentiate the various payment methods and policies employed by each study state agency.

The order of the payment program review is as follows:

- Minnesota WC
- WC methods by each study state in alphabetical order
- Medicare Reimbursement
- Medicaid Reimbursement

Reimbursement for inpatient and outpatient small hospital services is only for the hospital portion of services rendered as physician services provided to an inpatient are made under a separate reimbursement system.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA WORKER'S COMPENSATION – SMALL HOSPITALS

Hospitals with 100 or fewer licensed beds are reimbursed at 100% of the hospital's usual and customary charge, unless the commissioner or compensation judge determines the charge is unreasonably excessive.

CURRENT WORKER'S COMPENSATION REIMBURSEMENT METHODOLOGY FOR THE 15 COMPARATIVE STATES – SMALL HOSPITALS

California. California follows the Medicare methodology for both inpatient and outpatient hospital reimbursement.

Florida. Florida does not make a distinction on hospital size. Inpatient claims are reimbursed based on a per diem and outpatient claims are reimbursed based on a percent-of-charge.

Illinois. Illinois does not make a distinction on hospital size. Inpatient care is reimbursed base on MS-DRG and outpatient claims are reimbursed either fee schedule or a percent-of-charge.

Iowa. Iowa does not make a distinction on hospital size but the primary mechanism for payment is charges.

Louisiana. Louisiana will permit a hospital to re-classify itself into a different Standard Metropolitan Statistical Area if the hospital is recognized by Medicare as a rural referral center. This designation is not based on bed size.

Maryland. All hospitals are reimbursed under the Maryland waiver whereby the commission established by the State set the rates for hospital payments. As such, there is not a distinction made on hospital bed size.

Massachusetts. Massachusetts does not make a distinction based on hospital size. Inpatient claims are reimbursed at a percent-of-charge and outpatients are a mixed schedule of fees and a percent-of-charge.

Michigan. Michigan does not make a separate distinction for small hospitals. Payments are based on the individual hospital's cost-to-charge ratio.

Nebraska. Reimbursement is percent of charges based and varies by a tier level by which each hospital is assigned. The following apply with regard to Tier reimbursement:

- **Tier I:** Hospitals and licensed ambulatory surgical centers located in or within 15 miles of a Nebraska city of the metropolitan class or primary class and all hospitals and ambulatory centers located outside the boundaries of the State of Nebraska shall be Tier I facilities. The fee under this schedule for a Tier I facility shall be 85 percent of billed charges.
- **Tier II:** Hospitals with 51 or more licensed beds and not classified under Tier I and licensed ambulatory surgical centers located in or within 15 miles of a Nebraska city of the First Class shall be Tier II facilities. The fee under this schedule for a Tier II facility shall be 92.5 percent of billed charges.
- **Tier III:** Hospitals with 50 licensed beds or less and not classified under Tier I, all critical access hospitals, and licensed ambulatory surgical centers not classified under Tier I or Tier II shall be Tier III facilities. The fee under this schedule for a Tier III facility shall be 96 percent of billed charges.

Thus, a small hospital could have anywhere from 85% to 96% of charges reimbursed depending on the above criteria.

North Carolina. Critical Access Hospitals are reimbursed at 100% of allowed costs. They are reimbursed on an interim basis at 97% of allowed charges.

North Dakota. North Dakota does not make a separate distinction for small hospitals with regard to reimbursement.

Tennessee. Tennessee does not make a distinction in the reimbursement for small hospitals.

Washington. Washington does not make a distinction in the reimbursement for small hospitals with regard to inpatient care. For hospital outpatient services, critical access hospitals are paid at a percent of charge or fee schedule amount depending on the procedure.

Wisconsin. Wisconsin does not make a distinction in the reimbursement for small hospitals but rather, maintains a database of reasonable fees for use by insurers.

Wyoming. Wyoming does not make a distinction in reimbursement for small hospitals.

CURRENT REIMBURSEMENT METHODOLOGY FOR MEDICARE – SMALL HOSPITALS

Medicare currently recognizes three types of hospitals that meet the 100 bed or less criteria:

- Critical Access Hospitals (CAH)
- Sole Community Hospitals (SCH), and
- Medicare Dependent Hospitals (MDH)

The chart below describes the various Medicare designated provider types that may fall under the category of small hospitals and the associated reimbursement.

Critical Access Hospital (CAH)	Sole Community Hospitals (SCH)	Medicare Dependent Hospital (MDH)
<ul style="list-style-type: none">• <= 25 beds• > 35 miles from nearest like hospital• Have a 24-hour emergency room• Reimbursed at 101% of costs	<ul style="list-style-type: none">• > 35 miles from nearest like hospital, or• 25-35 miles from nearest like hospital, and<ul style="list-style-type: none">• < 50 beds, or• Exclusive Medicare provider, or• Other area hospitals are inaccessible due to terrain or unpredictable weather conditions inhibit access to these hospitals• Follows regular Medicare PPS systems but with a bump in payment rates if so legislated.• May include an urban hospital but be treated as rural if qualifications exist.	<ul style="list-style-type: none">• Must be rural• < 100 beds• Not eligible to be SCH• > 60% of discharges from Medicare• Follows regular Medicare PPS systems but with a bump in payment rates if so legislated.• The Affordable Care Act will no longer recognize the MDH program beginning October 1, 2012.

With regard to pricing, SCH and MDH should be handled seamlessly in most Medicare pricing software. CAH's are reimbursed on an interim basis for inpatient care on a per diem and outpatient via APCs but are ultimately cost reimbursed at 101% of costs.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA MEDICAID AND OTHER STATE MEDICAID AGENCIES – SMALL HOSPITALS

Minnesota. Minnesota reimburses inpatient claims for small hospitals on a DRG basis. MN has regulated an increase to small hospitals that range from 15% to 20% but are reduced by the hospital's Disproportionate Population Adjustment (DPA) and hospital payment adjustment for Medical Assistance (MA) payments only. These reductions do not apply to General Assistance Medical Care (GAMC) admissions. The increase is based on the following criteria:

- Rural hospitals with 100 or fewer licensed beds or more than 100 but fewer than 250 annualized admissions will receive an increase of 15%.
- Rural hospitals with 100 or fewer licensed beds and 100 or fewer annualized admissions will receive an increase of 20%.

California. Small rural hospitals have a different fee schedule than other hospital groups. Medi-Cal also may contract specifically with a provider so the provider rates will certainly vary. This is true for both inpatient and outpatient hospital services.

Florida. Florida Medicaid's per diem system does not exclude small hospitals. Each hospital in the state is reimbursed on a cost-based per diem. However, Florida is implementing DRGs in FY2013 that may change this inclusion. The details of the system are not yet known. With regard to outpatient services, all providers are reimbursed at cost.

Illinois. Illinois Medicaid reimburses rural and critical access hospitals on a per diem basis. Additional add-on payment adjustments a critical access hospital might be eligible for are: trauma, rehabilitation, direct and rural hospitals. For outpatient services, Illinois uses a fee schedule for all providers.

Iowa. The basis of payment for critical-access hospitals is reasonable cost achieved through retrospective cost settlement. Critical-access hospitals are reimbursed in the interim on an individually specific DRG basis for inpatient care and a percentage of charges for outpatient care, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. Once a hospital begins receiving reimbursement as a critical-access hospital, the prospective outpatient Medicaid cost-to-charge ratio is not subject to inflation factors and rebasing.

Louisiana. Small providers in Louisiana may be classified as critical access hospitals, sole community hospitals, and small rural hospitals. Reimbursement varies across these types of providers and the claim type.

- Small rural hospitals and sole community hospitals:
 - Inpatient reimbursement is a prospective per diem.
 - Outpatient reimbursement uses HCPCS procedures codes and reimbursement is either a cost-to-charge ratio or a set fee amount (e.g. lab services).

Small rural hospitals prospective per diem rate is the median cost amount plus 10 percent. The reimbursement for inpatient acute care services rendered by small rural hospitals are up to the Medicare upper payment limits for inpatient hospital services.

The reimbursement amount paid to small rural hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be as follows.

- Small rural hospitals receive an interim payment for claims which will be 110 percent of each hospital's cost to charge ratio as calculated from the latest filed cost report.
- Final reimbursement will be 110 percent of allowable cost as calculated through the cost report settlement process.

Maryland. Maryland's rate regulation policy limits the amount of overall revenue growth year-over-year. For rural Maryland hospital providers, this means their revenue is capped.

Massachusetts. MassHealth does not exclude critical access hospitals and rural hospitals from the Standard Payment per Adjusted Discharge (SPAD) system. The rate is based on hospital cost reporting and includes adjustments for case mix, geographic location, and capital. MassHealth does have a specific initiative that focuses on ensuring the financial viability of these hospital types by supporting such items as electronic health records.

Michigan. Michigan Medicaid does not have specific regulations with regard to small hospitals. Critical Access Hospitals and Children's hospitals are included within their IPPS and OPSS system's which is in contrast to Medicare.

Nebraska. Effective for cost reporting periods beginning after July 1, 2011, payment for outpatient services of a critical access hospital (CAH) is ninety seven point five percent (97.5%) of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement. Inpatient CAH reimbursement is at the

Medicare cost-to-charge ratio. Other small hospitals will fall under the peer group, AP-DRG reimbursement system.

North Carolina. All Medicaid-participating hospitals are guaranteed DRG payments no lower than the 45th percentile. At the end of the fiscal year, if a CAH's Medicaid costs are above the 45th percentile, Medicaid promises 100% cost settlement. If their costs are below the 45th percentile, the facility keeps the difference, receiving more than costs for their inpatient Medicaid services. For outpatient hospital services, hospitals are reimbursed at cost.

North Dakota. North Dakota uses the APR-DRG grouper for all inpatient acute care discharges. Where small hospitals are differentiated is the peer group structure for reimbursement rates. Outpatient hospital care is paid on the ASC fee schedule for procedures that could be performed in the hospital or the ASC setting while other hospital outpatient services are paid cost.

Tennessee. In TennCare, all Medicaid beneficiaries are enrolled in fully capitated managed care plans and hospitals negotiate their rates with the health plans. Thus, Medicaid does not have specific policies for hospital reimbursement for any category of hospitals. There are three primary carriers of TennCare: BlueCare by Blue Cross Blue Shield of Tennessee, Amerigroup of Norfolk, Virginia, and Americhoice, a subsidiary of United Healthcare. Each MCO has created network agreements with providers and payment methods will vary. TennCare retains oversight of how the MCOs operate and will dictate certain policies for which each MCO must comply.

BlueCare reimbursement for small hospitals is not differentiated any differently than large hospitals. The same reimbursement methods apply to both and negotiated rates will vary across hospitals.

Washington. Certain hospitals have been designated as "Critical Access Hospitals." These hospitals are paid for services on an interim basis over the course of the year, and are "cost settled" at the end of each year so that, after settlement, they are reimbursed for 100 percent of their allowable Medicaid costs. Other hospitals larger than 25 beds fall under the regular DRG reimbursement program for inpatient and APC for outpatient.

Wisconsin. Wisconsin Medicaid reimburses inpatient care at critical access hospitals the lower of the hospital's allowable cost or charges for the services provided to Medicaid recipients. If payments exceed costs, the Department will recover excess payments from the hospital. If costs exceed interim payments, the Department will reimburse the hospital the amount by which a hospital's costs exceed payments. Other small and/or rural hospitals also receive an add-on payment ("access payment") such that care is accessible and available at these locations. An annual funding amount is

allocated to this add-on pool annually and is paid on a per discharge basis. If the funds run out before the end of the state fiscal year, the add-on payment will not occur.

Outpatient interim payments are made at the critical access hospital's (CAH) average inflated cost per visit as calculated accordingly, including limitation of capital costs to no more than 8% of total cost. This payment is a cost based prospective payment per visit and is not subject to annual cost settlement. Like inpatient, other rural and small hospitals receive an access payment in addition to the per visit rate and is limited to the amount of funds available in the state fiscal year.

Wyoming. Critical access and other hospitals under 100 beds in Wyoming are reimbursed in the same manner as all hospitals. The rate is driven from the hospital's room rate. Separate provisions are made with regard to the reimbursement rate which, for outpatient, is higher than the general acute care facility.

AMBULATORY SURGERY CENTERS (ASC)

This section describes the reimbursement methodologies found for ambulatory surgery center payment for workers' compensation agencies, Medicare, and Medicaid. These descriptions are intended to provide a high level overview of how payments are made and how payment rates may vary across ASC providers. There is not sufficient detail contained within this report to completely define an ASC reimbursement program but rather enough detail is presented for the reader to differentiate the various payment methods and policies employed by each study state agency.

The order of the payment program review is as follows:

- Minnesota WC
- WC methods by each study state in alphabetical order
- Medicare Reimbursement
- Medicaid Reimbursement

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA WORKER'S COMPENSATION - ASC

Minnesota reimburses the lower of the maximum fee that applied to any service included in the relative value fee schedule, 85% of the facility's usual and customary charge, 85% of the prevailing charge, or the facility's actual charge. Minnesota provides for physician reimbursement under a separate regulation.

CURRENT WORKER'S COMPENSATION REIMBURSEMENT METHODOLOGY FOR THE 15 COMPARATIVE STATES - ASC

According to the Worker's Compensation Research Institute, policy choices shape interstate variations in outpatient hospital and ASC costs for similar outpatient surgical episodes. States with no fee schedule regulation on reimbursement for outpatient hospital and ASC services had higher costs compared to states with fee schedules. States with fee schedule regulations that were based on percentage of charges had higher costs compared with states with other types of fee schedules. Four studied states, Florida, Louisiana, Minnesota, North Carolina, set their hospital outpatient and/or ASC fee schedules for services related to surgeries mainly based on percent-of-charge.

California. Current ASC pricing for California is based on a percent of Medicare's payment system for ASC's.

Florida. Florida requires services provided in an ASC must be prior authorized. Specific procedures are identified by Florida and reimbursed at either the Maximum Reimbursement Amount (MRA) or a pre-arranged case price. For procedures not

specified in the manual, reimbursement is set at 70% of the charge for the first line item or a pre-arranged case price. Multiple procedure discounting applies at 50% of the second procedure charge or the MRA amount, whichever is lower. Surgical implants are covered under separate rates.

Illinois. Reimbursement for ASCs is very similar to how Illinois reimburses for hospital outpatient. There are four (4) separate regions in Illinois with different rates set for each region. Procedures recognized by CMS as “inpatient only” procedures are carved out of the fee methodology and paid at the Percent of Charge (POC) rate. The Ambulatory Surgical Treatment Center (ASTC) fee schedule provides the maximum medical fee schedule amount for surgical services administered in an ASTC setting for codes 10021 - 69990. The ASTC is a partial global reimbursement schedule in that all charges rendered during the operative session are subject to a single fee schedule amount; however, the following exceptions do exist – these are the carve-out categories/revenue codes:

- Prosthetics/orthotics
- Pacemaker
- Lens implants
- Implants
- Investigational devices
- Drugs requiring detailed coding

Charges billed under the above listed items will be at a provider’s normal rates under its standard charge master. Reimbursement is subject to the language in the section covering implants.

The fee schedule amounts listed do not include charges for radiology, pathology and laboratory; therefore, these charges must be submitted under separate claim forms. These charges will be subject to the professional services fee schedule.

Iowa. Iowa does not use a fee schedule and reimburses ASCs at charges.

Louisiana. Ambulatory surgical services are reimbursed at covered charges less a 10% discount.

Maryland. Maryland follows Medicare’s reimbursement for ASC’s. Prices are set at 125% of the Medicare rate.

Massachusetts. Massachusetts follows a fee schedule for free-standing ASCs. Modifiers are used in determining payment and carry the same meaning as used in the CMS ASC system. The final payment is the lower of the provider charge or the calculated fee.

Michigan. Reimbursement by Michigan WC for ASC's is based on Medicare's ASC payment methodology multiplied by a factor of 1.30. Implants that are a pass-through item in the Medicare system are paid via invoice plus a percentage.

Nebraska. Reimbursement is percent of charges based and varies by a tier level by which each hospital is assigned. Nebraska WC also includes a multiple procedure discounting whereby the highest paying procedure pays at 100% and the remaining procedures are discounted by 50%. The following apply with regard to Tier reimbursement:

- **Tier I:** Hospitals and licensed ambulatory surgical centers located in or within 15 miles of a Nebraska city of the metropolitan class or primary class and all hospitals and ambulatory centers located outside the boundaries of the State of Nebraska shall be Tier I facilities. The fee under this schedule for a Tier I facility shall be 85 percent of billed charges.
- **Tier II:** Hospitals with 51 or more licensed beds and not classified under Tier I and licensed ambulatory surgical centers located in or within 15 miles of a Nebraska city of the First Class shall be Tier II facilities. The fee under this schedule for a Tier II facility shall be 92.5 percent of billed charges.
- **Tier III:** Hospitals with 50 licensed beds or less and not classified under Tier I, all critical access hospitals, and licensed ambulatory surgical centers not classified under Tier I or Tier II shall be Tier III facilities. The fee under this schedule for a Tier III facility shall be 96 percent of billed charges.

North Carolina. Reimbursement is set at 79% of charges.

North Dakota. The Medicare OPPS payment system serves as a backbone for North Dakota WC ASCs, but with several notable exceptions:

- For services that Medicare pays on a fee schedule basis, payment is based on the appropriate WSI fee schedule amount in force at the time the service is rendered.
- Services that are identified by Medicare as paid at cost are reimbursed at invoice amount plus 20%.
- There is not a provision for outliers.
- Ancillary services (APC SI = X), Non pass-through items (APC SI = H), and drugs/biological (APC SI = G) are paid lesser of the calculated fee or charge.
- New codes for which the Medicare payment has not yet been established are reimbursed at 85% of charges.
- Only surgical services that are on the Medicare ASC approved list are eligible for reimbursement.

- Certain medical services are reimbursable if they exist on the Medicare OPPS tables.

North Dakota does follow the inpatient procedure code list and requires these services to be performed and billed as inpatients. The conversion factor is set at 124% of the Medicare amount and is updated annually.

Tennessee. The Medicare OPPS payment system serves as a backbone for Tennessee WC reimbursement for ASCs, but with several notable exceptions:

- The wage index adjustment is not considered.
- The final payment is the lesser of the calculated fee or charges at a claim level.
- For unlisted fee schedule items, the payment is 80% of charge.
- The technical component for radiology when done in hospital outpatient setting are paid at 150% of Medicare, but may only be broken out when the Medicare APC code does not include it.
- Outlier payments are not supported.
- Laboratory/pathology codes are reimbursed at 200% of Medicare.

Washington. Washington Labor and Industry (L&I) follows a modified version of the current Medicare ASC reimbursement methodology. L&I added select additional procedures to the approved procedure list.

Wisconsin. Wisconsin does not issue a specific ASC fee schedule. Each employer in the state is required to provide worker's compensation insurance via an independent insurance provider or through a third part administrator if the employer is approved to be self-insured. Fees from providers are regulated and must be reasonable. Reasonable charges are defined as data provided by a department approved database and the billed service fee must not be more than 1.4 standard deviations from the mean of the service from the approved database.

Wyoming. Fees for surgical centers other than for injections – prices are regulated with a per procedure methodology. Services are paid per the listed rates. Reimbursement amounts are all inclusive unless otherwise specifically noted. Providers may note specific bill(s) with a written request for an audit to elect payment under the hospital fee schedule.

CURRENT REIMBURSEMENT METHODOLOGY FOR MEDICARE - ASC

The ASC reimbursement methodology for Medicare has roots in the Medicare OPPS system. Key differentiating points with regard to ASC Medicare reimbursement are:

- Only a select number of procedures are eligible to be performed in the ASC,
- The reimbursement is approximately 40% lower than Hospital OPPS, and

- ASC's do not qualify for outlier payments, and
- The final payment is the lesser of the calculated fee or the provider charge.

The reimbursement policies and guidelines are the same as in the OPPTS. The payment to an ASC is inclusive the facility services only and the physician bills separately. Non-implantable Durable Medical Equipment (DME) and prosthetic devices are billed separately by the supplier.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA MEDICAID AND OTHER STATE MEDICAID AGENCIES - ASC

Minnesota. Minnesota Medicaid follows Medicare's reimbursement schedule for ASC's but with minor differences with regard to billing for bilateral procedures.

California. California's Medi-cal program uses a fee schedule for ASC reimbursement.

Florida. As of January 1, 2012, Florida Medicaid updated the ASC groups. The procedures permitted are the same as those permitted by Medicare but Florida has chosen to maintain nine (9) groups with regard to payment. Claims with multiple surgical procedures are reimbursed in a discounted manner of 100%, 50%, 25% for all other procedures. This method is similar to the former method that CMS used for ASC payment before the switch to an ASC version of APCs.

Illinois. Illinois Medicaid has established a fee schedule for ambulatory surgery services. CPT codes are mapped to one of five payment groups. Within each group there are different payment levels attached. The ASC fee is 75% of rate paid in outpatient hospital setting.

Iowa. Iowa Medicaid sets a fee for approved procedures done in an ASC setting. CPT codes are grouped to one of nine groups and a corresponding payment rate is set for each group. This is similar to the old method for Medicare reimbursement in an ASC before the adoption of APCs for ASCs.

Louisiana. Louisiana Medicaid uses the same fee schedule based on HCPCS codes for both free-standing ASCs, and hospital surgical services. The fee represents payment for the facility services only and physician services are billable by the performing physician.

Maryland. Maryland uses the Medicare ASC system for payment.

Massachusetts. MassHealth uses a fee schedule for ASC payment.

Michigan. Michigan Medicaid follows the Medicare reimbursement method for ASCs but applies a reduction factor to fit Michigan funding. State developed fee schedule rates are the same for both governmental and private ASC providers. Michigan Medicaid does not use the wage index adjustment. Additionally, benefit policy modifications may exist whereby a code may not be recognized by Michigan for payment although Medicare does and vice versa. For those items where Medicaid does recognize payment and Medicare does, a separate fee schedule exists.

Nebraska. Nebraska Medicaid follows the old Medicare ASC payment system whereby ASC eligible CPT codes are mapped to one of nine (9) payment groups. Payment covers the facility fees for services provided in an ambulatory surgical center (both free-standing and hospital-affiliated). If one covered surgical procedure is provided in a single operative session, Nebraska Medical Assistance Program (NMAP) pays 100 percent of the applicable group rate. If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure.

The ambulatory surgical center may also provide services which are not directly related to the performance of a surgical procedure, such as durable medical equipment, medical supplies, and ambulance services. Payment for these services will be made according to other NMAP established fee schedules.

North Carolina. North Carolina Medicaid has established a list of allowable CPT codes and its associated fee.

North Dakota. North Dakota Medicaid Assistance (NDMA) pays for all procedures that Medicare has identified as ambulatory surgical procedures, regardless of site of service, using a prospective payment methodology. The ASC fee schedule follows the old Medicare ASC system involving nine (9) payment groups. The ASC payment represents only those services that are on the fee schedule. Additional services such as lab and x-ray are billable and reimbursed when billed in accordance with standard practice. When two or more procedures are performed on separate body areas in the same operative session, the standard rate will be paid for the primary procedure. The second procedure will be paid at 50% of the procedure group. Additionally, many procedures require prior authorization.

Tennessee. In TennCare, all Medicaid beneficiaries are enrolled in fully capitated managed care plans and hospitals negotiate their rates with the health plans. Thus, Medicaid does not have specific policies for hospital reimbursement for any category of hospitals. There are three primary carriers of TennCare: BlueCare by Blue Cross Blue

Shield of Tennessee, Amerigroup of Norfolk, Virginia, and Americhoice, a subsidiary of United Healthcare. Each MCO has created network agreements with providers and payment methods will vary. TennCare retains oversight of how the MCOs operate and will dictate certain policies for which each MCO must comply.

BlueCare reimburses ASC's using case rates for all services.

Washington. Washington Health Care Authority (HCA) reimburses for ASC services similar to the old Medicare nine (9) ASC groups. Prior authorization authority has increased in the current year with more procedures requiring prior authorization. Multiple procedure discounting is used as a payment policy. Implantable devices are reimbursed separately at invoice cost.

Wisconsin. For each covered service, the Department of Health Services (DHS) shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the DHS. Multiple procedure discounting and the recognition of bilateral procedures do not receive special payment consideration.

Wyoming. Wyoming Medicaid follows the old Medicare nine (9) groups that existed before OPPS/APCs. Any new procedures billed by an ASC that does not currently exist on the grouping table will be paid at 70% of charge if internal review supports the procedure being done in an ASC. If the billed procedure exists on the ASC table, Medicaid pays the lower of the provider's usual and customary charge or the Medicaid fee schedule for services provided in ASCs. According to the 2011 Wyoming Annual Report, 60% of the ASC payments are now falling under the 70% of charge rule.

ANESTHESIA (HOSPITAL FACILITY AND PROFESSIONAL PROVIDER BASED)

This section describes the reimbursement methodologies found for anesthesiologist payment for workers' compensation agencies, Medicare, and Medicaid. These descriptions are intended to provide a high level overview of how payments are made and how payment rates may vary across providers of anesthesia services.

The order of the payment program review is as follows:

- Minnesota WC
- WC methods by each study state in alphabetical order
- Medicare Reimbursement
- Medicaid Reimbursement

The anesthesia discussion that follows represents the physician or nurse anesthetist services only.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA WORKER'S COMPENSATION – ANESTHESIA PROVIDERS

Reimbursement for anesthesiologists follows the same rule as the hospital or ASC in which it is performed. Thus, reimbursement may be a minimum of 85% of the usual and customary, prevailing charge, or 100% of charge at small hospitals.

CURRENT WORKER'S COMPENSATION REIMBURSEMENT METHODOLOGY FOR THE 15 COMPARATIVE STATES – ANESTHESIA PROVIDERS

California. For Anesthesia services (CPT Codes 00100 through 01999) rendered after January 1, 2004, the following formula is used: (basic value + modifying units (if any) + time value) × (conversion factor × .95) = maximum reasonable fee.

Where:

- Basic value = base units for the procedure from the fee table
- Modifying units = an addition or reduction to the basic value based on the modifier submitted
- Time value = the number minutes of anesthesia.

Florida. Florida reimburses anesthesia based on CPT coding, base values, time, and complexity of the patient. The highest time valued CPT code is reimbursed if more than one procedure is performed in the same operative session. Each CPT code is assigned a base value of units and is multiplied by the time units (15 minute segments = 1 unit), and then multiplied by a complexity value if applicable. The final value is then multiplied by the conversion factor to arrive at the reimbursed amount.

Illinois. Illinois reimburses Anesthesiologists in a similar manner to CMS. The payment formula follows:

$$\text{Base Value} + \text{Time Units} + \text{Modifying Units} = \text{Total Units}$$

$$\text{Total Units} \times \text{Conversion Factor} = \text{Fee}$$

The conversion factor varies by region. The final payment is the lesser of the calculated fee or the provider charge. There is not a payment variance based on whether the service was performed in the office or hospital setting.

Iowa. Iowa reimburses anesthesia at charges.

Louisiana. The total anesthesia allowance is calculated by adding the basic value units, time value units, plus any applicable modifier unit values and/or unusual qualifying circumstances units and multiplying the sum by a dollar amount allowed per unit. The current dollar conversion factor is \$50. The final payment is the lesser of the time based calculation or the provider's charge. If a CRNA is used, the CRNA receives the lesser of their charge or 80% of the current conversion factor.

Maryland. The reimbursement rate for anesthesiology services is calculated by adding the Time Units (TU) and the Base Units (BU) and multiplying the total by the applicable Maryland Specific Conversion Factor (MSCF) as follows:

$$\text{MRA} = (\text{TU} + \text{BU}) \times \text{MSCF}$$

Maryland uses the Medicare RBRVS weight schedule with regard to anesthesia procedure base units.

Massachusetts. Massachusetts worker's compensation for anesthesiologists follows the Medicare RBRVS methodology in terms of base units per procedure, time, and modifier. The current conversion factor is \$39.00.

Michigan. Michigan worker's compensation for anesthesiologists follows the Medicare RBRVS methodology in terms of base units per procedure, time, and modifier. The current conversion factor is \$42.00.

Nebraska. Nebraska covers anesthesia for anesthesiologists and CRNA's only. Anesthesia administered by the surgeon or assistant surgeons is not covered. The CRNA is reimbursed at 90% of the full anesthesia fee. The payment formula follows:

$$\text{Base Value} + \text{Time Units} + \text{Modifying Units} = \text{Total Units}$$

$$\text{Total Units} \times \text{Conversion Factor} = \text{Fee}$$

The current conversion factor for Nebraska is \$50.77.

North Carolina. North Carolina WC has established four (4) specific codes to be billed by anesthesiologists and CRNA's. The payment per unit is based on a per minute time period and two levels of the special codes that reflect complexity.

North Dakota. North Dakota follows Medicare's RBRVS reimbursement for anesthesia. The following payment formula applies:

(Basic Time Value Units + Physical Status Adjustment + Total Time Units) x Conversion Factor = Maximum Reimbursement

The current conversion factor is \$53.79. CRNA's that are directed by an anesthesiologist are reimbursed at 50% of the above calculation.

Tennessee. Tennessee uses Medicare's RBRVS for anesthesia. Reimbursement for anesthesia services is presently set at a maximum allowable of \$75.00 per unit. This is only applicable for anesthesia CPT codes, and does not include pain management services reimbursed under surgical codes (maximum reimbursement up to 200% of the Tennessee Medicare amount), or other injections. CRNA's are reimbursed at 90% of the calculated fee for anesthesiologists if performed not under the anesthesiologist's direction.

Washington. The Washington Labor and Industry reimbursement for anesthesia generally follows Medicare's RBRVS. A few overrides exist with regard to anesthesia base units that may be paid by report or the base units set to a different value than Medicare. Only anesthesiologists and CRNAs may be reimbursed. The final fee is the lesser of the provider charge or the calculated payment. The current conversion factor is \$48.30.

Wisconsin. Wisconsin does not issue a specific physician fee schedule. Each employer in the state is required to provide worker's compensation insurance via an independent insurance provider or through a third part administrator if the employer is approved to be self-insured. Fees from providers are regulated and must be reasonable. Reasonable charges are defined as data provided by a department approved database and the billed service fee must not be more than 1.4 standard deviations from the mean of the service from the approved database.

Wyoming. Wyoming uses the Relative Values for Physicians (RVP) as published by OptumInsight/Ingenix, Inc. The current conversion factor is \$51.12.

CURRENT REIMBURSEMENT METHODOLOGY FOR MEDICARE – ANESTHESIA PROVIDERS

Medicare payments for anesthesia services represent a departure from the RBRVS system. The most complex surgical, and usually primary procedure performed during any given surgical session is identified and linked to one and only one anesthesia code. The anesthesia time for any additional procedures during the same operative session is added to the time for the primary procedure. This time is then converted to units with 15 minutes equal to 1 unit.

Each anesthesia procedure code has a non-variable number of base units. Similar to the RBRVS work value, the base units represent the difficulty associated with a given group of procedures. The base units for the selected anesthesia code are added to the units related to anesthesia time, and the result is multiplied by a conversion factor to convert to dollars. The conversion factor is adjusted to a particular zip code/locality of where the service was performed.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA MEDICAID AND OTHER STATE MEDICAID AGENCIES – ANESTHESIA PROVIDERS

Minnesota. Anesthesia services rendered by physicians and certified registered nurse anesthetists (CRNAs) are paid according to the formula used by Medicare. If a CRNA performs under the direction of an anesthesiologist, the CRNA payment is reduced. The payment formula is: (base value + time units) x conversion factor.

California. Medi-Cal has established varying anesthesia conversion factors (CF) based on the site of service and type of anesthetist (M.D. or CRNA). Billing is based on CPT code and each have a base unit value. The payment formula is represented by:

$$\text{Payment} = (\text{Base Units} + \text{Time Units}) \times \text{CF} \times \text{Reduction Factor}$$

Where the reduction factor default is 1.0 and is less if the CRNA is monitored by the M.D.

Florida. Florida Medicaid anesthesia reimbursement is set at a base dollar amount per anesthesia code plus a per 15 minute unit dollar factor. Additional reimbursement is available for recipients under the age of 21 and for three specialties.

Illinois. Illinois Medicaid reimburses anesthesia services on a fee schedule. Anesthesia CPT codes are assigned a base value and a conversion factor is applied to arrive at the provider payment.

Iowa. Iowa Medicaid reimburses anesthesiologists and CRNAs based on a fee schedule. CRNA's are reimbursed at either 60% or 80% of the fee schedule based on whether they are directed by an anesthesiologist. The final payment is based on:

- The actual charge made by the provider of service.

- The maximum allowance under the fee schedule for the item of service in question.

Louisiana. Procedure codes in the Anesthesia section of the Current Procedural Terminology manual are to be used to bill for surgical anesthesia procedures.

- Reimbursement for surgical anesthesia procedures will be based on formulas using base units, time units (1= 15 min) and a conversion factor.
- Reimbursement for moderate sedation and maternity-related procedures, other than general anesthesia for vaginal delivery, will be a flat fee.
- Minutes must be reported on all anesthesia claims except where policy states otherwise.

Reimbursement is based on formulas related to a percentage of the 2009 Louisiana Medicare Region 99 allowable. Payment is not made for chronic pain management.

Maryland. Medicare payments for anesthesia services represent a departure from RBRVS. The most complex surgical (and usually primary) procedure performed during any given surgical session is identified and linked to one and only one anesthesia code. The anesthesia time for any additional procedures during the same operative session is added to the time for the primary procedure.

The Maryland Medicaid Program calculates the payment slightly differently from the Medicare by using minutes instead of quarter hour blocks.

Massachusetts. MassHealth reimburses for M.D. and CRNA's in a usual manner. CPT codes for anesthesia are used and have corresponding base units assigned. The final payment is the sum of base units for the highest procedure plus time units multiplied by the conversion factor. Only the procedure with the highest base units is paid when multiple procedures are performed in the same operative session.

Michigan. Michigan Medicaid follows the Medicare reimbursement method for anesthesia as closely as possible.

Nebraska. The Department covers, as a physician's service, the professional component of anesthesiology services provided by a physician to an individual patient. Claims for these services must indicate actual time in one-minute increments. Payments are based on an established fee schedule with the individual values based on the OptumInsight/Ingenix, Inc. Relative Value Scale. Payments will vary based on whether the service was performed by an anesthesiologist or a CRNA.

North Carolina. General anesthesia, regional anesthesia, and MAC services are considered a global package of services. The global anesthesia package includes the preoperative evaluation; the prescription of the anesthetic plan; the provision of general anesthesia, regional anesthesia, or MAC; the routine intra-operative monitoring and

laboratory evaluation; the administration of intravenous fluids including blood and/or blood products; the immediate postoperative care; and a postoperative visit if applicable. Providers shall bill their usual and customary charges. Medicaid accepts actual time when billing for anesthesia services. Each procedure approved for billing anesthesia is assigned base units according to the complexity of the procedure. The time units billed plus the assigned base units are used to calculate the reimbursement for the anesthesia services.

North Dakota. North Dakota reimburses for both M.D. and CRNA providers of anesthesia. As is common, the use of modifiers communicates which provided the service. Whether the anesthesia provider is independent or hospital based, they are paid the same. If provider based, the use of revenue codes indicates the provider based anesthesia service and is to be billed under revenue code 0964. North Dakota follows the American Society of Anesthesiology base units. The payment formula recognizes base units, time units, and a conversion factor.

Tennessee. In TennCare, all Medicaid beneficiaries are enrolled in fully capitated managed care plans and hospitals negotiate their rates with the health plans. Thus, Medicaid does not have specific policies for hospital reimbursement for any category of hospitals. There are three primary carriers of TennCare: BlueCare by Blue Cross Blue Shield of Tennessee, Amerigroup of Norfolk, Virginia, and Americhoice, a subsidiary of United Healthcare. Each MCO has created network agreements with providers and payment methods will vary. TennCare retains oversight of how the MCOs operate and will dictate certain policies for which each MCO must comply.

- BlueCare reimburses anesthesiologists based on a fee schedule that includes base values per procedure, time units, and a conversion factor.
- Amerigroup follows Medicare guidelines for billing and reimbursement unless there is a state mandate that alters that guidance. Reimbursement is the typical base units, plus time value, times the conversion factor but Amerigroup permits the total time recorded for each procedure if more than one is done in the same operative session. Only the base units from the most intensive procedure are used.
- Americhoice uses both the American Society of Anesthesiology (ASA) *Relative Value Guide* (RVG™) and Medicare's anesthesia base units. Reimbursement is the typical base units, plus time value, times the conversion factor but Americhoice permits the total time recorded for each procedure if more than one is done in the same operative session. Only the base units from the most intensive procedure are used. Additionally, CRNAs receive 50% of the full fee if directed by an M.D.

Washington. Washington HCA uses the Medicare base units per CPT code for anesthesia services. The payment for anesthesia is base plus time units in 15 minute increments. Patient acuity is not a factor. The current conversion factor is \$21.20. Anesthesiologists and CRNAs are permitted to bill and receive payment. Anesthesiologists may bill and be paid for pain management by using the appropriate CPT codes and are paid via a fee schedule and not the standard base plus time units.

Wisconsin. Wisconsin Medicaid sets the maximum allowable fee for each anesthesia service equal to or less than the Medicare base units. Time increments are to be billed in 15 minute blocks. Reimbursement is for anesthesiologists and CRNAs. Anesthesia provided by the surgeon during a procedure is not separately payable. The current conversion factor is \$17.75.

Wyoming. The fee schedule for anesthesiologists is based on RVUs developed and published by the American Society of Anesthesiologists. The payment formula incorporates the base value units, time in 15 minute increments, and the conversion factor. The current conversion factor is \$27.04.

SURGICAL IMPLANTS

This section describes the reimbursement methodologies found for surgical implant payment for workers' compensation agencies, Medicare, and Medicaid. These descriptions are intended to provide a high level overview of how payments are made and how payment rates may vary. Methods for surgical implant reimbursement center on either a carve-out of the primary payment system and paid at invoice plus a percentage, to a straight percentage of charge, or not excluded from the primary payment system in which the claim would be reimbursed.

The order of the payment program review is as follows:

- Minnesota WC
- WC methods by each study state in alphabetical order
- Medicare Reimbursement
- Medicaid Reimbursement

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA WORKER'S COMPENSATION – SURGICAL IMPLANTS

Minnesota worker's compensation does not separately provide for surgical implant payment. The reimbursement is included in the reimbursement of the facility type which largely is at a percentage of charge.

CURRENT WORKER'S COMPENSATION REIMBURSEMENT METHODOLOGY FOR THE 15 COMPARATIVE STATES – SURGICAL IMPLANTS

California. On an inpatient basis, any implantable device is covered under the DRG payment. An option exists with regard to inpatient outlier and the costs of the implant. Providers may elect to receive payment for the cost of the device plus an allowance of either 10% or a maximum of \$250 for select DRGs or the standard outlier payment. On an outpatient basis, implants are included as part of the payment within the OPSS.

Florida. Reimbursement for surgical implants shall be billed only under Revenue Code 278 when billing for inpatient or outpatient hospital services, and supplies shall be determined separately. Reimbursement for surgical implant(s), also referred to as "other implant" by the National Uniform Billing Manual, required during inpatient hospitalization billed under Revenue Code 278 shall be sixty percent (60%) over the manufacturer's acquisition invoice cost for the implant(s). Reimbursement for the associated disposable instrumentation required for the implantation of the surgical implant shall be twenty percent (20%) over the manufacturer's acquisition invoice cost, if the associated disposable instrumentation is received with the surgical implant and included on the manufacturer's invoice. Reimbursement for shipping and handling shall be at actual cost

shown on the invoice. Reimbursement for surgical implant(s) and associated disposable instrumentation shall be in addition to reimbursement of the Total Gross Charge After Implant Carve-Out; whether the charge is reimbursed by the Per Diem Method or the Stop Loss Method.

Surgical implants provided in an ASC shall be reimbursed for the Surgical Implant(s) at fifty percent (50%) over the acquisition invoice cost:

- The ASC shall be reimbursed for the Associated Disposable Instrumentation required for implantation of the Surgical Implant(s) at twenty percent (20%) over the acquisition invoice cost, if the Associated Disposable Instrumentation is received with the Surgical Implant(s) and included on the same implant acquisition invoice;
- The ASC shall be reimbursed for shipping and handling at the actual cost to the provider if listed on the invoice.
- Implants must be billed under revenue code 0278 with CPT 99070 and the modifiers SH=shipping, DI=disposable instrumentation, and blank for the implant itself.

Illinois. From the Illinois Act section 820ILCS305, section 8.2(a-1) (5): Implants shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges whether or not the implant charge is submitted by a provider in conjunction with a bill for all other services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or submitted by the manufacturer of the implant. "Implants" include the following codes or any substantially similar updated code as determined by the Commission: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Non-implantable devices or supplies within these codes shall be reimbursed at 65% of actual charge, which are the provider's normal rates under its standard charge-master. A standard charge-master is the provider's list of charges for procedures, treatments, products, supplies, or services used to bill payers in a consistent manner.

Iowa. Iowa worker's compensation does not have a fee schedule and reimburses claims at charges including implants.

Louisiana. Louisiana specifies a rate for implants when provided by a physician but is silent with regard to implants provided in a hospital setting. When provided by a physician, the reimbursement is invoice cost plus 20%.

Maryland. Maryland is a fully regulated state whereby the rate setting commission establishes the policies and payment levels to hospitals for all payers. There is not a

separate provision for special treatment of surgical implants. They are reimbursed according to the primary payment system covered for the claim.

Massachusetts. Massachusetts references implants as: Implanted DME, implanted prosthetic devices, replacement parts (External or Internal), accessories and supplies for the implanted DME. Regulations differ based on the claim type:

- With regard to inpatient claims, there is not a separate payment percentage from the PAF that applies to other inpatient charges.
- With regard to ASC claims, payment for items not included in the Medicare ASC fee but listed in 114.3 CMR 40.06(6) includes the associated fees. Otherwise payment for the items is the invoice cost as specified in 114.3 CMR 40.02. No separate payment shall be made for implanted devices that are included in the Medicare ASC fee.

Michigan. On an ASC or Freestanding Hospital Outpatient Facility (FHO), implants are included in the maximum allowable paid unless the CMS lists it as a pass through item. Pass through items will be listed in the health care service manual. If an item is implanted during the surgical procedure and the ASC or FHO bills the implant and includes the copy of the invoice, then the implant shall be reimbursed at the cost of the implant plus a percent markup as follows:

- Cost of implant: \$1.00 to \$500.00 shall receive cost plus 50%.
- Cost of implant: \$500.01 to \$1000.00 shall receive cost plus 30%.
- Cost of implant: \$1000.01 and higher shall receive cost plus 25%.

Nebraska. Nebraska includes in the base reimbursement for implanted devices if the cost and charge of such device is lower than \$10,000. If the cost and charges of the device is higher than \$10,000, the provider is reimbursed based on invoice cost plus 25%. Cost is defined as the provider's invoiced cost from the manufacturer plus applicable sales tax and shipping.

North Carolina. Implants are reimbursed in the normal course of the primary payment system of which the service was rendered.

North Dakota. Implants are reimbursed in the normal course of the primary payment system of which the service was rendered.

Tennessee. Implants for which billed charges are \$100.00 or less are capped at 80% of those charges. For implants over \$100.00, the maximum allowable is the manufacturers' invoice amount plus fifteen percent (15%) of invoice, with the 15% capped at a maximum of one thousand dollars (\$1,000). This calculation is per item and is not cumulative. The payer may request a copy of the invoice for payment, but it is not

required unless there is such a request. An inpatient claim is reimbursed for the per diem plus the applicable implant cost.

Washington. For inpatient and outpatient hospital services, no separate reimbursement is made over and above the currently employed payment systems which generally include the surgical implant within the weights used for payment. If the service is provided in an ASC setting, the cost of the device should be reported on the claim using specified CPT codes. The cost of the device is reimbursed.

Wisconsin. No specific mention is made with regard to surgical implants although the concept of reasonable charges applies to all services billed under workers' compensation.

Wyoming. According to the Wyoming Rules, Regulations and Fee Schedules, Chapter 9, any single supply / implant charged at \$1,000.00 or more shall require a suppliers' invoice. Reimbursement shall be at 130% of invoice cost. Shipping and handling charges shall not be reimbursed. Wyoming reserves the right to request the manufacturer's invoice for the implant from the provider.

CURRENT REIMBURSEMENT METHODOLOGY FOR MEDICARE – SURGICAL IMPLANTS

Medicare reimbursement for surgical implants is as follows:

- Inpatient hospital paid via DRG – the reimbursement is included within the DRG payment
- Inpatient hospital paid cost – the implant will be reimbursed at the hospital's cost-to-charge ratio
- Outpatient hospital paid via APC – the reimbursement is included within the payment of the surgical procedure to implant the device
- Outpatient hospital paid cost – the implant will be reimbursed at the hospital's cost-to-charge ratio
- Ambulatory Surgery Center – the reimbursement is included within the payment of the surgical procedure to implant the device

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA MEDICAID AND OTHER STATE MEDICAID AGENCIES – SURGICAL IMPLANTS

Minnesota. Minnesota Medicaid uses Medicare's APC system. There is not a specific carve-out for surgical implants and the cost of the devices are built into the APC weights associated with the surgical procedure to place the implant. The same is true for the DRG system for inpatients whereby the reimbursement system includes the cost of the device.

California. Implantable devices are reimbursed at full invoice cost with no markup, up to six months following the implant date. Reimbursement is automatically reduced by the system for claims submitted between seven and 12 months after the implant date. Providers may bill for an implantable device up to one year after the actual date of the surgical procedure. No payment is allowed past one year from the implant date.

Florida. Florida reimburses the vendor directly for cochlear implants via the Medicaid Hearing Services Program.

Illinois. Illinois Medicaid provides for a cost outlier for expensive drugs and devices. A defined list of CPT codes identifies which devices would qualify for the outlier and some may require prior authorization. The outlier payment is determined by reducing the claim charges to cost where the cost is specific to a provider as a percent of charge. The highest paying procedure is multiplied by a factor of four (4) to establish the threshold. If the costs of the claim exceed the threshold, a marginal cost factor of 80% is used to determine the outlier payment amount.

Iowa. Iowa Medicaid has established a fee schedule for implants based on CPT codes.

Louisiana. Louisiana Medicaid has established a fee schedule for implants based on CPT codes. Many codes may require prior authorization.

Maryland. A specific exclusion has not been made with regard to surgical implants and thus included within the standard claim payment according to the facility in which the service was rendered.

Massachusetts. MassHealth uses 3M's EAPG system for outpatient claims. A specific exclusion has not been made with regard to surgical implants and thus included within the standard claim payment. In this type of system, the cost of the implant is included within the weight of the surgical procedure. With regard to inpatient claims, the system is cost based thus devices will be covered at the cost-to-charge ratio.

Michigan. Michigan Medicaid follows Medicare for IPPS, OPSS, and ASC reimbursement. As such, the payment for any implants used for a procedure will be included within the respective payment system as the cost of the item is built in to the weighting system.

Nebraska. Nebraska Medicaid reimbursement for implants varies by the claim type of the patient. Implants provided to an inpatient will be reimbursed according to the AP-DRG system and outpatients are reimbursed based on a cost-to-charge ratio. Certain implants may require prior authorization.

North Carolina. North Carolina has established a fee schedule to reimburse for surgical implants.

North Dakota. North Dakota Medicaid uses the DME fee schedule and states the fee reimbursement for covered devices.

Tennessee. In TennCare, all Medicaid beneficiaries are enrolled in fully capitated managed care plans and hospitals negotiate their rates with the health plans. Thus, Medicaid does not have specific policies for hospital reimbursement for any category of hospitals. There are three primary carriers of TennCare: BlueCare by Blue Cross Blue Shield of Tennessee, Amerigroup of Norfolk, Virginia, and Americhoice, a subsidiary of United Healthcare. Each MCO has created network agreements with providers and payment methods will vary. TennCare retains oversight of how the MCOs operate and will dictate certain policies for which each MCO must comply.

- BlueCare includes the reimbursement for surgical implants within the payment system. That is, if a case rate or other weighting method is used, the cost of the implant is included within the primary payment and not reimbursed separately. Since contracts are negotiated with hospitals, there may be exceptions.

Washington. Washington Medicaid follows the Medicare APC system and does not provide a carve-out for surgical implants. As such, the cost of the device is included in the reimbursement of the surgical procedure for outpatient claims. Implants are included within the AP-DRG system for inpatient claims.

Wisconsin. Wisconsin Medicaid reimburses cochlear implants and associated equipment and nerve stimulators based on a set fee. For all other implants, the fee is determined via the prior authorization process.

Wyoming. Wyoming uses prospective payment systems for inpatient and outpatient care. As such, no separate payment provision is made for surgical implants.

CURRENT REIMBURSEMENT METHODOLOGY FOR MINNESOTA GROUP HEALTH INSURERS, AND OTHER GROUP HEALTH INSURERS

CGI contacted four (4) group health insurance companies in MN: BCBS of MN, HealthPartners Insurance Company, Medica Insurance Company and Assurant Health. We also searched the internet for provider billing manuals as these documents will provide insight to the payment methodology used. Limited information has been found on the reimbursement methodologies.

Blue Cross Blue Shield of Minnesota. Blue Cross pays inpatient claims at DRG (Diagnosis-related group) rates for most hospitals. Some rural hospitals may continue to be paid at a percentage of charge.

HealthPartners Insurance. HealthPartners Insurance uses both a DRG and a per diem methodology for their hospital inpatient reimbursement. Prior authorization is required for all inpatient admissions unless an emergency.

Massachusetts. Health insurers use a variety of methods to pay for hospital inpatient and outpatient services, reflecting their different arrangements with hospitals or hospital systems. For inpatient services, most health insurers used several methods to pay for inpatient services in their largest commercial products (most often diagnosis-related groups (DRGs) [11 out of 12] health insurers) or per diem payments [11 out of 12]. Most health insurers (10 out of 12) paid for at least some hospitalizations with discounted charges in their largest commercial products. Only two health insurers paid hospitals on a per capita basis in their commercial products (and only for their largest HMO products).

Blue Cross Blue Shield of Tennessee. BCBST uses MS-DRGs for inpatient hospital reimbursement.

COST CONTAINMENT

CGI conducted a literature search and reviewed health care cost control articles spanning the past 20 years. A brief review of the history is important to understand why health care reimbursement in the U.S. is where we find it today as many of the same issues continue to plague the system.

In the mid 1990's, managed care, specifically Health Maintenance Organizations (HMOs) were highly used as cost controlling entities. HMOs represented the strictest form of medical service utilization management and fell out of vogue due to intense enrollee dissatisfaction and the publicity of specific cases involving the revoking and denial of care. The health care payer industry then moved to Preferred Provider Organizations (PPOs) which created extensive provider networks with more choice by the enrollee and satisfaction with health insurance increased. Today, PPOs are the most prevalent form of contracting. Also during this time we saw major consolidation of hospitals into very large systems dramatically increasing their bargaining power and importance to the payer's network.

The health care market is a contentious environment. While payers are ever seeking to control price increases, health care providers face the challenge of increased costs while maintaining or even increasing revenue. Cost controls seek to balance prices paid and utilization. Prices set too low may cause access to care issues and prices set too high may cause over-utilization. Over-utilization may occur regardless of reimbursement levels and payers find that utilization management methods must be considered a vital component of any payment system.

Cost containment strategies can take many forms. Some of the more commonly used methods are:

- Provider limits in the form of enrollee's initial choice and change options. Some studies report that employees achieve greater satisfaction in being able to use their own provider for treatment, and treatments are generally more effective at getting the employee back to work as the patient/provider relationship has already been established. However, providers with specific knowledge of occupational medicine are also effective in optimizing the goals of cost effective treatment and appropriate back-to-work turnaround. Each geographic market and employer situation will vary.
- Treatment guidelines and limitations. The goal of workers' compensation medical reimbursement is to treat the injury and return the employee back to work as efficiently and effectively as possible. Treatment guidelines and limitations promote appropriate care delivery and support the cost containment initiative in the absence of a prospectively set payment system. The need for treatment

guidelines and limitations that are well supported by established standards of care are increasingly used by payers to improve quality and positive outcomes as well as controlling costs.

- Fee regulation. Fee regulation takes many forms. Some methods are more effective than others and only serve as one part of the complete cost containment concept. Fees paid for health care services will vary based on the type of provider and the type of service rendered. A detailed discussion of reimbursement methods is found in the next section.

According to WCRI's Worker's Compensation Medical Cost Containment report from April 2011, the following methods are employed by the states included in this report:

Common Cost Containment Strategies in Use as of January 1, 2011																
State	Limited Initial Provider Choice	Limited Provider change	Managed Care Regulations	Non-Facility Medical Provider Fee Regulation	Treatment Limitations	Co-Insurance on Palliative Treatment	Hospital Inpatient Fee Regulation	Hospital Outpatient Fee Regulation	Urgent Care Fee Regulation	Ambulatory Surgical Center Fee Regulation	Pre-Authorization for Non-Emergency Care	Utilization Review	Bill Review	Treatment Guidelines	Pharmaceutical Fee Regulation	Note
MN		X	X	X	X		X	X	X	X		X	X	X	X	
CA	X	X	X	X	X		X	X	X	X		X	X	X	X	1
FL	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
IL		X		X			X	X	X	X		X				2
IA	X	X														
LA	X	X		X			X	X			X	X	X		X	
MD				X			X	X		X						
MA				X	X		X	X		X	X	X		X		
MI	X			X			X	X	X	X			X		X	
NE	X	X	X	X			X	X	X	X						
NC	X	X	X	X	X		X	X		X	X	X	X	X		3
ND		X	X	X	X		X	X	X	X	X	X	X	X	X	
TN	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
WA				X	X		X	X	X	X	X	X	X	X	X	
WI		X												X	X	
WY	X	X		X	X		X	X	X	X	X		X		X	

Source: WCRI – Workers' Compensation Medical Cost Containment: A National Inventory, 2011

(1) CA: 2008 responses. No 2011 data were provided.

(2) IL: Bill review is part of utilization review.

(3) NC: 2008 responses. No 2011 data were provided.

Although the cost containment strategies appear to be relatively uniform, the definition and implementation of each method needs to be clearly defined in order to make any inferences. The following table extracts from the WCRI Worker's Compensation

Medical Cost Containment: A National Inventory, 2011 all of the cost containment methods identified by WCRI. *The methods used by MN-DLI are shown in bold/italics.*

MN-DLI' s approach uses a significant number of cost control methods, not all of which are created equal. For example, although utilization and case management may be in place, as long as a charge based payment system is used, payments will increase in proportion to provider charge increases and these may not be justified.

<u>Initial treating provider and change of provider</u>	<u>Authorized primary treating medical provider</u>	<u>Managed Care – mandatory elements</u>
<ul style="list-style-type: none"> • Employee selects provider without limitation • Employer selects provider without limitation • <i>Employee selects unless employer has approved managed care arrangement</i> • Employee selects from a list provided by the employer • Employee selects unless employer is self-insured and has their own network • Either the employee or the employer may select. Once done, the other can request change later 	<p><i>MD, DO, DDS, DC, podiatrist, OD, psychologist, PT, OT, RN, LPN, PA, acupuncturist, spiritual healer, psychiatric social worker, Christian Science practitioner</i></p>	<ul style="list-style-type: none"> • <i>Effective date of managed care regulations</i> • <i>Statutory cite and rule reference</i> • <i>Approval or certification required</i> • <i>Numbers and locations of medical providers</i> • <i>Specialties that must be included</i> • <i>Utilization review,</i> • <i>Case management services</i> • <i>Use of treatment guidelines</i> • <i>Internal dispute resolution</i> • Quality assurance program • Patient education • <i>Office staff education</i> • <i>Provider education</i>

<u>Mandatory elements within managed care arrangements</u>	<u>Dispute Resolution within Managed Care Arrangements</u>	<u>Quality Assurance Requirements in Workers' Compensation Managed Care</u>
<ul style="list-style-type: none"> • <i>Time frame within which worker must be seen after request for treatment</i> • <i>Details defining adequate number of providers within a geographical location</i> • <i>Review of treatment plans for reasonableness and necessity (prospective, concurrent, and retrospective)</i> • <i>Review of individual services for reasonableness and necessity (prospective, concurrent, and retrospective)</i> • <i>Review of inpatient and outpatient hospitalizations for reasonableness and necessity (prospective, concurrent, and retrospective)</i> • <i>Review of outpatient and ambulatory surgery for reasonableness and necessity (prospective, concurrent, and retrospective)</i> • <i>Definition of medical care coordination and/or case management</i> • <i>Required use of treatment guidelines</i> 	<ul style="list-style-type: none"> • <i>Written grievance procedure</i> • <i>Toll free number for the reporting of grievance</i> • <i>Prompt review and response to grievant</i> • <i>Expedited procedure for emergency care</i> • <i>Peer review</i> • <i>An appeal process</i> • <i>Required time frame for grievance decision</i> • <i>An explanation to grievant on rights to pursue</i> • <i>Filing of an annual report of all grievances to the agency</i> 	<ul style="list-style-type: none"> • <i>Measurement of accessibility of services</i> • <i>Measurement of availability of services</i> • <i>Measurement of adequacy of services</i> • <i>Measurement of appropriateness of services</i> • <i>Measurement of effectiveness of services</i> • <i>Measurement of timeliness of services</i> • <i>Measurement of injured worker satisfaction with care</i> • <i>Measurement of the cost of treatment</i> • <i>Measurement of the outcomes of treatment for the worker</i>

<u>Application of Non-Facility Provider Fee Schedules</u>	<u>Characteristics of Non-Facility Provider Fee Schedules</u>	<u>Limitation on Medical Services</u>
<p><i>Medical and surgical services</i></p> <p><i>Emergency services</i></p> <p><i>Radiology services</i></p> <p>Anesthesia services</p> <p><i>Pathology and laboratory services</i></p> <p><i>Chiropractic services</i></p> <p><i>Physical therapy services</i></p> <p><i>Occupational therapy services</i></p> <p><i>Prescriptions</i></p> <p>Home health care services</p> <p>Ambulatory care services</p> <p>Medical equipment</p> <p><i>Optometrist services</i></p> <p>Dental services</p> <p><i>Psychological services</i></p> <p><i>IME's (Independent medical examination)</i></p>	<p>Basis of non-facility provider fee schedule</p> <ul style="list-style-type: none"> • Blue Cross/Blue Shield RVS • <i>Medicare's RBRVS</i> • California's RVS, 1974 • RV for physicians – St. Anthony's Press or other • State developed RVS (other than California) 	<ul style="list-style-type: none"> • <i>Limitation on evaluation and management services</i> • <i>Limitation on chiropractic treatment</i> • <i>Limitation on physical therapy</i> • <i>Limitation on occupational therapy</i> • <i>Limitation on work hardening</i> • <i>Limitation on psychotherapy</i> • Pre-authorization required for spinal surgery

<u>Hospital Inpatient Fee Regulations</u>	<u>Hospital Outpatient Fee Regulations</u>	<u>Ambulatory Surgical Center Fee Regulations</u>
<p>Form of hospital inpatient fee regulation</p> <ul style="list-style-type: none"> • Per case (DRG or other) • Per procedure per diem (or by service) • Cost-based • Discounted charges <p>How schedules are applied</p> <ul style="list-style-type: none"> • All hospitals have the same allowable fees • Hospitals have differing allowable fees based on location • Hospitals have differing allowable fees based on size • Hospitals have differing allowable fees based on negotiations • Hospitals have differing allowable fees based on committee or agency decision <p>Pre-authorization required for non-emergency inpatient care</p>	<p>Method used for hospital outpatient fee regulations</p> <ul style="list-style-type: none"> • Same as hospital inpatient fees (fee by service code) • Same as hospital inpatient fees (cost based) • Same as hospital inpatient fees (discounted charges) • Same as hospital inpatient fees (fee by procedure code) • Used a varied method 	<p>Method used for ambulatory surgical center fee regulations</p> <ul style="list-style-type: none"> • Same as hospital outpatient fees • Same as hospital inpatient fees (fee by service code) • Same as hospital inpatient fees (fee by procedure code) • Other <p>Agency advice to payers if no schedule</p>

<u>Utilization Requirements in WC Non-Managed Care Arrangements</u>	<u>Use of Treatment Guidelines in Workers' Compensation</u>	<u>Low Back Treatment Guidelines</u>
<p>Who is authorized to perform utilization review functions</p> <ul style="list-style-type: none">• State agency employees• State agency through peer review• Private payers• Private payers to use only organizations approved by state agency <p>Which claims are subject to utilization review?</p> <ul style="list-style-type: none">• All claims• All claims but for prospective treatment only• Claims referred to the agency• When medical costs exceed specific amounts• When disability days exceed specific numbers• All inpatient hospitalizations• Planned invasive surgery <p>Documentation necessary for claim that treatment not necessary</p>	<ul style="list-style-type: none">• Use of treatment guidelines mandatory• Cervical spine• Thoracic spine• Lumbar spine• Upper extremity• Lower extremity• Carpal tunnel• Occupational Asthma• Pain management• Use of controlled substance• What was to be accomplished with the use of mandatory treatment guidelines	<ul style="list-style-type: none">• Appropriate diagnostic assessment• Appropriate type of treatment• Appropriate length of treatment• Appropriate medication for treatment of symptoms• Appropriate return to work expectations

Payment Systems Overview

Fee regulation refers to methods employed to reimburse providers for healthcare services rendered. The various methods can be relatively simple to greatly complex. The history of healthcare consumption and payment for services continues to evolve as health care payers attempt to manage expenditures in an environment where core costs continue to rise and healthcare providers are challenged to maintain or maximize reimbursement. The history of healthcare payment systems has seen the following payment methods:

- Charge-based methods:
 - Usual and customary charges
 - Discount on charges
 - Cost and cost-plus reimbursement
- Fee-for-Service:
 - Case based patient classification systems (e.g. Diagnosis Related Groups, Enhanced Ambulatory Patient Groups, Ambulatory Patient Classification)
 - Fee Schedules
- Capitation

Although the above payment system examples cover at least the last 50 years, a review of the various methods used in today's healthcare system shows that payment methods have not radically changed. Different methods are employed for different provider types. In the absence of any other controls, charge-based methods do not allow the payer to predict expenses as utilization will vary greatly based on the provider and case. Fee-for-service systems vary in their ability to predict with precision what health care expenditures will be but some fee-for-service systems do permit utilization control via the system structure itself. Capitation systems represent total utilization control but may not fit well with workers' compensation programs. We will discuss each below.

CHARGE-BASED REIMBURSEMENT

The charge based reimbursement system, usual and customary charges, sometimes also referred to as usual, customary and reasonable charges (UCR), refers to the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area. The determination of "usual and customary" ranges from creation of unique fee schedule from one's own data to the purchase of a commercially available database. Some payers will recognize 100% of the UCR to a certain percentile of the UCR to set reimbursement.

Discount from charges simply is a negotiated or legislated discount of the provider charge. Discount from charges is simple to administer as complex calculations are not required. Charge based reimbursement does little to control costs simply because utilization of services is not confined. This reimbursement method is common across hospital and physician/allied professional providers. A payment system based on charges presented on a claim leads to line item review by the payer as to the applicability of the charge in treating the patient. In a workers' compensation environment, this leads to longer claim processing time and potential litigation.

"Medicare and other payers have moved away from charge-based payment. Medicaid programs have become increasingly vulnerable to charge inflation. Nationwide, hospital charges are now three times higher than hospital cost, and the gap is larger for outpatient care than inpatient." [Gerard F. Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing," *Health Affairs* 26:3 (May/June 2007), p. 783.] Given that payers have very little control over the charges a given provider may charge, charge based payment systems keep all of the risk on the health care payer. In the absence of state regulation that would dampen the annual increases of charges (e.g. Maryland), a charge based payment system would do little for controlling payer costs over time.

COST-BASED REIMBURSEMENT

Cost and cost-plus payment arrangements attempt to reimburse providers at some percentage above costs. Costs are typically gathered via a cost reporting program such as the one administered by Medicare. The Medicare cost reports gather hospital costs for all services regardless of payer and then costs for Medicare recipients are allocated based on the volume of Medicare discharges, in the case of inpatients, and visits in the case of outpatient claims. The same allocation method is used to determine the Medicaid costs.

A cost-based charge ratio at a macro level (e.g. determined as a blend of all services) may not adequately reimburse all types of claims thus separate inpatient and outpatient cost-to-charge ratios would need to be calculated. It is important to note that each hospital will utilize varying methods with regard to allocated overhead and cost basis methods will produce different results particularly when increasing the granularity of the costs. If refinement or targeted cost ratios are desired, the ability of each hospital to parse their data appropriately will differ. With regard to micro-level set costs (e.g. revenue center level), extensive studies have concluded that there exists no relationship between any particular revenue center in a hospital to the costs and charges associated with each service. Thus, some services may have a small markup (e.g. expensive devices) and other inexpensive items have a large markup. If a revenue center contains both expensive and inexpensive items, the resulting cost-to-charge ratio will be

skewed. The majority of hospital payments are based on a per-episode or per-case basis and hospital charge masters are not managed as tightly as they used to be when cost-based reimbursement was common. That is to say, the charge in the charge master bears little if no relationship to the true cost of the item or service.

Determining which expenses to be recognized as costs can be administratively burdensome for the payer. Decisions such as: are only operating costs to be considered or are capital costs considered as well need to be made and to what extent. Will all expenses that a hospital may incur be included in their costs or will there be some that are not allowable? A payment system based on costs will continue to incur increasing expenses as the hospital provider does not have any incentive to be conservative in their spending.

Reimbursement based on costs again permits the provider to freely incur expenses that may be unnecessary. Without other guidelines or restrictions on a per claim basis, no incentives exist for the provider to limit services as that will result in lower revenue. Just as with a charge-based system, the cost-based system is administratively simple from a claims payment standpoint as the calculation is not complex. However, line item review and potential denials may occur with a cost-based system as the payer attempts to manage utilization retrospectively.

CASE-BASED PAYMENT SYSTEMS

Case based classification systems began in 1982 when Medicare implemented the Diagnosis Related Groups (DRGs) as the backbone for reimbursement of inpatient stays. The prior system used for inpatient was a cost-based system that involved the collection of year-end cost reports to tally up any remaining reimbursement variances. Medicare moved to the DRG system in order to place controls on the rapidly increasing costs incurred by the program. At the time, inpatient care was the primary place of service. The DRG system was originally developed by Yale University to organize patient visits in a manner that would facilitate comparative studies. A DRG system uses different patient characteristics and attempts to classify them in a clinically and resource similar manner.

There are several DRG grouper systems each with their own merits based on the population for which a payer is responsible. For example, the AP-DRG grouper adds additional refinement for the differentiation of neonatal care. With regard to outpatient classification systems, the Enhanced Ambulatory Patient Groups (EAPG) by 3M and the Ambulatory Patient Classification (APC) system used by CMS are two examples of case based payment systems. The groupers for each are very different yet both attempt to consolidate the multitude of outpatient services delivered on a per visit basis. Case-based reimbursement methods are common for hospital providers.

The advantage to using a case based system, such as a DRG system, is that the provider must deliver patient care in an efficient, cost-effective manner as the payment is intended to cover all the services needed by the patient for a particular episode. In contrast, a fee schedule based system merely provides for payment based on the number of services delivered regardless of whether the services are needed.

A case-based payment system can be designed in a simple, straight-forward manner or it can be made more complex simply by creating a multitude of complex payment policies that may have little benefit in terms of affecting overall payments. Line item review of the claim is typically not needed as the provider is not incentivized to conduct more services or tests as reimbursement is not impacted. In fact, the provider is incentivized to provide only those services necessary to treat the patient effectively for the desired outcome as an increase in the case payment does not increase when additional services are rendered.

FEE SCHEDULES

Fee schedules are fairly straightforward. Typically, each billable service is defined at a set reimbursement rate. Other payment policies may coexist with the fee schedule, but consolidation into another per case interpretation is not represented by a fee schedule type of arrangement. Costs, although fairly predictable, are not as efficiently confined as with a per case or episode payment as the provider is not incentivized to control the utilization of services. Commonly known fee schedules include the Medicare Laboratory Fee Schedule, and the Medicare Physician Fee Schedule for physician and allied professional reimbursement.

Fee schedule reimbursement is common for hospital outpatient services and physician/allied professional providers. Line item review and potential denial by payers is increased with a fee schedule arrangement as payers attempt to control health care expenditures on a per-service rendered basis. Fee schedules can be cumbersome to create if a custom one is developed while the use of a commercially available fee schedule has its risks as well. In either case, the payer must understand how the fee schedule is constructed and how it relates to provider payments. While fee schedules permit the payer to predict expenditures and limit prices paid, providers are not incentivized to provide fewer services for the same outcome.

CAPITATION

Capitation involves contracting with a provider for a defined group of members for which the coordination of care is directed. This is the purest form of “gatekeeper” management of healthcare resource utilization. Capitation was quite popular in the late 1980’s and 1990’s but has lessened in prevalence. The basis of capitation is that providers are assigned members of a payer’s enrollees. The provider that is put in

control is typically a physician. This physician directs all instances of care, outside of an emergency, and utilization is controlled by the physician. The physician is reimbursed a per-member-per-month amount and this is intended to cover all medical expenses. Reinsurance by a specialized company will be utilized for payment of catastrophic cases.

PAYMENT SYSTEM COMPARISON

Below is a recap of each system concept and the pro's and con's associated:

	Charge-Based		Fee-for-Service		Capitation
	Charge	Cost	Case-Based	Fee Schedule	Capitation
Admin Complexity (payment calculation)	Simple	Simple	Moderate to Complex	Simple to Moderate	Simple
Admin Complexity (system maintenance)	Moderate based on allowed charge definition	Moderate to Complex based on allowable costs and level of detail	Moderate to Complex based on payment policies	Simple to Moderate	Complex due to capitation rate setting
Utilization Control	None – a separate function	None – a separate function	High – the payment system influences resources	Low – a separate function	High
Timely Claim Processing	Barrier if line item review undertaken	Barrier if line item review undertaken	Low risk of barrier as case-based systems utilize extensive claim editors	Barrier if line item review undertaken	Low risk of barrier
Common Providers Covered	All providers	Only providers with cost report information	Hospital providers	All providers	Physician gatekeeper

To influence health care expenditures, utilization control is a primary key regardless of the payment system used. A case-based system puts the utilization control and responsibility on the provider of the service whereas the fee schedule and charge-based

systems put the utilization control on the payer. All of the systems in the grid can be made complex whether the complexity be on the allowable services to be billed, the allowable services to be used as costs, or the payment policies involved in a case-based system.

INPATIENT HOSPITAL – COMPARATIVE ANALYSIS OF REIMBURSEMENT METHODS

Inpatient hospital reimbursement methods used today are:

- Percentage of charges
- Cost-based reimbursement
- Per diem based on the service level (e.g. surgical v. medical)
- DRG grouper based

PERCENTAGE OF CHARGES AND COST-BASED REIMBURSEMENT

The percentage of charges method is simply a pre-negotiated discount from the healthcare provider's charge master. It offers little incentive to control costs from a provider perspective. Similarly, the cost-based method has its challenges as well. Unless the payer accepts the cost information reported to CMS, the additional reporting can be administratively cumbersome for the provider. Not all providers participate in the Medicare program so cost report information is not always available. However, the vast majority of hospitals do participate in Medicare. There has been much debate on the validity of cost information as the markups in each revenue center at a hospital are not uniform. Expensive implantable devices may receive a smaller markup and other cheaper supplies and tests might receive very high markups. Even with the markup debate, reimbursement based on costs is an improvement on the percentage of charge method as overall prices paid are typically lower than any discount from charges arrangement. However, there is little control over price inflation as the provider has no incentive to control the number of services rendered. In fact, the more services rendered, the higher the reimbursement regardless of whether the reimbursement is based on costs or a discount from charges. Potential barriers to timely claim payment may involve the line item review by the payer as this is the only method available to the payer to control prices paid.

PER DIEM

A per diem based reimbursement system is a pre-defined payment made per approved day of the inpatient stay. Per diem based inpatient systems may have a tie to a DRG composite methodology whereby "like" DRGs are grouped and a corresponding per diem is established while other per diem systems create a per diem for surgical cases, maternity and neonatal cases, medical, mental health, and so forth. Utilization and case management are keys to dampening lengths of stay "creep" whereby a day or two unnecessarily added to many stays can result in increased costs. Utilization and case management can be costly functions for a payer especially when implemented to solely control the length of stay. Worker's compensation programs do greatly benefit from case management from the standpoint of the right care, at the right time for the proper

length of time and treatment guidelines will influence the length of stay. Once defined, a per diem payment of inpatient hospital care is administratively simple to calculate a claim payment. Potential barriers to timely claim payment may involve the denial of days being submitted for payment.

DRG SYSTEMS

There are several DRG systems available today with the Medicare DRG system being a publicly available grouper to many proprietary systems. Listed below are the most widely known and used DRG groupers:

- Medical Severity DRGs (MS-DRGs) – used by Medicare
- All Patient DRGS (AP-DRGs) – developed by 3M
- All Patient Refined DRGs (APR-DRGs) – developed by 3M
- All Patient Severity DRGs (APS-DRGs) – developed by Optum/Ingenix

Each DRG system uses data elements communicated on the UB-04 claim form. In an electronic environment, these data elements are communicated via the 837I transaction. The data elements common across all DRG groupers are:

- Gender
- Age
- Discharge diagnosis codes
- Procedure codes
- Discharge patient disposition

The APS-DRG, AP-DRG and APR-DRG require the addition of patient birth weight to better differentiate characteristics of newborn cases. The APS-DRG and AP-DRG groupers are largely based the old CMS-DRG grouper but with the addition of special neonatal DRGs and/or refinements in psychiatric DRGs. The APR-DRG grouper contains a similar base DRG set as the AP-DRG and MS-DRG grouper but differentiates cases within the DRG via a severity of illness (SOI) indicator. The SOI breaks down the DRG case into minor, moderate, major, and extreme representations. The MS-DRG grouper, with its target population of Medicare recipients, does not contain a robust set of DRGs for newborn cases. Instead, like the APR-DRG and unlike the AP-DRG grouper, the MS-DRG grouper attempts to be more descriptive of the various extremes cases may have but not to the extent of the APR-DRG grouper system.

DRG-based reimbursement systems all have the following common characteristics that may be customized to the payer and will be discussed in detail below:

- Relative weights – relative weights are but one part of the reimbursement formula and may be either publicly available as in the Medicare relative weight or

available from the vendor of the grouper. Relative weights are specific to the grouper being used.

- Provider rates – provider rates are the dollar conversion factor that is multiplied by the relative weight to arrive at a case payment. These may be provider based, peer based, or some other defined basis.
- Payment policies – outlier payments for extraordinarily costly cases, transfer payments for short stays for patients that get transferred to another inpatient hospital.

Each DRG system needs a set of relative weights. Relative weights will vary based on the grouper and even the payer, and are intended to reflect the relative intensity of services that one DRG will have over another. That is to say, a DRG relative weight of 1.50 should have service intensity that is 50% greater than a DRG weight of 1.0. DRG relative weights are available commercially for any grouper or, if substantial volume exists, a payer may create its own set of relative weights. Additionally, although a DRG system may be the primary backbone to a commercial payer for inpatient claims, select DRGs may be carved-out (e.g. mental health and substance abuse) and paid via a different method or where historical utilization does not exist, certain DRGs might be paid a per diem, or a percent-of-charge. A departure from the DRG weighting system in the case of low volume DRGs to a per diem or percent-of-charge payment method represents low risk to the payer due to the low volume.

DRG payment rates represent another area of variability in use by payers. Some payers, if using the Medicare MS-DRGs and weights, will simply contract for a percent above Medicare. Other DRG payment rates seen in the marketplace may differentiate providers based on peer groups (e.g. teaching, non-teaching urban, rural, children's, etc), or develop provider specific rates based on budget neutrality to a former payment system. Commercial payers that have considerable market share may have a contracting advantage when negotiating DRG provider rates whereas Medicaid agencies are mandated to provide payments that are sufficient to enlist enough providers such that care is available to Medicaid recipients in the geographic regions served.

Most DRG based inpatient payment systems will include a several payment policy provisions. The most common are for an outlier case and transfer cases. An outlier case would be cases that are extraordinarily costly whether that is determined as a cost calculation or in a length of stay basis. Additionally, payment provisions for transfer cases will also be employed. Typically, if a patient is transferred to another similar type facility and does not stay at the transferring hospital for the average length of stay, a fraction of the full payment is made. There are many varying calculations for transfer payments in that a surgical case might have a higher or "front loaded" transfer payment

due to the surgery, to a straight per diem for each day of the stay. Usually transfer case payments will not exceed the full DRG payment.

The following table describes key variables across three primary DRG groupers. Since the AP-DRG grouper is not currently being slated for ICD-10 diagnosis and procedure coding compliance, it has been left off of the grid. ICD-10 claim coding will represent a major change to coding claims in terms of diagnosis and procedure coding. This change will modify many payment systems. The effective date for this change has been postponed several times by CMS and again has been delayed as of the writing of this report. However, for any future decision making on the part of MN-DLI, the capability of any DRG based system that uses diagnosis and procedure coding is relevant and should be considered.

Comparison of Frequently Used DRG Systems

Characteristic	MS-DRGs v28 (CMS – Maintained by 3M)	APR-DRGs v28 (3M and NACHRI)	APS-DRGs v28 (OptumInsight/Ingenix)
Overall approach and treatment of complications and co-morbidities	Intended for use in Medicare population. Includes 335 base DRGs, initially separated by severity into “no CC”, “with CC” or “with major CC”. Low volume DRGs are then combined.	Structure unrelated to Medicare. Includes 314 base DRGs, each with four severity levels. There is no CC or major CC list; instead, severity depends on the number and interaction of CCs.	Structure based on MS-DRGs but adapted to be suitable for an all-patient population. Includes 407 base DRGs, each with three severity levels. Same CC and major CC list as MS-DRGs.
Number of DRGs	746	1,258	1,223
Newborn DRGs	7 DRGs, no use of birth weight	28 base DRGs, each with four severity levels (total 112)	9 base DRGs, each with three levels of severity, based in part on birth weight (total 27)
Psychiatric DRGs	9 DRGs; most stays group to “psychoses”	24 DRGs, each with four severity levels (96 total)	10 base DRGs, each with three severity levels (30 total)
Payment Use by Medicaid	MI, NH, NM, OK, OR, SD, WI, NC	<u>Operational:</u> MA, MD, MT, NY, PA, RI, SC <u>Planned:</u> CA, CO, IL, MS, ND, TX	None
Payment use by Workers Comp	CA, IL, ND (all 3 are planning to move to APR-DRG)	MD	None
Payment use by other payers	Commercial plan use	BCBSMA, BCBSTN (analysis purposes only)	Commercial plan use

ICD-10 Ready	Yes	Yes	Yes
Other users	Medicare, hospitals	Hospitals, AHRQ, MedPAC, JCAHO, various state “report cards”	Hospitals, AHRQ, various state “report cards”
Other uses	Used as a risk adjustor in measuring readmissions. Used to reduce payment for hospital acquired conditions	Used as a risk adjustor in measuring mortality, readmissions, complications	Used as a risk adjustor in measuring mortality and readmissions and to reduce payment for hospital acquired conditions

Source: Quinn, K., Courts, C. Sound Practices in Medicaid Payment for Hospital Care; Center for Healthcare Strategies, November 2010 with information provided by Navigant and updated by CGI Federal.

The APS-DRGs are not used in payer settings and therefore, not recommended for use by MN-DLI. Either of the remaining DRG based systems would be suitable for use by MN-DLI. Although the MS-DRG system has been developed for use in a Medicare population, one of the primary reasons other DRG systems were created were for the differentiation of neonatal cases. This would be of no benefit to MN-DLI. There may be advantages to using the APR-DRG system in terms of differentiation in the severity of cases. A data modeling exercise would be one step in determining the usefulness of either DRG system.

As part of this report, CGI researched the various payment methods for inpatient hospital reimbursement used by both worker’s compensation and Medicaid agencies for select states. The chart below shows a side-by-side comparison for ease of comparison:

Comparison of Inpatient Payment Methods: WC to Medicaid			
State	Worker’s Compensation	Medicaid	Additional Information
Minnesota	% Charge	CMS-DRG	
California	MS-DRG (120% of Medicare Excludes Cancer, Children’s & CAH)	Per Diem & Per Discharge as contracted	WC: Implants carved out of outlier; reimbursed 110% of cost if elected
Florida	Per Diem	Per Diem with Peer Rates (DRG in FY2013)	WC: Implants at 160% of cost MCD: Implants not included in outlier calculation
Illinois	MS-DRG (some POC for low volume/unstable)	CMS-DRG v12	
Iowa	Charges	CMS-DRG v24	
Louisiana	Lesser of charge or Per Diem	Per Diem with Peer Rates	WC: Implants – 120% of cost MCD: Implants – fee schedule

Comparison of Inpatient Payment Methods: WC to Medicaid			
State	Worker's Compensation	Medicaid	Additional Information
			with prior authorization
Maryland	APR-DRG	APR-DRG	
Massachusetts	% of Charge (State regulates charges)	Case Mix Adjusted Cost based Per Diem (case mix based on APR-DRG)	
Michigan	Cost Based	MS-DRG (custom weights)	
Nebraska	MS-DRG (only WC related DRGs available)	AP-DRG (CCR for carveouts)	WC: Implants paid at 125% if costs & charges > \$10,000
North Carolina	75% of Charges	Per Diem – Rehab MS-DRG	
North Dakota	MS-DRG (No DSH/IME)	APR-DRG	
Tennessee	Per Diem (Lesser of charge or Per Diem; declining per diem)	100% Managed Care	WC: Implants at cost and not part of outlier calculation
Washington	AP-DRG	AP-DRG	
Wisconsin	Varies by WC Managed Care Insurer	MS-DRG with AP-DRG for neonates	
Wyoming	Usual & Customary Charges	Level of Care (LOC) for general; Per diem for rehab	WC: Implants at 130% of cost

The comparison above shows us that:

- 40% (6/15) WC agencies and 73% (11/15) of Medicaid agencies follow a DRG system
- 20% (3/15) WC agencies and 13% (2/15) Medicaid agencies follow a per diem system
- 33% (5/15) WC agencies and no Medicaid agencies follow a percent-of-charge or cost based system
- 33% (5/15) WC and Medicaid agencies follow a DRG based system within the same state

- 13% (2/15) WC and Medicaid agencies follow a per diem based system within the same state
- 40% (6/15) WC and 13% (2/15) Medicaid agencies have special handling of surgical implants outside of the primary inpatient payment system

INPATIENT REIMBURSEMENT RECOMMENDATION

CGI recommends that MN-DLI assess the implementation of worker’s compensation based on the Medicare MS-DRG grouper. This methodology should apply to all hospital provider suppliers of inpatient hospital acute care (i.e. acute care, critical access, small hospitals). The per-case reimbursement method that describes a DRG system will represent a definite step towards reigning in the inflationary inpatient hospital expenditures created currently by the discount from charges system. The DRG methodology moves towards more responsible resource utilization by providers since they would have the incentive to provide the appropriate care and avoid unnecessary services.

DRG systems are widely used in many commercial and public payers (Medicare, Medicaid) and custom weights would make the system unique to worker’s compensation if the volume of cases permits. The ultimate decision of which DRG system to use would be best determined by a data modeling assessment. CGI recommends that any DRG system (weights, payment policies) should be kept as simple and straightforward as possible. CGI clients that currently employ complicated DRG reimbursement systems in which many items such as implants have carved-out exceptions report that the exceptions by provider are more difficult to maintain and analyze for comparison. The system design should be as transparent as possible in that DRG weights, provider rates (as much as possible), and pricing logic be fully documented and made public in a single document that references sections on rulemaking. The use of a DRG based system will also permit case mix analysis of worker’s compensation claims which is useful in monitoring the system both from a payment perspective and from a provider by provider perspective.

The following table describes the key DRG reimbursement system components and key MN-DLI design decisions:

MS-DRG Reimbursement System Component	MN-DLI Decisions
Obtain Supporting Data	<ul style="list-style-type: none"> • Obtain two years of claims data in order to evaluate the impact to the system that affects both payers and providers • Identify and evaluate cost data to be used in determination of outlier payments, and provider margin analysis • Identify inflation factors to be used to adjust claims data to

	current
Groupers	<ul style="list-style-type: none"> • Identify the version of MS-DRGs to begin implementation • Identify vendors to support grouping and pricing
DRG Weights	<ul style="list-style-type: none"> • Identify and evaluate Medicare DRG weights or the creation of custom DRG weights • Identify and evaluate charge-based or cost-based weights
Payment Policies	<ul style="list-style-type: none"> • Determine base rates • Identify supporting payment policies: <ul style="list-style-type: none"> ○ Transfer policy ○ Outlier policy ○ Provider preventable conditions ○ Readmissions ○ Short stay policy • Determine included and excluded inpatient services
System Maintenance	<ul style="list-style-type: none"> • Determine system update schedule and for which components

Below we will discuss the design considerations for the inpatient MS-DRG reimbursement system components and describe the more commonly seen implementation in the marketplace.

OBTAIN SUPPORTING DATA

When evaluating the implementation of a DRG based inpatient reimbursement system, two years of paid claims data are typically used for evaluation. Two years of data provides enough history to identify trends in utilization and payments, and create DRG weights if needed when not using a commercially available weight set. Additionally, cost data are typically gathered as well to evaluate provider margins and in support of DRG weight development if cost-based custom weights are to be created. The cost information could be obtained from Medicare cost reports for Medicare participating providers or from internal cost report information if collected. Finally, inflation factors should be gathered so that the historical data may be modeled under current conditions. Commonly used inflation factors are the Medicare Medical Market Basket or internal reports that measure healthcare expenditures within the state.

Key decision points for this step:

- Source of provider cost information if custom DRG weights are to be created and based on a cost translation of claim charges
- Inflation factors

GROUPER

The MS-DRG grouper as used by Medicare is updated annually based on the federal fiscal year that begins on October 1. Since the MS-DRG grouper is used by CMS, it is cost effective to use if the underlying population is fairly represented. For example, the MS-DRG system does not adequately reflect resources used by newborns and neonates. Since the worker's compensation system does not represent newborns and neonates, the MS-DRG system is a reasonable choice for use by MN-DLI as the advantages of other grouper systems, when cost is taken into consideration, do not provide enough benefits to outweigh the cost.

There are many vendors of the MS-DRG grouper. The grouper is the software that takes the information provided on the claim and assigns the claim to a specific DRG. Installations can range from an off-the-shelf implementation of the Medicare grouping and pricing to a custom design of the pricing system. Typically, manipulation of the grouper is not done but rather, the components that surround the DRG grouper are manipulated such as the non-recognition of certain DRGs for reimbursement or the editing of the claim for non-reimbursed revenue codes may be made. As customization of the design of the MS-DRG system, the higher the costs will be to implement.

Key decision points for this step:

- Identify vendors and the costs associated for a standard installation versus a custom program
- Identify whether the software will be licensed by each individual payer, or if a web service may be obtained that all payers can subscribe to. A central web-based service that reflects all of the policies of the MN-DLI inpatient hospital payment design will ensure consistency of payment.
- If following the Medicare grouper, identify if MN-DLI will apply the grouper based on the federal fiscal year or some other update schedule. Due to claim coding requirements for diagnosis and procedures, it is optimal to update according to the Medicare schedule however, alternate schedule updates are commonly seen.

DRG WEIGHTS

DRG weights represent the relative resource consumption by clinically similar cases and describe these differences in terms of a number. It is the DRG weight that serves as one key component in determining the payment for an inpatient case. DRG weights may be created custom based on historical utilization of MN worker's compensation

claims or the Medicare MS-DRG weights may be used. The creation of custom weights will incur higher costs to implement than using the Medicare weights and there may not be sufficient claims volume to determine a stable DRG weight for worker's compensation cases. CGI has seen many commercial payers switch from using custom created DRG weights to using the Medicare weights and then the payer only concentrates on developing the provider base rates or uses a percentage of the Medicare payment to affect their desired plan payment outcome. Data modeling is essential to understanding the distribution of WC cases across DRGs.

The DRG weights should be updated each time a new grouper is installed. Therefore, if custom weights are pursued, the recalculation of the weights needs to be done each time the grouper is changed to a new version. This is done to reflect the different resource consumption brought on by the rearrangement of cases within the DRG grouper.

If custom weights are pursued, a decision needs to be made with regard to creating charge-based weights or cost-based weights. Medicare uses cost-based weights because Medicare determined that the charges by provider no longer reflected resource cost differences amongst cases and that revenue center based costs, aggregated to a claim level would better reflect the true cost of the case. Custom weights would be beneficial when the case distribution of WC cases is such that they are materially different than what is seen in the Medicare population. Modeling historical claims under the standard Medicare system would identify if this is the case. The identification of the source of costs would need to be made whether the costs would be derived from the Medicare cost reports or some other cost information that relates to the providers in MN. Again, the benefits of creating a custom DRG weight set would need to be evaluated against using a commercially available weight set for the MS-DRG grouper.

Key decision points from this step:

- Evaluate historical claims DRG distribution of WC claims to the Medicare population. If substantially different, custom DRG weights may be warranted.
- Custom DRG weights may be charge-based or cost-based. Cost-based information may be derived from the Medicare cost reports or from some other internally generated cost information.
- DRG weights must be updated when a new DRG grouper version is used.
- Custom DRG weights increase the implementation and maintenance costs and may not provide substantial value.

PAYMENT POLICIES

Payment policies work in concert with the DRG weights to arrive at a case payment. Payment policies encompass the provider base rates, transfer, outlier, and other rules that affect the case payment.

Establishing provider base rates may range from using the Medicare provider base rate to the creation of custom provider base rates. If Medicare provider base rates are used, a decision must be made whether to reimburse at Medicare or some percentage above or below. Most commercial plans reimburse at some percentage above Medicare if they are following Medicare precisely. Other options include the creation of provider base rates that are custom to WC. Custom base rates can be provider based, peer group based, statewide based, or some blend of the three. The more complex the provider base rate derivation, the more costly the initial implementation will be along with the ongoing maintenance. Typically, instituting a system that follows standard Medicare payments and then establishing a percent above Medicare is the least complicated and therefore the least expensive to implement. However, MN-DLI would need to follow Medicare closely and determine if the payment direction of Medicare reflects the WC goals. If the initial implementation would be at a percent of Medicare and there becomes an incongruence of the goals of WC and the Medicare payment, custom provider base rates could then be pursued and maintained while still continuing to use the Medicare MS-DRGs.

In addition to provider base rates, payment policies to manage atypical cases need to be established. Using Medicare again as a base, these payment policies include transfers to another medical institution and affects shorter stay cases, outlier payments for extraordinarily costly cases, reimbursement for provider preventable conditions or hospital acquired conditions, payments for new technology and readmissions for inappropriately discharged patients in order to receive a separate DRG payment. The review of medical records in the case of potential inappropriate early discharge resulting in a readmission is more of a function of a retrospective review rather than a pricing policy. Payments for transfers, outliers, provider preventable conditions and new technology are a function of the standard Medicare DRG pricer. Customization of payment policies would increase system maintenance and costs.

Whether a percent of Medicare is chosen or a customization of the provider base rates is undertaken, either choice allows MN-DLI to implement the system budget neutral, that is, although the underlying system for payment has changed, overall payments remain the same. Budget neutrality can be set as a system-wide calculation or at an individual provider basis. The decision to achieve budget neutrality is typically set for first year implementation only and from then on a predetermined increase is usually put in place. This lessens the burden of recalculating provider base rates on an annual basis. Whether to implement the system in a budget neutral fashion or some other

basis is purely up to MN-DLI. Provider push-back may be lessened if the system is implemented in a budget neutral fashion to each provider or in the aggregate based on peer groups if that route is chosen.

Key decision points from this step:

- Provider payments may be created by establishing a percent of Medicare which would involve the monitoring of Medicare policy to the creation of custom provider base rates. Many options exist with regard to custom provider base rates and would increase system implementation and maintenance costs.
- Payment policies that affect payment for atypical cases need to be understood if following Medicare or established and maintained if custom policies were to be pursued. Again, custom designed policies would increase system maintenance and costs and would need to be updated each time the grouper changes.

SYSTEM MAINTENANCE

System maintenance is tied to the overall design. If following standard Medicare, changes would occur each October 1st as the federal fiscal year changes. It is possible to delay an update to the MS-DRG system and remain on a certain version for a length of time. However, it then becomes substantial to update to a current version if that path is followed as major payment distributions are likely to occur. Most commercial installations that are based on a percentage of Medicare follow the annual Medicare update schedule.

Any customization of the system components requires the establishment of an update schedule. Typically the grouper is not manipulated but rather the choice may be to not change from the currently installed grouper to the latest version. Updates to provider base rates and policies may be changed annually or on some other schedule. Changes to provider base rates may be made without any other system changes such as DRG weights and payment policies. Typically, if the DRG grouper is updated, then the DRG weights and payment policies are updated as well along with provider base rates.

Key decision points from this step:

- Determine the system update schedule. This will depend on whether standard Medicare is followed or some other customized system is designed.

OUTPATIENT HOSPITAL – SURGICAL SERVICES – COMPARATIVE ANALYSIS OF REIMBURSEMENT METHODS

Similar to inpatient hospital methods, outpatient hospital reimbursement methods used today are:

- Percentage of charges

- Cost-based reimbursement
- Per case/per visit based (APC, APG, other blended case rate systems)

PERCENTAGE OF CHARGE OR COST-BASED REIMBURSEMENT FOR OUTPATIENT HOSPITAL

Percentage of charges and cost-based reimbursement for outpatient hospital claims reimbursement function the same as inpatient. Either charges are reduced by some factor as a discount or charges are recognized at some factor that reflects cost as a function of charges. Just as with inpatient reimbursement, these two payment types offer little protection against charge inflation as each service rendered is reimburse. Robust analysis and program expenditures do not exist as they do under grouper based systems. When the percentage of charge or cost based reimbursement systems are used, the use of a grouping system such as Ambulatory Patient Classifications (APCs) or Enhance Ambulatory Patient Groups (EAPGs) is often used in addition to assess utilization and case mix to explain variances in provider resource consumption.

PER CASE OR PER VISIT (EPISODE)

Per case or per visit systems encompass CMS's APCs and 3M's EAPGs as the most widely used grouper systems for outpatient claims. Both of these systems use the UB-04/837I transaction claim information with nothing else needed unless a specific payment policy is enacted such as paying invoice cost for surgical implants. Even then, the costs of a surgical implant can be specifically coded in a manner MN-DLI mandates while MN-DLI reserves the right to audit the invoice accuracy. Although the focus of MN-DLI was for outpatient surgical care reimbursement, additional services must be provided to support the surgery so a wider perspective is presented. CMS's APCs and 3M's EAPGs are discussed separately below because these are somewhat complicated systems if the reader is unfamiliar.

CMS's APCs represent a line level fee schedule of differing origins and have very little consolidation or packaging of services. That is to say, the system is not bundled extensively. If a CPT is presented on the claim, it is eligible for payment if policy supports. The system is built around CPT or HCPCS codes that are assigned a payment treatment outcome. An extensive editor called the Integrated Outpatient Code Editor (IOCE) is considered the grouper and it provides the editing of claims and the application of pricing variables for use by a pricer. Pricers for APCs are a custom product that needs to be tailored to the payer. These outcomes range from a fee payment, to a zero-pay or package designation. Not all services provided in an outpatient hospital visit are paid via APCs. When the system was implemented by CMS, any service that was already assigned to a fee schedule (e.g. laboratory, physical/occupational/speech therapies) was not enveloped into the APC method. The existing fee schedule services remained on the fee schedule. Only the previous cost-

based reimbursed services were assigned to the APC side of the payment system. Almost all APCs are assigned a relative weight. A relative weight in terms of outpatient is interpreted the same way as a relative weight for inpatient. It is a relative measure of the service intensity, or cost, in relation to all the other services within the mix. More than one APC will be assigned to a claim. Not all APC services are assigned to a weight but instead have an APC payment rate assigned. The use of the CMS APC system for MN-DLI purposes would require a full assessment and modeling as there may be service differentials that Medicare pays for and MN-DLI does not and vice versa. A data modeling assessment will highlight these differences and a payment determination would need to be made. Depending on the vendor chosen to support the APC system, the customization offered by the vendor needs to be evaluated. Additionally, just as inpatient DRG weights often are customized, APC weights for a given payer are often customized as well. While the adoption by commercial payers has been on the slower side, many have chosen this method over any other simply because it's easier for the provider to code and understand the payment system and particular fee schedule items are easier to use. In terms of the system ability to predict or influence healthcare expenditures, again, the amount of customization, and other surrounding benefit limits together will dictate success. Because the APC system is essentially a large fee schedule, over-utilization can persist but because fees are set, expense inflation is better controlled over a charge or cost-based system.

EAPGs by 3M, represents a more clinically oriented system and is intended to reflect the resource utilization by the entire patient encounter. Although not as popular as CMS APCs in the marketplace, EAPGs are worth the review. Like APCs, the system is dependent on the coding of CPT/HCPCS codes used during the encounter and all necessary coding is contained within the UB04 and its electronic equivalent. EAPGs are much more consolidated than APCs meaning, there's a greater collapsing of services that are intended to be more meaningful clinically. More than one EAPG may be payable on a claim and each EAPG does have a weight although some payers choose to not pay certain EAPGs within the weighting system and will carve them out to be paid under a different methodology such as a fee schedule (e.g. expensive drugs). Most payers will customize the EAPG weights to suit their utilization and provider mix. The system is also customizable with regard to the packaging of services. An important note about the EAPG system is that, unlike APCs, the system is meant for use across all populations and not just Medicare.

The chart below presents a side-by-side comparison of the outpatient hospital payment methods for the states in this study:

Comparison of Outpatient Hospital Payment Methods: WC to Medicaid			
State	Worker's Compensation	Medicaid	Additional Information

Minnesota	% Charge	APC	
California	APC	Fee Schedule/Per Visit	
Florida	% Charge/Max Fee	Cost	
Illinois	Fee Schedule/% Charge	Fee Schedule	
Iowa	Charges	APC	
Louisiana	% Charge	Mixed Fee Schedule/Cost	
Maryland	EAPG	EAPG	
Massachusetts	Fee Schedule/% Charge	EAPG	
Michigan	Cost	APC	
Nebraska	% Charge	Cost	
North Carolina	% Charge	Cost	
North Dakota	APC	Mixed Fee Schedule/Cost	
Tennessee	APC	Managed Care	Although TN Medicaid is 100% managed care, the primary payers all use some sort of fee schedule in their commercial business.
Washington	APC	APC	
Wisconsin	Managed Care	EAPG	
Wyoming	Fee Schedule	APC	

The comparison above shows us that:

- 27% (4/15) WC and 27% Medicaid agencies use APCs
- 27% (4/15) WC and 0% Medicaid agencies use a percentage of charges
- 20% (3/15) WC and 27% (4/15) Medicaid agencies use a fee schedule
- 47% (7/15) Medicaid agencies use either APCs or EAPGs
- Washington State is the only non-regulated state where the payment methodologies for WC and Medicaid are purposefully aligned.
- Maryland is a regulated state whereby the same method is used.

Recommendation: MN-DLI should perform an assessment for utilization under the APC and EAPG system provided HCPCS codes are present in claims data. At a minimum, the move towards a fee schedule or episode based system is warranted due to the ability to control prices paid. A fee schedule is but one part of a payment system for hospital outpatient services. Managing utilization also needs to coexist in order for a more optimally balanced system of cost containment to be achieved. Minnesota already has in place treatment guidelines and utilization review and provided these are followed by the responsible parties, an expanded fee schedule would only enhance the ability to manage healthcare costs. The decision to follow either the current Medicare payment for outpatient hospital services or use the 3M EAPG system is challenging but attainable. Either method will facilitate reimbursement of hospital services and influence the growth of expenditures over time.

The following table identifies the key decision points that need to be considered when considering the Medicare APC system or the 3M EAPG system:

Decision Point	Medicare APC	3M EAPG
Population Covered	Uses only Medicare data for system design	Intended for coverage of the entire population
Bundled Service Payment	Limited	Extensive
Emergency Room Payment	By procedure code	By diagnosis code
Clinic Visit Payment	By procedure code	By diagnosis code
Surgical Visit Payment	By procedure code	By procedure code
Clinical Meaningfulness	Limited	Extensive
Relative Weights	Medicare or custom	Custom
Claim Editing for Correct Coding	Extensive	Extensive
Ease of System Understanding	Straightforward	Complex
Maintenance	Annual primary system changes and quarterly for interim code updates	Annual and quarterly coding updates
System Transparency	Complete transparency if published in that manner	Complete transparency if published in that manner
Prevalence in the market	Used by both State Medicaid agencies and commercial payers	Increasingly chosen by State Medicaid agencies and limited commercial payer use

Either payment system will influence prices paid for outpatient hospital services. MN-DLI must make a decision on how tightly prices paid should be, and the level of ease of understanding of the payment system which will affect cases brought forth in litigation. Since both systems have merit, we will discuss the implementation decisions below.

IMPLEMENTING MEDICARE APCS FOR OUTPATIENT HOSPITAL SERVICES

Medicare payment for outpatient hospital services encompasses all services hospitals provide in an outpatient setting. These services range from simple lab tests, xrays, surgery, physical rehabilitation, to emergency services. The payment is for hospital services only and any physician involvement is billed and paid for separately under a different system. Basing a payment system on Medicare implies that the user understands and accepts Medicare payment policy and if differences are needed, additional expenses will be incurred to maintain the system. The primary advantage of using the Medicare APC system is the familiarity in the provider community and the primary disadvantage when compared to EAPGs is that financial incentives to provide more services is more prevalent in the APC system than in the EAPG system.

The following items would need to be addressed when implementing an outpatient hospital payment system based on Medicare APCs:

- Establish an analytical claims database. Two years of historical paid claims data are typically used in analyzing the impact of using Medicare APCs although one year of data would suffice. The needed data elements are those that are

submitted on the UB from the hospital along with any payer payments so that the impact by provider may be assessed. Key data elements from the UB data are: line level service date, HCPCS code, revenue code, units of service, line service charge, hospital ID, patient gender, primary diagnosis code, patient age. Some assumptions may be made with regard to patient gender and age but not having the line service date, HCPCS code, units of service, and line service charge would not permit analysis to be conducted.

- Evaluate the edits in the Integrated Outpatient Code Editor (IOCE). The IOCE acts as the claim editor for items such correct billing of modifiers for bilateral procedures, correct patient gender and procedure matching, validation of current HCPCS codes. It contains approximately 83 different edits. The IOCE additionally assigns the flags to each service line and claim that directs the claim pricer to appropriately recognize each service for payment. Each edit contains a code list by which the claim data are evaluated. Decisions must be made whether to recognize the edit in its entirety or a select subset of the codes. This step is custom to any user of the Medicare IOCE system and is conducted as part of the implementation analysis and design. Differences in the services that are considered as covered services will be identified in this step. Once the coverage differences have been identified, then alternate payment methods need to be defined at a HCPCS level. Typically, the alternate payment method is a fee schedule.
- Identify providers not covered by the Medicare APC system. The Medicare APC system includes payment to short term acute care hospitals including rural referral and Medicare dependent hospitals, critical access hospitals, children's hospitals. Critical access hospitals and children's hospitals are considered exempt from Medicare APCs as they are held harmless but they are paid on an interim basis on the Medicare APC system. This would enable MN-DLI to include these in the rule making without having to create a separate payment system. MN-DLI would not need to recognize the hold harmless provision. For any other hospitals falling out of the outpatient provider file, the file that contains the eligible providers for payment under Medicare APCs, it is possible to include those facilities as well by creating a provider record with the key variables for payment. These variables are the Core Based Statistical Area (CBSA) designation, and the cost-to-charge ratio that is used in calculating an outlier payment.
- Identify the payment level and policies. Payments are driven by the weight assigned to the service line. In its most simplistic view, the weight is multiplied by a conversion factor (dollar per unit), claim line units, and a discount formula factor. Options for calculating the payment would be to recognize 100% of Medicare, some factor above Medicare at a stated percentage, or the complete customization of conversion factor or factors in the case of peer group rates. The Medicare APC system provides for payments of outliers for individually qualifying service lines. The cutoff point or minimum threshold for determining an outlier may be customized. The further away from base Medicare, the higher the cost to maintain the system due to the custom data analysis.

- Annual system maintenance. The Medicare APC system updates annually on a calendar year basis. Notice of changes are published in early November permitting approximately two months for analysis before new changes take effect. MN-DLI's annual decision making would be to identify any changes in providers to be included or excluded, individual HCPCS codes that would be affected by benefit coverage differences where those that are not covered by Medicare would need to have a fee established, a review of code changes to the IOCE, and a conversion factor review. It is possible to delay the update of the payment system by maintaining a diagnosis and HCPCS mapping table whereby new codes are backward mapped to the old codes so that timely claim processing is maintained. This would permit additional time for data analysis and changes in the system.
- Payer impact. Several options exist for assisting payers in claims processing. A central claims clearinghouse for which the MN-DLI outpatient hospital program policies are maintained would create consistency in the application of the program rules. Each payer would then process their claims through the central clearinghouse and consistency of payment rules would occur. Another option would be to have each payer separately contract for the claims processing by any vendor of choice. This method would create excess system costs across the payers and may introduce variance in understanding of the payment rules. Regardless of the claims processing method chosen, a clearly stated provider manual that details the program rules and payments at a HCPCS level is recommended.

IMPLEMENTING 3M EAPGS FOR OUTPATIENT HOSPITAL SERVICES

The 3M EAPG system will facilitate payment for outpatient hospital services and encompasses all services hospitals provide in an outpatient setting. These services range from simple lab tests, xrays, surgery, physical rehabilitation, to emergency services. The EAPG payment is for hospital services only and any physician involvement should be billed and paid for separately under a different system. The advantages of using the 3M EAPG system are that financial incentives are built into the system due to the extensive bundling of services and payments for evaluation and management services is reliant on diagnosis coding making the visit less open for judgment as to whether the HCPCS code was correctly identified. Additionally, all hospitals can be included in the system. The disadvantages of the 3M EAPG system is that it is a proprietary system, it can be expensive to license, and familiarity of the system is light in the industry although that trend is changing particularly in the Medicaid arena.

The following items would need to be addressed when implementing an outpatient hospital payment system based on 3M EAPGs:

- Establish an analytical claims database. Two years of historical paid claims data are typically used for data analysis. The needed data elements are those that are submitted on the UB from the hospital along with any payer payments so that the impact by provider may be assessed. Key data elements from the UB data are: line level service date, HCPCS code, revenue code, units of service, line service

charge, hospital ID, patient gender, primary diagnosis code, patient age. Some assumptions may be made with regard to patient gender and age but not having the line service date, HCPCS code, units of service, and line service charge would not permit analysis to be conducted.

- Grouper Review. While most outpatient hospital services are included in the system for payment, a review of the services that are not considered part of the outpatient system would need to be reviewed for policy making. For example, certain procedures are considered to be inpatient only procedures. A decision would need to be made whether to accept the list as is or modify the procedures that exist on the list. If exceptions were to be initiated, a payment mechanism such as a fee schedule would need to be created.
- Identify claim processing edits. Similar to the Medicare IOCE, the 3M EAPG system does contain extensive coding edits within the system. These edits must be reviewed for consistency with MN-DLI policy.
- Create the EAPG weights. As a national EAPG weight set is not published, a custom EAPG weight table would need to be created.
- Identify the payment level and policies. The EAPG system has enough flexibility to accommodate one or more conversion factors for determining payments. The conversion factors may be set by provider, peer group, statewide or some blend as desired. All providers can be included as needed. Additionally, payment policies such as outliers may be established, and a policy that caps claims at charges may also be considered. Further, options exist in pricing in setting up discounting structures for repeat procedures, and multiple surgical procedures. In contrast with Medicare APCs, there is not one way to price EAPG claims but rather flexibility exists. CGI recommends that conversion factors and policies be kept as simple as possible given the complex nature of the EAPG grouper.
- Annual system maintenance. The EAPG grouper is updated annually and tweaked quarterly as HCPCS codes are issued and modified. Policies should be reviewed annually for appropriateness.
- Payer impact. Several options exist for assisting payers in claims processing. A central claims clearinghouse for which the MN-DLI outpatient hospital program policies are maintained would create consistency in the application of the program rules. Each payer would then process their claims through the central clearinghouse and consistency of payment rules would occur. Another option would be to have each payer separately contract for the claims processing by any vendor of choice. This method would create excess system costs across the payers and may introduce variance in understanding of the payment rules.

SMALL HOSPITALS – LESS THAN 100 BEDS – COMPARATIVE ANALYSIS OF REIMBURSEMENT METHODS

The following chart summarizes the findings of this study with regard to the treatment of small hospitals and the associated reimbursement:

Comparison of Small Hospital Payment Methods: WC to Medicaid			
State	Worker's Compensation	Medicaid	Additional Information
Minnesota	100% Charge	DRG + 15%/20%	
California	Follows Medicare	Separate Schedule	
Florida	No Separate Distinction	No Separate Distinction	
Illinois	No Separate Distinction	No Separate Distinction	MCD: Peer group rates for IP
Iowa	Charges	Cost	
Louisiana	Location – not size	IP: Per Diem OP: 110% Cost	
Maryland	No Separate Distinction	Revenue Regulated	
Massachusetts	No Separate Distinction	Cost w/incentives	
Michigan	No Separate Distinction	No Separate Distinction	
Nebraska	Bed size & location	IP: Cost OP: 97.5% Charge	
North Carolina	Cost	Cost	
North Dakota	No Separate Distinction	No Separate Distinction	
Tennessee	No Separate Distinction	Managed Care	TN Medicaid is fully managed care to 3 primary payers whose information is largely private.
Washington	CAH – OP=POC	CAH – Cost No other distinction	
Wisconsin	No Separate Distinction	Cost	
Wyoming	No Separate Distinction	Increase in Standard Rate	

The chart above reveals:

- 67% (10/15) WC and 27% (4/15) Medicaid agencies make no separate distinction with regard to pricing for small hospitals
- Inpatient Medicaid reimbursement, if any modification is made for small hospitals, it is typically handled through a provider base rate but they do not have a separate reimbursement mechanism from the primary system.
- Washington recognizes only CAHs for special consideration

Evaluating small hospital reimbursement differentials and making inferences is somewhat difficult. Each state differs geographically in terms of population density in any particular area and some states are more concentrated than others to just a few major metropolitan areas. In terms of reimbursement methods, creating provider based rates rather than state wide rates potentially eliminates any need for special recognition of small hospitals. Of course, when converting from a cost or charge based method to

one of a fee schedule or grouper, the initial starting base of revenue to the provider is key as it will set the stage for future reimbursements.

Recommendation: Small hospitals should not be excluded from other hospitals with regard to incentivizing efficient delivery of services. They may be recognized for additional reimbursement to support the special circumstances for which they operate, such as, labor market forces and any other particular circumstances that may exist within the State of Minnesota. The treatment of small hospitals should coincide with any changes to reimbursement for regular acute care hospitals as stated above in the inpatient and outpatient hospital sections above.

AMBULATORY SURGICAL CENTERS (ASC) – COMPARATIVE ANALYSIS OF REIMBURSEMENT METHODS

The chart below summarizes the methods of reimbursement used by the study states:

Comparison of ASC Hospital Payment Methods: WC to Medicaid			
State	Worker's Compensation	Medicaid	Additional Information
Minnesota	% Charge	Medicare ASC	
California	Medicare ASC	Fee Schedule	
Florida	Fee Schedule & % Charge	9 ASC Groups	
Illinois	Fee Schedule	5 ASC Groups	
Iowa	Charges	9 ASC Groups	
Louisiana	90% Charge	Fee Schedule	
Maryland	125% Medicare	Medicare ASC	
Massachusetts	Fee Schedule	Fee Schedule	
Michigan	130% Medicare	% of Medicare	WC Implants: invoice + %
Nebraska	% Charge by Tiers based on size	9 ASC Groups	
North Carolina	79% Charge	Fee Schedule	
North Dakota	124% Medicare	9 ASC Groups	
Tennessee	Medicare ASC	Managed Care	
Washington	Medicare ASC	Charges or Max Fee	
Wisconsin	Managed Care	9 ASC Groups	
Wyoming	Fee Schedule	9 ASC Groups	

Overall:

- 40% (6/15) WC and 20% (3/15) Medicaid agencies reimburse a percent of Medicare APC for ASC.
- 27% (4/15) WC and 7% (1/15) Medicaid agencies reimburse at either charges or a percent-of-charge
- 20% (3/15) WC and Medicaid agencies reimburse based on a fee schedule
- 47% (7/15) Medicaid agencies reimburse based on the former Medicare ASC payment system that uses 9 ASC groups (Illinois uses only 5 groups)

Reimbursement for ASCs does not need to differentiate from the reimbursement systems in place for outpatient hospitals. ASCs typically have a less expensive cost structure in that they are not in the business of a 24-hour operation with a full service emergency department that a hospital needs to support. ASC procedures are typically of a short duration that are not expected to involve an overnight stay, and involve patient risk that is appropriate for the level of service the ASC setting can provide. As a result, the primary remaining consideration is the level of payment appropriate for reimbursement to ASCs. It is difficult to measure the costs of services at an ASC as

neither Medicare nor Medicaid requires ASCs to file cost reports. While that concept is currently being assessed by CMS, cost information is not available today.

This study reveals that for the states reviewed, 40% of WC and 67% of Medicaid agencies use some form of Medicare based reimbursement for ASCs. The two Medicare reimbursement methods used are the old set of nine (9) ASC groups and the current version, in use since 2008, Medicare APC/ASC.

Prior to 2008, Medicare reimbursement for ASCs was based on nine groups and each had an associated payment rate. The number of CPTs that were eligible to be performed in an ASC setting is very restrictive as compared to the services permitted today. Medicare was required to update the ASC payment system and the Medicare APCs for ASCs is the result.

The current Medicare reimbursement for ASCs aligns itself with the Medicare APCs with some notable exceptions:

- ASCs are still limited in the procedures that may be performed in that setting but the number has increased greatly over the old system.
- ASC coding and billing requirements are the same as APCs.
- ASC weights are recalculated based on the services able to be performed in an ASC but use the APC weights as the base.
- The ASC conversion factor (payment rate) is approximately 40% less than the conversion factor for APCs.
- ASCs do not receive outlier payments as no cost report information is available to set cost-to-charge ratios.

Recommendation: ASC reimbursement is still evolving to an extent. The vulnerabilities that were discussed earlier in this report regarding reimbursement systems based on charges apply to ASCs as well. In terms of ease of use, following Medicare APCs for ASCs makes sense as long as the underlying use for Medicare fits the worker's compensation market. The system is straightforward to implement. As with outpatient hospital APCs, benefit variances (i.e. HCPCS code level of coverage) would need to be reviewed but would not be as extensive as APCs. In contrast, maintenance of a straight fee schedule tailored to meet worker's compensation needs would involve significant time by either in-house staff or a consulting arrangement. Therefore, Medicare APCs for ASCs is the recommended course for payment due to the ease of understanding by the provider community and the cost to implement. The payment to the ASC facility is for the facility portion of the service only and the physician activity is billed and paid separately under the physician fee schedule.

The following items would need to be addressed when implementing an ASC payment system based on the Medicare ASC methodology:

- Establish an analytical claims database. Two years of historical paid claims data are typically used in analyzing the impact of using Medicare ASCs although one year of data would suffice. The needed data elements are those that are submitted on the claim form (either the UB or the HCFA 1500) from the ASC along with any payer payments so that the impact by provider may be assessed. Key data elements from the claim data are: line level service date, HCPCS code, revenue code, units of service, line service charge, ASC ID, patient gender, primary diagnosis code, patient age. Some assumptions may be made with regard to patient gender and age but not having the line service date, HCPCS code, units of service, and line service charge would not permit analysis to be conducted.
- Evaluate the services covered in an ASC setting. The Medicare ASC methodology is a subset of services within the Medicare APC methodology. MN-DLI would need to review the list of covered ASC services and identify if any differences exist with current coverage policy. Once the coverage differences have been identified, then alternate payment methods need to be defined at a HCPCS level. Typically, the alternate payment method is a fee schedule.
- Identify providers not covered by the Medicare ASC system. The Medicare ASC payment system is intended for facility ASC billing only. Physician services are billed and paid separately in addition to the ASC facility claim. CGI suggests that MN-DLI follow the Medicare ASC certification identification of ASCs to be included in this method as that will align payment with the providers intended by the Medicare ASC method.
- Identify the payment level and policies. Payments are driven by the weight assigned to the service line. In its most simplistic view, the weight is multiplied by a conversion factor (dollar per unit), claim line units, and a discount formula factor. Options for calculating the payment would be to recognize 100% of Medicare, some factor above Medicare at a stated percentage, or the complete customization of conversion factor or factors in the case of peer group rates (e.g. urban v rural). The Medicare ASC system does not provide payments for outliers. The further away from base Medicare, the higher the cost to maintain the system due to the custom data analysis.
- Annual system maintenance. The Medicare ASC system updates annually on a calendar year basis. Notice of changes are published in early November permitting approximately two months for analysis before new changes take effect. MN-DLI's annual decision making would be to identify any changes in providers to be included or excluded, individual HCPCS codes that would be affected by benefit coverage differences where those that are not covered by Medicare would need to have a fee established, a review of code changes to the covered services, and a conversion factor review. It is possible to delay the update of the payment system by maintaining a diagnosis and HCPCS mapping table whereby new codes are backward mapped to the old codes so that timely

claim processing is maintained. This would permit additional time for data analysis and changes in the system.

- Payer impact. Several options exist for assisting payers in claims processing. A central claims clearinghouse for which the MN-DLI ASC program policies are maintained would create consistency in the application of the program rules. Each payer would then process their claims through the central clearinghouse and consistency of payment rules would occur. Another option would be to have each payer separately contract for the claims processing by any vendor of choice. This method would create excess system costs across the payers and may introduce variance in understanding of the payment rules. Regardless of the claims processing method chosen, a clearly stated provider manual that details the program rules and payments at a HCPCS level is recommended.

ANESTHESIA – COMPARATIVE ANALYSIS OF REIMBURSEMENT METHODS

The following chart reveals the reimbursement methods for the study states:

Comparison of Anesthesia Payment Methods: WC to Medicaid			
** RVU implies the use of base units, time units, conversion factor but not all base units will be equal **			
State	Worker's Compensation	Medicaid	Additional Information
Minnesota	% Charge	RVU	
California	RVU	RVU	
Florida	RVU	RVU	
Illinois	RVU	Fee Schedule	
Iowa	Charges	Fee Schedule	
Louisiana	RVU	RVU	
Maryland	RVU	RVU	
Massachusetts	RVU	RVU	
Michigan	RVU	RVU	
Nebraska	RVU	RVU	
North Carolina	4 Specific Codes	RVU	
North Dakota	RVU	Undetermined	CGI contacted ND Medicaid for clarification but the response did not yield a definitive method.
Tennessee	RVU	RVU	
Washington	RVU	RVU	
Wisconsin	Managed Care	RVU	
Wyoming	RVU	RVU	

A relative value method (RVU) is used by both worker's compensation and Medicaid for 87% (13/15) for reimbursement to anesthesiologists. In all instances, reimbursement provisions exist for both anesthesiologists (M.D.) and certified registered nurse anesthetists (CRNA). Both providers are reimbursed from the same schedule and the CRNA may be paid a lesser amount if supervised by the M.D. Additionally, most RVU methods follow the Medicare base units schedule.

Two components of the RVU system that varied across the agencies:

- The conversion factor (used to convert the anesthesia units to a payment)
- The use of a patient risk factor – this was not used by all agencies.

The RVU method is a function of:

- Base units assigned by CPT code
- Time factor (may be expressed in terms of minutes or 15 minute increments)
- Patient risk factor (not employed across all study agencies)
- Conversion factor (the factor expressed in terms of dollars to arrive at payment)
- CPT modifiers (used to identify CRNA or possibly reduced services for which a payment reduction would occur)

The formula that results is:

$$\text{Payment} = (\text{Base units} + \text{Time units} + \text{Risk factor}) \times \text{Conversion Factor} \times \text{Modifier factor}$$

CGI notes that anesthesia services were almost completely billed separately from the facility provider. When anesthesia professional services were to be billed on the hospital or surgery center claim, the anesthesia codes and time units along with anesthesia revenue codes were required and the anesthesia service lines were still reimbursed at the anesthesiology RVU method. Additionally, with regard to pain management reimbursement, these services were directed to the regular fee schedule and not the anesthesiology RVU method. Pain management was often restricted with case management involvement.

Recommendation: The prevalence in use of the Medicare RVU scale for anesthesia and the billing policies that are associated with the system would be easily recognized by anesthesia providers. The primary consideration then would be the level at which to set the conversion factor. An assessment or modeling of anesthesia claims should be undertaken provided the required data elements are available. A Medicare benchmark could be made at that point and be compared to what was actually paid and an acceptable worker's compensation conversion factor could be developed.

The following items would need to be addressed when implementing an anesthesia payment system based on the Medicare reimbursement for Anesthesia providers:

- **Establish an analytical claims database.** Two years of historical paid claims data are typically used for analysis but one year would suffice. The needed data elements are those that are submitted on the HCFA1500 claim form along with any payer payments so that the impact by provider may be assessed if desired. Key data elements from the claim data are: line level service date, HCPCS code, service units, HCPCS code modifier, line service charge, and provider ID. Some assumptions may be made with regard to patient gender and age but not having the line service date, HCPCS code, units of service, and line service charge would not permit analysis to be conducted.
- **Identify the payment level and policies.** Options for calculating the payment would be to recognize 100% of Medicare, some factor above Medicare at a stated percentage, or the complete customization of the conversion factor.
- **Annual system maintenance.** The Medicare RVU system updates annually on a calendar year basis. Notice of changes are published in early November permitting approximately two months for analysis before new changes take effect. MN-DLI's annual decision making would be to identify any changes to the conversion factor are necessary. It is possible to delay the update of the payment system by maintaining a diagnosis and HCPCS mapping table whereby new codes are backward mapped to the old codes so that timely claim processing is maintained. This would permit additional time for data analysis and changes in the system.

- Payer impact. Several options exist for assisting payers in claims processing. A central claims clearinghouse for which the MN-DLI program policies are maintained would create consistency in the application of the program rules. Each payer would then process their claims through the central clearinghouse and consistency of payment rules would occur. Another option would be to have each payer separately contract for the claims processing by any vendor of choice. This method would create excess system costs across the payers and may introduce variance in understanding of the payment rules. Regardless of the claims processing method chosen, a clearly stated provider manual that details the program rules and payments at a HCPCS level is recommended.

SURGICAL IMPLANTS – COMPARATIVE ANALYSIS OF REIMBURSEMENT METHODS

The following chart summarizes the reimbursement methods encountered:

Comparison of Surgical Implant Payment Methods: WC to Medicaid			
State	Worker's Compensation	Medicaid	Additional Information
Minnesota	% Charge	No Separate Payment	
California	No Separate Payment	Invoice	
Florida	Hosp: Invoice + 60% ASC: Invoice + 50%	Cochlear Implants – Invoice	
Illinois	Invoice + 25%	Via outlier calculation	
Iowa	Charge	Fee Schedule	
Louisiana	Physician: Invoice + 20%	Fee Schedule	
Maryland	No Separate Payment	No Separate Payment	
Massachusetts	No Separate Payment	IP: Cost OP: No separate payment	
Michigan	Invoice + % (varies)	No Separate Payment	
Nebraska	Invoice + 25% if > \$10k	IP – No separate payment OP – Cost	
North Carolina	No Separate Payment	Fee Schedule	
North Dakota	No Separate Payment	Fee Schedule	
Tennessee	> \$100 = Invoice + 15% up to \$1,000	Managed Care	BlueCare: included in case rates unless contracted otherwise
Washington	IP/OP: No Separate Payment ASC – Invoice	No Separate Payment	
Wisconsin	Managed Care	Prior Auth	
Wyoming	> \$1,000 – Invoice + 30%	No Separate Payment	

The payment for surgical implants on the worker's compensation side cluster into either included within the primary payment system or reimbursed at invoice cost plus some factor. Similarly, for Medicaid, reimbursement is primarily included within the primary payment system or paid via a fee schedule. That is to say, the implant reimbursement is included within the primary system which is a DRG based system for inpatient and the Medicare APC for outpatient. In terms of reimbursement philosophy, reimbursing implants at invoice cost or cost plus seems reasonable but perhaps administratively complex to an extent. Even when an invoice is required to be produced upon audit, it is unclear if the invoice is the true cost to the provider as other arrangements may exist between the provider and the manufacturer that are not able to be confirmed without undue effort. South Carolina's worker's compensation commission created an initiative in 2011 to develop the maximum allowable for each surgical implant.

Recommendation: If the primary reimbursement system is based on a set of weights, whether it be a DRG, or APC/EAPG system, and if the cost of the implant is included in the weight calculation, separate reimbursement for implants should not be provided as the cost of the implant is included in the case weight. If the primary reimbursement system is percent-of-charge or cost-based, it is advantageous to carve out the surgical implants and reimburse at invoice or invoice plus a percentage. Specific billing instructions may be instituted such that the invoice cost associated to the device would appear on the claim form. The regulations should include a provision that the payer would be able to request the actual manufacturers invoice for audit and if an invoice was not produced, the implant payment would be recovered.

PAYMENT METHOD ASSOCIATED COSTS & CONSIDERATIONS

CGI has evaluated the significant vendors in the current marketplace. The following choices represent what we believe to be the “best of breed”. Costs vary significantly, depending on claim volume processed, and reimbursement methodologies employed. Note that the various vendors are not listed in any particular order.

Most vendors offer a desktop based solution, which is typically licensed on a per user basis, with escalators for increasing claim volumes being processed. The biggest benefit to a desktop based solution is data security. A desktop based solution is typically installed behind multiple layers of firewall, and normally does not risk exposing patient health information (PHI) to potentially unauthorized parties. Maintenance costs are higher with a desktop solution, because updating pricing and rate tables must be done by the user.

Some vendors have recently begun to introduce “cloud based” pricing available as a service. There are operating conveniences associated with cloud based services. The primary benefit is the lack of maintenance that needs to be performed by the user. With a cloud based service, there is no need to worry about having to update the tables used to drive pricing algorithms. The service vendor updates the tables on their server, with no action required on the part of the user. Some operating cost reduction is also realized from removing the need for a support person to perform the table updates. However, data security could be an issue with cloud based services. Some insurers prohibit exposing claims data to the cloud as a safeguard against exposing patient health information (PHI) to potentially unauthorized parties. CGI recommends extreme caution and vigilance when there is a risk of possible PHI exposure. More detailed information can be found in Appendix A.

Inpatient Hospital

CGI contacted 3M, OptumInsight, Microdyn, and Medassets. These vendors represent some of the more popularly selected systems with 3M and OptumInsight being the most mentioned. All vendors can supply a MS-DRG grouper/pricer but some are more flexible than others in terms of pricing capabilities. 3M, Microdyn, and OptumInsight are the three vendors with the most customizable payment parameters. Following is the pricing for each:

- 3M Core Grouping System: based on claim volume, ranges from \$1,219 to \$9,093 per quarter for MS-DRGs and \$4,634 to \$816,808 for APR-DRGs
- OptumInsight: Licensing costs vary.
- Microdyn: \$22,970 per year, per desktop

- Medassets: Licensing costs vary.

3M, OptumInsight, and Medassets all feature callable grouping and pricing system in that they can be seamlessly integrated into a claims processing system or they can function as standalone batch pricers. Microdyn is simply a standalone system. In terms of annual maintenance of the system, from a software standpoint, all vendors comply with CMS rules and regulations in a timely fashion based on when the Final Rule is published. Each vendor has their own “push” technology to distribute the software updates to an appointed contact person. Both the 3M and OptumInsight systems offer an array of easily managed pricer options such that additional customized programming is minimized.

In terms of staffing, the annual estimate from a software standpoint is less than one full time employee (FTE) when the base system is used. Where staffing becomes difficult to estimate depends on the degree of customization of a DRG payment system or even a per diem system is designed with regard to exceptions to common rules such as custom DRG weights or mapping of diagnosis and procedure codes to identify and support a per diem system. Many of the functions can be performed by an experienced FTE or consultants may be hired to perform the annual or biannual system recalibration of the payment parameters (weights, reimbursement rates, policy analysis). This is true for any prospective payment system.

Outpatient Hospital

CGI contacted 3M, OptumInsight, Microdyn, and MedAssets. These vendors represent some of the more popularly selected systems with 3M and OptumInsight being the most mentioned. MedAssets is able to license the APC product but is unable to separately license the 3M product for EAPGs. All vendors can supply an APC based grouper/pricer but some are more flexible than others in terms of pricing capabilities. Only 3M offers the EAPG system. 3M, Microdyn, and OptumInsight are the three vendors with the most customizable payment parameters. Following is the pricing for each:

- 3M Core Grouping System: based on claim volume, ranges from \$3,863 to \$108,489 per year for either the EAPG or APC system
- OptumInsight: Licensing costs vary.
- Microdyn: \$22,970 per year, per desktop
- Medassets: Licensing vary.

3M and OptumInsight all feature callable grouping and pricing system in that they can seamlessly be integrated into a claims processing system or they can function as standalone batch pricers. Microdyn is simply a standalone system.

With regard to the APC system and annual maintenance of the system, from a software standpoint, all vendors comply with CMS rules and regulations in a timely fashion based on when the Final Rule is published. Each vendor has their own “push” technology to distribute the software updates to an appointed contact person. 3M, as the proprietary owner of EAPGs, annually maintains the system and since 3M is a primary contractor to CMS for APCs, similarities may exist between the two systems.

Both the 3M and OptumInsight systems offer an array of easily managed pricer options such that additional customized programming is minimized. In terms of staffing, the annual estimate from a software standpoint is less than one full time employee (FTE) when the base system is used. Staffing to support the outpatient payment system beyond straight systems maintenance is difficult to estimate. This is due to the complexity that may be chosen by the payer. The more complex, the more likely a higher staffing levels of very experienced FTEs will be needed. Some payers choose to use consultants to maintain their systems partly due to impartiality that they can provide and the experience consultants will have of multiple installations of an outpatient payment system. Many of the functions can be performed by an experienced FTE or consultants may be hired to perform the annual or biannual system recalibration of the payment parameters (weights, reimbursement rates, policy analysis).

The key decisions for any outpatient hospital payment system include:

- Providers affected. All providers can be included in any payment system if sufficient system configuration is maintained. Difficulties may be encountered if the desire is to configure the payment as a percent of Medicare. With that comes all of the system design that is in place for Medicare and which providers are reimbursed under the particular method. A flexible and customizable provider table would be the key to including providers in an APC system that ordinarily would not be represented under Medicare.
- Benefit differences. If choosing a Medicare based system, an analysis should be conducted to identify coverage variances and to facilitate decision making on how to reimburse for these services.
- Policy. In any system, the designation of policy items (e.g. geographic variances, outliers, multiple procedure discounting) would need to be identified and evaluated. Clearly documenting and communicating policy to stakeholders is integral for a successful understanding of the payment system. Nothing should be “black box”.
- Payment. The conversion factor or factors would need to be modeled to assess the functioning of all the system design choices and provide for feedback as to provider impact. Benchmarking against Medicare is a common task that is conducted in order to determine adequacy of provider reimbursement. This can

be performed regardless of the system (e.g. APC, EAPG, fee schedule) so long as the key analysis variables are captured and reliable.

Ambulatory Surgery Center (ASC)

Reimbursement for ASCs can take many forms. A review of the methods used by the various payers range from percent-of-charge, preset fee for services rendered (fee schedule), and Medicare APCs for ASCs. Only the current Medicare system would require a vendor supplied system. Percent-of-charge would not require a standardized system nor would a fee schedule based system. These two systems would require substantial personnel to analyze data and determine the proper fee or percent to be used.

With regard to a Medicare based ASC payment system, any of the vendors that supply the primary Medicare APC system are also able to the Medicare ASC system. The functionality that is used for handling the APC billing and payment would also exist for handling ASC claims. The same decisions that were needed to support outpatient hospital reimbursement would be needed for ASCs as well.

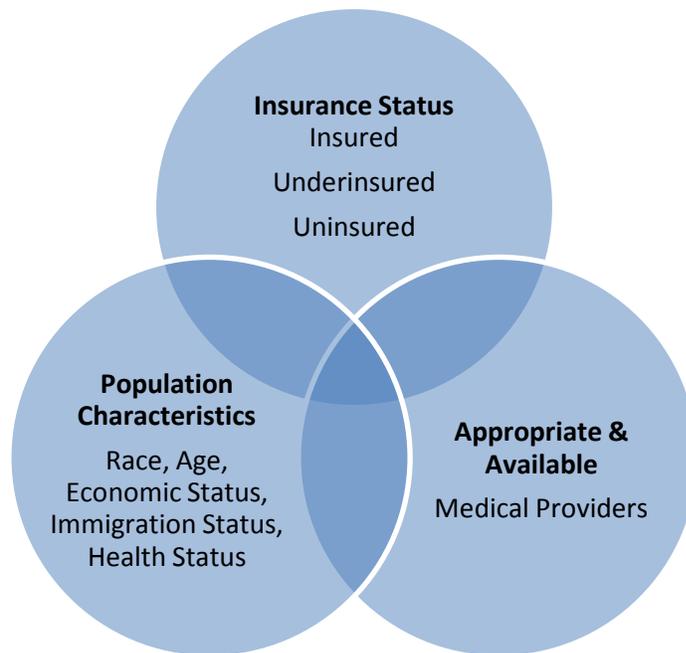
Small Hospital, Surgical Implants, and Anesthesia

Vendor assessments for small hospitals, surgical implants, and anesthesia are not presented as reimbursement for these types of providers or services is typically handled within the primary payment system methodology. That is to say, entire payment methodologies are not represented by these categories.

ACCESS TO CARE, QUALITY OF CARE, SYSTEM VULNERABILITIES

Access to Care

Access-to-care issues are not just found within the worker’s compensation system. The healthcare delivery system is complex, multidimensional and contains many inter-relationships:



Although worker’s compensation insurance is paid for by the employer with no cost-sharing expenses passed on to the employee, many additional access issues may still occur. According to the study “Access to Medical Care for Work-Related Injuries and Illnesses: Why Comprehensive Insurance Coverage is Not Enough to Assure Timely and Appropriate Care” by Allard Dembe, et al, the following table highlights potential barriers to accessing medical care in the worker’s compensation system as compared to general medical care:

	General Medical Care	Workers' Compensation Medical Care
Primary Access (blocked entry to the system)	Lack of insurance, under-insurance* Coverage and eligibility restrictions Insufficient number, type of providers Inadequate location of providers	Employer doesn't carry WC insurance** Coverage and eligibility restrictions Insufficient number, type of providers Inadequate location of providers Need to prove occupational causation** Insurer denials & group health exclusions** Employer suppression of reporting** Inadequate knowledge about WC filing**

Secondary Access (structural barriers within the system)	Limitations on services covered* Excessive premiums, co-pays, cost-sharing* Limitations on choice of provider Aggressive utilization review Inability to see specialists Delays in getting appointments	Limitations on choice of provider Low WC fee schedules in some states** Aggressive utilization review Inability to see specialists Out-of-pocket expenses (prescription drugs) Delays in getting appointments Lack of rehabilitation and therapy services** Medical-legal exigencies (e.g., IMEs)**
Tertiary Access (failure to address patient needs)	Inadequate knowledge and skills Poor provider-patient communication Cultural/language barriers Poor care continuity	Inadequate knowledge of occupational care** Poor provider-patient communication Cultural/language barriers Lack of coordination with general health care** Inability to assess job demands/function** Pressure to return to work prematurely** Few preventive services** Mistrust in WC impairs doc-patient relationship
<p>*Problems particularly distinctive to general medical care</p> <p>** Problems particularly distinctive to workers' compensation medical care</p>		

Dembe classifies potential access to care barriers in three levels: Primary, Secondary, and Tertiary. The primary access level refers to claim initialization. Presuming an employer does comply with state regulations and retains WC insurance, the insurance plan setup may be overly complex or restrictive, workplace dynamics may influence the employee to not seek medical care for fear of being fired or other disincentives to issuing a WC claim, the employee may not know the WC system is available to them for work related injuries, and issues with the provider's available in the marketplace.

Secondary access refers to the next level of potential barriers after the claim has been submitted. These issues range from provider availability which can be a function of both reimbursement, and geographic distribution to the possible aggressiveness of the WC insurers in their prior authorization process.

The tertiary level presents yet another layer of potential problems in the system. Once care is approved for the injury, there may be inadequate provider knowledge in treating and supporting the expedient return-to-work goal. Provider issues are not the only potential problem with returning the employee to work; the employee themselves may attempt to manipulate the system.

The WC system also needs to address unique challenges and concerns of individuals in accessing care. All components of the WC system across the state must work together to create an environment that is not overly complex and ineffective in use. Involving all of the stakeholders in the WC system in the improvement and management of the

process are key to success as any level of mistrust by any party in the group will create a vulnerability in the system.

Quality of Care

Working in concert with access to care is the quality of care in the system. According to the Rand Corporation “Workers’ compensation policymakers, payors, and providers around the country appear to accept that quality care can produce value—yet few, if any, have implemented programs to monitor or improve quality. Deterrents include a lack of relevant quality measures, a misperception that limiting excessive use of medical care solves most quality problems, and a lack of early adopters from whom others can learn the “why” and “how” of quality improvement.” Quality of care is the current subject across the board in the U.S. There are many opinions as to what quality should be and just as many opinions on how it should be measured. No single consensus has been developed.

Measurement is necessary in order to assess quality with regard to the workers’ compensation medical care received. The MN-DLI should create a structure that establishes clear goals and expectations that are measurable so that corrective action plans can be created should a particular measure fall short of expectations. One such set of measures is discussed in the report by URAC, a leader in healthcare quality accreditation, called “Measuring Quality in Workers’ Compensation Managed Care Organizations: Technical Manual of Performance Measures”. URAC’s quality performance framework contains the following:

Category of Measure	Name of Measure	Data Source
Access	<ul style="list-style-type: none"> • Getting needed care • Wait for care 	Patient Survey
Coordination of care	<ul style="list-style-type: none"> • Volume of case managed claims • Timely referral to case management • Timely initial contact by case manager 	Administrative
Communication	<ul style="list-style-type: none"> • Provider communicates well with worker • Provider treats worker with respect 	Patient Survey
Work-related Outcomes	<ul style="list-style-type: none"> • Initial return to work • Premature return to work • Returned to work but had additional lost time • Work-related functioning post injury 	Patient Survey
	<ul style="list-style-type: none"> • Time to return to work • Lost time days • Total compensation days 	Administrative
Health Related Outcomes	<ul style="list-style-type: none"> • Physical functioning post injury (SF-12) 	
Patient Satisfaction	<ul style="list-style-type: none"> • With the number of doctors to choose from • With pain management 	Patient Survey

Category of Measure	Name of Measure	Data Source
	<ul style="list-style-type: none"> • With MCO doctor seen most often • Changing doctors because dissatisfied • With medical services overall 	
Prevention	<ul style="list-style-type: none"> • Injury prevention counseling 	Patient Survey
Appropriateness	For low back pain, shoulder complaint, knee complaint and forearm, wrist and hand complaint: <ul style="list-style-type: none"> • Adequate medical history • Occupational risk assessment • Appropriate focused physical exam • Appropriate work restrictions • Attempt to place on modified duty • Appropriate patient education • Re-assessment if injury unimproved 	Medical Record
	<ul style="list-style-type: none"> • Provider asks job requirements • Patient education about the injury given • Provider discusses return to work 	Patient Survey
Cost	Overall and for 4 injury groups: LBP, shoulder, knee and forearm/wrist/hand injury: <ul style="list-style-type: none"> • Medical costs • Temporary disability costs • Permanent disability costs • Other benefit costs • Medical service costs 	Administrative
Utilization	<ul style="list-style-type: none"> • Medical service utilization (overall and for 4 injury groups – LBP, shoulder, knee and forearm/wrist/hand injury) • Treatment patterns for workers with pain, sprain and strain of the shoulder • Treatment patterns for workers with low back pain, sprain and strain • Treatment patterns for workers with pain, sprain and strain of the knee • Treatment patterns for workers with pain, sprain and strain of the forearm, wrist, or hand • Physical medicine encounters • Radiology encounters 	Administrative

URAC states that the program has not been rigorously tested in the marketplace mostly due to MCOs not wanting to incur the costs and potential publicity associated with a possible less than desirable outcome. In the limited testing that did occur, MCO files did not contain the needed data elements for assessment and the difficulties encountered with any patient survey were present as well. URAC reports that all parties involved in the provision of workers' compensation agree that the measures have importance and that for widespread utilization it is likely that state regulators would need to take up the

initiative and require a measurement system to be implemented. While CGI conceptually agrees with the measurement categories, we are concerned about the number of measures that require patient survey feedback. CGI recommends that alternative sources of measurement be evaluated for categories involving patient feedback particularly those measures that involve something other than patient opinion. Even with appropriate measurement in place, accountability must be addressed as well.

The URAC group already has a presence within the Minnesota government system:

Minnesota (Health Plan/Medicaid & Commercial; Health Network/Medicaid & Commercial) Minnesota defines URAC as a “nationally recognized independent organization” through Minnesota Statutes Chapter 62Q.37 (H.F. 2277, 2004). For health plan companies subject to each commissioner’s jurisdiction, this law allows the Commissioners of Health, Commerce and Human Services to accept the results of independent audits as meeting or partially meeting state requirements. Chapter 62Q.37 applies to health maintenance organizations and “community integrated service networks” regulated by the Department of Health; “nonprofit health service plan corporations” (e.g. Blue Cross & Blue Shield of Minnesota) regulated by the Department of Commerce; and managed care organizations under contract with the Department of Human Services to serve enrollees in state health care programs (i.e., MinnesotaCare and General Assistance Medical Care).

System Vulnerabilities

Vulnerabilities in the WC system encompass many aspects:

- **Workplace:** The culture in the workplace environment that may inhibit the filing of WC claims. Vulnerabilities in the workplace will vary by industry and are particularly prevalent in industries that have a high utilization of immigrant workers. Insufficient ability to accommodate language barriers represents vulnerability.
- **Payers:** From the payer perspective, having to interpret and follow complex regulations and payment systems that do not protect from provider charge inflation present significant system vulnerability. In order to maintain a particular medical loss ratio, payers may follow an overly restrictive practice of treatment approval that might not need to occur if payment systems shared the risk across the system players.

This study’s focus is on the payment for health care services. We have discussed in other sections the vulnerability that is created when reimbursement is based on provider charge and is not managed via a fee schedule or case based payment. While a fee schedule is a step towards managing the expense vulnerability, a case based payment

system further extends the effort in closing that part of the system vulnerability. Even when fee schedule or case based systems are put into place, annual system maintenance and fee updates are necessary for the system to keep pace and maintain any system successes achieved.

BARRIERS TO CLEAN, TIMELY CLAIM PROCESSING

In this section we review the barriers to a clean, timely claim process. Our intent is not to assess the Minnesota system but rather provide information to spur conversation. To that end, the following are discussed:

- A delay occurs with claim submission, or
- A delay occurs due to system complexity, or
- A delay occurs due to payment rules that are vague and permit a broad interpretation of intent

Opportunities for a claim delay can occur anywhere in the system. Claims submission may be delayed due to inadequate communication protocols between the employer, insurer and providers of medical care. The employee's perceived culture surrounding the employer with regard to workers' compensation may cause a delay in even reporting the injury. Not all injuries are created equal. Clearly, those injuries that occur at work that result in emergency care are more easily assessed. The less emergent the injury, the more likely the need to investigate the claim first before processing it under the workers' compensation benefit. Each insurer should have clear claim evaluation protocols for intake of a new claim and clear guidelines of how the claim should process. The state regulators should perform audits to ensure the processes used are adequate. Complaints received by the state and a review of cases making it to litigation will provide insight into system breakdowns.

The complexity of the documentation of a workers' compensation case and communication of the information to all of the parties involved is much more involved than is seen in group health. A properly designed electronic shared system between the employer, insurer, and provider will speed up the claim process and improve the accuracy of the information shared. If the process is manual, delays and inconsistencies may occur. Regulations that require additional work with little added value need to be assessed and revised as appropriate.

A delay in payment in the context of this report relates to the application of payment rules rather than case authorization for payment in the system. A common provider billing manual should be created for use by all Minnesota WC insurers and providers. Medical provider claim form content information should be clear and concise and ideally, in a single downloadable document. In the manual, payment calculations can be clearly communicated along with any special coding requirements. For example, if inpatient hospital claims will not cover charges for patient take-home supplies, the specific revenue codes that are exempt from payment can be clearly stated.

Difficult to navigate regulations with extensive use of links makes it difficult for the provider to understand which regulations apply to them. For example, the provider billing manual published by Michigan Medicaid provides clear expectations in terms of what they want to see in the claim form, clearly identify services which are not covered, identify services requiring prior authorization, and how the payments are calculated. A section is devoted to each provider type in the system, that is, inpatient hospital, outpatient hospital, physician, medical equipment providers, and so forth.

WORKER'S COMPENSATION REFORMS AND OUTCOMES

When looking to other states for workers' compensation reforms and outcomes, we caution that more than just the surface description of the reform is needed. Each state will vary in terms of its political climate, existing regulations that define the system, and the particular industry demographics that define the state's workers. One common theme exists though and that is buy-in and input is needed from all stakeholders in the system.

In a report by Property Casualty 360^o published on August 20, 2012 titled "Workers' Comp State Legislation Battles to Watch", the focus in 2012 and into 2013 with regard to payment reforms center around prescription utilization. Other reforms cited center around provisions other than payment system change. The states mentioned in this aspect are Texas, California (described by some as the seven year cycle), Oklahoma, Maryland, and New York.

For payment system reform in terms of the claim types focused on in this report, we need to look further back over the past 10 years. CGI looked to WCRI's reports for the various states in this study. The information is found in each states WCRI report series for anatomy of medical costs. The chart below summarizes the findings:

State	Reform Description	Outcome
CA	Reforms occurred over several years (Oct 1998 – Sept 2004) Enacted the use of DRGs and APCs. Outpatient hospital payments were previously not regulated.	Decreases in utilization likely due to limits and guidelines put into place for practitioners. Decrease in OP hospital payments due to the enactment of a

State	Reform Description	Outcome
		regulated payment system instead of a percent of charge.
FL	2004 Fee Schedule changes. Substantial increase for primary care physicians and a decrease in OP hospital.	Medical costs were flat initially but then increased in year two. The OP hospital payment was percent-of-charge based and only the percent reimbursement was reduced.
IL	Provider fee schedule modifications in 2006 based on area.	Prior to reforms IL had one of the highest medical payments per claims and the new fee schedule did not materially affect that standing.
MD	Fee schedule changes in 2004, 2006, 2008. Moved to a Medicare-based fee schedule which increased rates for physical medicine and office visits but lowered rates for surgery in 2004. In 2006, neurological and orthopedic surgery rates increased. In 2008, all rates increased due to Medicare RVU changes.	Lower prices due to the fee schedule and lower utilization lead to lower per claim medical payments.

It is difficult to pinpoint reform successes that are due to payment system reform since many WC reform aspects are completed at the same time that are not payment specific but may influence overall system expenditures. Although prospective payment systems, such as a DRG or APC/EAPG system, are typically more suited to controlling health care expenditures than a charge or discount of charges system, even they can be set too high to achieve reduced payments. What prospective payments systems can do though if properly configured is to control the rate of increase in expenditures. However, the prospective payment system is just one tool in the toolbox for managing health care expenditures. Elsewhere in this report we have touched upon limitations on the number of visits, prior authorization, case management, and the demographics of the worker's as all having influence on total health care expense management.

CURRENT HEALTH REFORM INITIATIVES

There is no doubt that Medicare influences payment systems used, and payment levels throughout U.S. health care systems. Medicare is often used as the benchmark for payment levels for all health care payers from Medicaid to commercial group health plans and workers' compensation agencies. Adoption by these market payers of the Medicare systems themselves is also prevalent but each are uniquely implemented. CGI has rarely seen an implementation of a Medicare-based payment system be true to 100% of the policies and rates. With that said, Medicare currently has a number of significant initiatives that may alter the future landscape of health care payment and service delivery. According to CMS, their goal is to invest in comprehensive primary

care, increase preventive medicine use, reward providers for keeping patients well and not simply deliver more services.

We describe the initiatives that would be relevant to workers' compensation programs below as not all CMS innovations fit in the acute nature that encompasses WC programs but may benefit WC programs in an indirect way through more effective care coordination, and the quality of care delivered as the health care system alters its delivery methods.

Initiative	WC Potential Benefit	Timeframe
Improving Patient Safety in Hospitals	Reduced hospital-acquired conditions and preventable hospital readmissions will benefit WC by reducing the costs associated with treatment.	January 2012 – 7,100 organizations participating including more than 3,200 hospitals. Demonstration measurement: 3 years
Pioneer Accountable Care Organizations (ACOs)	If ACOs are successful, the method of bundled payments for coordination of care may have value in the WC system as coordination of care for WC is key to return-to-work turnaround.	January 2012 – 3 years (optional 2 yr extension); 32 ACOs participating
Advanced Payment ACO Model	Pre-payment a portion of future shared savings focuses on more physician-based and rural ACOs. This program might not be useful to WC programs unless consistent injuries are seen which is not the goal of workplace safety programs.	Mid 2012 – 2 years
Bundled Payments for Care Improvement	Reimbursement is a bundled payment based on conditions that make sense to bundle. Focuses on inpatient care.	2012 – 3 years

Most of the above initiatives began this year and are slated to end in two to three years. Once the evaluation of the initiatives is complete, we expect to see modifications to the original plan. It is difficult to say today if any of the initiatives will become permanent but one thing is certain, CMS is committed to altering the health care delivery and payment system in an incentive based manner.

APPENDIX A -REFERENCES

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APPENDIX B -GLOSSARY

Administrative Services Only (ASO) Plan – An arrangement where a third party handles the administration of a self-funded benefit program for a fee.

Access - The patient's ability to obtain medical care. The ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, and hours of operation and cost of care, and individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage.

Acute Care - A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Specialized personnel using complex and sophisticated technical equipment and materials usually give acute care in a hospital. Unlike chronic care, acute care is often necessary for only a short time.

All Patient Diagnosis Related Groups (APDRG) - An enhancement of the original DRGs, designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases.

All Patient Refined Diagnosis Related Groups (APRDRG) - An enhancement of the original APRDRGs, designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APRDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases and includes measures for severity of illness and risk of mortality.

Allowed Costs – The amount paid to a provider for a medical service or supply after provider discounts. Also defined as negotiated rates paid by a health plan to a provider for a medical service or supply that qualifies as a covered expense. This amount is the shared responsibility of the health plan and beneficiary, and excludes amounts for non-covered services. Includes the price paid by the insurer and the out-of-pocket payments of the beneficiary.

Ambulatory Payment Classification (APC) – A system of grouping hospital outpatient services with similar clinical characteristics, costs, and procedure codes. These groupings were developed by the Centers for Medicare & Medicaid Services (CMS).¹
Ambulatory Payment Classification (APC) Weight – Prospectively-determined relative weight assigned to each APC grouping by CMS, published in the Hospital Outpatient Prospective Payment System Final Rule each calendar year.

Ambulatory Surgical Center (ASC) - also known as surgicenters, outpatient surgery centers or same-day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed. These types of surgeries are often less complicated than those requiring hospitalization. Avoiding hospitalization can mean lower costs for the patient's health insurance company, or other payer, which can help contain the cost of health insurance.

Benefits - Benefits are specific areas of Plan coverage's, i.e., outpatient visits, hospitalization and so forth, that makes up the range of medical services that a payer markets to its subscribers. Also, a contractual agreement, specified in an Evidence of Coverage, determining covered services provided by insurers to members.

Bundled Payment - A single comprehensive payment for a group of related services. Bundled payments have become the norm in recent years and CMS and other payers investigate unbundled services closely. Unbundling service charges has been a common form of fraud as defined by CMS.

Capital Costs - Capital costs usually involve equipment and physical plant costs, not consumable supplies. Included in these costs can be interest, leases, rentals, taxes and insurance on physical assets like plant and equipment. Capital costs are usually reimbursed to cost based facilities through submission of these costs on annual cost reports to the CMS intermediaries. Depreciation schedules usually apply.

Capitation (Cap, Capped, Capitate) - Specified amount paid periodically to health provider for a group of specified health services, regardless of quantity rendered. Amounts are determined by assessing a payment "per covered life" or per member.

Carve Out - Practice of excluding specific services from a managed care organization's capitated rate. In some instances, the same provider will still provide the service, but they will be reimbursed on a fee-for-service basis.

Case Management - Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost effective manner. The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services. The process by which all health-related matters of a case are managed by a physician or nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referral to consultants, specialists, hospitals, ancillary providers and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the mis-utilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

Case Mix - The mix of patients treated within a particular institutional setting, such as the hospital. Patient classification systems like DRGs can be used to measure hospital case mix.

Case-Mix Index (CMI) - The average DRG weight for all cases paid under PPS. The CMI is a measure of the relative costliness of the patients treated in each hospital or group of hospitals.

Case Rate - Flat fee paid for a client's treatment based on their diagnosis and/or presenting problem.

Case Severity - A measure of intensity or gravity of a given condition or diagnosis for a patient. May have direct correlation with the amount of service provided and the associated costs or payments allowed.

Centers for Medicare and Medicaid Services (CMS) - The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health

Insurance Program (SCHIP), HIPAA and CLIA. Formerly was HCFA. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Charges - These are the published prices of services provided by a facility. CMS requires hospitals to apply the same schedule of charges to all patients, regardless of the expected sources or amount of payment. Controversy exists today because of the often wide disparity between published prices and contract prices. The majority of payers, including Medicare and Medicaid, are becoming managed by health plans that negotiate rates lower than published prices. Often these negotiated rates average 40% to 60% of the published rates and may be all-inclusive bundled rates.

Comorbid Condition - A medical condition that, along with the principal diagnosis, exists at admission and is expected to increase hospital length of stay by at least one day for most patients.

Complication - A medical condition that arises during a course of treatment and is expected to increase the length of stay by at least one day for most patients.

Conversion Factor (CF) - The dollar amount used to multiply the Relative Value Schedule (RVS) of a procedure to arrive at the maximum allowable for that procedure.

Cost Containment - Control of inefficiencies in the consumption, allocation, or production of health care services that contribute to higher than necessary costs. Inefficiencies are thought to exist in consumption when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and, inefficiencies in production exist when the costs of producing health services could be reduced by using a different combination of resources. Cost containment is a word used freely in healthcare to describe most cost reduction activities by providers.

Cost Outlier - A case that is more costly to treat compared with other patients in a particular diagnosis related group. Outliers also refer to any unusual occurrence of cost, cases that skew average costs or unusual procedures.

Covered Benefit - A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

Critical Access Hospital (CAH) – Hospitals with 25 beds or less and usually located in rural areas.

Current Procedural Terminology (CPT) - A standardized mechanism of reporting services using numeric codes as established and updated annually by the AMA. A manual that assigns five digit codes to medical services and procedures to standardize claims processing and data analysis. The coding system for physicians' services developed by the CPT Editorial Panel of

the American Medical Association; basis of the Medicare coding system for physicians services. A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions. See Coding.

Customary charge - One of the factors determining a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period.

Diagnosis Related Groups (DRGs) - An inpatient or hospital classification system used to pay a hospital or other provider for their services and to categorize illness by diagnosis and treatment. A classification scheme used by Medicare that clusters patients into 468 categories on the basis of patients' illnesses, diseases and medical problems. Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. System involving classification of medical cases and payment to hospitals on the basis of diagnosis. Used under Medicare's prospective payment system to reimburse inpatient hospitals, regardless of the cost to the hospital to provide services.

Diagnosis-Related Groups (DRG) Weights – A metric that captures the average resources used to treat patients within a DRG in a specific fiscal year.

Enhanced Ambulatory Patient Groups (EAPG) – An outpatient hospital patient classification system developed by 3M that features extensive service bundling for payment to incentivize hospital providers to provide the appropriate number of services for treatment.

Facility Claim – Request for payment from a facility that provided a medical service. The cost of using a room and associated services within the facility; it does not include any procedures performed by health professionals on the beneficiary. Charges for physician services are rendered separately, as “professional claims.”

Fee-For-Service (FFS) - Traditional method of payment for health care services where specific payment is made for specific services rendered. Usually people speak of this in contrast to capitation, DRG or per diem discounted rates, none of which are similar to the traditional fee for service method of reimbursement.

Fee Schedule - A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.

Gatekeeper - A primary care physician, utilization review, case management, local agency or managed care entity responsible for determining when and what services a patient can access and receive reimbursement for. An arrangement in which a primary care provider serves as the patient's agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals. A PCP is involved in overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the PCP must preauthorize the visit, unless there is an emergency. The term gatekeeper is also used in health care business to describe anyone (EAP, employer based case manager, UR entity, etc.) that makes the decision of where a patient will receive services.

Inpatient Prospective Payment System (IPPS) – Typically refers to the inpatient hospital payment system as administered by Medicare. May be generically used for any inpatient hospital reimbursement system where provider rates are prospectively set.

Medicare Severity Diagnosis Related Groups (MSDRG) – The name of the public domain grouper used by Medicare that is intended to reflect the severity of inpatient hospital visits.

Outpatient Prospective Payment System (OPPS) – Typically refers to the outpatient hospital payment system as administered by Medicare. Refers to the mix of Medicare payments for outpatient hospital care that are fee schedule, cost, and weight based payments. May be generically used for any outpatient hospital reimbursement system where provider rates are prospectively set.

Professional Claim – Claim filed by a health care professional for medical services rendered. This includes claims for professional procedures, as opposed to facility claims.

Prospective Payment System (PPS) - A payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs.

Provider - Usually refers to a hospital or doctor who "provides" care. A health plan, managed care company or insurance carrier is not a healthcare provider. Those entities are called payers.

Relative Value Units (RVU) – A reimbursement scheme based on the skill, effort, and time required by a health care professional for a given medical procedure or service in comparison to other medical procedures and services. Based on two main components—the relative level of time and intensity associated with furnishing the service; and the expense of maintaining a practice including malpractice expense.

Revenue Code – Code assigned to a medical service or treatment for receiving proper payment, typically in a hospital setting.

APPENDIX C – ADDITIONAL PAYMENT SYSTEM FACT SHEETS

Following are fact sheets with additional information regarding:

- Medicare Inpatient PPS (IPPS)
- Medicare Outpatient PPS (OPPS/APC)
- Medicare Critical Access & Rural Hospital (CAH)
- Medicare Physician Fee Schedule (MPFS) – includes anesthesia
- 3M Enhance Ambulatory Patient Groups (EAPGs)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Official CMS Information for
Medicare Fee-For-Service Providers

Acute Care Hospital Inpatient Prospective Payment System

PAYMENT SYSTEM FACT SHEET SERIES





immediately preceding the date of a beneficiary's inpatient admission must be included on the claim for the beneficiary's inpatient stay and must not be separately billed to Medicare Part B.

Discharges are assigned to diagnosis-related groups (DRG), a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay. The beneficiary's principal diagnosis and up to 24 secondary diagnoses that indicate comorbidities and complications will determine the DRG assignment. Similarly, DRG assignment can be affected by up to 25 procedures furnished during the stay. The Centers for Medicare & Medicaid Services (CMS) reviews the DRG definitions annually to ensure that each group continues to include cases with clinically similar conditions that require comparable amounts of inpatient resources. When the review shows that subsets of clinically similar cases within a DRG consume significantly different amounts of resources, CMS may assign them to a different DRG with comparable resource use or create a new DRG.

For discharges occurring on or after October 1, 2007, CMS is using a new DRG system called Medicare Severity (MS)-DRG to better account for severity of illness and resource consumption for Medicare beneficiaries. Use of MS-DRGs was transitioned during a two-year period. For the period October 1, 2007, through September 30, 2008, payment was based on a 50/50 blend of MS-DRGs and the previous DRG system. Beginning October 1, 2008 (fiscal year [FY] 2009) and after, payment is based solely on the MS-DRGs.

There are three levels of severity in the MS-DRGs based on secondary diagnosis codes:

- 1) MCC – Major Complication/Comorbidity, which reflect the highest level of severity;
- 2) CC – Complication/Comorbidity, which is the next level of severity; and
- 3) Non-CC – Non-Complication/Comorbidity, which do not significantly affect severity of illness and resource use.

Payment Rates

The IPPS per-discharge payment is based on two national base payment rates or "standardized amounts": one that provides for operating expenses

This publication provides the following information about the Acute Care Hospital Inpatient Prospective Payment System (IPPS):

- ❖ Background;
- ❖ Basis for IPPS payment;
- ❖ Payment rates;
- ❖ How payment rates are set; and
- ❖ Resources.

Background

Facilities contract with Medicare to furnish acute hospital inpatient care and agree to accept predetermined acute IPPS rates as payment in full.

The inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness with an additional 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted and end after they have been out of the hospital or Skilled Nursing Facility (SNF) for 60 consecutive days.

Basis for Inpatient Prospective Payment System Payment

Generally, hospitals receive Medicare IPPS payment on a per discharge or per case basis for Medicare beneficiaries with inpatient stays. All outpatient diagnostic services and admission-related outpatient nondiagnostic services provided by the admitting hospital or an entity that is wholly owned or operated by the admitting hospital on the date of a beneficiary's inpatient admission or within three days

and another for capital expenses. These payment rates are adjusted to account for:

- ❖ The costs associated with the beneficiary's clinical condition and related treatment relative to the costs of the average Medicare case (i.e., the DRG relative weight, as described in the "How Payment Rates Are Set" section below); and
- ❖ Market conditions in the facility's location relative to national conditions (i.e., the wage index, as described in the "How Payment Rates Are Set" section below).

In addition to these adjusted per discharge base payment rates, hospitals can qualify for outlier payments for cases that are extremely costly. Hospitals that train residents in approved Graduate Medical Education (GME) Programs also receive a payment separate from the IPPS for the direct costs of training residents. The operating and capital payment rates for these teaching hospitals are increased to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals or indirect costs of graduate medical education (Indirect Medical Education [IME]). Operating and capital payment rates are also increased for facilities that treat a disproportionate share of low-income patients. In addition, hospitals may be paid an additional amount for treating patients with certain approved technologies that are new and costly and offer a substantial clinical improvement over existing treatments available to Medicare beneficiaries. Finally, in some cases, payment is reduced when a beneficiary has a short length of stay (LOS) and is transferred to another acute care hospital or, in some circumstances, to a post-acute care setting.

The steps for determining an IPPS payment are as follows:

- 1) The hospital submits a bill to the Medicare Administrative Contractor (MAC) for each Medicare patient it treats. Based on the information on the bill, the MAC categorizes the case into a DRG;
- 2) The base payment rate, or standardized amount (a dollar figure), includes a labor-related and nonlabor-related share. The labor-related share is adjusted by a wage index to reflect area differences in the cost of labor. If the area wage index is greater than 1.0000, the labor share equals 68.8 percent. The law requires the labor

share to equal 62 percent if the area wage index is less than or equal to 1.0000. The nonlabor-related share is adjusted by a cost-of-living adjustment (COLA) factor, which equals 1.0000 for all States except Alaska and Hawaii;

- 3) The wage-adjusted standardized amount is multiplied by a relative weight for the DRG. The relative weight is specific to each of 751 DRGs (for FY 2012) and represents the relative average costs associated with one DRG; and
- 4) If applicable, additional amounts will be added to the IPPS payment as follows:
 - The hospital engages in teaching medical residents to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals;
 - The hospital treats a disproportionate share of low-income patients;
 - Cases that involve certain approved new technologies; and
 - High-cost outlier cases.

The charts on page 4 show the formulas for calculating the Acute Care Hospital IPPS operating base payment rate and the capital base payment rate.

How Payment Rates Are Set

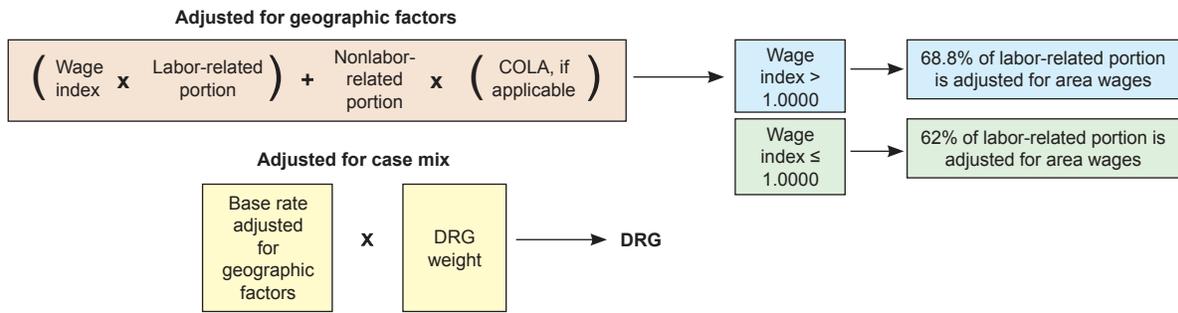
IPPS payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The base rates are updated annually and unless there are other policy changes, the update raises all payment rates proportionately.

Base Payment Amounts

Discharge base rates, also known as standardized payment amounts, for operating payments and the Federal rate for capital payments are set for the operating and capital costs that efficient facilities are expected to incur in furnishing covered inpatient services. Some costs (e.g., direct costs of operating GME Programs and organ acquisition costs) are excluded from the IPPS and paid separately. For FY 2012, the national IPPS operating base rate is \$5,209.74. Capital payments cover costs for depreciation, interest, rent, and property-related

Acute Care Hospital Inpatient Prospective Payment System

Operating Base Payment Rate

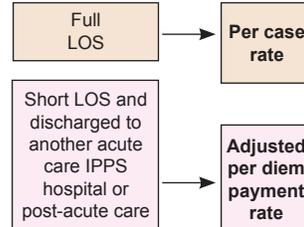


Policy adjustments for qualifying hospitals:

I. Additional operating amounts



II. Adjustment for transfers



III. If case is extraordinarily costly

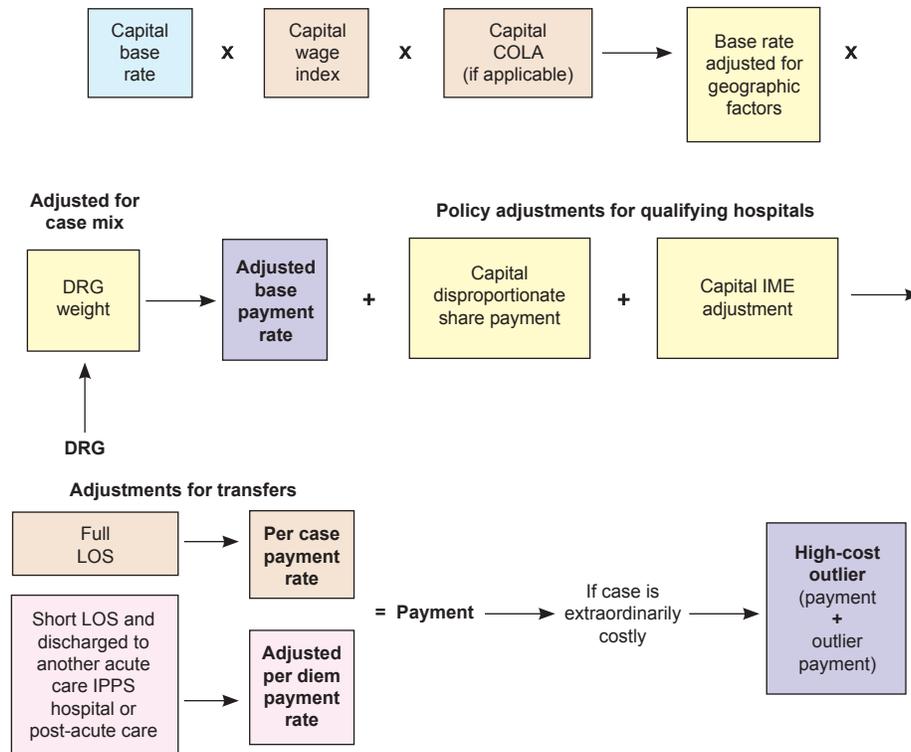


IV. If case qualifies for new technology add-on



Acute Care Hospital Inpatient Prospective Payment System

Capital Base Payment Rate





insurance and taxes. For FY 2012, the national IPPS capital base rate is \$421.42. Hospitals in Puerto Rico receive a 75 percent/25 percent blend of the Federal base payment amount and a Puerto Rico-specific rate, respectively, for both operating and capital payments.

Diagnosis-Related Group Relative Weights

A weight is assigned to each MS-DRG that reflects the average relative costliness of cases in that group compared with the costliness for the average Medicare case. The same MS-DRG weights are used to set operating and capital payment rates. The MS-DRG weights are recalibrated annually, without affecting overall payments, based on standardized charges and costs for all IPPS cases in each MS-DRG. Hospitals' billed charges are standardized to improve comparability, which involves adjusting charges to remove differences associated with hospital wage rates across labor markets, the size and intensity of the hospital's resident training activities, and the number of low-income patients the hospital treats. The charges are reduced to costs by using national average ratios of hospital costs to charges for 15 different hospital departments.

Adjustment for Market Conditions

Base operating and capital rates are adjusted by an area wage index to reflect the expected differences in local market prices for labor, which is intended to measure differences in hospital wage rates among labor markets by comparing the average hourly wage for hospital workers in each urban or statewide rural

area to the nationwide average. CMS uses the Office of Management and Budget's Core-Based Statistical Area definitions (with some modifications) to define each labor market area. The wage index is revised each year based on wage data reported by IPPS hospitals. A hospital may request geographic reclassification if it believes it competes for labor with a different area than the one in which it is located. A COLA, which reflects the higher costs of supplies and other nonlabor resources, is also applied to the base operating and capital rates of IPPS hospitals in Hawaii and Alaska. The wage index is applied to the labor-related portion or labor share of the operating base rate, which reflects an estimated portion of costs affected by local wage rates and fringe benefits. Additionally, the wage index is applied to the whole capital base rate. The current estimate of the national operating labor share is 68.8 percent, which is applied to hospitals with a wage index greater than 1.0000. The national operating labor share is 62 percent for areas with a wage index less than or equal to 1.0000. There are alternative labor shares that are applicable to hospitals located in Puerto Rico. The wage index applied to the capital base rate is raised to a fractional power, which narrows the geographic variation in wage index values among market areas.

Bad Debts

Acute care hospitals are reimbursed for 70 percent of bad debts resulting from beneficiaries' nonpayment of copayments and deductibles after a reasonable effort has been made to collect the unpaid amounts.

Policy Adjustments

Additional operating and capital amounts are paid as described below.

Direct Graduate Medical Education

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs receive Direct Graduate Medical Education (DGME) payments that reflect the direct costs of operating approved residency training programs and are paid separately from the IPPS. DGME payments are generally based on the product of:

- ❖ Updated hospital-specific costs per resident in a historical base year; and
- ❖ The number of residents a hospital trains; and



- ❖ The hospital's Medicare patient load (the proportion of Medicare inpatient days to total inpatient days).

Indirect Costs of Graduate Medical Education

Teaching hospitals or hospitals that train residents in approved medical, osteopathic, dental, or podiatry residency programs also receive IME adjustments to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. The size of the IME adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by the hospital's number of residents trained per inpatient bed (i.e., the resident-to-bed ratio). In FYs 2009, 2010, and 2011, the operating IME adjustment increased per-case payments by 5.5 percent for approximately every 10 percent increase in the resident-to-bed ratio. In FY 2012, the rate is still 5.5 percent.

Medicare Disproportionate Share Hospitals

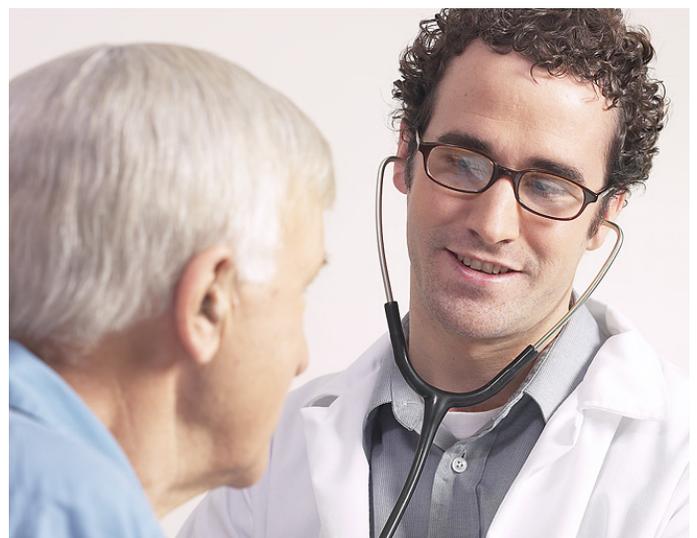
Hospitals that treat a disproportionate share of low-income patients receive additional operating and capital payments. A hospital can qualify for the Medicare operating disproportionate share hospital (DSH) adjustment by using one of the following methods:

- ❖ Primary method – Pertains to hospitals that serve a significantly disproportionate number of low-income patients and is based on the disproportionate patient percentage (DPP), which is equal to the sum of the percentage of Medicare inpatient days (including Medicare Advantage inpatient days) attributable to

patients entitled to both Medicare Part A and Supplemental Security Income and the percentage of total patient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A (including patient days not covered under Part A and patient days in which Part A benefits are exhausted). If a hospital's DPP equals or exceeds a specified threshold amount, the hospital qualifies for the Medicare DSH adjustment; or

- ❖ The alternate special exception method – Applies to hospitals that are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid). These hospitals are also known as "Pickle" hospitals. If a hospital qualifies under this method, the statute provides for a specific Medicare DSH adjustment.

For hospitals with a DSH patient percentage that exceeds 15 percent, operating DSH payments are based on a statutory formula. The DSH payment add-on rate is capped at 12 percent of base inpatient payments for rural hospitals with fewer than 500 beds and for urban hospitals with fewer than 100 beds. Rural Referral Center payments are based on a separate formula. Hospitals that qualify for a DSH payment under the Pickle methodology (i.e., they receive at least 30 percent of inpatient revenue from State and local government subsidies) have a 35 percent adjustment rate. Urban hospitals with 100 or more beds and all hospitals that receive at





least 30 percent of inpatient revenue from State and local government subsidies are eligible for capital DSH payments (regardless of their DSH patient percentage). The capital DSH add-on payment is based on the empirically estimated cost effect of treating low-income patients.

Sole Community Hospitals

Sole Community Hospitals (SCH) can receive operating payments based on their hospital-specific payment rate, while their capital payments are solely based on the capital base rate (i.e., like all other IPPS hospitals).

SCH payments are made based upon whichever of the following yields the greatest aggregate payment for the cost reporting period:

- ❖ The IPPS Federal rate applicable to the hospital;
- ❖ The updated hospital-specific rate based on FY 1982 costs per discharge;
- ❖ The updated hospital-specific rate based on FY 1987 costs per discharge;
- ❖ The updated hospital-specific rate based on FY 1996 costs per discharge; or
- ❖ The updated hospital-specific rate based on FY 2006 costs per discharge.

To qualify as a SCH, a hospital must meet one of the following criteria:

- 1) The hospital is located at least 35 miles from other like hospitals;

- 2) The hospital is rural (located in a rural area), located between 25 and 35 miles from other like hospitals, AND meets ONE of the following criteria:
 - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area; or
 - The hospital has fewer than 50 beds and would meet the 25 percent criterion above if not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital;
- 3) The hospital is rural and located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years; or
- 4) The hospital is rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.



A like hospital:

- ❖ Furnishes short-term, acute care;
- ❖ Is paid under the Acute Care Hospital IPPS;
- ❖ Is not a Critical Access Hospital (CAH); and
- ❖ Is not paid under any other Medicare PPS.

SCHs may also qualify for a payment adjustment for hospitals experiencing a significant volume decrease.

Certain hospitals formerly designated as Essential Access Community Hospitals are also treated as SCHs for payment purposes under the IPPS.

Medicare Dependent Hospitals

Medicare Dependent Hospitals (MDH) can also receive operating payments based on their hospital-specific payment rate, while their capital payments are solely based on the capital base rate.

For discharges on or after October 1, 2006, MDHs are paid for their inpatient operating costs based on the Federal rate or, if higher, the Federal rate plus 75 percent of the amount by which the Federal rate payment is exceeded by the MDH's updated hospital-specific rate payment based on its FY 1982, FY 1987, or FY 2002 costs per discharge, whichever of these hospital-specific rates is highest.

For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and ending before October 1, 2012, a MDH is an IPPS hospital that meets all of the following criteria:

- ❖ It is rural (located in a rural area);
- ❖ It has 100 or fewer beds during the cost reporting period;
- ❖ It is not also classified as a SCH; and
- ❖ At least 60 percent of its inpatient days or discharges were attributable to those beneficiaries entitled to Medicare Part A during the hospital's cost reporting period or periods as follows:
 - For its cost reporting period ending on or after September 30, 1987, and before September 30, 1988; or

- For its cost reporting period beginning on or after October 1, 1986, and before October 1, 1987 (only if the hospital does not have a cost reporting period that meets the preceding requirement); or
- For at least two of the last three most recent audited cost reporting periods for which there is a settled cost report.

If the cost reporting periods are for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

MDHs may also qualify for a payment adjustment for hospitals experiencing a significant volume decrease.

Low-Volume Hospitals

Under the Affordable Care Act, qualifying low-volume hospitals receive add-on payments in FYs 2011 and 2012 as follows:

- ❖ Those with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each discharge; and
- ❖ Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula $[(4/14) - (\text{Medicare discharges}/5600)]$.

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- ❖ Be more than 15 road miles from the nearest subsection (d) hospital; and
- ❖ Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data.

Qualifying Hospitals

Under Section 1109 of Public Law 111-152, qualifying hospitals will receive annual add-on payments in FYs 2011 and 2012. A qualifying hospital is located in a county that ranks per enrollee within the lowest quartile of such counties in the U.S. based on its ranking in age-, sex-, and race-adjusted spending for benefits under Medicare Parts A and B.



Outlier Payments

To promote access to high quality inpatient care for seriously ill beneficiaries, additional payments are made for outlier or extremely costly cases. These cases are identified by comparing their estimated operating and capital costs to a fixed loss threshold. The fixed loss amount is set each year, which is adjusted to reflect labor costs in the hospital’s local market. The table below shows the fixed loss amount for FYs 2010 – 2012.

Fixed Loss Amount

Fiscal Year	Fixed Loss Amount
2010	\$23,140 for discharges on or after October 1, 2010, through discharges on or before March 31, 2010
	\$23,135 for discharges on or after April 1, 2010, through discharges on or before September 30, 2010
2011	\$23,075
2012	\$22,385

Hospitals are paid 80 percent of their costs above their fixed loss thresholds and 90 percent of costs above the outlier threshold for burn cases. Outliers are financed by offsetting reductions in the operating and capital base rates (i.e., there is a reduction to the rates paid to all cases so that the amount paid as outliers does not increase or decrease estimated aggregate Medicare spending). The national fixed loss amount is established at the level that will result in estimated outlier payments equaling 5.1 percent of total payments for the FY. To find an

outlier calculation example, visit http://www.cms.gov/AcuteInpatientPPS/Downloads/outlier_example_fy07.zip on the CMS website.

Transfer Policy

DRG payments are reduced when:

- ❖ The beneficiary’s LOS is at least one day less than the geometric mean LOS for the DRG;
- ❖ The beneficiary is transferred to another hospital covered by the Acute Care Hospital IPPS or, for certain MS-DRGs, discharged to a post-acute setting;
- ❖ The beneficiary is transferred to a hospital that does not have an agreement to participate in the Medicare Program (effective October 1, 2010); and
- ❖ The beneficiary is transferred to a CAH (effective October 1, 2010).

The following post-acute care settings are included in the transfer policy:

- ❖ Long-term care hospitals;
- ❖ Rehabilitation facilities;
- ❖ Psychiatric facilities;
- ❖ SNFs;
- ❖ Home health care when the beneficiary receives clinically related care that begins within three days after the hospital stay;
- ❖ Rehabilitation distinct part (DP) units located in an acute care hospital or a CAH;
- ❖ Psychiatric DP units located in an acute care hospital or a CAH;
- ❖ Cancer hospitals; and
- ❖ Children’s hospitals.

Payment Updates

The operating and capital payment rates are updated annually. The operating update is set by Congress, considering the projected increase in the market basket index. The market basket index measures the price increases of goods and services hospitals buy to produce patient care. For FY 2012, the applicable percentage increase for IPPS hospitals equals the rate-of-increase in the hospital market basket

for IPPS hospitals in all areas reduced by 0.25 percentage point. The Secretary of the Department of Health and Human Services (HHS) determines the capital update based on an update framework.

Hospitals that report specific quality data to HHS receive the full operating update set by Congress. In 2012, if a hospital does not report the quality data, it will receive the operating update of the rate-of-increase in the hospital market basket for IPPS hospitals in all areas reduced by 0.25 percentage point less an additional 2.0 percentage points. (Currently there is no adjustment to the capital update based on the reporting of quality data.)

Resources

For more information about the Acute Care Hospital IPPS, visit http://www.cms.gov/AcuteInpatientPPS/01_overview.asp and refer to the “Medicare Benefit Policy Manual” (Publication 100-02) and the “Medicare Claims Processing Manual” (Publication 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Official CMS Information for
Medicare Fee-For-Service Providers

Hospital Outpatient Prospective Payment System

PAYMENT SYSTEM FACT SHEET SERIES





Certain types of services are excluded from payment under the OPSS (e.g., clinical diagnostic laboratory services, outpatient therapy services, and screening and diagnostic mammography). For more information about services that are excluded from payment under the OPSS, refer to Section 1833(t) of the Act and the “Code of Federal Regulations” at 42 CFR 419.22 located at <http://www.gpo.gov/fdsys/search/home.action> on the U.S. Government Printing Office website.

The Balanced Budget Refinement Act of 1999 mandated the following additional OPSS provisions:

This publication provides the following information about the Hospital Outpatient Prospective Payment System (OPSS):

- ❖ Background;
- ❖ Ambulatory payment classifications (APC);
- ❖ How payment rates are set;
- ❖ Payment rates; and
- ❖ Resources.

Background

On August 1, 2000, the Centers for Medicare & Medicaid Services (CMS) began using the OPSS, which was authorized by Section 1833(t) of the Social Security Act (the Act) as amended by Section 4533 of the Balanced Budget Act of 1997. The OPSS was implemented in calendar year (CY) 2000 and pays for:

- ❖ Designated hospital outpatient services;
- ❖ Certain Medicare Part B services furnished to hospital inpatients who do not have Part A coverage;
- ❖ Partial hospitalization services furnished by hospitals or Community Mental Health Centers (CMHC);
- ❖ Hepatitis B vaccines and their administration, splints, casts, and antigens furnished by a Home Health Agency (HHA) to patients who are not under an HHA plan or treatment or to hospice patients for treatment of non-terminal illness; and
- ❖ An initial preventive physical exam performed within the first 12 months of Medicare Part B coverage.

- ❖ Establish payments in a budget neutral manner based on estimates of amounts payable in 1999 from the Medicare Part B Trust Fund and beneficiary coinsurance under the system in effect prior to the OPSS;
- ❖ Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs through the first date the OPSS is implemented;
- ❖ Require annual update of payment weights, relative payment rates, wage adjustments, outlier payments, other adjustments, and APC groups;
- ❖ Require annual consultation with an expert provider Advisory Panel for review and updating of APC groups;
- ❖ Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all OPSS services included on the submitted outpatient bill for services furnished before January 1, 2002, and thereafter based on the individual services billed;
- ❖ Provide transitional pass-through payments for the additional costs of new and current medical devices, drugs, and biologicals for at least two years but not more than three years;
- ❖ Provide payment under the OPSS for implantable devices, including durable medical equipment (DME), prosthetics, and DME used in diagnostic testing;
- ❖ Establish transitional outpatient payments to limit providers’ losses under the OPSS as follows:
 - Three and one-half years for CMHCs and most hospitals; and
 - Permanently for cancer hospitals; and
- ❖ Limit beneficiary copayment for an individual service paid under the OPSS to the inpatient deductible in a given year.



The Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 included the following revisions to the OPSS:

- ❖ Accelerated reductions of beneficiary copayments;
- ❖ Increase in market basket update for 2001;
- ❖ Transitional corridor provision for transitional outpatient payments for providers that did not file 1996 cost reports; and
- ❖ Permanent transitional outpatient payments for children's hospitals.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included the following changes regarding how Medicare pays for drugs under the OPSS:

- ❖ For 2004 and 2005, enacted payment rates for many separately payable drugs that were tied to the drugs' average wholesale price as of May 1, 2003 (rates apply to separately paid radiopharmaceuticals and drugs and biologicals that were pass-through items prior to January 1, 2003);
- ❖ For services furnished in 2006 and thereafter, separately payable drugs are paid at the average hospital acquisition cost;
- ❖ APC weights for specified covered outpatient drugs may be adjusted to take into account the costs hospitals incur in handling these drugs;
- ❖ Separate APCs were established for drugs and biologicals that cost at least \$50 per administration in 2005 and 2006 (drugs costing less were packaged). In 2007, when CMS began updating the packaging threshold, the threshold was set at the cost per day; and
- ❖ Separately paid drugs and biologicals are excluded from outlier payments.

The Affordable Care Act included the following changes regarding certain preventive services:

- ❖ Effective January 1, 2011, beneficiary cost-sharing requirements for most Medicare-covered preventive services are waived, and Medicare pays fully for these services. No coinsurance or deductible is required for personalized prevention plan services and any covered preventive service that is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

The OPSS applies to designated hospital outpatient services furnished in all classes of hospitals, with the exception of the following:

- ❖ Hospitals that only provide Part B services to inpatients (effective January 1, 2002);
- ❖ Critical Access Hospitals (CAH);
- ❖ Indian Health Service (IHS) and Tribal hospitals, including IHS Tribal CAHs;
- ❖ Hospitals located in American Samoa, Guam, and Commonwealth of the Northern Mariana Islands;
- ❖ Effective January 1, 2002, hospitals located in the Virgin Islands; and
- ❖ Hospitals in Maryland (that are paid under Maryland waiver provisions).



Ambulatory Payment Classifications

In most cases, the unit of payment under the OPPTS is the APC. CMS assigns individual services (Healthcare Common Procedure Coding System [HCPCS] codes) to APCs based on similar clinical characteristics and similar costs. The payment rate and copayment calculated for an APC apply to each service within the APC. Sometimes new services are assigned to New Technology APCs, which are based on similarity of resource use only, until clinical and cost data are available to permit assignment to a clinical APC. The payment rate for a New Technology APC is set at the midpoint of the applicable New Technology APC's cost range.

Most services are paid separately including, but not limited to, the following:

- ❖ Most surgical, diagnostic, and nonsurgical therapeutic procedures;
- ❖ Blood and blood products;
- ❖ Most clinic and emergency department visits;
- ❖ Some drugs, biologicals, and radiopharmaceuticals;
- ❖ Brachytherapy sources; and
- ❖ Corneal tissue acquisition costs.

Partial hospitalization is paid on a per diem basis, with the payment rates dependent upon the number of individual services provided to the patient on one day. The payment represents the expected cost of a day of intensive outpatient mental health care in the hospital or in a CMHC. Beginning January 1, 2011, there are two APCs (based on intensity of day) for partial hospitalization furnished by hospitals and two APCs (based on intensity of day) for partial hospitalization furnished by CMHCs.

Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under the OPPTS. Some examples of usually packaged services are:

- ❖ Routine supplies;
- ❖ Anesthesia;
- ❖ Operating and recovery room use;

- ❖ Implantable medical devices (e.g., pacemakers);
- ❖ Inexpensive drugs under a per day drug threshold packaging amount (\$75 in 2012);
- ❖ Guidance services;
- ❖ Image processing services;
- ❖ Intraoperative services;
- ❖ Imaging supervision and interpretation services;
- ❖ Diagnostic radiopharmaceuticals;
- ❖ Contrast agents; and
- ❖ Observation services.

How Payment Rates Are Set

The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates. CMS publishes the national unadjusted payment rate and copayment for each HCPCS code for which separate payment is made that applies to the date of service in the Addenda of the CY 2012 Hospital Outpatient Prospective Payment Final Rule with comment period (CMS-1525-FC).



To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area in which the hospital being paid is located. The remaining 40 percent is not adjusted. Hospitals may also receive the following payments in addition to standard OPPS payments:

- ❖ Pass-through payments for specific drugs, biologicals, and devices used in the delivery of services that meet the criteria for pass-through status (these items are generally too new to be well represented in data used to set payment rates);
- ❖ Outlier payments for individual services that cost hospitals much more than the payment rates for the services' APC groups;
- ❖ Transitional outpatient payments for certain cancer hospitals and children's hospitals;
- ❖ An adjustment for certain cancer hospitals; and
- ❖ A rural adjustment (currently an increased payment of 7.1 percent) for most services furnished by Sole Community Hospitals (SCH), which includes Essential Access Community Hospitals that are located in rural areas (effective January 1, 2006).

The annual review of APCs and their relative weights considers:

- ❖ Changes in hospital and medical practices;
- ❖ Changes in technology;
- ❖ Addition of new services and cessation of obsolete services;
- ❖ New cost data;
- ❖ Advice furnished by the APC Advisory Panel; and
- ❖ Other relevant information.

The OPPS is a budget neutral payment system in which the CF is also updated annually by the Outpatient Department Fee Schedule (OPD FS) increase factor unless Congress stipulates otherwise. The OPD FS increase factor is commonly known as the hospital market basket update and is the same update that applies to inpatient hospital payment. The Affordable Care Act requires that the OPD FS increase factor be reduced by

0.1 percentage points as well as a multifactor productivity adjustment, resulting in an OPD FS increase factor of 1.9 percent for CY 2012. The CF update is further reduced by 2 percentage points for hospitals that fail to meet the requirements of the hospital outpatient quality data reporting program for the update year, resulting in reduced payment for most of their services. Payment rates for certain other categories of items and services, including separately payable drugs and biologicals, brachytherapy sources, therapeutic radiopharmaceuticals, and services assigned to New Technology APCs, are established through alternative methodologies that are applicable to the payment year.

The OPPS payment files are updated on a quarterly basis to account for mid-year changes such as:

- ❖ Adding new pass-through drugs and/or devices;
- ❖ Adding new treatments and procedures to clinical and New Technology APCs;
- ❖ Recognizing new HCPCS codes that are added during the year; and
- ❖ Updating payment rates for separately payable drugs and biologicals based on the most recent available average sales price data.

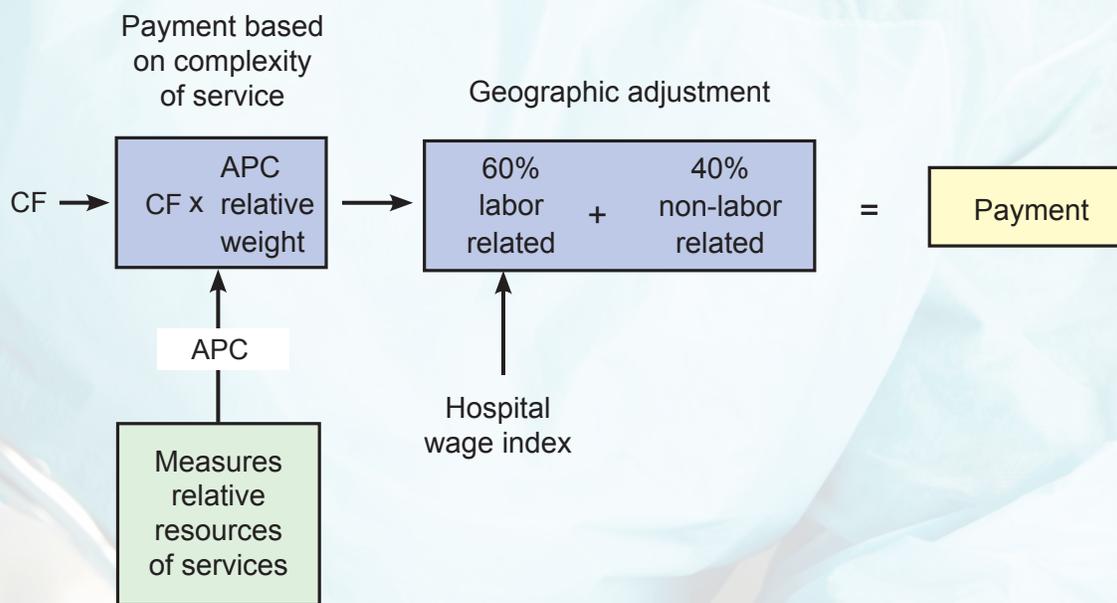
However, the payments for items and services that are based on scaled relative weights are established annually and are generally not revised quarterly. Annual updates are made final through the publication of proposed and final rules in the "Federal Register" after review and response to the public comments.



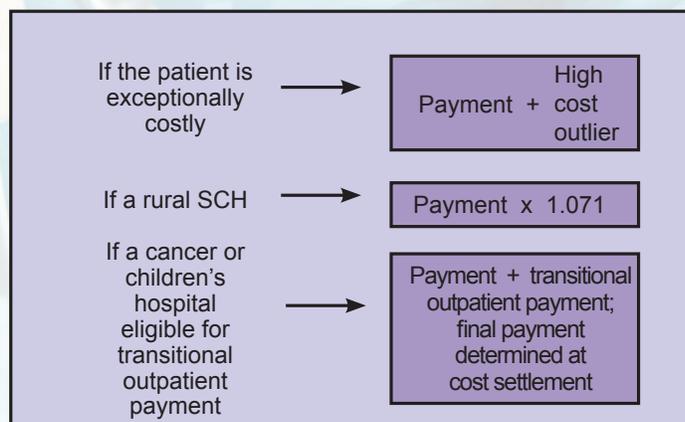


Payment Rates

The chart below shows payment rates under the OPSS.



Special Exceptions





Resources

For more information about the OPPTS, visit <http://www.cms.gov/HospitalOutpatientPPS> and refer to the “Reimbursement” section of the Medicare Learning Network® (MLN) publication titled “MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Providers” booklet at http://www.cms.gov/MLNEdWebGuide/downloads/Guided_Pathways_Intermediate_PartA_Booklet.pdf on the CMS website. For more information about each year’s OPPTS proposed and final rules and all supporting files and documentation, visit <http://www.cms.gov/HospitalOutpatientPPS/HORD/list.asp> on the CMS website. To find a compilation of the Social Security laws, visit http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website. To access the “Federal Register,” visit <http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR> on the U.S. Government Printing Office website. To

find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Critical Access Hospital



RURAL HEALTH FACT SHEET SERIES

This publication provides the following information about Critical Access Hospitals (CAH):

- ❖ Background;
- ❖ CAH designation;
- ❖ CAH payments;
- ❖ Reasonable cost payment principles that do **not** apply to CAHs;
- ❖ Election of Standard Payment Method or Optional (Elective) Payment Method;
- ❖ Medicare Rural Pass-Through funding for certain anesthesia services;
- ❖ Incentive payments;
- ❖ Grants to States under the Medicare Rural Hospital Flexibility Program; and
- ❖ Resources.

Background

Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized States to establish a State Medicare Rural Hospital Flexibility Program

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(Flex Program) under which certain facilities participating in Medicare can become CAHs. The following providers may be eligible to become CAHs:

- ❖ Currently participating Medicare hospitals;
- ❖ Hospitals that ceased operation after November 29, 1989; or
- ❖ Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

Unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. The CoPs for CAHs are listed in the "Code of Federal Regulations" (CFR) at 42 CFR 485.601–647.





Critical Access Hospital Designation

A Medicare participating hospital must meet the following criteria to be designated as a CAH:

- ❖ Be located in a State that has established a State rural health plan for the State Flex Program (as of September 2011, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have a State Flex Program);
- ❖ Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- ❖ Demonstrate compliance with the CoPs found at 42 CFR Part 485 subpart F at the time of application for CAH status;
- ❖ Furnish 24-hour emergency care services 7 days a week, using either on-site or on-call staff;
- ❖ Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services; however, it may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- ❖ Have an average annual length of stay of 96 hours or less per patient for acute care (excluding swing bed services and beds that are within distinct part units); and
- ❖ Be located either more than a 35-mile drive from the nearest hospital or CAH or more than a 15-mile drive in areas with mountainous terrain or only secondary roads OR certified as a CAH prior to January 1, 2006, based on State designation as a “necessary provider” of health care services to residents in the area.

Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries at 101 percent of

reasonable costs. Under the Medicare ambulance benefit, if a CAH or an entity that is owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35-mile drive of that CAH, the CAH or the CAH-owned and operated entity is paid 101 percent of the reasonable costs of the CAH or entity in furnishing ambulance services. Additionally, if there is no other provider or supplier of ambulance services within a 35-mile drive of the CAH but there is a CAH-owned and operated entity furnishing ambulance services that is more than a 35-mile drive from the CAH, that CAH-owned and operated entity can be paid 101 percent of reasonable costs for its ambulance services as long as it is the closest provider or supplier of ambulance services to the CAH. CAHs are not subject to the Inpatient Prospective Payment System (IPPS) and the Hospital Outpatient Prospective Payment System (OPPS).

The Medicare Part A and Part B deductible and coinsurance rules applicable to hospital services also apply to CAHs. All outpatient CAH services are subject to Part B deductible and coinsurance, with the exception of certain preventive services. To find additional information about Medicare preventive services, visit <http://www.cms.gov/PrevntionGenInfo> on the Centers for Medicare & Medicaid Services (CMS) website.

Reasonable Cost Payment Principles That Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is **not** subject to the following reasonable cost principles:

- ❖ Lesser of cost or charges; and
- ❖ Reasonable compensation equivalent limits.

In addition, payment to a CAH for inpatient CAH services is not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions applicable to hospitals paid under the IPPS and OPSS.

Election of Standard Payment Method or Optional (Elective) Payment Method

Standard Payment Method – Reasonable Cost-Based Facility Services, With Billing of Medicare Carrier or A/B Medicare Administrative Contractor for Professional Services

Under Section 1834(g)(1) of the Social Security Act (the Act), a CAH is paid under the Standard Payment Method unless it elects to be paid under the Optional Payment Method. For cost reporting periods beginning

on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- ❖ 80 percent of the 101 percent of reasonable costs for outpatient CAH services; or
- ❖ 101 percent of the reasonable costs of the CAH in furnishing outpatient CAH services less the applicable Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to registered CAH outpatients is made by the Medicare Carrier or A/B Medicare Administrative Contractor (MAC) under the Medicare Physician Fee Schedule (PFS), as is the case when such professional services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services furnished by a physician or other qualified practitioner.

Optional Payment Method – Reasonable Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)

Under Section 1834(g)(2) of the Act, a CAH may elect the Optional Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) or A/B MAC for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner who furnishes professional services to CAH outpatients can choose whether to:

- ❖ Reassign his or her billing rights to the CAH, agree to be included under the Optional Payment Method, attest in writing that he or she will not bill the Medicare Carrier or A/B MAC for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; or
- ❖ File claims for his or her professional services with the Medicare Carrier or A/B MAC for standard payment under the Medicare PFS (i.e., either by billing directly to the Medicare Carrier or A/B MAC or by authorizing the CAH to bill on his or her behalf via a valid reassignment of benefits).

If you, the practitioner who furnishes professional services to CAH outpatients, reassign your Part B billing rights and agree to be included under a CAH's Optional Payment Method, you must not bill the Medicare Carrier or A/B MAC for any outpatient professional services furnished at the CAH once the reassignment becomes effective. You must sign an attestation which clearly states that you will not bill the Medicare Carrier or A/B MAC for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. For each physician or practitioner who agrees to be included



under the Optional Payment Method and reassigns benefits accordingly, the CAH must forward a copy of the completed assignment form (Form CMS 855R) to the FI and Medicare Carrier or A/B MAC and keep the original on file. This attestation will remain at the CAH.

Once the Optional Payment Method is elected, it will remain in effect until the CAH submits a termination request to its FI or A/B MAC. A CAH is no longer required to make an annual election in order to be paid under the Optional Payment Method in a subsequent year. If a CAH elects to terminate its Optional Payment Method, the termination request must be submitted in writing to the FI or A/B MAC at least 30 days prior to the start of the next cost reporting period. The optional method election applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who have agreed to be included under the Optional Payment Method, completed a Form CMS 855R, and attested in writing that they will not bill the Medicare Carrier or A/B MAC for their outpatient professional services. To find Form CMS 855R, visit <http://www.cms.gov/CMSForms/CMSForms/list.asp> on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional Payment Method is based on the sum of:

- ❖ For facility services – 101 percent of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner has reassigned his or her billing rights to the CAH; and
- ❖ For physician professional services – 115 percent of the allowable amount, after applicable deductions, under the Medicare PFS. Payment for non-physician practitioner (NPP) professional services is 115 percent of the amount that otherwise would be paid for the practitioner's professional services under the Medicare PFS.

Effective January 1, 2007, the payment amount is 80 percent of the Medicare PFS for telehealth services when the distant site physician or other practitioner is located in a CAH that has elected the Optional Payment Method and the physician or practitioner has reassigned his or her benefits to the CAH.

Medicare Rural Pass-Through Funding for Certain Anesthesia Services

CAHs may receive reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The “CFR” at 42 CFR 412.113(c) lists the specific requirements hospitals or CAHs must fulfill to receive rural pass-through funding from Medicare for anesthesia services furnished by certified registered nurse anesthetists (CRNA) that they employ or contract with to furnish such services to CAH patients. CAHs that qualify for CRNA pass-through payments receive reasonable cost-based payments for CRNA professional services regardless of whether they choose the Standard Payment Method or the Optional Payment Method for outpatient services, unless they opt to include CRNA outpatient professional services under their optional method election. For CAHs that opt to receive payment for outpatient anesthesia as a professional service, the anesthesia is paid on the anesthesia fee schedule and the CAH gives up the CRNA pass-through exemption for both outpatient and inpatient services.



Incentive Payments

Health Professional Shortage Area Incentive Bonus Payment

Physicians (including psychiatrists) who furnish care in a CAH that is located within a geographic-based, primary care Health Professional Shortage Area (HPSA) and psychiatrists who furnish care in a CAH that is located in a geographic-based mental health HPSA are eligible for a 10 percent HPSA bonus payment for outpatient professional services furnished to a Medicare beneficiary. If you, the physician, have reassigned your billing rights and the CAH has elected the Optional Payment Method, the CAH will receive 115 percent of the otherwise applicable Medicare PFS amount multiplied by 110 percent, based on all claims processed during the quarter.

On an annual basis CMS publishes an updated list of ZIP codes that are eligible for automatic payment of the HPSA bonus. The list is effective for services furnished on or after January 1 of each calendar year. If you furnished services in an area that is on the CMS list of ZIP codes, the HPSA bonus will be paid automatically on a quarterly basis. An area may be eligible for the HPSA bonus payment but the ZIP code may not be on the list because:

1. It does not fall entirely within a designated full county HPSA bonus area;
2. It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service;
3. It is partially within a non-full county HPSA; or
4. Services are provided in a ZIP code area that was not included in the automated file of HPSA areas based on the date of the data used to create the file.

In these situations, you must utilize the AQ modifier – Physician providing a service in an unlisted Health Professional Shortage Area (HPSA) – to receive payment. You must verify that you are eligible for the bonus and that the modifier was used only if you are eligible during the current year. Only services furnished in an area that was designated as of December 31 of the prior year are eligible for the HPSA bonus during the current year.

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, general surgeons who furnish a 10- or 90-day global surgical procedure in ZIP codes that are located in a HPSA are eligible for a 10 percent HPSA bonus payment and a 10 percent HPSA Surgical Incentive Payment.

Primary Care Incentive Payment

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, the following physician and NPP specialties are potentially eligible for a Primary Care Incentive Payment of 10 percent of allowed charges for Part B primary care services furnished to beneficiaries:

- ❖ Family, internal, geriatric, and pediatric medicine physicians;
- ❖ Clinical nurse specialists;
- ❖ Nurse practitioners; and
- ❖ Physician assistants.

Only those practitioners enrolled in Medicare with one of the specialties listed above **and** whose primary care services accounted for at least 60 percent of his or her allowed charges under the Medicare PFS (excluding hospital inpatient care and emergency department visits) during the designated period are eligible. Eligibility for the incentive payment is determined annually.

The chart below lists the primary care services that are eligible for the incentive payment.

Service	Current Procedural Terminology (CPT) Code
New and Established Patient Office or Other Outpatient Visits	CPT codes 99201 – 99215
Nursing Facility Care Visits and Domiciliary, Rest Home, or Home Care Plan Oversight Services	CPT codes 99304 – 99340
Patient Home Visits	CPT codes 99341 – 99350

The incentive payment is paid on a quarterly basis and is in addition to other applicable physician incentive payments.

Grants to States Under the Medicare Rural Hospital Flexibility Program

The Flex Program, which was authorized by Section 4201 of the BBA (Public Law 105-33), consists of two separate but complementary components:

- ❖ A Medicare reimbursement program that provides reasonable cost-based reimbursement for Medicare-certified CAHs, which is administered by CMS; and

- ❖ A State grant program that supports the development of community-based rural organized systems of care in participating States, which is administered by the Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, States must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- ❖ Designates and supports the conversions to CAHs;
- ❖ Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- ❖ Develops rural health networks to assist and support CAHs;
- ❖ Develops and supports quality improvement initiatives; and
- ❖ Evaluates State programs within the framework of national program goals.

Resources

For more information about CAHs, refer to the following:

- ❖ The “Medicare Claims Processing Manual” (Publication 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website;
- ❖ The “Critical Access Hospital” section of the Medicare Learning Network® publication titled “MLN Guided Pathways to Medicare Resources Provider Specific” booklet at http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website; and
- ❖ The “CFR” located at <http://www.gpo.gov/fdsys/search/home.action> on the U.S. Government Printing Office website.

For more information about HPSAs, including eligible ZIP codes, visit http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp on the CMS website. To find the compilation of Social Security laws, visit http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.

Helpful Websites

American Hospital Association Rural Health Care

<http://www.aha.org/advocacy-issues/rural>

Critical Access Hospitals Center

<http://www.cms.gov/center/cah.asp>

Disproportionate Share Hospital

http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp

Federally Qualified Health Centers Center

<http://www.cms.gov/center/fqhc.asp>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<http://www.cms.gov/center/hospital.asp>

HPSA/PSA (Physician Bonuses)

<http://www.cms.gov/hpsapsaphysicianbonuses>

Medicare Learning Network

<http://www.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://www.narhc.org>

National Rural Health Association

<http://www.ruralhealthweb.org>

Rural Health Clinics Center

<http://www.cms.gov/center/rural.asp>

Rural Assistance Center

<http://www.raconline.org>

Swing Bed Providers

http://www.cms.gov/SNFPPS/03_SwingBed.asp

Telehealth

<http://www.cms.gov/Telehealth>

U.S. Census Bureau

<http://www.census.gov>

Regional Office Rural Health Coordinators

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

Region I – Boston

Rick Hoover

E-mail: rick.hoover@cms.hhs.gov

Telephone: (617) 565-1258

States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region II – New York

Miechal Lefkowitz

E-mail:

miechal.lefkowitz@cms.hhs.gov

Telephone: (212) 616-2517

States: New Jersey, New York, Puerto Rico, and Virgin Islands

Region III – Philadelphia

Patrick Hamilton

E-mail:

patrick.hamilton@cms.hhs.gov

Telephone: (215) 861-4097

States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

Region IV – Atlanta

Lana Dennis

E-mail: lane.dennis@cms.hhs.gov

Telephone: (404) 562-7379

States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region V – Chicago

Christine Davidson

E-mail:

christine.davidson@cms.hhs.gov

Telephone: (312) 886-3642

States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region VI – Dallas

Becky Peal-Sconce

E-mail:

becky.peal-sconce@cms.hhs.gov

Telephone: (214) 767-6444

States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region VII – Kansas City

Claudia Odgers

E-mail:

claudia.odgers@cms.hhs.gov

Telephone: (816) 426-6524

States: Iowa, Kansas, Missouri, and Nebraska

Region VIII – Denver

Lyla Nichols

E-mail: lyla.nichols@cms.hhs.gov

Telephone: (303) 844-6218

States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region IX – San Francisco

Neal Logue

E-mail: neal.logue@cms.hhs.gov

Telephone: (415) 744-3551

States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, American Samoa, Marshall Islands, Republic of Palau, and Federated States of Micronesia

Region X – Seattle

Teresa Cumpston

E-mail:

teresa.cumpston@cms.hhs.gov

Telephone: (206) 615-2391

States: Alaska, Idaho, Oregon, and Washington



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3M™ Enhanced Ambulatory Patient Grouping System

- Simplifies the ambulatory visit for analysis and reporting
- Identifies the key procedures of an ambulatory visit
- Determines which items are paid within an outpatient prospective payment system (OPPS)

A brief history of Ambulatory Patient Groups (APGs)

Before APGs, outpatient care was difficult to analyze and manage. In response to an increasingly complex outpatient healthcare sector, the Centers for Medicare and Medicaid Services (CMS) contracted with 3M Health Information Systems in 1988 to develop an outpatient prospective payment system (OPPS).

The resulting Ambulatory Patient Groups (APGs) were introduced in 1990, with a major update in 1995. The APGs were designed to clearly describe and define each ambulatory visit for both clinical and financial purposes.

Today, several states and third-party payers continue to operate under an OPPS developed using APGs as the classification system.

The benefits of APGs

APGs provide users with a framework for better analyzing and managing the unique complexities of outpatient care. These complexities include:

- Patients receive care in many settings
- Many different procedures may be provided for similar diagnosis codes
- Resource intensity varies for similar diagnosis codes
- Documentation of services is less centralized
- Outpatient volumes are significantly higher compared to inpatient care (about 16:1)

By reducing claims complexity, APGs can help you increase the potential for identifying cost-recovery opportunities and improving profitability.

The benefits of an enhanced APG System

In 2007, 3M Health Information Systems updated the APGs to better reflect current clinical care complexities and practices and the current outpatient cost structure. The result of this major modification and update is the 3M Enhanced Ambulatory Patient Grouping System (3M Enhanced APGS), a proprietary product of 3M Health Information Systems. 3M Enhanced APGS simplifies and streamlines the APG process for better analysis and management of the OPPS environment.

3M Enhanced APGS: Product features and functions

- **Designation of APG types.** HCPCS and ICD-9-CM diagnosis codes are assigned to one of seven broad types to help in the ordering and discussion of APGs and services provided by hospitals. The seven types are: Ancillary, DME, Drug, Incidental, Medical Visit, Per Diem, and Significant Procedure.



3M™ Enhanced Ambulatory Patient Grouping System

- **Assignment of APG categories.** In addition to types, APGs are organized into one of 54 clinical categories that provide a framework for product line analysis and reporting at a more general level than APGs. Examples of the categories include: Musculoskeletal System Procedures, Nuclear Medicine, and Diseases and Disorders of the Digestive System.
- **Grouping assignments.** APGs are defined using ICD-9-CM diagnosis codes and HCPCS level 1 and 2 codes and modifiers. As these coding sets are updated regularly, the “from date” on the claim is used to designate the code and APG versions that are used for a given claim. These codes establish relative weights and determine reimbursement.

Significant procedure APGs are assigned based on the presence of appropriate HCPCS codes. The medical APGs are defined based on the primary diagnosis code. Also required for the determination of a medical APG is an appropriate hospital E&M CPT® code and the absence of a significant procedure APG. In some cases, where a significant procedure is present in conjunction with the medical visit requirements, and it is appropriate to code a modifier 25 on the E&M code, both a medical APG and a significant APG are assigned.

Ancillary service APGs are assigned based on the presence of the appropriate HCPCS code. The assignment of APGs to several of the service line items may result in multiple APGs being assigned per claim.

- **Significant procedure consolidation.** When a patient has multiple significant procedures, some significant procedures may require minimal additional time or resources. With significant procedure consolidation, multiple APGs are collapsed into a single APG for the purpose of determining payment. When APGs are consolidated, only one of them is paid. However, all APGs are identified to allow for reporting and analysis.

There are two types of consolidation: Same APG and Clinical. Same APG consolidation is where multiple occurrences of the same APG are collapsed. Clinical consolidation is the collapsing of multiple related APGs.



Health Information Systems

575 West Murray Boulevard
Salt Lake City, UT 84123
U.S.A.
800 367 2447
www.3Mhis.com

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- **Ancillary packaging.** A patient with a significant procedure or a medical visit may have ancillary services performed as part of the visit. With ancillary packaging, certain ancillary services are included in the APG payment rate for a significant procedure or medical visit. A uniform list of ancillary APGs that are always packaged into a significant procedure or medical visit is also included with the APG system.
- **Multiple visit definition.** A claim for ambulatory care may represent services provided on a single date or over a period of several calendar days. The multiple visit definition allows claims to be treated as a single day claim whether there are multiple dates of service on the claim or not.
- **Per diem payments.** APGs allow the definition of per diem payments for ambulatory mental health and substance abuse services based on the presence of predefined services on the claim.

Related grouping products available now

- **Interactive grouping: 3M™ APGfinder™ Software** incorporates the 3M Enhanced APGs and is an add-on software component of the 3M™ Coding and Reimbursement System. The software provides APG grouping assignment for use in the HIM department and by those who code patient charts, offering the same hands-on, interactive features as other 3M groupers linked to the coding system.
- **Batch grouping:** Two 3M batch grouping products now include the 3M Enhanced APGs: **3M™ Core Grouping Software** (for PC platforms), and **3M™ Enhanced APG Software** (for mainframes). Both products provide the robust APG grouping needed for large volumes of outpatient claims. When all claims data is fully integrated, patient financial services personnel can use these solutions to interface with the hospital billing application before submitting final claims.

Call today

For more information, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at **www.3Mhis.com**.

Future product integration

At present, 3M Health Information Systems is planning to integrate 3M Enhanced APGs within its HIM abstracting systems and the 3M™ Ambulatory Revenue Management Software to provide hospitals with the rich reporting they are used to performing with these tools.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Medicare Physician Fee Schedule

PAYMENT SYSTEM FACT SHEET SERIES





This publication provides the following information about the Medicare Physician Fee Schedule (PFS):

- ❖ Physician services;
- ❖ Therapy services;
- ❖ Medicare PFS payment rates;
- ❖ The Medicare PFS rates formula; and
- ❖ Resources.

Physician Services

Medicare Part B pays for physician services based on the Medicare PFS, which lists the more than 7,400 unique covered services and their payment rates. Physicians' services include the following:

- ❖ Office visits;
- ❖ Surgical procedures;
- ❖ Anesthesia services; and
- ❖ A range of other diagnostic and therapeutic services.

Physicians' services are furnished in all settings including:

- ❖ Physicians' offices;
- ❖ Hospitals;
- ❖ Ambulatory Surgical Centers;
- ❖ Skilled Nursing Facilities (SNF) and other post-acute care settings;

- ❖ Hospices;
- ❖ Outpatient dialysis facilities;
- ❖ Clinical laboratories; and
- ❖ Beneficiaries' homes.

Therapy Services

Medicare Part B also pays for the services of physical therapists, occupational therapists, and speech-language pathologists based on the Medicare PFS. Therapy services paid based on the Medicare PFS may be furnished in the following settings:

- ❖ Offices of therapists in private practice;
- ❖ Hospital outpatient departments;
- ❖ SNFs;
- ❖ Home Health Agencies (for beneficiaries who are not under a home health plan of care);
- ❖ Outpatient physical therapy providers; and
- ❖ Comprehensive Outpatient Rehabilitation Facilities.

Medicare Physician Fee Schedule Payment Rates

Payment rates for an individual service are based on the following three components:

- 1) Relative Value Units (RVU);
- 2) Conversion Factor (CF); and
- 3) Geographic Practice Cost Indices (GPCI).

Each component is discussed in more detail below.

1) Relative Value Units (RVU)

Three separate RVUs are associated with the calculation of a payment under the Medicare PFS:

- ❖ Work RVUs reflect the relative levels of time and intensity associated with furnishing a Medicare PFS service and account for approximately 50 percent of the total payment associated with a service. By statute, all work

RVUs must be examined no less often than every five years. As noted in the calendar year (CY) 2010 Medicare PFS final rule, the fourth five-year review of work was initiated in 2009. Changes to work RVUs resulting from this review are effective beginning in CY 2012. In addition, beginning in CY 2013, the five-year review of physician work process has been consolidated with the misvalued codes initiative to allow for ongoing annual public input from interested stakeholders who can nominate codes to review;

- ❖ Practice expense (PE) RVUs reflect the costs of maintaining a practice (e.g., renting office space, buying supplies and equipment, and staff costs). For CY 2012, indirect cost data that are used in the calculation of PE RVUs for most specialties were updated using the American Medical Association's Physician Practice Information Survey (PPIS) data. The PPIS is a multispecialty, nationally representative indirect PE survey of both physicians and non-physician practitioners. Its use is being transitioned over a four-year period beginning in CY 2010; and
- ❖ Malpractice (MP) RVUs represent the remaining portion of the total payment associated with a service. The second five-year review of MP RVUs was completed in CY 2009.

2) Conversion Factor (CF)

To determine the payment rate for a particular service, each of the three separate RVUs, identified in 1) Relative Value Units (RVU) above, is adjusted by the corresponding GPCI as explained in 3) Geographic Practice Cost Indices (GPCI) below. The sum of the geographically adjusted RVUs is multiplied by a dollar CF. The CF is updated on an annual basis according to a formula specified by statute. The formula specifies that the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR). The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The SGR is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in Fee-For-Service Medicare, and changes in law or regulation. Based on the criteria discussed above, the update to the CF for CY 2012 is \$24.6712.

3) Geographic Practice Cost Indices (GPCI)

GPICs are adjustments that are applied to each of the three relative values used in calculating a physician payment, as described in 1) Relative Value Units (RVU) above. The purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country. The Centers for Medicare & Medicaid Services (CMS) is required to update the GPICs every three years and to phase in any changes over two years. The GPCI work floor provisions for CY 2012 are as follows:

- ❖ The 1.0 work floor will remain in effect for services furnished in frontier States only. Frontier States include:
 - Montana;
 - Nevada;
 - North Dakota;
 - South Dakota; and
 - Wyoming; and
- ❖ The 1.5 work floor for Alaska will remain in place.

The Medicare Physician Fee Schedule Payment Rates Formula

The Medicare PFS payment rates formula is shown below:

$$[(\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{CF}$$



Resources

For more information about the Medicare PFS, visit http://www.cms.gov/PhysicianFeeSched/01_overview.asp and refer to the “Medicare Reimbursement” section of the Medicare Learning Network® (MLN) publication titled “MLN Guided Pathways to Medicare Resources Basic Curriculum for Health Care Professionals, Suppliers, and Providers” booklet at http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. To access the Physician Fee Schedule Lookup Tool, visit <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx> on the CMS website. You can access the following via the search tool:

- ❖ Pricing amounts;
- ❖ Various payment policy indicators;
- ❖ RVUs;
- ❖ GPCIs by a single procedure code, a range, and a list of procedure codes;
- ❖ National payment amounts; and
- ❖ A specific Medicare Contractor and a specific Medicare Contractor locality.

For more information about how to use the searchable PFS, refer to the MLN publication titled “How to Use the Searchable Medicare Physician Fee Schedule (MPFS)” located at http://www.cms.gov/MLNProducts/downloads/How_to_MPFS_Booklet_ICN901344.pdf on the CMS website.

To find final rules, visit <http://www.gpo.gov/fdsys/search/home.action> on the U.S. Government Printing Office website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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