



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

February 16, 2007

TO: Interested Party

RE: Consultation Summary
Project #0666-OPPS

Thank you for your comment(s) to the Medical Services Administration relative to Project Number 0666-OPPS. Your comment(s) has been considered in the preparation of the final publication, a copy of which is attached for your information.

Responses to specific comments are addressed below.

Comment: The policy statement "67.4% of the 2007 Medicare rate" is unclear or inaccurate. It could be interpreted as the State is not applying the 67.4% to the true Medicare rates, since the hospital-specific Medicare Wage Index is not being applied.

Response: In the referenced statement, "2007 Medicare rate" is referring to the CMS rates published in the Federal Register (available online via the CMS website). As published in policy bulletin MSA 06-47, Michigan Department of Community Health (MDCH) will not utilize Medicare wage indices. A factor of 1.0 will be applied for all providers.

Comment: The State should utilize a full year of data in determining the Reduction Factor (RF).

Response: Time limitations precluded the State completing additional data analysis prior to the April 1, 2007 Outpatient Prospective Payment System (OPPS) implementation date. The State used first and second quarter 2005 data when first analyzing the impact. This data was then used in determining if the available 2006 data was representative. The outcome decision by Milliman (the MDCH actuarial consultant) confirmed the data was representative within reasonable expectations (given the constraints in data availability due to coding variations between current Michigan Medicaid billing requirements and Medicare billing requirements).

Comment: Several comments were received expressing concerns about the possibility of implementation problems for Medicaid Health Plans (MHPs) and noted that the State's claims processing may adversely affect hospitals. It was suggested the State be prepared to implement interim payments to hospitals immediately to avoid cash flow disruptions.

Response: Interim payments were considered by the State and a decision made not to adopt them for OPPS implementation. The State has been, and continues, committing the resources necessary to assure its processing system will be able to accept and pay claims appropriately. It has also strived to encourage and maintain communication with its providers affected by OPPS.

Comment: Several comments requested clarification of the ongoing budget neutrality adjustments, specifically citing the process used to implement inpatient rate changes. It was suggested we follow the inpatient rate change methodology for future OPPS rate changes.

Response: Since complete data will not be available for an estimated six to nine months post OPSS implementation, the following method will be used for the initial post implementation budget neutrality analysis. The previous years' data (in summary) will be used to establish the expected corridors. The data as discussed will be reviewed and summarized by hospital (including category specific data) for 2005 data outcomes. The State recognizes population and inflation changes (increases) over the past two years, and understands how a strict corridor (based on 2005) potentially under represents expected costs/payment for 2007. Therefore the initial corridor will be adjusted for population increases and inflation increases (charge inflation - estimated at 8% per year).

The State's intent (for OPSS) is to apply the same methodology currently applied to inpatient rate changes. For example, the 2009 rate impact may be determined using claim dates of service from April 1, 2007 through March 31, 2008. These claims will be submitted through a grouper and pricer program to determine the 2008 and 2009 payment. The difference in the payment will constitute the effect of the rate changes and demonstrates how to establish the RF applied to the 2009 rates.

Comment: Comments questioned the intent of the State to implement prospective rate adjustments to recover funds if prior payments were higher than expected, noting this is of particular concern for the initial implementation period (April through December, 2007).

Response: The State has no plans to implement a prospective rate adjustment to recover prior overpayments. However, it does reserve the right to adjust the RF if significant budget concerns arise following OPSS implementation.

Comment: The application of a 10% factor should be applied (by hospital) to minimize the redistributive effect of the implementation of the OPSS. Any facilities with an expected payment ratio (OPSS:Pre-OPSS) greater than 1.00 should have an adjustor of 90% applied, and any facility with an expected ratio less than 1.00, should have an adjustor of 110% applied.

Response: The State is not positioned to apply any hospital specific adjustor or transitional hold-harmless adjustment. The State will keep this comment under consideration post implementation when there is appropriate data available for further analysis.

Comment: The RF should not be applied to those APC categories that CMS determines payment of average cost. Specifically, status indicator "K" services (Non-pass through drugs and biologicals) are based upon an "average sales price plus 6%" and as such, the 67.4% RF will not reimburse at cost.

Response: The State will not exclude status indicator "K" from the RF. Analysis of the claims data utilized for OPSS development indicated category "K" services account for approximately 2.5% of statewide outpatient charges. CMS establishes reimbursement for these services based on a national average sales price. This is significantly different from reimbursement for SI "F" and "H" services (to which the RF will not be applied), which are reimbursed on a cost to charge ratio.

Comment: A significant reduction in reimbursement for cochlear devices (CPT 69930) is potentially possible. It is suggested either a wrap around code logic be applied to current reimbursement, or the RF not be applied to this particular code.

Response: After analysis of claims data, the determination has been made to leave the cochlear devices in the APC pricing methodology. MDCH understands that moving from its current outpatient reimbursement to OPSS will impact reimbursement, positively or negatively, for many services. While cochlear implants may have a significant reduction, other services such as PET scans will have a significant increase. Implementing OPSS provides the opportunity for payment predictability, equity and consistency of payments among providers.

- Comment:** For MHPs to implement OPPS according to Medicaid guidelines, MHPs need specific details on how MDCH is setting up OPPS. MDCH indicated they will use OPPS to reimburse hospitals for observation stays and will be modifying the diagnosis list and request the list be shared with providers. This information is needed before implementation for MHPs to address any changes.
- Response:** MSA Bulletin 07-07 Outpatient Hospitals for Observation Care Services was issued February 1, 2007 with an effective date of April 1, 2007. MDCH expanded its observation coverage by adopting Medicare's Observation Care Services coverage and billing policy.
- Comment:** MDCH inquired about MHPs testing with hospitals however before testing with hospitals, we propose MHPs test with MDCH to ensure the MHP pricing methods are set up correctly. This testing needs to be completed prior to testing with hospitals.
- Response:** MDCH began the Business-to-Business (B2B) testing process in July 2006 and OPPS project updates (including B2B testing information) have been broadly communicated (e.g., MHP meetings, OPPS-APC Hospital Workgroup updates, APC Project E-mails, the Hospital Reimbursement Workgroup, MPAA meetings, etc). While MDCH continues to encourage MHPs and providers impacted by OPPS to participate in the B2B process, it is not required.
- Comment:** Many MHPs have capitulated outpatient laboratory agreements and there is concern implementing APC pricing methodology may result in MHPs paying for laboratory services two times.
- Response:** MHPs with capitulated outpatient laboratory agreements should continue to recognize the terms of the agreement. MHPs should not be paying for laboratory services twice if they follow their own agreements.
- Comment:** MHPs have not been able to move forward with systems programming of APC/OPPS until MDCH rules/pricer/grouper information has been finalized. MHPs require time to load into claims processing systems, test internally, test externally, and implement. We recommend MDCH consider extending the implementation date to allow MHPs adequate time for this to occur.
- Response:** MDCH acknowledged identified implementation concerns when initially raised with the initial kick-off of the OPPS/APC Project in 2003. Since that time, MDCH has openly communicated with MHPs and OPPS affected providers and has delayed implementation twice. Due to system limitations and the need to facilitate transition to the new CHAMPS system currently under development, MDCH will implement OPPS April 1, 2007.

I trust your concerns have been addressed. If you wish to comment further, send your comments to Sue Schwenn at: (517) 335-5128

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Sincerely,



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