June 8, 2000

Dear State Medicaid Director:

This purpose of this letter is to share background information with you regarding the pending change in Medicare's implementation of the Outpatient Prospective Payment System (OPPS). We strongly recommend that your staff continue to work closely with the Medicare Fiscal Intermediary in your State to ensure an effective implementation on behalf of Medicaid beneficiaries who also have Medicare coverage.

Background

The Balanced Budget Act of 1997 directed the Health Care Financing Administration (HCFA) to implement a prospective payment system for hospital outpatient services. Under OPPS, the Ambulatory Patient Group (APG) system has been replaced with Ambulatory Payment Classifications (APCs). Hospital billing systems and Medicare Fiscal Intermediary payment systems are being modified to handle the new payment methodology and coding classifications.

The implementation of the OPPS by Medicare may impact the way State Medicaid agencies (SMA) handle payments to hospitals, since hospitals will be making adjustments to their systems to comply with OPPS rules. Other potential implications may involve payment policies and amounts for coinsurance and deductibles for dual eligibles.

The extent to which these changes impact a particular State varies widely depending upon its claims processing systems, its method for handling copayments, and other factors. Thus, the most expeditious way to ensure a smooth transition is to work closely with your Medicare fiscal Intermediary.

Changes to the Coordination of Benefits (COB) Format

Certain infrastructure changes had to be made to support OPPS (and home health PPS, scheduled to be implemented this fall). These changes make line item processing possible, and include new formats for UB-92 Flat File, COB claim records, and the remittance advice (providers).

HCFA announced new formats for the UB-92 Flat File and remittance advice in the Medicare Intermediary manual, Transmittal 1788/CR 1080, issued in January 2000. A second Transmittal 1796/

CR 1151, issued in April 2000, included new formats for the COB claim records.

Electronic copies of the transmittals are available for downloading from the Internet at www.hcfa.gov/pubforms/transmit/transmittals. On this Web page, you will receive a list of all recent transmittals. The entry for the April update is listed in the table as:

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FILE COMM DATE MANUAL IMPL DATE CR NUMR1796.A3
4/14/2000 PUB13.3 7/1/2000 CR1151
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A click on the transmittal number ("FILE") will link to a hypertext version of the entire transmittal.

Prior versions of the UB-92, versions 5.0, 4.1 and earlier that are used by the States for COB claims can accommodate up to 297 lines for line item expansion. Until the States migrate to version 6.0 of the UB92, they will have to split the claim in order to process more than 297 line items.

Summary of Changes: The Medicare changes required by OPPS that are likely to affect States include:

1 The claim will capture more line items (450 lines of service);
2 The coinsurance may be calculated on each line item;
3 The "total" coinsurance figure will not appear on the claim; and
4 Modifiers will be used with some HCFA Common Procedure Coding System codes

Providers and trading partners must utilize version 6.0 of the UB-92 flat file beginning on December 31, 2000, as HCFA will no longer support earlier flat file versions after that date.

Enclosed with this letter is a brief overview of OPPS (see Enclosure). In addition you may find the following web sites helpful:

1 OPPS Final Regulation, Titled: "The Prospective Payment System for Hospital Outpatient Services" (HCFA-1005-FC). Federal Register, April 7, 2000; URL: http://www.hcfa.gov/regs/ hopps/
2 Medicare Intermediary Manual Instructions and the Medicare Hospital Manual URL: http://www. hcfa.gov/medicare/hopsmain.htm
3 The Blue Cross and Blue Shield Association on behalf of the Health Care Financing Administration (HCFA) developed training materials for the Medicare Outpatient Prospective Payment System. Those training materials can be obtained at URL: http://www.hcfa.gov/ medlearn/oppstrn.htm.Page 3 - State Medicaid Director

HCFA will shortly issue a Program Memorandum (PM) that instructs the Fiscal Intermediaries to notify their trading partners, including SMA's, of OPPS changes as they relate to crossovers and the availability for testing, in writing. If your data and technical staff have not yet received information from their Fiscal Intermediary contact, they should expect to within the next couple of weeks. As soon as the PM is available we will forward a copy to you.

For further information, please contact your local Medicare Fiscal Intermediary. If you have questions regarding this letter, please contact, Mary Hogan, Director of the Data and Systems Group, 410-786-6333.

Sincerely,

/S/

Timothy M. Westmoreland

Enclosure

cc: All HCFA Regional Administrators All HCFA Associate Regional Administrators for Medicaid and State Operations Lee Partridge - Director, Health Policy Unit, American Public Human Services Association Joy Wilson - Director, Health Committee, National Conference of State Legislatures Matt Salo - Director of Health Legislation, National Governors' Association

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GENERAL BACKGROUND INFORMATION ON OPPS

1. The system will apply to all hospitals (except critical access hospitals, Maryland hospitals, and, at this time, Indian Health Centers) and partial hospitalization services furnished by Community Mental Health Centers (CMHCs). It also requires a new method for calculating beneficiary copayments for the hospital outpatient services included under OPPS.

Under the current outpatient system, beneficiaries pay 20 percent of hospital charges rather than 20 percent of Medicare payments. Historically, since charges have risen faster than payments, Medicare beneficiaries often pay well over 20 percent of the total payment received by the hospital. One of the goals of the OPPS is for beneficiary copayments to eventually equal 20 percent of Medicare payments.

2. The major components of OPPS are:

Establishment of Ambulatory Payment Classification (APC) Groups - There are 459 groups of services that are related clinically and in terms of their resource use.

APC Payment Rates - Relative weights will be assigned to each group based on the median cost (operating and capital) of the services included in the group. Weights for each group will be converted to payment rates by using a national conversion factor.

Implementation of Packaging - Packaging means including payments for related ancillary services in a payment for a procedure or medical visit. Examples of services packaged include operating room, medical/surgical supplies, and recovery and observation.

Geographic Adjustments based on differences in wages across geographic areas.

Copayments - OPPS legislation freezes beneficiary copayment at 20% of the national median charge for each of the APCs.

Medicare payment is prohibited for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital, unless the services are furnished under an arrangement with the hospital.

3. The BBA authorized HCFA to develop a classification system consisting of groups of services such that services within each group are comparable clinically and with respect to the use of resources. HCFA has established relative payment weights for each group based on median hospital costs and estimated frequencies of utilization of services in 1999.

The BBA further directed HCFA to establish a wage adjustment factor and other adjustments

determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals.

4. The following services are included in the scope of hospital OPPS:

Certain services for patients who have exhausted their Part A benefits

Partial hospitalization services for Community Mental Health Centers (CMCH)

Services designated by the Secretary: surgical procedures, radiology (including radiation therapy), clinic visits, partial hospitalization for the mentally ill, surgical pathology and cancer chemotherapy

Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating Skilled Nursing Facility (SNF), but who is not considered to be a SNF resident for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans

Certain preventive services furnished to healthy persons, e.g., colorectal screening

Hospital outpatient PPS for certain medical and other health services when they are furnished by other providers, such as Comprehensive Outpatient Rehabilitation Facilities (CORFs), and Home Health Agencies (HHAs), or to hospice patients for the treatment of a non-terminal illness.

Implants

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