Chapter 7: Acute Care Inpatient/ Outpatient Hospital Services

Executive Summary

Description

Acute care hospitals are the largest group of enrolled hospital providers. Kansas Medicaid has 144 acute care hospitals, 5 state institutions, 5 rehabilitation hospitals, and 3 psychiatric hospitals enrolled within the state. Over 540 similar out-of-state hospitals are also enrolled. All but nine of Kansas 105 counties have an acute care hospital: two-thirds of those (68) have just one. Most inpatient hospitals are reimbursed based on diagnosis related groups (DRG) with rates that vary as a proportion of Medicare. Outpatient hospitals are reimbursed as fee-for-service.

Key Points

- In 2005, legislation funded a DRG rate increase through a hospital provider assessment.
- Overall spending on inpatient services has increased each year.
- The majority of top DRGs by reimbursement are related to births and the majority of reimbursements based on procedure codes are related to the emergency room visits.
- KHPA updates the DRGs and realigns (but does not increase overall) payment rates each year with the annual Medicare DRG updates. However, KHPA frequently receives the DRG updates late in the year making it difficult to implement them by January 1, resulting in administrative challenges.
- In 2007, Medicare's payment update included a significant adjustment in many DRG rates, along with the addition of many new DRGs, to better reflect the true costs of care in general versus specialty hospitals. KHPA was not able to make these changes in 2007, but is planning to incorporate these more significant changes in January 2009. Currently, Medicaid sets rates for new outpatient service codes at 65% of the Medicare Outpatient Prospective Payment (OPPS) amount. However, over time Medicaid's fixed prices erode and leave wide variability in rates.
- In 2008, Medicare's payment update includes adjustments to remove payment for so-called "never events" or hospital acquired conditions, where the hospital itself is the cause of an illness or expenditure. The changes are intended to better align payment with appropriate incentives for high quality outcomes and patient safety. Kansas Medicaid will follow Medicare's lead.

- In 2008, the Legislature created the Physician Workforce and Accreditation Task Force in part to examine the role that enhanced funding for graduate medical education (GME) could play in expanding the supply of primary care physicians in Kansas. Medicaid provides a percentage add-on to inpatient reimbursements to help cover the costs of GME in the state's training institutions. KHPA has concerns about the regulatory integrity of the existing Medicaid GME program, and has identified opportunities for program enhancements to support the Task Force's overall goals. KHPA is a statutory member of the Task Force.

Recommendations

- A number of administrative changes for acute care services are being implemented in FY 2009.
    - Switching to the new "MS-DRG" system implemented by Medicare in 2007
    - Implementing the 2008 Medicare payment methodology and stop paying for "never events"
    - Shifting to a cost-based payment methodology for critical access hospitals
    - Updating reimbursements for high-cost cases at Children's Mercy Hospital

  The fiscal impact of these changes is already reflected in baseline Medicaid spending (caseload)
- Review outpatient reimbursement to investigate the possibility of adopting Medicare's prospective payment methodology
- Conduct focused review of emergency room use
- Support the activities of the legislative Task Force in improving the GME program to ensure regulatory compliance and better meet the physician training needs of the state.

Program Overview

The Kansas Medicaid fee-for-service program reimburses for health care services in a number of different types of hospitals including: acute care, psychiatric, rehabilitative, and state institutions. Acute care hospital providers represent the largest group of enrolled hospital providers in Kansas Medicaid and receive the highest amount of reimbursement. The hospital program is composed of two service categories: inpatient and outpatient. In most settings the inpatient and outpatient hospitals are located within the same facility, but in distinct sections of the hospital.

Most inpatient hospitals are paid on a per-admission basis using diagnosis related group (DRG) reimbursement. Rates are determined using the federal Medicare program's payment methodology. Within that methodology, Kansas specific rates are calculated by Kansas Health Policy Authority's (KHPA) Actuarial Consultant for institutional reimbursements (Myers and Stauffer). These rates are set to ensure overall budget neutrality from one year to the next. Outpatient hospitals are reimbursed on a per-procedure basis using a fee-for-service methodology, which uses specific reimbursement rates set by KHPA.

A facility becomes a Kansas Medicaid provider by requesting provider status and enrolling. Hospitals can enroll in one of several provider types and specialties. Currently Kansas Medicaid has:

- 144 Acute Care Hospitals, five State Institutions, five Rehabilitation Hospitals, and three Psychiatric Hospitals enrolled as in-state hospital providers.
    - 96 out of 105 Kansas counties have acute care hospitals: 68 counties have only one

hospital.

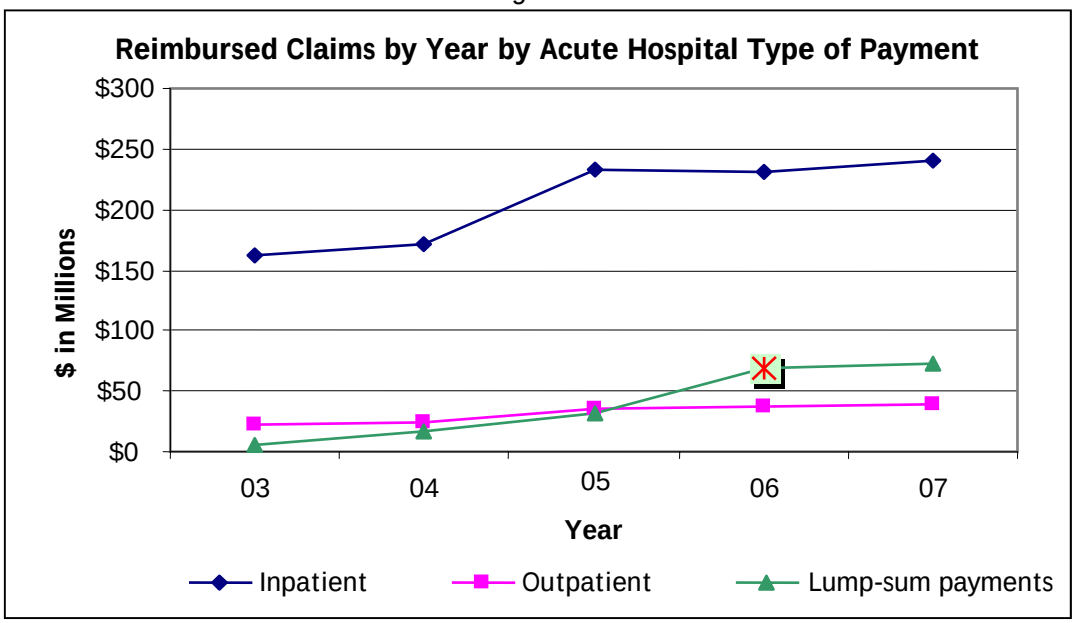
- 541 Acute Care Hospitals, three Rehabilitation Hospitals, and nine Psychiatric Hospitals enrolled as out-of-state hospital providers.

Kansas only pays for out-of-state services that are emergencies or services not available in state. Those services must be prior authorized and approved by the KHPA program manager before they are rendered. Hospitals are required to enroll as Kansas Medicaid providers in order to receive payment for services. Some hospitals enroll to receive reimbursement for as few as one Kansas Medicaid beneficiary. The hospital becomes inactive 18 months after the last claim submission however they are not removed from the rolls. This accounts for the high number of out-of-state hospital providers in the program.

The purpose of this report is to review policy decisions, fiscal trends, and other activities that have occurred in the fee-for-service hospital program during the last year in order to inform the budgetary and strategic planning process for fiscal year FY 2009 and beyond. Services reviewed include those provided to beneficiaries on a fee-for-service basis, including those enrolled in the Health Connect PCCM, but do not include hospital services provided through HealthWave, KHPA's capitated managed care program.

Analysis of Program Expenditures

Figure 1



* In 2006, a large adjustment was paid out to providers. This graphic presents the fiscal expenditures that would be expected had the adjustment payment not been made.

Figure 1 shows the overall changes in inpatient reimbursements each year. KHPA updates the DRG payment rates each year with the newest Medicare approved DRGs. This update involves a complex formula that takes into account Kansas hospital-specific costs and severity of illness. The update is keyed to the new Medicare Severity (MS) DRGs and uses total provider costs in a manner that targets budget neutrality. This is done to ensure that the overall total Medicaid inpatient expenditure does not increase from year to year. In 2004, the Legislature approved an increase in reimbursements for inpatient rates, outpatient rates and access payments to hospitals. Other

lump-sum payments include targeted Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME) payments. Broad based "access payments" total about $24 million per year and are funded by a new assessment (tax) on cost and utilization measures in inpatient and outpatient hospitals, which was implemented in 2006. The graph shows, for the purposes of trends, reimbursement amounts adjusted to what they would have been without the large one-time lump sum payment made in FY 2006. The actual numbers are presented in Table A.

The expected increase in expenditures in FY2006 due to the implementation of the provider assessment and access payment program appears to come one year early, but the increase in hospital reimbursements in FY 2005 is an artifact of two one-time events. First, as the calendar fell that year, FY 2005 included 53 weeks of payment rather than the normal 52. In addition, due to state budget concerns, claims from one week in June 2004 were pended into state fiscal year 2005, resulting in an additional week of payments in FY 2005.

Figure 2

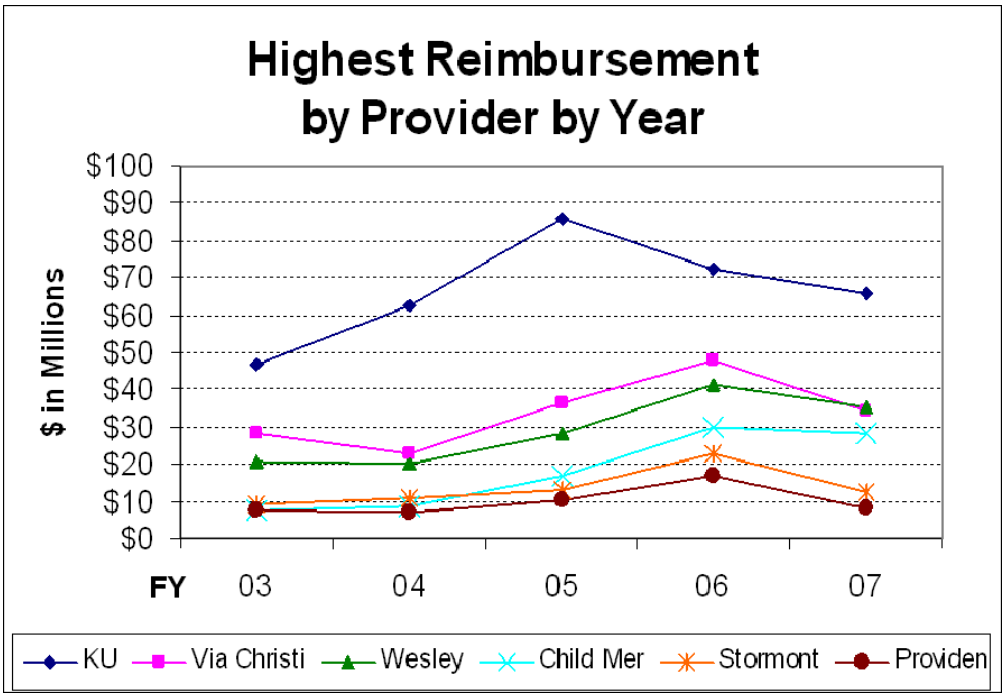


Figure 2 shows totals for hospital reimbursements for the top six providers and includes inpatient reimbursements, fiscal expenditures (lump sum payments), outpatient reimbursements, and also the provider assessment that was implemented in FY 2006. In FY 2006, KHPA made double payments to hospital providers as part of the implementation of provider assessment. The Legislature approved the use of the provider assessment to fund a rate increase starting in 2005 and the increases were implemented in 2006. As a result, Medicaid paid providers for the 2005 and 2006 increases in 2006.

Unlike Figure 1, these double payments are shown in Figure 2, resulting in apparent declines in spending in FY 2007. Another explanation for this apparent decline is the departure of approximately 50,000 beneficiaries from the FFS Medicaid which are reflected in these costs. The beneficiaries moved to the HealthWave program, which is not reflected in the costs. The two HealthWave MCOs, Children's Mercy Family Health Partners, and Unicare, contract independently with providers at privately negotiated rates. They then reimburse providers directly using a fixed monthly payment from KHPA for each member that must cover all health care costs.

Despite this independent process, there is a relationship between hospital spending in the FFS and HealthWave programs. In recognition of the Access Payment program, which pre-dates KHPA's contracts with the two health plans, the MCOs have committed to pay each physician and hospital in their network at least the rate available through FFS. The trending also shows a lot of variation in the changes in reimbursements from year to year. DSH payments were substantially reformed in 2008 and with these changes the hospitals should receive more consistent reimbursements.

Reimbursements to the University of Kansas hospital (KU) do not follow the overall pattern of spending in other large hospitals. KU is paid on a cost basis using a Medicare-based formula. This ensures that the state receives federal Medicaid matching funds for all Medicaid expenses, and results in a higher overall reimbursement for KU in comparison to other large private community hospitals. Because of its unique payment arrangement as Kansas' only public community hospital, KU does not participate in the provider assessment program, and receives a reduced amount of supplemental lump-sum payments for uncompensated care (see discussion of the disproportionate share hospital program below) beginning in FY 2008. KU provides the state share of Medicaid payments above the level of payment they would receive as a private hospital. These funds are made available to KHPA in the form of an intergovernmental transfer. The level of reimbursement and the amount of the transfer are re-evaluated each year based on updated cost information from the hospital.

Figure 3

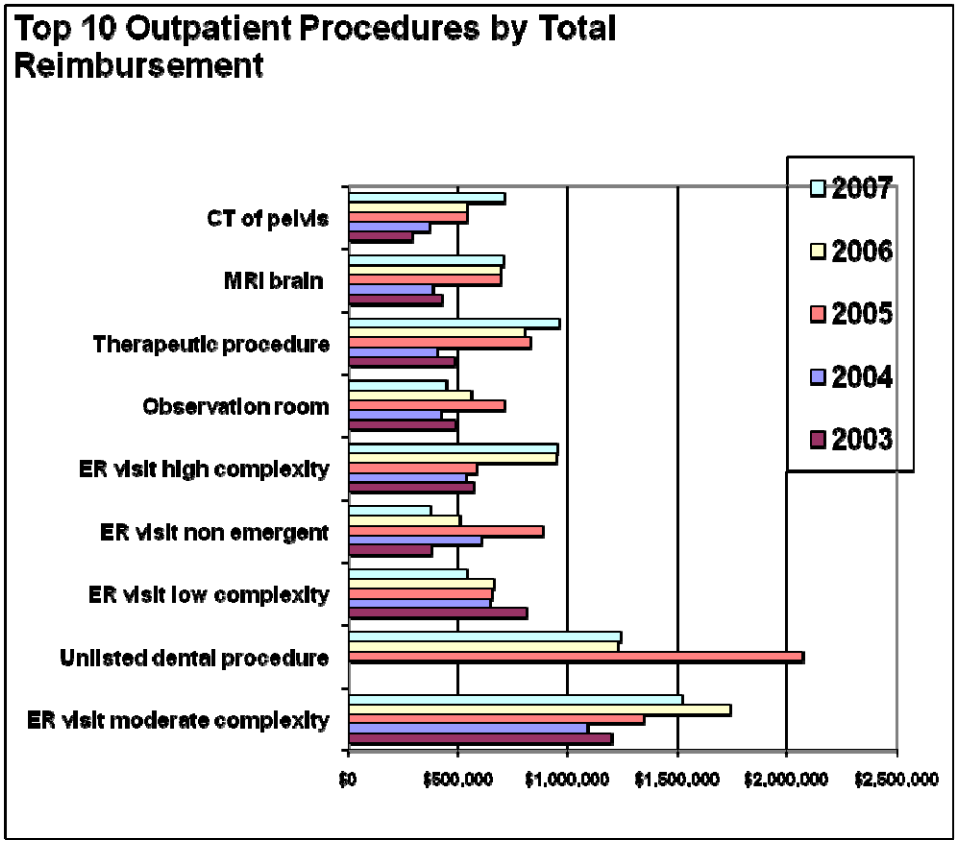


Figure 3 shows the top 10 outpatient procedure codes by the total level of reimbursement. The majority of these procedure codes represent services received in the emergency room. Procedure codes representing evaluation and management (E & M) procedure codes are usually billed

whenever a service is performed in an emergency room. Emergency room services are often the most frequently billed services since the emergency department is a major entry into an inpatient hospital and a source of usual care for some beneficiaries. The emergency room visits represent procedures of increasing complexity from non-emergent to severe complexity. Moderate intensity visits are more frequent than any other visit intensity. Overall expenditures for emergency room services are tempered by unusually low rates of reimbursement, which have not been raised since 1996 and average about 33% of Medicare's rates.

KHPA has considered a policy to increase reimbursement for emergency room services that have remained at the same rate since 1996. However, moving all of these reimbursements to the agency's standard for new outpatient codes of 65% of the Medicare rate would require an increase in reimbursement of 195% on average. In addition, the policy impact of increased ER reimbursement is unclear, given the high rates of use at existing levels. We have no indication that access to ER services is limited by reimbursement. A more pressing question is how to address the use of the ER for non-emergent or preventable conditions.

Unlisted dental procedure represents the code used to reimburse a facility for dental procedures that can not be performed in an office setting, such as special needs children and adults with acute dental conditions. FY 2005 was the first year we allowed reimbursement for this code. The large number of claims processed that year represents a backlog of claims from the previous year. Since 2005 the Medicaid program has placed restrictions on the use of the unlisted dental procedure code, requiring prior authorization and approval before it is reimbursed.

Figure 4

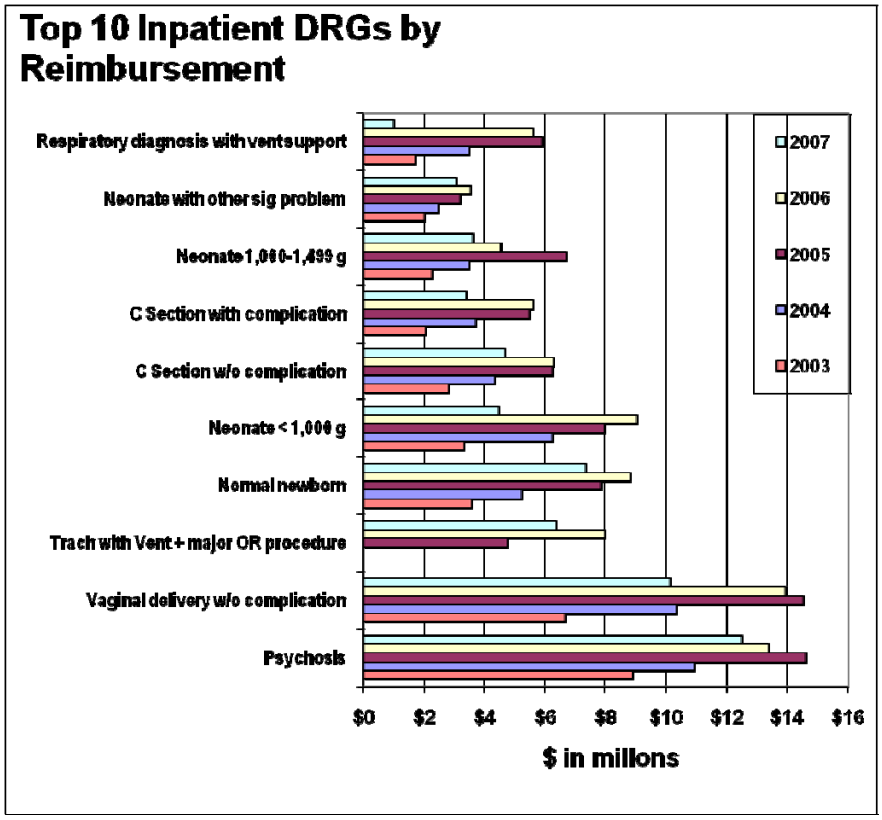


Figure 4 shows the top 10 DRGs by reimbursement. The majority of the DRGs represented on these tables represent billings for births. Births usually result in at least a minimal stay for the mother and the infant even if both have no complications. The downward trending of the birth DRGs

represents the expansion of HealthWave. As mentioned earlier, this is because 50,000 low-income families, including children and pregnant women, were enrolled in a HealthWave MCO rather than the Medicaid fee-for-service or HealthConnect programs. The spikes in reimbursements seen in FY 2005 can be attributed to: FY2005 being 53 weeks long vs. the standard 52 weeks; a large amount of claims delayed from FY 2004 for payment in FY 2005; and an increase in users of inpatient hospital services. The increases in reimbursements seen in FY 2006 are most likely due to the provider assessment. The downward trend from FY 2006 to FY 2007 in the Psychosis DRG is noteworthy, but not well-understood.

Ongoing Issues

Outpatient Reimbursement Rates

Kansas Medicaid reimburses outpatient hospital services using the same payment reimbursement rates as Ambulatory Surgical Centers (ASC). This has been the payment methodology used by Kansas Medicaid for decades. Medicare introduced a new payment methodology for outpatient hospitals called Outpatient Prospective Payment System (OPPS) in August 2000. Medicare OPPS treats outpatient hospitals as unique facilities and does not use the same coverage and reimbursement rates as they do for Medicare ASCs. This new payment system increased the reimbursement rates received by outpatient hospitals and was designed to better represent the cost of the services provided in an outpatient hospital setting.

KHPA has taken initial steps toward implementing OPPS reimbursement rates to better mirror Medicare's payment methodology for outpatient hospitals. The first step is to give outpatient hospitals their own rate type and "coverage windows" instead of having them as part of the ASC rate type and coverage windows. Coverage windows are sections of the KHPA payment system where benefit plan coverage and payment rate types are defined. There are some major differences between Medicare OPPS reimbursements and coverage compared to Medicare ASC reimbursements and coverage. By implementing a Medicaid version of OPPS, KHPA would not only better mirror Medicare, but would also give the providers more comprehensive coverage and more consistent reimbursement for the services they offer.

While KHPA has considered recommending OPPS for all outpatient services to mirror Medicare, the agency has not yet decided to implement a Medicaid version of OPPS. This is because of the fiscal impact that would result if facilities were to be "held harmless" in the transition. However, for new procedure codes in outpatient hospitals, KHPA since 2004 has been using Medicare's OPPS guidelines and rates instead of Medicare's ASC guidelines and rates to establish coverage and reimbursement.

The next step for KHPA will be to compare Medicare coverage to Medicaid coverage and analyze the differences. Ultimately this could lead to proposals to bring the outpatient reimbursements up to a standard percentage of Medicare OPPS.

Covered Procedure Codes

Each year Medicare releases quarterly "procedure code updates" and the Kansas Medicaid program managers review these new procedure codes for possible coverage. Many of the new procedure codes replace existing codes, or represent more detailed descriptions of currently covered services. In addition, new procedure codes are researched by the program managers for possible

coverage for Kansas Medicaid consistent with evidence based medicine. The program managers review the list of codes along with any information that is available (e.g. other insurance coverage, requests from providers), then recommend which new procedure codes receive coverage and at what reimbursement rate. Coverage is approved or denied by a reviewing team of program managers and then by agency leadership. Reimbursement rates are determined based on a percentage (65%) of proposed Medicare reimbursement rates.

CMS mandates specific procedure codes for coverage. For those codes not mandated each individual state decides to either cover or not cover a given service. Kansas has tried to balance adequate coverage of procedures deemed medically necessary with budgetary constraints. Coverage research for new procedures and currently non-covered procedures is ongoing. Providers contact KHPA program managers and request that they research new coverage, changes in coverage, and reimbursement changes on a daily basis. This demand-driven process is intended to be responsive to changes in medical care, but may also lead to inconsistency in the reimbursement policy. An alternative approach would be to adopt Medicare coverage policies in whole at a set percentage of the Federal reimbursement rate. This would bring Medicaid coverage in line with Medicare and private coverage, which typically follows Medicare, but would most likely be more expensive.

Recent Changes

KHPA has made several recent improvements to the acute care hospital program. A number of other changes are planned in the future.

End-stage Renal Disease Rates

KHPA is currently implementing an increase in End Stage Renal Dialysis (ESRD) facility reimbursement rates. This policy is intended to increase the reimbursement rates to better reflect national trends and preserve access for beneficiaries. Prior to this policy, Kansas' reimbursement rate was the lowest of 35 known states, and with these changes Kansas will rank 17th out of 35 states. This policy will also provide ESRD facilities their own provider type and specialty in the billing system. Currently ESRDs are assigned physician provider types and specialties. By providing the ESRDs with their own provider type and specialty, KHPA will be able to clearly track ESRD usage and reimbursements. This information will provide KHPA with more accurate data to make better policy in the future.

Because of the growth and high level of emergency room usage, KHPA is researching the possibility of doing a special project to review appropriate emergency room usage among our beneficiaries. Currently KHPA "down codes" instead of denying emergency room services that are billed with a "non-emergent" primary or secondary diagnosis code. KHPA has classified every covered diagnosis code as always emergent, sometimes emergent, or never emergent. These codes are used to determine if the service that was provided was emergent. If the service has been determined to be non-emergent the procedure code billed by the provider is automatically down coded to a lower-paying non-emergent emergency room service code.

Some state Medicaid programs have already begun to implement changes in emergency room program coverage and reimbursement for inappropriate emergency room services. Some states deny emergency room services if not considered to be emergent. Other states have increased or added co-pays for non-emergent emergency room services. Currently KHPA does not charge a co-pay for non-emergent emergency room services.

Disproportionate Share Hospital (DSH)

The federal government provides special matching funds to states through the Disproportionate Share Hospital (DSH) program. These funds provide added payments to hospitals that treat significant populations of indigent patients (Medicaid and the uninsured) through the DSH program.

DSH payments in Kansas have fluctuated drastically in the past due to large hospitals that may not participate in the program equally from year to year. Therefore, the years that these large hospitals have large uncompensated care costs there will be less available monies for other hospitals. In addition, the full DSH allotment has not always been used.

During FY 2007, KHPA worked with consultants, accountants, several Kansas hospitals, and the Kansas Hospital Association to create a new DSH payment methodology. The new methodology better represents hospital losses for uncompensated care and Medicaid costs, and ensures that KHPA uses all available Federal DSH funds. The updated methodology also better targets payments to community hospitals that provide critical care to their patients.

On May 16, 2008, KHPA received approval from the Centers for Medicare and Medicaid Services (CMS) for a new DSH methodology. The new DSH methodology amended the state plan and was effective for FY 2008. In order to determine DSH payments, the amount of uncompensated care (as a percentage of total costs) is calculated for each hospital. This provides a clear picture of the actual burden of uncompensated care provided in each hospital relative to its size. Similar to the Medicare program, the new methodology formula ensures that smaller rural hospitals receive their "fair share" by paying them "cost based reimbursement."

Critical Access Hospitals (CAH) Cost Reimbursement

On March 5, 2008, KHPA received approval from the Centers for Medicare and Medicaid Services (CMS) for a new Critical Access Hospitals (CAH) cost reimbursement methodology. The new CAH cost reimbursement methodology amended the state plan and was effective October 5, 2007.

Under this new methodology, CAHs will continue to receive initial inpatient and outpatient reimbursements using the standard reimbursement methods. Currently inpatient stays are reimbursed using a DRG reimbursement model and outpatient services are paid using a fee-for-service (FFS) reimbursement model. CAHs will then be issued a Kansas Medicaid cost settlement for hospital inpatient and outpatient services, based on filing of the Medicaid FFS claims data on the Title XIX sections of the Medicare cost report. These cost settlements will reimburse the CAH for 100% of their reasonable costs of providing inpatient and outpatient services as determined under applicable Medicare principles of reimbursement.

By using this new cost reimbursement methodology, KHPA will provide the CAHs with more accurate reimbursements to represent their specific costs. Since the CAHs will have less uncompensated care balance under this new cost reimbursement model, they will qualify for less, if any, DSH reimbursements. The DSH funds not used by the CAHs will be available for distribution to other hospitals serving a disproportionate number of Medicaid beneficiaries and the uninsured.

Health Reform Act of 2008 (Senate Bill 81)

The bill amends two statutes in the Primary Care Safety Net Clinic Capital Loan Guarantee Act to

create a definition of "provider-based indigent care clinic." Such a clinic would have to be located in a Medicare-certified hospital, nursing facility, or home health agency and would be included within the definition of a "primary care safety net clinic." Additionally, the Secretary of the Kansas Department of Health and Environment would be allowed to enter into agreements with provider-based indigent care clinics to allow such clinics to act as primary care safety net clinics.

This law is intended to fund more safety net clinics in order to decrease hospital emergency room usage for services that can be provided in a safety net clinic setting.

Border City Children's Hospital Reimbursement

Children's Mercy Hospital of Kansas City, Missouri, is the largest safety net and tertiary care children's hospital in the region, serving children throughout Kansas. Because of the types of cases referred to Children's Mercy, the hospital experiences greater lengths of stay and greater costs than other hospitals serving Kansas Medicaid children. Because of the severity of patients they serve, Children's Mercy has relied increasingly on DSH payments and cost outliers to reimburse for its costs.

In March 2008, KHPA submitted a new state plan to CMS proposing to provide these providers with a modified cost outlier methodology. CMS has not finalized their review of these changes, which take effect in FY 2009.

Recognizing that Children's Mercy incurs a relatively high loss ratio in terms of outlier claims, the modified outlier payment formula will target reimbursement toward higher cost cases. Increasing the outlier recovery percentage will generate additional reimbursement and permit improved cost recovery while at the same time freeing up limited DSH funds for Kansas hospitals.

The estimated increase in changing the outlier recovery percentage will allow Children's Mercy to recover approximately 86% of the cost of providing care for Kansas children, a rate just below the largest Kansas hospitals serving Medicaid beneficiaries.

Recommendations for FY 2009

KHPA is committed to ensuring access to quality care for Medicaid beneficiaries. In this report we review current and planned policies for hospital reimbursement. Ensuring equitable yet fiscally responsible reimbursement for all our providers is a key strategy for maintaining access for our beneficiaries. Recent or pending changes in hospital reimbursement have both increased reimbursements and improved equity in those payments. Recommendations for FY 2009 include a more focused review of ER reimbursements to identify opportunities for improved efficiency and quality care, and adoption of Medicare impatient rates that further improve equity by better targeting high cost cases.

Emergency Room Usage

Because of the growth and high level of emergency room usage, KHPA has begun to plan a special project to review the appropriateness of emergency room usage by the Medicaid population. KHPA would use this information to determine if any program changes would be appropriate.

DRG Reimbursements

Currently Kansas Medicaid uses a DRG payment methodology provided by CMS and rates specific to Kansas prepared by an outside actuary. These calculations are modified with every Medicare update. Kansas Medicaid tries to implement DRG updates in a timely manner in accordance with Medicare; however, due to the timing of the release of the Medicare Inpatient final rule, it is difficult for KHPA to update concurrent with Medicare.

In FY 2008, Medicare implemented a new MS-DRG payment methodology for inpatient hospitals. The new DRG system recognizes severity of illness and resource use and is based on the complexity of both. These changes will provide the ability to identify groups of patients with varying levels of severity using secondary diagnoses. The MS-DRG methodology increased the number of reimbursable DRG's from 335 to 745.

KHPA implemented a system "crosswalk" from the current DRG version 24 to the new Medicare MS-DRG. KHPA will use this crosswalk until KHPA can successfully implement the new MS-DRG methodology which is scheduled for January 23, 2009. With the new MS-DRG implementation, KHPA will mirror Medicare's payment updates that includes adjustments to reduce payments for so-called "hospital acquired conditions," where the hospital itself is the cause of an illness or expenditure. The changes are intended to better align payment with appropriate incentives for high quality outcomes and patient safety. If and when Medicare changes its policies to deny payment entirely for "never events," KHPA would plan to follow suit adjusting Medicaid payments as well.

See Table A
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Table A
Annual trends for Acute Hospital indicators

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2006 (a)	FY 2007
Number of consumers	36,400	43,664	52,203	69,500		41,816
Acute care hospitals						
Total payments	$ 162,804,523	$ 172,125,034	$ 232,182,394	$ 231,321,607		$ 241,250,184
Number of claims	51,300	53,078	69,912	63,001		58,050
Avg. payment per claim	$ 3,174	$ 3,243	$ 3,321	$ 3,672		$ 4,156
Outpatient providers						
Total payments	$ 21,460,899	$ 23,625,582	$ 34,954,875	$ 36,677,915		$ 39,451,430
Number of claims	903,950	953,543	1,427,411	1,268,890		1,360,566
Avg. payment per claim	$ 23	$ 25	$ 24	$ 29		$ 29
Financial (lump-sum) expenditures						
Total payments	$ 5,350,638	$ 17,495,902	$ 31,597,643	$ 138,187,840	$ 69,093,920	$ 73,573,059
Number of claims	75	228	341	622	622	391
Avg. payment per claim	$ 71,342	$ 76,736	$ 92,662	$ 222,167	$ 111,083	$ 188,166

(a) reflects adjusted totals that exclude one-time catch-up access payments in 2006.