Report to the Health and Human Services Appropriations Subcommittee

Changing Medicaid Outpatient Reimbursement

Prepared by the Division of Medicaid and Health Financing

September 2009

UTAH DEPARTMENT OF HEALTH

EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed by the 2009 Legislature:

"The Legislature intends that the Department of Health shall provide a report to the Health and Human Services Appropriations Subcommittee by October 1, 2009 on how to change outpatient hospital reimbursement to a fee-for-service system within the Medicaid program and the estimated savings."

Current Reimbursement Methodology: Percentage of Charges

In Utah Medicaid, most outpatient claims are currently reimbursed as a percentage of charges. This method gives the State no control over the growth in outpatient payments to hospitals. In recent history, the State has not been able to reduce the percentage paid, as the Centers for Medicare and Medicaid Services (CMS) would not approve state plan changes that include percentage of charges.

Two Ways to Implement Fee-For-Service

There are two ways in which Medicaid could change outpatient hospital reimbursement to a fee-for service system:

- Implement a Revenue Code fee schedule, or
- Adopt the CMS Outpatient Prospective Payment System (OPPS)

Both allow more control over reimbursement inflation and both can be used to set reimbursement to a desired level.

Cost Savings

Neither method includes an inherent immediate reduction in reimbursement. Either method can be used to control inflation or to reduce reimbursement. The Revenue Code fee schedule does, however, include two modifications which can logically be used to reduce reimbursement:

- Ranking surgery codes and
- Paying all CPT/HCPCS codes according to the fee schedule.

Recommendation: A Revenue Code Fee Schedule

Of the two methodologies, implementing the Revenue Code fee schedule appears preferable. It has the following advantages:

- Can help control reimbursement inflation
- Can be used to implement reimbursement reduction
- Requires minimal change from the current system
- Is comparatively easy to implement
- Requires minimal maintenance and
- Does not inherently reduce level of care

Introduction

According to the Utah Medicaid State Plan, Medicaid currently pays hospitals a percentage of charges for outpatient claims. Such a reimbursement methodology has no mechanism to limit or control inflation, especially since 2004 when the Centers for Medicare and Medicaid Services (CMS) told the State it would not approve state plan changes that include percentage of charges. More recent discussions with CMS under the current administration have signaled some additional flexibility on this issue.

Terminology

It is useful to explain a few terms at this point, for clarity:

- *APC* means Ambulatory Payment Classification
- *CPT* means "Current Procedural Terminology." CPT codes are determined by the American Medical Association and are primarily used for Physician services.
- *DRG* means Diagnosis Related Group
- *HCPCS* means "Health Care Procedure Coding System." HCPCS codes were developed by CMS and are used for medical supplies, dental procedures, rehabilitative services, drugs etc.
- *NDC* means the National Drug Code as developed by the US Food and Drug Administration (FDA)
- *OPPS* means Outpatient Prospective Payment System as developed by CMS
- *Revenue Code* means the codes developed by the National Uniform Billing Committee. The codes are specific to hospital revenue centers (i.e., the laboratory).

Current Payment Methodology

Before considering potential changes, decision makers should have an understanding of the current outpatient reimbursement methodology.

Currently there are two major sub-divisions of outpatient reimbursement:

- Most claims are reimbursed as a percentage of charges
    - Rural claims are reimbursed at a higher rate than urban claims (93 percent vs. 77 percent or charges)

- Emergency Room claims for "true" emergencies[1] are reimbursed at the highest rate (98 percent of charges)
- ER claims that are not for "true" emergencies are reimbursed at a lower rate (65 percent if rural, or 40 percent if urban)

- Other claims are reimbursed according to the CPT/HCPCS fee schedule. These include
  - Laboratory and Radiology claims
  - Physical and Occupational Therapy claims
  - Lithotripsy claims
- In each case, if a lesser amount is billed, Medicaid pays the billed amount.
- Payment for partially completed services, as noted by the appropriate modifier, is paid at 50 percent of the regularly scheduled rate.

Alternative One: A Revenue Code Fee Schedule

Proposed Payment Methodology

One approach to changing outpatient hospital reimbursement to a fee-for-service system within the Medicaid program is to create a Revenue Code fee schedule.

When a hospital submits an outpatient claim, each line of that claim includes a Revenue Code. Some lines also include a CPT/HCPCS code, and some of these also include an NDC.

Reimbursement under this alternative would be as follows:

- Claim lines with a CPT/HCPCS code would be reimbursed using the already existing CPT/HCPCS fee schedule.
  - The surgery ranking system that currently applies in other venues would now also apply to outpatient claims.

    This means that the surgery code with highest reimbursement would be reimbursed at 100 percent of the fee schedule. The surgery code with the next highest reimbursement is paid at 50 percent of the fee schedule and the rest at 25 percent. This only applies to surgery codes.
- Claim lines without a CPT/HCPCS code but with an NDC would be reimbursed using the already existing NDC fee schedule.

[1] Determination of a "true" emergency is based upon the principal diagnosis code.

- Claim lines with neither a CPT/HCPCS code nor an NDC would be reimbursed using the Revenue Code fee schedule.
    - In order to maintain the current relationship between emergency and other claims, claim lines reimbursed using the Revenue Code fee schedule would be multiplied by the following factors:

Urban, not through the ER	1.000	
Rural, not through the ER	1.208	(equal to 93 / 77)
Urban or Rural, through the ER, emergency	1.273	(equal to 98 / 77)
Urban, through the ER, non-emergency	0.519	(equal to 40 / 77)
Rural, through the ER, non-emergency	0.844	(equal to 65 / 77)

Changes Required

In order to move from the current methodology to this alternative, the following would need to be done:

- Develop and implement a Revenue Code fee schedule,
- Amend the State Plan to gain CMS approval for payment via fee schedule,
- Apply the surgery ranking system to outpatient claims,
- Model the impact of the new system on payments
- Coordinate the implementation of the new payment system with hospitals
- Implement the multiplier factors,

Each of these items would take a substantial level of effort and would require changes in both Utah Medicaid and hospital information systems.

The Revenue Code fee schedule could be developed using historical submitted charges per Revenue Code.

If necessary, it is possible to add additional reimbursement for outlier claim amounts, using a threshold multiplier and percentage payment over that multiplier. Claim variability is low enough that there should be very few outliers, though individual outliers can have very high charges. Pharmacy claims have the highest variability, but these would not be reimbursed using the Revenue Code fee schedule.

Alternative Two: Using the CMS OPPs

Proposed Payment Methodology

Another approach to changing outpatient hospital reimbursement to a fee-for-service system within the Medicaid program is to reimburse using the CMS Outpatient Prospective Payment System (OPPS).

This system assigns Ambulatory Payment Classifications (APCs) based on the HCPCS codes submitted for payment. These classifications are similar to Diagnosis Related Grouping (DRG) classifications used for inpatient hospital claims.

- HCPCS codes are assigned into APCs. (An individual outpatient claim may include multiple APCs.)
- Similar to DRGs, each APC has a weight, which is the average relative effort to perform the required procedure(s).
- The weight is multiplied by a base rate, a dollar value that converts the weight to a reimbursement amount.
- Payments for services integral or ancillary to the delivery of a procedure or medical visit can be packaged into the payment for that procedure or visit.
- When multiple significant procedures are performed or when the same service is performed multiple times, a discount may be applied. The full payment amount is paid for the surgical procedure with the highest weight and 50 percent of the payment amount is paid for other surgical procedures during the same visit.
- Procedures terminated prior to anesthesia are reimbursed at 50 percent.
- Codes that should not be billed together for the same patient on the same day would not both be paid.
- Ambulance, diagnostic clinical laboratory, screening mammography, physical therapy, speech therapy and occupational therapy services are paid according to a fee schedule instead.
- The wage portion of the base reimbursement is adjusted according to local wages.
- Outliers are paid at 50 percent of the facility's cost-to-charge ratio adjusted submitted charges over and above the threshold. The 2009 threshold is the higher of 175 percent of the base reimbursement for that APC or the APC plus a fixed threshold of $1,800. For example: If the facility's cost-to-charge ratio was 60 percent, submitted charges were $4,000 and the base OPPS payment was $100, then the facility would receive $100 plus $250.[2]

Changes Required

In order to move from the current methodology to this alternative, Medicaid would need to do the following:

- Obtain a copy of the CMS OPPS grouper and integrate it into claims payment systems
- Change the State Plan to authorize payments based on the CMS OPPS

[2] $250 = ((4000 * 0.6 – 1,900) * 0.5) Threshold of 1,900 = Higher of (100 x 1.75) or (100 + 1,800)

- Develop weights for the APCs in the grouper
- Program reimbursement based on the weights and outlier logic
- Model the impact of the new system on payments
- Coordinate the implementation of the new payment system with hospitals
- Develop and/or maintain payment methodology for services excluded from the grouper
- Update the grouper when CMS does

Advantages and Disadvantages of Each Method

Advantages of a Revenue Code Fee Schedule

- The payment process is very similar to what Medicaid does currently.
- There can be explainable savings from
    - Ranking outpatient surgery codes as Medicaid does in office surgery codes
    - Paying HCPCS codes according to the physician fee schedule
- There should be no added incentive (other than any proposed rate cuts) for providers who continue to see Medicaid patients to reduce the level of care they provide.

Disadvantages of a Revenue Code Fee Schedule

- It does not limit future increases in the number of procedures performed per patient, but such controls could be implemented via utilization edits.

Advantages of the CMS OPPS

- The incentive for providers to maximize costs for a few (but not all) procedures is limited by the grouping of procedures into a single payment per APC.
- Providers have some familiarity with the method because it is used by Medicare.

Disadvantages of the CMS OPPS

- The State would incur costs to purchase and maintain APC grouper software.
- More programming is required to interface with the OPPS with Medicaid claims payment systems, and thus more time required for implementation. (In addition to the required

Grouper interface, the electronic remittance advice detail would need to be revised to report the applicable APC for each HCPCS code.)

- Continued updates would be required to keep current with changes in OPPS groupers and payment methodology. (Medicare updates its APC grouper on a quarterly basis.)

Estimated Savings

No Immediate Savings Inherent in Either Method

While both methods can be used to reduce reimbursement (by reducing reimbursement per item on the fee schedule, or per APC) such a reimbursement reduction is not inherent in either system.

Both proposed methods can be implemented in a budget neutral fashion.

Impact on Inflation

Both methods do, however, have an inherent impact on reimbursement inflation. Higher charges per procedure would no longer translate into higher reimbursement. This would eliminate the need for outpatient hospital reimbursement to be included in the “forced” inflation building block requests that the subcommittee considers each legislative session. Inflationary appropriations would then be at the discretion of the Legislature.

Reimbursement Reduction Can Now Be Specified

Both methods would allow reduction in reimbursement - by reducing reimbursement per item on the fee schedule, or per APC.

This reduction can be to almost any chosen level of reimbursement that still affords client access to services.

Recommendation

If the decision is made to move away from outpatient hospital reimbursement based on a percentage of charges, then Medicaid recommends the implementation of a Revenue Code fee schedule reimbursement methodology.