

OKLAHOMA HEALTH CARE AUTHORITY
SFY10 Budget Reduction Analysis
And Staff Recommendations
Detailed Descriptions

Administration

OHCA will absorb a 5% cut in administration. These cuts will come from restricted purchases of furniture & equipment, non-essential travel, discretionary supplies, and administrative service contracts. In addition, vacant positions will be reviewed and evaluated for cost savings.

Proposed state reduction - \$2.8 million

Dental

Reduce payment for posterior fillings to amalgam rate.

The payment for posterior fillings will be reimbursed at the rate paid for amalgam fillings. Reimbursement rate for resin fillings will be reduced by 45%.

Proposed state reduction - \$1.8 million

Durable Medical Equipment (DME)

- Pricing adjustments for oxygen and capped rental
All pricing for the rental of stationary and portable oxygen will be reduced by 11% and 8% respectively to match Medicare 2009 fee schedule for oxygen. Capped rental of oxygen items were adjusted to match the total outlay for Medicare Capped Rental items (Medicare discounts 25% for rental months 4 – 13). OHCA brought its capped rental in alignment with Medicare's capped rental policies. However, oxygen remains a continuous rental item per OHCA's policies.
Proposed state reduction - \$178k

- Reduce oxygen payment rate for adults
Stationary and portable oxygen pricing rates for adult members not residing in a nursing facility will be reduced by 10%. Stationary and portable oxygen pricing rates for adult members residing in nursing facilities will be reduced by 24%.
Proposed state reduction - \$168k

- Pricing adjustments for children's nebulizers and eliminate adult nebulizers
Pricing for compressor driven nebulizers will be reduced by 36%. Adult coverage of compressor driven nebulizers will be eliminated.
Proposed state reduction - \$189k
Adults affected – 1,500

- Restrict number of blood glucose test strips without a prior authorization from 300 to 100 strips
Restricting test strips to 100 w/out a Prior authorization will reduce utilization by 40%. In addition, applied discounted rate for mail order supplies dispensed by using CMS modifier will allow for an additional 15% reduction.
Proposed state reduction - \$272k

- Eliminate other adult DME products
Adult coverage of the following items will be eliminated:
Negative pressure wound therapy Blood glucose monitors
Osteogenic stimulators Portable oxygen contents
Form fitting conductive garments Water circulating heat pad w/pump
Proposed state reduction - \$127k
Adults affected – 2,843

DME TOTALS

Proposed state reduction - \$934k

Pharmacy

- Change script limit to 2 brand + 4 generic
Currently members receive 6 prescriptions per month with a maximum of 3 brands within the 6 script limit. This change will decrease the number of brands to 2 brands within the 6 script limit. The impact also includes the loss of related drug rebate revenue.
Proposed state reduction - \$572k
- Utilization management of triptans, otics, fibromyalgia, and antipsychotics (eff. 4/01/10)
These categories will be added to the product based prior authorization program.
Proposed state reduction - \$622k
- Revise reimbursement methodology for certain injectable drugs including but not limited to growth hormone and blood factor.
Proposed state reduction - \$462k

PHARMACY TOTALS

Proposed state reduction - \$ 1.7 million

Provider Payment Changes

- Hospital crossover co-insurance and deductible change
OHCA will reduce the Medicaid allowable for Medicare Part A & Part B crossover claims from 100% of the Medicaid allowable for co-insurance (part B) and deductibles (part A) to 25% of the Medicaid allowable for co-insurance and 75% of the Medicaid allowable for deductibles. However, providers can list this unpaid amount as “bad debt” on hospital Medicare cost reporting to CMS. Under the Medicare statutes, a provider is entitled to claim as reimbursable cost bad debts attributable to amounts unpaid for Medicare co-insurance and deductible amounts. According to the Oklahoma Hospital Association 70% of the unpaid amount is reimbursable by Medicare.
Proposed state reduction - \$5.3 million
- Implement cost caps for behavioral health utilization for outpatient levels of care.
Behavioral health categorizes outpatient services of care into 4 levels with level 4 being the most intensive method of service delivery. All services are authorized with a maximum of units available within each level of care from levels 1 - 4. OHCA will reduce the utilization cap on levels of care 3 & 4 by 25%.
Proposed state reduction - \$630k
Members affected – 3,000
- Modify payment methodology to a tiered reimbursement schedule for Psychiatric (eff. 4/01/10) Residential Treatment Facilities (PRTF). Reimbursement for residential treatment in PRTF’s will be reduced after 30 days by 15%. An additional 15% will be reduced from the rate after 60 days of residential treatment. Accordingly the PRTF’s rates will remain at 70% of the initial rate throughout the completion of the residential treatment. In addition, program savings have been offset with additional costs due to enhanced continuum of care services in outpatient.
Proposed state reduction - \$639k
- Increase member’s co-pay not to exceed federal maximum (eff. 4/01/10)
Member’s co-pay will be increased for the following provider groups:
Inpatient Hospital will increase from \$3.00 to \$10.00 per day with a cap of \$90.00
Adult behavioral health will increase from -0- to \$3.00 per visit
Home Health will increase from \$1.00 to \$3.00 per visit
DME will increase from -0- to \$3.00 per visit

Pharmacy will increase from \$1.00 to \$2.00 for prescriptions having a Medicaid allowable of \$29.99 or less and will increase from \$2.00 to \$3.00 for prescriptions having a Medicaid allowable of \$30.00 or more. In addition, preferred generic prescriptions will decrease to a zero co-pay.

Proposed state reduction – 218k

Adults affected – 280,000

- **Eliminate Modifier 57 code**
This change will eliminate payment for the evaluation & management (E&M) service which resulted in the decision to perform a major surgery, which is reported by appending Modifier 57 to the E&M service code when the E&M service is performed on the day before or the day of said major surgery. (A major surgery is defined as a surgery having a 90-day global period).
Proposed state reduction - \$41k
- **Eliminate separate payment for impacted earwax**
OHCA will no longer provide a separate payment for impacted earwax removal.
Proposed state reduction - \$34k
- **Never Events / Present on Admission**
CMS has established National Coverage Determinations that nationally “non-cover” three surgical errors. These errors are: 1) wrong surgical or other invasive procedures performed; 2) surgical or other invasive procedures performed on the wrong body part; and, 3) surgical or invasive procedures performed on the wrong patient. OHCA is adopting the same policy position effective February 1, 2010. Additionally, hospitals will not receive reimbursement for conditions that are acquired during a hospital stay (termed POA, or present on admission). Payment will be made as though this secondary diagnosis was not present.
- **Medical necessity inpatient review**
The pool of inpatient claims will be expanded to review more claims for medical necessity.
Proposed state reduction - \$70k
- **Inpatient Hospital Stay Reviews**
Instances have been noted during a current review in which hospitals were billed and reimbursed inappropriately for one-day stays. Claims should have been made for an emergency room visit, observation visit, or outpatient surgery, but were instead billed as an inpatient hospital admission. Overpayments will be recouped and appropriate edits will be added to the claims payment system to assist in cost avoided overpayments in the future.
Proposed state reduction - \$2.5 million

PROVIDER PAYMENT TOTALS

Proposed state reductions - \$9.6 million