Legislation Text

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Fee Schedule Review for Lake County Health Department (all fees for clinical services) for Implementation in FY 2017 - Riley

The Lake County Health Department and Community Health Center (LCHD/CHC) contracted with a consultant to review the current fee schedule for all clinical services performed. The medical services performed at the T.B. Clinic were included, as well. To meet this request, a fee schedule review was conducted.

As background for this analysis, it is important to understand the role of the chargemaster and a fee schedule within any organization. The chargemaster is a tool used across the organization to charge for services provided to a patient. Fees in the chargemaster are established for each type of service provided, such as a visit, procedure, or medication. Each service is defined by a unique code that describes the specific service being provided. Either a CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) code is used.

An important principle is that the same fee is charged for the same service throughout the organization. Note that fees or charges are not the same as the amount that is actually reimbursed by a payor (i.e., Medicaid, Medicare, or commercial insurance). Also, fees do not necessarily represent what is actually collected from a patient or third party.

The chargemaster is an essential tool in the following processes:

- Revenue capture
- Enables the tracking of services provided
- Determining self-pay patients' eligibility for a sliding fee scale
- Comparing organizational fees to the market
- Negotiating appropriate payment rates for managed care and other third-party contracts

The strategy underlying the proposed revised fee schedule is based on the following assumptions:

- Access to services for individuals with limited financial means is part of the Health Department's mission and needs to be maintained.
- The financial resources of the Health Department are limited.
- Changes to fees affect self-pay patients, contract rates for commercial and fee-based Medicaid and Medicare contracts. In addition, fee changes will affect levels that Medicare patients seen in the FQHC are reimbursed.
- The methodology for fee development is consistent between LCHD/CHC and T.B. Clinic (i.e., methodology should follow the approach used in developing fees for medical, dental, and behavioral health). This is critical from an administrative and compliance perspective.

METHODOLOGY

To complete the analysis, current fees for all clinical services provided at the LCHD/CHC and T.B. Clinic were reviewed.

Data from the NextGen financial module was provided by LCHD/CHC and includes volume of visits by

procedure code (CPT). Adaptations were implemented for some codes. For example, in some instances special state codes (i.e., for prenatal care, substance abuse, and mental health) are used in lieu of a CPT code. When this occurred, an appropriate CPT code was assigned.

Fee data for LCHD/CHC fees was then compared with fees of other clinical providers in the local market. This is an industry-accepted approach for determining appropriate fee levels. To conduct the assessment, data was purchased from Optum360, formerly Ingenix, a company considered an expert resource for providing financial data to healthcare organizations. The 2016 Optum360 (Ingenix) *Customized Fee Analyzer* is a special report based on charges submitted to insurance companies. Fee data is provided by CPT code and is specific to the specialty from the LCHD/CHC geozip. For each CPT code, a range of charges is detailed based on percentiles.

The 75th market percentile is used as the starting point for this price comparison. This is based on fees charged by local providers submitting claims by CPT code. This change to a higher percentile was implemented in 2015 and was necessary for several reasons:

- Chargemaster rates are proposed at levels above the latest Blue Cross fee schedule to ensure that all reimbursement available is collected. (Blue Cross is LCHD/CHC's largest commercial carrier).
- Use of the 75th percentile ensures that Medicare reimbursement for FQHC's is appropriately captured.
- Greater access to insurance is now available to uninsured patients due to the expansion of eligibility criteria for Medicaid patients and the option of purchasing commercial insurance on the governmental insurance exchange.
- A discount is still provided for self-pay patients with limited means through the sliding fee scale.

There were some exceptions to the methodology of the 75% percentile of the 2016 Optum360 customized fee analyzer which are illustrated on the attached Summary Grid of Fee Rationale chart.

Impact of Proposed Fees
The following points summarize the major trends seen in the proposed fee changes which would be implemented in FY 2017.

The fees would change as follows:

- 44% of fees would increase
- 40% of fees would remain the same or within $1 of current levels
- 16% of fees would decrease

The fees could be reviewed and adjusted during the year if new contracts are entered into or contractual service agreements, such as from the state or other contractual partner like Quest, are increased greater than these proposed fees. If new services are provided, then a CPT code will be assigned by the Medical Coding Manager and the fee will be assigned using the 75th percentile of using the 2016 Optum360 (Ingenix) *Customized Fee Analyzer or* other method per the attached Summary Grid of Fee Rationale. All fees are effective December 1, 2016, with the exception of the flu fees, these new fees would be effective July 1, 2017.

To approve the Medical, Dental and Behavioral Health fee schedule effective December 1, 2016 with the exception of the flu codes to be effective July 1, 2017 and to use the methodology described in the attached Summary Grid of Fee Rationale for assigning a fee to any CPT codes added during the next fiscal year not listed but required for billing purposes.