IssueBrief

MACPAC

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Medicaid Outpatient Payment Policy

Overview

Medicaid outpatient hospital services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished to Medicaid enrollees in hospital outpatient departments. A Medicaid agency may exclude those types of items and services that are not generally furnished by most hospitals in the state from the definition of outpatient hospital services.

States have broad flexibility to determine payment policies, including payment amounts, for outpatient services. In fiscal year (FY) 2014, Medicaid fee-for-service spending on acute outpatient services exceeded $26 billion (MACPAC 2015a). MACPAC has documented state-specific methodologies that govern payment for these services and emergency care in State Medicaid Payment Policies for Outpatient Hospital Services.

Payment methods

State Medicaid programs generally use one of four approaches to pay for hospital outpatient services:

- **Fee schedule:** A fee schedule is a state's complete list of services and the corresponding payment amounts, which are typically determined based on market value, an internal process, or as a percentage of the Medicare rate. States often have accommodations for services without an established fee.

- **Cost-based reimbursement:** States pay a percentage of hospital costs, typically as reported in a hospital's Medicare cost report. These costs have a maximum allowable reimbursement rate as well as other state-specific limits.

- **Ambulatory patient classification (APC) groups:** The APC system, used by Medicare, bundles individual services into one of 833 APCs based on clinical and cost similarity. All services within an APC have the same payment rate. A single visit may have multiple APCs and multiple separate payments.

- **Enhanced ambulatory patient groups (EAPGs):** EAPGs bundle ancillary and other services commonly provided in the same medical visit; payment is based on the complexity of a patient's illness.

States generally use one of these approaches to establish a base payment rate and may apply a variety of adjustments and incentives, as described below.

As of November 2015, 13 states used a fee schedule, 16 used a cost-based system, and 19 used a bundled payment approach, such as APC or EAPG, with 1 state using a mix of cost and APC systems.[1] Maryland has a unique all-payer hospital rate regulation system. Under this system, a global budget for all hospital services is established for each hospital based on a historical base period and adjusted to account for a number of factors, including inflation, infrastructure requirements, volume increases, and performance in quality-based of efficiency-based programs (HSCRC 2016).

Medicaid and CHIP Payment and Access Commission

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Payment adjustments

States may adjust outpatient payment rates according to a variety of factors. These include but are not limited to:

- **Hospital type:** Some states adjust the base payment or use a different payment method entirely for certain hospitals. For example, 29 states have separate payment policies for small hospitals and critical access hospitals. Less commonly, states establish separate payment policies for teaching hospitals (16 states), government-owned hospitals (11 states), children's hospitals (9 states), and psychiatric facilities (8 states).

- **Geography:** Six Medicaid programs adjust payments for services provided in specific geographic areas, to reflect significant underlying differences in the cost to provide care in rural versus urban areas.

- **Out-of-state services:** The most common adjustment is for services provided out of state; only nine states use the same payment methodology for outpatient services provided in state and out of state.

- **Exempt services:** Other services, such as clinical lab services and partial hospitalizations, are excluded from the outpatient payment methodologies in most states.[2] These services are usually paid for using a different method, such as a fee schedule or cost-based reimbursement.

- **Other Provider Preventable Conditions:** The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) prohibits states from paying for services used to treat health care-acquired conditions. A list of such conditions, adopted from Medicare's National Coverage Determinations, includes services such as the wrong procedure being performed on a patient, or a procedure being performed on the wrong body part or patient.

Forty-five states require prior authorization for certain services before approving payment. The most common services requiring prior authorization are various forms of rehabilitation; physical, occupational, and speech therapies; mental health and certain psychiatric services, and certain diagnostic imaging or radiology services.

Service-specific payment exceptions

Even when a state specifies a broad payment approach for outpatient hospital services, it may establish alternative payment methods for certain services provided in an outpatient setting. For example, a state's general approach may be based on cost for most services but on a fee schedule for laboratory services. Other outpatient services that often have their own payment rules include:

- **Emergency services:** Most states have specific payment methodologies for services provided in the emergency department, with about a third paying on a cost basis, a third utilizing an APC or EAPG system, and a third using a fee schedule. About half of the states also have a specific payment methodology for non-emergent services provided in the emergency department.

- **Laboratory:** Most states have alternate methodologies for lab services; the vast majority of the states use a fee schedule.

About half of the states have separate payment methods for services such as radiology, prescription drugs provided during an outpatient visit, outpatient observation, and physical, occupational, and speech

therapy. Fewer states have separate methodologies for services such as vaccines, mental health, and dental health.

Supplemental payments

States may also provide incentive or add-on payments for outpatient hospital services in addition to the base payment. These payments are most often issued using the upper payment limit methodology. States commonly provide add-on payments to the following hospital types:

- **Government owned:** Just over 20 percent of US hospitals in 2011 were state or local government owned or operated (MACPAC 2015b). About a third of states provide supplemental payments to these hospitals for outpatient services.
- **Safety net:** Safety-net hospitals provide a significant amount of care to vulnerable populations. Nine states make supplemental payments to safety-net hospitals for outpatient services.
- **Academic health center:** Some states make additional payments for services provided in an academic health center to account for higher patient acuity. As of November 2015, 13 states identified making an additional payment to these outpatient teaching hospitals.
- **Quality incentives**: Six states make incentive payments as part of initiatives to improve the quality of health care or to reward hospital efficiency.

Cost sharing

State Medicaid programs can require enrollees to pay a portion of health care costs out of pocket, referred to as cost sharing. Thirty-five states report that they require some form of cost sharing for enrollees, and the majority of these (33 states) use a copayment. Minnesota requires a copay and a deductible, and Alaska and South Dakota require coinsurance only.

While states may determine the specific cost sharing amounts (up to federal limits), the amounts are generally nominal. Cost sharing amounts can vary with enrollee income or the total cost of services, but in most cases services cannot be withheld due to failure to pay. Among states with a copayment requirement, amounts collected ranged from $0.50 to $10.

Under federal regulations, states cannot impose out-of-pocket costs for emergency services. However, cost sharing can be applied to non-emergent services rendered in an emergency department. The states are relatively evenly split as to whether they require cost sharing for non-emergent services, with 24 states requiring cost sharing and 21 states that do not have this cost sharing requirement.

Payment Process

State and federal policies include a wide variety of requirements that providers must comply with in order to receive payment for services.

Generally, physicians and other professionals have discretion in determining which covered services are medically necessary in an outpatient hospital setting. In some cases, providers must first obtain prior authorization, to assure that the service is both covered by the Medicaid program and appropriate for the enrollee who is to receive the service.

Once a service has been furnished, providers typically submit claims to the state Medicaid agency for payment. Most claims are submitted electronically in a standardized format consistent with the requirements of the Health Insurance

Portability and Accountability Act (HIPAA, P.L.104-191) and other federal regulations, including the use of a provider's national provider identifier.

Each claim contains a record of services provided. Hospital services are reported using a variety of codes that describe the patient's condition and procedures performed. Services that are not related to a particular procedure or diagnosis are typically reported using revenue codes that indicate the service type and location.

Codes offer providers a strong incentive for accurate reporting. A code can not only determine the amount paid, but also effects whether a claim is denied. On the other hand, a potential risk associated with code-based payment may be the incentive to "upcode," or report codes for more complex procedures that result in higher payment.

State and federal administrators conduct a variety of pre- and post-payment reviews to correct under- and over-payments and identify potential fraud and abuse. For example, the Centers for Medicare & Medicaid Services (CMS) measures improper Medicaid fee-for-service outpatient hospital payments annual through the Payment Error Rate Measurement (PERM) program. CMS found that outpatient hospital services and clinics had a 10.4 percent improper payment rate in 2014, mainly due to payments for non-covered services, insufficient documentation, or missing documentation (CMS 2015a). Providers may also conduct their own post-payment reviews to assure payment accuracy and preempt recovery efforts. If providers identify errors, they typically can correct them by submitting claim adjustments.

For more information, please see MACPAC's issue brief on the Medicaid fee-for-service payment process.

Payment Policy Issues

Federal rules do not prescribe how outpatient hospital services should be paid or how much they should be paid, but require that Medicaid payment policies should promote efficiency, economy, quality, access, and safeguard against unnecessary utilization. While almost all states use four basic payment methodologies, there is considerable variation in fees across states.

Many states also make supplemental payments, which make up the difference between state Medicaid payments for services and the maximum payment level allowed under the federal upper payment limit (UPL) for those services. UPLs are applied in the aggregate and are based on what Medicare would have paid for the same services. Because UPLs are tied to the services rendered by entire classes of providers rather than by individual providers, states have discretion in allocating these supplemental payments among individual institutions within the class, including hospitals, nursing facilities, intermediate care facilities for persons with intellectual disabilities, and freestanding non-hospital clinics. See MACPAC's March 2015 report for more information on MACPAC's framework for evaluating these payment factors.

States have been required since 2013 to submit these UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. The UPL demonstration data is collected by CMS regional offices and maintained separately from other Medicaid payment data. At this time the data are not expected to be available for analysis outside of CMS (MACPAC 2014).

In developing outpatient payment policies and fee schedules, states generally try to balance economy (setting payment rates at a reasonable level

compared to costs) with access (implementing payment policies that attract sufficient numbers of providers or providing additional payments to promote access to certain provider types). States are increasingly seeking to incorporate quality incentives into payment arrangements, including incentives for better coordination of care via value-based bundled payments, which has traditionally been focused on inpatient care.

Faced with difficult tradeoffs in balancing budgets, states sometimes consider and implement changes to outpatient payment policies. These changes—payment reductions in particular—often lead to questions regarding the adequacy of Medicaid payments. In some cases, physicians and other providers have gone to the federal courts to contest payment reductions. However, on March 31, 2015, the U.S. Supreme Court precluded future lawsuits when it decided, in *Armstrong v. Exceptional Child Center, Inc.*, that Medicaid providers do not have the right to sue Medicaid agencies regarding payment rates under the Supremacy Clause of the Constitution or under Section 1902(a)(30)(A) of the Social Security Act.

CMS implemented a rule in January 2016 that creates a standardized, transparent process for states to follow prior to implementing Medicaid provider payment rate reductions or changes in fee-for-service provider payment methods (CMS 2015b). States are now required to consider input from providers, beneficiaries, and other stakeholders when evaluating the potential impacts of provider rate changes. In addition, states will need to perform an analysis of the effect that rate changes will have on beneficiary access to care, and monitor how changes affect access for at least three years after the change is implemented.

Endnotes

[1] Payment methodology could not be found for fee-for-service outpatient hospital services in Tennessee's Medicaid program.

[2] State Medicaid agencies can adopt their own definitions of partial hospitalization programs. These programs typically provide intensive outpatient mental health services, consisting of individual, group, family therapy, medication management and other services. These programs may be defined as full-day or half-day, based on a specified number of hours (Sanchez 2016).

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