A New Hospital Outpatient Payment Method for Rhode Island Medicaid

Frequently Asked Questions

The Rhode Island Medicaid program will move to a new method of paying for hospital outpatient services based on Medicare's APC method. Our goals are to implement a new method that is sustainable, increases fairness, reduces administrative burden, rewards economy and improves transparency.

This document provides questions and answers about the new method. We invite additional questions and we welcome suggestions. The Department is working with a hospital finance advisory group on questions of payment policy, implementation and provider education.

Please note that changes, although unlikely, to this document may occur before the implementation date. If so, an update will be sent to hospitals.

OVERVIEW QUESTIONS

1. When will the new method be implemented?

Dates of service starting October 1, 2009.

2. What change is being made?

On an interim basis, the Department will change its current payment method, a retrospective, cost-based method known as "Maxicap," to a fee schedule based on, but not identical to, Medicare Ambulatory Payment Classifications (APCs).

3. Why interim?

Medicaid needs a new outpatient payment method that can be used for ten or more years. A decision on a permanent method will require months of work, as will its design and implementation. Because of the time required, and because of the work already in progress on a new inpatient payment method, a permanent outpatient method almost certainly could not be implemented before 2011. For the new method, two leading options include a comprehensive version of Medicare APCs or a method based on Ambulatory Patient Groups (APGs). In the interim, the Department wishes to implement a method that will at least partially address the problems with the current method.

4. What providers and services would be affected by the interim APC fee schedule?

The new method would apply to all outpatient services provided by acute care hospitals, including general hospitals, specialty hospitals (e.g., psychiatric, rehabilitation) and distinct-part units within general hospitals.

Within these hospitals, the new interim method would not apply to Medicare crossover claims or Medicaid Managed Care (i.e., RIte Care and Rhody Health Partners).

Outpatient services provided by community mental health centers, the Eleanor Slater Hospital, dialysis clinics, physician offices, and other non-hospitals are unaffected. If a hospital bills for a "provider-based" physician clinic, then the APC fee schedule would apply to facility services (UB-04 bill) but not physician services (CMS-1500 bill).

5. How much money is affected?

In 2008, Medicaid fee-for-service payments to hospitals for outpatient care were approximately $34 million, including the expected net impact of year-end settlement. The future volume of services affected by the APC fee schedule will depend on trends in utilization and on the number of people who voluntarily enroll in Rhody Health Partners.

The $34 million figure excludes payments for Medicare crossover claims, payments for Medicaid managed care patients, and supplementary "UPL" payments.

6. How does the current payment method work?

The Department's current method dates from 1971. Each year Medicaid and the hospital industry negotiate an overall percentage increase in hospital costs for serving Medicaid beneficiaries. In principle, the "Maxicap" is a starting place for hospital-specific budget agreements, but in practice each hospital almost always receives the same Maxicap percentage increase. Since hospitals are paid per claim, and claims do not have cost information, interim payments are made at a percentage of charges that reflects each hospital's expected ratio of cost to charges (RCC). A year-end settlement process then reconciles interim payments with the negotiated budgets. Adjustments are made only if Medicaid volumes or the ratio of cost to charges differ from agreed-upon expectations.

Out-of-state hospitals are paid at a percentage of charges, without year-end settlement.

For all hospitals, lab and imaging services are an exception. They are already paid using fee schedules, with no year-end settlement.

7. Why change to the new payment method?

The Department has five reasons.

- ***Implement a sustainable payment method.*** The current payment method was last rebased to hospital-specific costs 16 years ago. Going forward, the Department needs a method that can be sustained over time, with adaptations as appropriate to promote access to quality care.

- ***Increase fairness.*** The current method results in different hospitals being paid sharply different amounts for similar care. Often, one hospital is paid twice as much for a particular service as another hospital. Whatever differences that existed among hospitals in 1993 have simply been rolled forward since then.

- ***Reduce administrative burden.*** The current method, involving both Maxicap negotiations and the year-end settlement process, is burdensome. In particular, the lag between discharge and final settlement—which has ranged to several years—bedevils financial planning efforts by both hospitals and the Department.

- ***Reward economy.*** In principle, the current cost-based method penalizes hospitals that reduce the

cost of care. Although the lack of rebasing mitigates the perverse incentive, this is not a principle followed by leading purchasers of hospital care in 2009.

- ***Improve purchasing clarity.*** It is currently very difficult to understand how much Medicaid is paying for what. Medicaid wishes to implement a payment method that will improve purchasing clarity.

PAYMENT CALCULATIONS

8. What will be the basic approach?

The basic approach is quite simple. Hospitals will be paid according to the CPT/HCPCS procedure code listed on a claim. If a claim line has no procedure code, then no payment will be made for that line. If a claim line has a procedure code, then the payment for that line will equal the fee times the billed units.

9. What are the exceptions to the basic approach?

To minimize complexity, the Department is making only six exceptions to the basic approach, as follows.

- ***Bilateral services.*** The presence of modifier 50 for a bilateral procedure in the first modifier position will result in payment at 150% of the otherwise-applicable amount.

- ***Discounted payment for significant procedures.*** If a claim contains multiple lines with procedure codes that have APC status code T (significant procedure subject to discounting) then the highest-paid procedure would be paid at 100% of the fee, the second-highest at 50% of the fee, the third-highest at 25% of the fee, and all subsequent procedures would be packaged (i.e., paid at 0%). This payment policy is similar to what Medicare does, except that the 100%-50%-25%-0% list is similar to what Medicaid already does for physician services.

- ***Discounted payment for imaging procedures.*** Medicaid will apply a similar discounting policy to imaging services that have an APC status code value of Z. This is a difference from Medicare, which applies a more complex packaging policy to imaging services and does not have an APC status Z. See Question 16 for an explanation of this payment policy.

- ***Packaged services.*** Some services will be "packaged," that is, the fee will be zero because payment is considered packaged into the payment for other services on the claim. Packaging will apply to any services billed with anesthesia or recovery room revenue codes (037X, 071X) and any procedure codes with APC status code values N or Q1.

- ***Services without fees.*** A few procedure codes, indicated by APC status code values H or U, do not have fees and will be paid at the hospital-specific ratio of cost to charges. Less than 1% of payments are expected to be made on this basis. There will be no year-end settlement.

- ***340B hospitals.*** Hospitals that provide drugs under Section 340B of the Public Health Service Act will be paid 100% of charges when modifier UD is present on the claim line.

10. Where do the APC status codes come from?

For almost all services, Medicaid will assign the same APC status code to a procedure that Medicare does. The chief exception is that Medicaid will assign imaging services to status code Z. In a few cases,

Medicaid and Medicare may use different APC status codes because of differences between Medicare and Medicaid coverage policy. (See Question 14.)

11. What will the fees be?

The Department's present intention is to set the fees at 100% of the fees paid by Medicare in Rhode Island. For some services, such as observation, Medicaid's fee may differ from Medicare.

COMPARISON WITH MEDICARE

12. How does the interim APC fee schedule compare with Medicare?

Hospitals should find the similarities much more notable than the differences. Under both payers, the payment method essentially will be a fee schedule approach.

13. What are the key differences between the Medicare and Medicaid methods?

- ***Outpatient Code Editor.*** Medicaid will not use the OCE, although claims will be subject to Medicaid-specific edits as described in question 21.

- ***Conditional packaging.*** Under Medicare, procedure codes with APC status values Q1, Q2 and Q3 are sometimes paid and sometimes packaged, depending on what other codes are on the claim. Medicaid will always package procedure codes with status values Q1 and always pay procedure codes with status values Q2 and Q3.

- ***Composite APCs.*** Medicare uses "composite APCs" to make bundled payments for certain services. In 2009 this approach was expanded to include certain imaging services. Implementation of composite APCs is complex and, for several APCs, geared specifically to the Medicare program. Although Medicaid will not implement composite APCs, we will implement discounting for imaging procedures. See question 16.

- ***Modifier impacts.*** Only modifiers 50 and UD will affect pricing under Medicaid. Under Medicare, pricing can also be affected by modifiers 25, 52, 59, 73, 74, 76, 77, 78, 79, CA, FB, and FC. (Note that modifiers may affect current editing under ClaimCheck. See question 21.)

- ***Outliers.*** Medicaid will not make outpatient outlier payments.

- ***Quality reporting.*** Medicare reduces payments to hospitals that do not report outpatient quality data. Medicaid has no similar program.

- ***Discounting formula.*** As noted under question 9, Medicaid's discounting formula will differ slightly from Medicare's.

- ***Special treatment for some hospital types.*** Medicare has special payment provisions for children's hospitals, cancer hospitals, rural hospitals and critical access hospitals. Medicaid will use the same payment method for all hospitals.

- ***Cost-sharing.*** Medicare has minimum and maximum coinsurance rates by service. Medicaid is making no changes to its cost-sharing policy, which is available at www.dhs.state.ri.us/dhs/heacre/provsvcs/manuals/hospital/outpat.htm.

COVERAGE AND PAYMENT FOR SPECIFIC SERVICES

14. What changes, if any, will be made to Medicaid policy on covered services?

Like Medicare, Medicaid covers a very wide range of hospital outpatient services. Differences do exist in coverage policy, in which case the Medicaid policy will continue to apply.

15. What changes, if any, will be made to Medicaid prior authorization policy?

The change in payment methods has no impact on Medicaid prior authorization policy. For that policy, go to www.dhs.state.ri.us/dhs/dheacre.htm.

16. Why implement discounting for imaging services?

Medicaid plans to reduce, or "discount," payment when more than one imaging procedure is performed on the same patient on the same day. The imaging procedures have been defined into "families" with APC status codes Z1 to Z6. For example, if more than one procedure on a claim has APC status Z1, then the line with the highest fee would pay at 100%, the line with the second-highest fee would pay at 50%, the line with the third-highest fee would pay at 25%, and all additional lines would pay at 0%. The discounting policy is patterned after, but separate from, the discounting policy for significant procedures with status T.

RI Medicaid APC Status Codes for Imaging	
Z1	Computed tomography (CT)
Z2	MRI
Z3	Nuclear medicine
Z4	Radiation therapy
Z5	Ultrasound
Z6	X-ray
Note: See the fee schedule for the Medicaid status code for each specific service	

The primary reason for discounting is to align payment with hospital resource use. In the example of significant procedures, the hospital's costs are lower when fractures of the tibia and femur are reduced in the same operation as compared with two separate operations. Similarly, CT scans of the head and pelvis are less costly if the two scans are done at the same time than if they are done separately.

Although Medicare discounts payment for significant procedures, it does not do so for imaging procedures. For 2009, instead, Medicare implemented "composite APCs" under which a hospital receives a single payment when more than one procedure code is billed within a single imaging family of codes. Rather than try to replicate the complex Medicare-specific pricing logic, the interim Medicaid payment method will include the simple discounting logic. The logic will apply to any imaging service with a Medicaid APC status code of Z1 to Z6. Discounting will only occur within a family of codes. If, for example, a claim includes one code with status Z1 and one code with status Z2, then both codes would be paid at 100%.

17. How will payment be made for lab services?

Medicaid fees will continue to reflect the clinical lab fee schedule, which Medicare also uses. (For Medicare, lab services are outside the scope of its APC-based payment method.)

18. How will payment be made for physical, occupational, and speech therapy?

Medicaid will use the Medicare fees currently paid to Rhode Island hospitals. These fees, in turn, are based on the Medicare RBRVS fee schedule for independent practitioners. (For Medicare, therapy

services are outside the scope of its APC-based payment method.)

19. How will payment be made in other special situations?

These situations include screening mammography, preventive care visits and other services where Medicare either doesn't cover the service in the hospital outpatient setting or pays for it outside the APC payment method. In most cases, Medicaid has simply set a fee for the service. For observation, Medicaid's existing policy is to pay for up to 48 hours of observation. Payment will equal $25 an hour for hours 8 through 48. Observation should be billed using G0378, where the unit of service is explicitly one hour. Other observation codes such as 99217 will have their fees set at zero and should not be billed.

BILLING AND EDITING

20. What billing practices will be important for hospitals to follow?

By intention, the following list is very similar to the list for Medicare.

- ***Procedure code billing.*** Since claim lines without procedure codes will be packaged (i.e., paid at zero), hospitals should list procedure codes wherever appropriate. Like Medicare, Medicaid will require procedure codes for most revenue codes. Notable exceptions are the pharmacy and supply revenue codes 025X, 027X, 062X and 063X. For those revenue codes, a procedure code may or may not be appropriate but if it is appropriate then the hospital should list it in case it results in payment for that line.

- ***Procedure code units.*** Hospitals are asked to pay particular attention to billed units, which must be appropriate for the specific CPT or HCPCS code description. Tricky situations can arise with therapy codes and drugs billed using J codes or other HCPCS codes.

- ***Same-day billing.*** Hospitals are expected to bill all services provided on the same day to the same patient on the same claim.

- ***Visit levels.*** In billing for emergency room and clinic visits (e.g., 99281-99285), hospitals are expected to follow the same guidelines as they do for Medicare. For example, see page 66805 of the November 27, 2007 *Federal Register* (available at www.gpoaccess.gov/fr/retrieve.html) for Medicare guidance on assigning ER visit levels. Medicare also has guidance on the definitions of new and established patients in a hospital context.

- ***Observation.*** Bill observation using code G0378, showing hours as the number of units. See question 19.

21. What edits will hospital outpatient claims be subject to?

Again by intention, the list is very similar to current practices in the Rhode Island claims processing system. In addition to standard edits related to eligibility, enrolled provider, timely filing, valid data values, prior authorization, etc., the following edits will apply to hospital outpatient claims specifically.

- ***Covered services.*** Both revenue codes and procedure codes are checked to ensure that Medicaid covers specific services in the hospital outpatient department.

- ***Maximum units.*** Billed units are checked for reasonableness. If the claim is denied then the

hospital is asked to correct the units or appeal on grounds of medical necessity.

- ***Procedure code required.*** The list of revenue codes that require procedure codes will be expanded to reflect the current Medicare list.

- ***McKesson ClaimCheck.*** Current ClaimCheck code auditing edits will continue in place.

- ***National Drug Codes.*** Current edits to require NDC codes will continue in place.

OTHER QUESTIONS

22. Will hospitals still have to submit cost reports?

Yes. The Department uses cost reports in calculating hospital utilization fees and in reviewing hospital payments overall.

23. Will payments be subject to adjustment after cost reports have been submitted?

No. Payment based on the interim APC fee schedule will be final. That also applies to the few services paid at a hospital-specific ratio of cost to charges.

24. Will the new payment method have any impact on the provider tax calculations?

No.

25. What is Medicaid doing to involve and inform hospitals during the development of the interim APC fee schedule?

- ***FAQ.*** Updates of this document will be distributed to hospitals.

- ***Financial simulation.*** Each hospital has received financial simulation results at the line-specific level. For additional information, contact kevin.quinn@acs-inc.com or david.bontemps@acs-inc.com.

- ***Fee schedule.*** A copy of the fee schedule in Excel form is available from kelly.leighton@eds.com or kevin.quinn@acs-inc.com.

26. Who can I contact for more information?

- ***Technical questions about the interim APC fee schedule.*** Kevin Quinn, Director, Payment Method Development, ACS Government Healthcare Solutions, kevin.quinn@acs-inc.com, 406-457-9550; David Bontemps, Senior Consultant, Payment Method Development, ACS Government Healthcare Solutions, david.bontemps@acs-inc.com, 770-829-1497.

- ***Questions about billing and claims processing.*** Kelly M. Leighton, Provider Representative, EDS, kelly.leighton@eds.com, 401-784-3823.

- ***Questions about Department policy.*** Ralph Racca, Administrator, Center for Finance and Administration, Rhode Island Department of Human Services, rracca@dhs.ri.gov, 401-462-1879.