Medicaid Issues —

MEDICAID REIMBURSEMENT OF OUTPATIENT HOSPITAL SERVICES

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Issue Statement

While outpatient hospital services represent only a small fraction of the overall hospital services budget ($71 million, or 3.5 percent of total expenditures in North Carolina in FY92), it is a rapidly growing segment. If not addressed concurrently with proposed changes in the inpatient hospital reimbursement system, the problems associated with containing costs for outpatient care become even greater. Efforts to control expenditures in one area frequently result in increased costs in other, related areas, if a comprehensive strategy gives way to a segmented and uncoordinated approach.

Reimbursement policies for outpatient hospital services must be implemented in order to control the rate of increase in this rapidly growing area. This issue paper examines alternative cost containment strategies for North Carolina.

Background

In recent years, use of outpatient hospital services has increased at both the national and state level. This has caused states and other payors to focus on the cost-effective use of outpatient hospital services as a primary objective in the evaluation of outpatient reimbursement methodologies. The outpatient hospital reimbursement methodology should provide a complementary set of economic incentives which support the delivery of all types of services in the most appropriate and cost-effective setting. Outpatient reimbursement policies, if they are to be effective in controlling costs, must be directed at the level and intensity of the service, not the setting in which it is delivered. Similar services should be reimbursed at commensurate levels so that providers have the financial incentive to utilize the least costly alternative setting. One of the primary goals in developing alternative outpatient reimbursement methodologies is to reduce unnecessary use of the emergency room setting for non-emergency care. Another is to facilitate the movement of outpatient care to the less expensive physician's office or clinic setting.

The increased utilization of outpatient hospital services may be attributed to a number of factors. Technological advances have enabled the performance of a large number of surgical procedures in an outpatient hospital setting. Private insurers have also increased their efforts to encourage the provision of selected surgical procedures on an ambulatory basis. Finally, hospitals have developed many new products, such as intensive day treatment for mental health, which they are offering on an outpatient basis.

In addition to the shifting of inpatient services to the outpatient hospital setting, increased utilization of outpatient hospital services may result from a trend on the part of patients to use the hospital in lieu of the physician's office for primary care services, particularly for Medicaid patients. The outpatient hospital department or emergency room may be perceived as a convenient place to receive care; the facility, unlike the physician's office, is always open and does not require an appointment. Use of outpatient hospital facilities in order to obtain primary

care may reflect a choice on the part of patients; however, it may also result from a lack of physicians willing to accept Medicaid patients. In areas where few physicians serve Medicaid patients, the outpatient hospital department may be the only setting available for primary care.

Due to the additional resources necessary to maintain an emergency room setting, substantial savings occur when the use of emergency room services for primary care is reduced. For this reason, states have devised payment programs which discourage use of outpatient hospital services for primary care, particularly emergency room services. However, care must be exercised to prevent penalizing hospital providers for patient behavior and self-referral patterns beyond their control.

The Medicare Program has been evaluating alternative prospective payment methodologies for several years and many states have taken a "wait and see" attitude, hoping to adopt the new system implemented by that program. Currently, the leading candidate under consideration by Medicare is the Ambulatory Patient Groups (APGs) system. The APG patient classification system is much like the DRG classification system for inpatient services, however, the APG system is procedure-based rather than diagnosis-based. This system is useful because it is comprehensive, has a manageable number of groups and uses routinely collected information. In the APG system, patients are bundled into categories of outpatient service based on HCPCS codes, ICD-9-CM codes, and patient sex. Because Medicare implementation of this approach does not appear to be immediately imminent, it is apparent that states must take the lead and implement prospective payment systems for outpatient services if they want to gain control over this program area. It is important, however, to develop approaches that are compatible with what Medicare is proposing to ensure billing forms and coding requirements will be similar.

A number of policy goals should be considered in the identification and evaluation of payment alternatives and the development of reimbursement strategies. The alternatives considered should:

- Recognize special characteristics of the North Carolina outpatient hospital/primary care market
- Encourage appropriate use of outpatient hospital services
- Encourage provision of services in a cost-effective setting
- Promote access to care
- Recognize extraordinary costs of providing certain types of care, such as trauma services
- Minimize administrative burden, to state and providers

- Complement the strategies of other reimbursement programs, including inpatient and physician reimbursement systems

- Increase the predictability of expenditures in an area facing rapidly expanding utilization and expenditures levels

- Use the same billing and coding system methods for reimbursement as Medicare, where practical, thereby reducing administrative burden for providers

- Allow flexibility in the periodic updating of rates

Findings

Finding 1: ***Cost-based reimbursement has been ineffective in controlling outpatient hospital expenditures.***

Medicaid expenditures for outpatient hospital services tripled between FY87 and FY92. Over the same time period, expenditures per recipient more than doubled. (See Exhibit 1.) Data provided by the Health Care Financing Administration (HCFA) indicate that in FY92, the average payment per outpatient hospital visit was $89 in North Carolina, compared to a national average of $48. (See Exhibit 2.) Average expenditures per Medicaid recipient, however, were $217, well below the 1990 national average of $293. (See Exhibit 3.) No conclusions can be draw regarding this lower rate of utilization by North Carolina Medicaid recipients without further examination of benefit coverages and limitations of other states' programs.

The North Carolina Medicaid reimbursement methodology for outpatient hospital services pays facilities eighty percent of allowable costs. Based on federal requirements, radiology and laboratory services are paid prospectively and cannot exceed limitations established by Federal law.

In addition, this offers relative simplicity in its implementation and administration for both providers and the Medicaid agency. However, such a system provides few incentives for hospitals to contain costs and ensure the proper utilization of outpatient hospital services. Because the system is based on costs, hospitals have no incentives to control volume or scope of services.

In addition, after Medicare implemented the Diagnosis-Related Grouping (DRG) approach for inpatient services, hospitals changed their policies, and their charge structures, to optimize reimbursement in the relatively uncontrolled area of outpatient hospital cost-to-

EXHIBIT 1

NORTH CAROLINA MEDICAID PROGRAM 1987-1992
EXPENDITURES FOR OUTPATIENT HOSPITAL SERVICES

Fiscal Year	Payments	% Increase Decrease	Recipients	% Increase Decrease	$ Per Recipient	% Increase Decrease
1987	$16,801,954.94		225,730		$74.43	
1988	$19,243,077.36	14.53	238,498	5.66	$80.68	8.40
1989	$26,378,359.52	37.08	272,735	14.36	$96.72	19.87
1990	$35,169,408.26	33.33	326,762	19.81	$107.63	11.28
1991	$49,799,846.41	41.60	394,672	20.78	$126.18	17.24
1992	$71,224,671.78	43.02	394,672	25.13	$144.22	14.30
1987-1992		323.91		118.78		93.76

Source: Health Care Financing Administration, Report on State Medicaid Expenditures

EXHIBIT 2

COMPARISON OF STATE MEDICAID EXPENDITURES PER VISIT

	1989	1990	Percent Change
Georgia	$40.75	$30.22	-25.8
South Carolina	$32.29	$45.81	41.9
National Average	$49.87	$47.73	-4.3
HCFA Region IV	$55.45	$64.47	16.3
Tennessee	$83.52	$67.35	-19.4
Kentucky	$61.57	$67.74	10.0
North Carolina	$76.55	$89.30	16.7
Virginia	$101.42	$120.41	18.7

Source: Health Care Financing Administration, Report on State Medicaid Expenditures

EXHIBIT 3

COMPARISON OF STATE EXPENDITURES PER RECIPIENT

	1989	1990	Percent Change
Virginia	$284	$349	22.6
Georgia	$277	$337	21.6
National Average	$243	$287	18.3
Kentucky	$260	$285	9.8
Tennessee	$182	$217	18.8
North Carolina	$127	$164	28.9
South Carolina	$275	$293	6.5

Source: Health Care Financing Administration, Report on State Medicaid Expenditures

charge ratio. Since "charges" are based on hospital's own pricing policies, they are adjusted based on competitive strategies. "Costs," are then driven by hospitals' own policies. Thus, increases in "allowable" costs can occur at rates that exceed the increases granted to other Medicaid program areas.

Finding 2: North Carolina Medicaid outpatient hospital reimbursement policy does not provide comparable payment across providers for comparable care.

Outpatient hospital services, with the exception of emergency (e.g., trauma) services, are somewhat comparable to physician and clinic type services. If comparable services are paid at comparable fixed rates, significant savings can be achieved. For example, the average emergency room visit payment ranges from $135 to $170 and is significantly higher than the $35 average payment rate for a physician office visit.

There are many other services, such as therapy services, which could also be provided in the clinic or physician office setting. Payment for these services can be made comparable across settings to achieve significant cost savings.

Two controversial issues arise in establishing fixed fee schedules for outpatient hospital services. First, as explained earlier, it is difficult for hospitals to control recipients' inappropriate use of the emergency room. Once an individual presents him/herself for treatment, the patient cannot, by state law, be turned away. If the payment system is designed to reduce payment for inappropriate utilization of the emergency room, hospitals may be unfairly penalized. This issue is being addressed through the primary care case management program, Carolina Access, which links recipients to a primary care provider who is available to them 24 hours a day. In addition, under a soon-to-be implemented approach, hospitals will receive a triage-fee of $22 in order to assess the condition of a patient who presents him/herself to the emergency room and refer the patient back to his or her primary care physician if a non-emergent condition exists.

The second issue is payment for "true" emergency services. It may be difficult to establish a flat fee for use of the emergency room because of the wider variation of cases treated there. Ohio developed an approach by classifying levels of emergencies. South Carolina and Arizona have establish tiered fees based on charge groupings, for example, payment for claims with charges from $100-150 are paid $80; for charges from $151-200, $120, and so on. While charge-based payment is less desirable from a policy perspective, this approach recognizes the need for compromise and, more importantly, the need to encourage hospitals to provide care to Medicaid recipients for these services.

Finding 3: Reporting on hospital outpatient claims is insufficient to determine exactly what kinds of services are being provided.

Hospitals bill on the universal billing form for outpatient hospital services. Information is billed by "revenue code", such as emergency room, clinic, surgery, etc. While it is possible to determine, for example, that charges of $100 were incurred for a clinic visit, and the diagnosis which was treated, it is not possible to determine the precise nature of services delivered during that visit. The Health Care Financing Administration's Common Procedure Coding System (HCPCS) provides the more detailed information needed for prospective ratesetting, and comparing services across settings.

In many states where moves to a HCPCS-based fee schedule have been contemplated, hospitals have been opposed to the new billing requirements (which require training of hospital billing staff). Medicare changes, however, that are currently in development, rely on HCPCS codes, and it can be argued that hospitals will have to make this change anyway.

Recommendations

Recommendation 1: Move away from a cost based payment approach for outpatient hospital services to a "bundled" prospective payment approach.

Prospective reimbursement of outpatient hospital services encourages hospitals to control costs and efficiently use resources. The recommended system relies on a fee schedules for specific service "bundles". "Bundles" are groups of services which are provided on the same day or as part of the same incident of care.

Fee schedules provide flat, fixed rates for individual services or groups of services. Generally, payment is made based on the current median payment amount for each service. Rates may be statewide, or peer grouped by class of facility. In particular, designated trauma centers may be singled out for peer group treatment. Services should be based on a combination of revenue and HCPCS coding.

Under the bundling approach, payment rates would be assigned to each of a number of global care categories (such as emergency, outpatient surgery). The global fee is intended to pay for all but a few add-on services, such as complex radiology and laboratory services, which are reimbursed separately. The utilization of complex laboratory and radiology services exhibit extremely variable patterns; payment for these services as part of the global fee may place undue financial burden on facilities whose outpatient departments treat large numbers of complicated cases or provide specialized outpatient services for chronically ill patients.

This approach provides incentives for hospitals to control costs and allocate resources efficiently. Also, this approach avoids the problem of billing fragmentation. A bundling or global fee approach requires few billing changes for hospitals; the "bundling" of services is performed by the claims processing system.

Although the bundling approach offers many desirable features, it has some disadvantages. If payment rates are established statewide, facilities that serve more seriously ill patients may be underpaid. Peer grouping could be used to address this situation if analysis indicates differential rates are warranted.

Key elements of a bundled service methodology for outpatient hospital include:

- Prospective fee-for-service payment versus current cost-settled arrangement
- Payment of non-emergency care at comparable clinic or office visit rates
- Flat-rate payment for all facilities versus current facility-specific percentage of costs
- Rates set based on relative cost of "bundled services" versus current service-specific costs
- Payment for outpatient surgeries at rates based on Medicare's Ambulatory Surgery Center (ASC) Groups
- Rebasing on a multi-year cycle, with annual updates based on an inflator

A service bundling scenario for prospective outpatient hospital reimbursement is highly compatible with proposed HCFA initiatives for Medicare. A sample outpatient services bundling hierarchy is described in Exhibit 4.

The experience of other states provides the basis for determining the potential impact of changes in outpatient care reimbursement to a bundled service approach. The changes in payment levels cited below were based on estimated outpatient hospital reimbursement set at varying percentages of median facility cost as compared to a previous level of facility payment.

- Emergency Room - 18 percent reduction
- Emergency Room used for non emergency care - 13 percent reduction
- Stand-alone services (therapies and MRI) - 8 percent reduction
- Cast Room - 4 percent reduction
- Labor and Delivery Room - one-half percent reduction

EXHIBIT 4

SAMPLE OUTPATIENT SERVICE BUNDLING HIERARCHY

Service Bundling Level	Basis of Assignment to Bundling Level
1	If the claim has an Operating Room, Recovery Room or Ambulatory Surgery revenue code, assign the claim to the Ambulatory Surgery category.
2	If the claim has an Emergency Room revenue code and a diagnosis which matches the state-specific definition of an emergency[1], assign the claim to the Emergency category.
3	If the claim has a Labor and Delivery Room revenue code, assign to Labor and Delivery category.
4	If the claim has a Hemodialysis revenue code, assign to Hemodialysis category.
5	If the claim has an Emergency Room revenue code and a diagnosis which is not on the state's emergency diagnosis list, or if the claim has a Clinic or Cast Room revenue code, assign to the Clinic category.
6	Assign all other claims (those without outpatient accommodation codes) to a stand-alone category.

[1] The state may develop a list of diagnoses which it deems to be emergency care and use the list as a screening device for emergency room claims. The system is designed to reduce the reimbursement for non-emergency cases treated in the emergency room to a level consistent with those for services delivered in a clinic or physician office setting.

Although potential savings from developing ambulatory surgery bundles are difficult to calculate precisely without the detailed analysis of paid claims data, the proposed methods of reimbursement suggest that savings may be significant. Based on eight Medicare ambulatory surgery groups, a change in reimbursement would produce savings to the extent of any difference between current payment levels and payment at the statewide median payment.

In addition to the benefits mentioned above, prospective outpatient reimbursement systems enable states to better forecast and budget costs of Medicaid programs. Also, state Medicaid agencies are better able to monitor the utilization of particular services and the allocation of resources.

Implications:

- Outpatient hospital providers may be reluctant to embrace prospective payment as a policy because of the potential financial risk; risk can be mitigated, however, through use of peer group payments, and a process which continues to assure adequate payment for emergency services.

- Hospitals must change their billing practices and use HCPCS codes on their claims. This change will be mandated by the Medicare program when a new prospective system is implemented.

- Medicaid Management Information Systems changes are needed to support the "bundling" system.

- The State will gain greater control over this segment of expenditures.

Cost Savings

Cost savings for changing the Medicaid reimbursement methodology for outpatient hospital services were based on the following assumptions:

- Average payment per recipient for outpatient would increase 14.2 percent annually, based on increases per recipient between 1987-1992.

- States that have moved from a fee-for-service to a median-based peer grouped payment methodology experienced, at least, a 3 percent reduction in rates.

Initial cost savings for the first year of the median-based peer grouped payment was approximately $600,000. Cumulative savings over the ten-year period was $12 million. For further cost savings information refer to Exhibit 5.

EXHIBIT 5

RECOMMENDATIONS FOR MEDICAID REIMBURSEMENT OF OUTPATIENT HOSPITAL SERVICES
PROJECTED COST SAVINGS (In Millions)

Fiscal Year	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Expenditures	$20.4	$23.3	$26.6	$30.4	$34.7	$39.7	$45.3	$51.7	459.1	$67.5
Implementing Prospective, Bundled Rates	$0.6	$0.7	$0.8	$0.9	$1.0	$1.2	$1.4	$1.6	$1.8	$2.0
Revised Budget	$19.8	$22.6	$25.8	$29.5	$33.7	$38.5	$43.9	$50.2	$57.3	$65.5
Total Savings Per Year	$0.6	$0.7	$0.8	$0.9	$1.0	$1.2	$1.4	$1.6	$1.8	$2.0
Cumulative Savings	$0.6	$1.3	$2.1	$3.0	$4.0	$5.2	$6.6	$8.2	$10.0	$12.0

Assumptions

- Current program expenditure increase @ 14.2 percent based on increases per recipient between 1987 and 1992
- Three percent reduction in rates due to changes in methodology