

Washington State Health Care Authority

Report to the Legislature

HOSPITAL-BASED CLINIC SERVICES

ESSB 6002, Section 213(55)

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Overview & Summary

This report provides detail on the usage of hospital-based clinics, and the payment methods that the Washington State Health Care Authority (agency) provides for clinic services. This report is provided in accordance with the 2014 supplemental operating budget effective April 4, 2014. 3 Engrossed Substitute Senate Bill 6002, Section 213 (55) reads:

By December 1, 2014, the authority shall report to the legislative fiscal committees with options for reducing payments to hospital owned physician practices or clinics that are higher than the maximum resource based relative value scale fee rates received by nonhospital owned physician practices or clinics for the same procedures. The authority shall include options for exempting certain hospital owned clinics from the reductions and the fiscal impacts of those options. The authority shall not enter into or renew any contracts under RCW 74.60.160 that would restrict the authority's ability to implement any of these options in the 2015-2017 fiscal biennium.

First, this report will provide detail on clinic services and current payment methods utilized by the agency for both facility and non-facility settings. Next, the report will discuss potential methods for identifying clinic based services within an outpatient setting. Once those options are established, the agency will provide options for changing the payment methodology for these services.

The agency will then provide a recommendation for reducing the payments on hospital-based clinic services. In brief, the agency proposes lowering payments to outpatient hospital clinic services for a specific set of evaluation and management (E&M) procedures, using the differential method described in section III. This proposal is expected to result in an overall spending reduction of \$42,311,000 in the 2015-2017 biennium. This proposal was chosen for consistency, ease of implementation, and to ensure that the scope of services impacted from this change can be targeted and controlled.

At the end of this report, the agency will provide data assumptions supporting the figures used throughout this report. This report also includes a glossary of terms, and links to further information available on this topic.

Part I: Clinic Services and Current Payment Methods

A clinic is defined by the Center for Medicare and Medicaid Services (CMS) as “a facility established primarily for the provision of outpatient physicians’ services”.

The agency currently pays physicians for services provided at a clinic, other than a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), using the Resource Based Relative Value Scale (RBRVS) system. The RBRVS payment for a physician service is based on the average amount of resources used for a service of that type, and includes a component for administrative and overhead costs of operating a clinic or physician practice. RBRVS payments do not vary based on the provider’s location.

When a clinic is owned by a hospital and integrated into a hospital system, the agency pays for both a physician service and a facility fee associated with the clinic service. The physician payment remains based on the RBRVS system, but at a rate which excludes administrative and overhead costs. In addition, the agency provides a separate payment based on the agency’s outpatient hospital payment method.

For outpatient hospital services, the agency pays using one of two methods:

1. Weighted Cost to Charges – a cost based payment method exclusive to Critical Access Hospitals (CAH)
2. Enhanced Ambulatory Patient Groups (EAPG) – an outpatient prospective payment system (OPPS) for all other hospitals

Using either the CAH or OPPS method, the payment for an outpatient clinic visit is significantly greater than the payment for the same service performed at a non-hospital based clinic. The majority of outpatient services are performed at hospitals reimbursed under the OPPS method.

For example, a standard doctor’s visit identified by procedure code 99213 pays \$38.39 when the submitted professional claim indicates that the service was performed in a non-facility setting. If a facility setting was indicated, the physician payment is \$25.47, a reduction of approximately 33% due to the exclusion of the administration and overhead costs. However, an outpatient claim for this service will pay an additional \$73.68 facility fee, resulting in a total payment for the service of \$99.15.

	Independent Clinic	Hospital-Based Clinic
Physician Payment	\$ 38.39	\$ 25.47
Facility Fee	\$ 0.00	\$ 73.68
Total Payment	\$ 38.39	\$ 99.15

Figure 1: Clinic payment example

In addition, the agency is experiencing growth in hospital-based clinic services at a rate significantly higher than that of other outpatient services. Between state fiscal year (SFY) 2009 and SFY 2013, the agency’s outpatient services grew from 1.61 million services per year to 1.68 million services per year, an increase of approximately 5%. During the same time period, clinic services grew from 295,000 outpatient hospital services per year to 460,000 services, a growth rate of more than 50%.

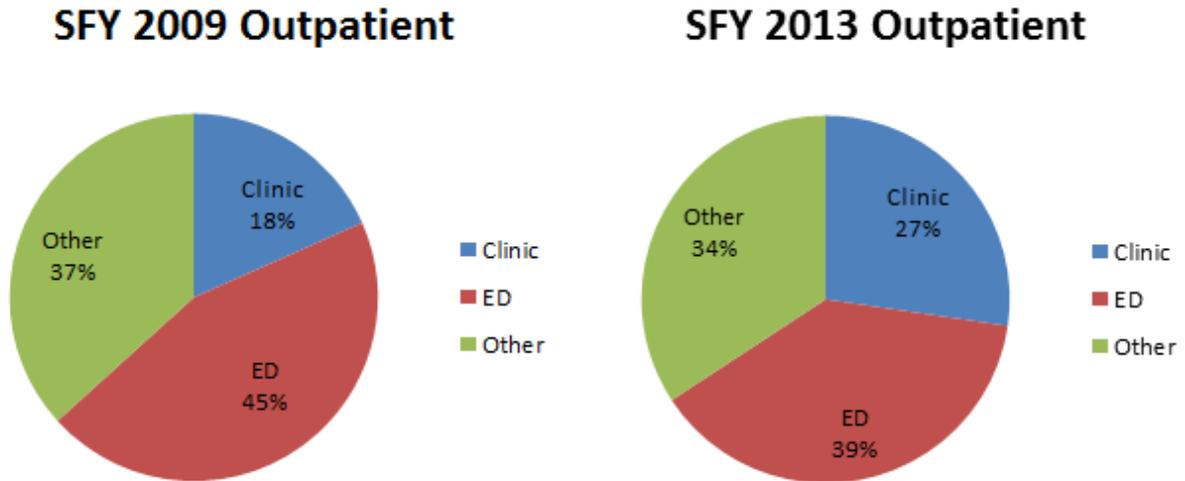


Figure 2: Clinic services growth as a percentage of outpatient volume

Washington’s experience with hospital-based clinic growth is not unique. In its June 2013 report, the Medicare Payment Advisory Commission (MedPAC) said the following regarding the growth of services in outpatient departments (OPD):

Payment variations across settings urgently need to be addressed because many services have been migrating from physicians’ offices to the usually higher paid OPD setting, as hospital employment of physicians has grown. This shift toward OPDs has resulted in higher program spending and beneficiary cost sharing without significant changes in patient care. From 2010 to 2011, for example, the share of evaluation and management (E&M) office visits provided in OPDs increased by 9 percent

The current payment methods in place promote increased cost for Medicaid services without a comparable increase in patient care. As Washington proceeds towards a goal of value-based purchasing, the current methods for paying services at hospital-based clinics need to be reevaluated.

Part II: Identifying Hospital-Based Clinic Services

Current billing policies at both the federal and state level do not allow for a clear distinction between services performed at a hospital-based clinic and those performed within the hospital proper. Federal requirements allow for a hospital-based clinic to bill using the National Provider Identifier (NPI) of the base hospital. This results in services performed at an off-site hospital clinic being indistinguishable from clinical services provided on the hospital grounds.

The agency is anticipating CMS will provide a modifier which will be required for off-site hospital-based clinics to utilize when submitting outpatient claims effective January 1, 2015. Once these rules have been established by CMS, the agency will update the corresponding Medicaid Provider Guide (MPG) to require outpatient hospitals to utilize this modifier on claims submitted to the agency. While outside of the scope of this report, this will allow the agency to differentiate between off-site and on-site hospital-based clinics in the future.

EVALUATION AND MANAGEMENT (E&M) PROCEDURES

Outpatient hospital claims for both clinic and non-clinic services require procedure codes in order to determine the appropriate payment. E&M codes represent encounters between a physician and a client, as opposed to a service being performed on a client. E&M codes which represent basic physician visits or encounters, and are identified with procedure codes between 99201 and 99215 or G0463. These codes represent an office or basic outpatient visit unrelated to a hospital stay, and are the first option for payment reductions for clinic services.

Procedure	Services	Original Payment
99201	1417	\$ 56,884
99202	3149	\$ 168,307
99203	4743	\$ 329,020
99204	13544	\$ 1,320,444
99205	4196	\$ 537,603
99211	63612	\$ 2,547,087
99212	142845	\$ 7,621,545
99213	106266	\$ 5,693,020
99214	103278	\$ 7,453,743
99215	18518	\$ 1,741,418
Total	461568	\$ 27,469,071

Figure 3: E&M procedure volume in SFY 2013 data

The agency does not propose a reduction to payments on E&M codes related to observation services, emergency department visits, or inpatient services.

REVENUE CODES

In addition to procedure codes, hospital claims are submitted using a four-digit revenue code which identifies the department or cost center from which a particular service has been billed. The agency currently allows outpatient hospitals to bill using two revenue codes, 0510 and 0519, to identify a service as clinic-based. The agency does not currently allow CAHs to bill using these revenue codes.

The 0510 series can be utilized appropriately for many services under the outpatient benefit, ranging from E&M visits to minor surgeries. As such, using a revenue code to define a change in payment method creates a much wider impact on services. In turn, this creates a large administrative burden to ensure that all services are paid in accordance with program requirements.

Procedure Category	Group	Services	Original Payment
E&M	FFS	109113	\$ 6,863,043
E&M	MC	269013	\$ 16,087,592
Surgical	FFS	3597	\$ 463,892
Surgical	MC	7070	\$ 882,602
Other	FFS	5554	\$ 281,344
Other	MC	12311	\$ 376,375
		406658	\$ 24,954,850

Figure 4: Revenue code 0510 by procedure code category in SFY 2013 data

There is a significant overlap between the E&M procedures listed above and the 0510 revenue code series: approximately 90.8% of services (by payment volume) using the above E&M codes are submitted using the 0510 series revenue codes.

Revenue Code	Group	Svcs	Original Payment
Clinic	FFS	109113	\$ 6,863,043
Clinic	MC	269013	\$ 16,087,592
ER/ED	FFS	2092	\$ 119,523
ER/ED	MC	8762	\$ 494,898
Treatment Room	FFS	21164	\$ 1,181,531
Treatment Room	MC	45617	\$ 2,478,921
Other	FFS	1221	\$ 65,392
Other	MC	4586	\$ 178,171
		461568	\$ 27,469,071

Figure 5: E&M procedure codes by revenue code category in SFY 2013 data

Part III: Potential Payment Methods

Regardless of the method used for identifying or targeting clinic services subject to the reduction, there are two potential methods for determining the payment under this proposal: the RBRVS differential, or a flat fee.

RBRVS DIFFERENTIAL

The RBRVS differential is quite simply the difference between the facility and non-facility payment to a physician. In part I of this report, we provided an example for procedure code 99213 paid under the facility and non-facility settings using the RBRVS.

The differential method ensures a defensible, consistent method to calculate rates payable on clinic services in an outpatient setting. This method also provides the greatest chance of ensuring payments for services are the same regardless of performance at a facility or non-facility setting.

SFY	Group	Svcs	Original Payment	Estimated Payment	Savings	Trend	Projected Savings
2016	FFS	133590	\$ 8,212,529	\$ 2,058,207.63	\$ 6,154,322	1.0643	\$ 6,550,045
2016	MC	327978	\$ 19,256,542	\$ 5,740,475.93	\$ 13,516,066	1.0643	\$ 14,385,149
2016	Total	461568	\$ 27,469,071	\$ 7,798,683.56	\$ 19,670,388		\$ 20,935,194

Figure 6: E&M code payment using RBRVS differential method

The largest risk posed by the RBRVS differential is the potential for services to receive no payment. This would occur when the facility setting rate is the same as the non-facility rate for a given service. This risk exists only when defining clinic services based on revenue code; as all identified E&M codes have a site of service differential.

FLAT FEE

Effective January 1, 2014, CMS required all services previously billed under E&M codes 99201-99215 to be billed using a new procedure code, G0463. This procedure represented a flat base rate for E&M services regardless of resource intensity. In a similar proposal, MedPAC recommended paying a flat facility rate based on E&M 99213.

Utilizing MedPAC's recommendation of E&M 99213 as a basis, the agency would determine the differential as \$12.07. Over the course of 461,568 services, this results in an annual payment of \$5.6 million dollars for SFY 2013 services. This mitigates any risk associated to a service not receiving payment, as all payments are paid at the determined fee.

There is precedent at the Federal level for determining one flat fee for a group of services. However, the agency believes that this carries a legal risk due to the method used to calculate the fee being viewed as arbitrary during a legal proceeding.

SFY	Group	Svcs	Original Payment	Estimated Payment	Savings	Trend	Projected Savings
2016	FFS	133590	\$ 8,212,529	\$ 1,612,431.30	\$ 6,600,098	1.0643	\$ 7,024,484
2016	MC	327978	\$ 19,256,542	\$ 3,958,694.46	\$ 15,297,847	1.0643	\$ 16,281,499
2016	Total	461568	\$ 27,469,071	\$ 5,571,125.76	\$ 21,897,945		\$ 23,305,983

Figure 7: E&M code payment using flat fee method

Below is a comparison of E&M service payments between the differential method and the flat fee method:

Procedure	Differential Method	Flat Fee Method
99201	\$ 10.05	\$ 12.07
99202	\$ 14.17	\$ 12.07
99203	\$ 18.30	\$ 12.07
99204	\$ 20.09	\$ 12.07
99205	\$ 21.71	\$ 12.07
99211	\$ 6.64	\$ 12.07
99212	\$ 10.76	\$ 12.07
99213	\$ 12.92	\$ 12.07
99214	\$ 16.86	\$ 12.07
99215	\$ 19.37	\$ 12.07
Average	\$ 15.09	\$ 12.07

Figure 8: E&M code payment comparison

Part IV: Recommendation and Implementation

The agency recommends outpatient services for E&M codes 99201 through 99205, 99211 through 99215, using the differential method described in Part III. This proposal is expected to result in an overall spending reduction of \$42,311,000 in the 2015-2017 biennium. This proposal was chosen for consistency, ease of implementation, and to ensure that the scope of services impacted from this change can be targeted and controlled. The agency does not recommend applying reductions to cost-based payments to Critical Access Hospitals, FQHCs, or RHCs.

In order to implement reductions proposed under this recommendation, the agency will need to do the following:

- Update multiple sections of Chapter 182-550 WAC
- Submit an amendment to the agency's Medicaid State Plan
- Notify hospital providers of the change
- Update the agency's Medicaid Provider Guide.
- Update the agency's Medicaid claims payment system, ProviderOne

Note that this recommendation, as proposed, can be implemented with only minor, configurable changes to ProviderOne. This is managed using the existing functionality of setting each affected procedure code to a fee payment.

The agency does not recommend excluding clinics or hospitals from this reduction based on scope of care or volume of care. Either of these options increases the risk that the reduction will be considered arbitrary, and has the potential to be overturned under current Medicaid law. In addition, ProviderOne does not currently have a provider-based delineation for hospital services paid at fee, and would therefore require a significant change in order to implement any such payment methods.

Part V: Data Assumptions

- Analysis is based on claims and encounter data for State Fiscal Year 2013, with reductions applied to remove payment increase awarded by the Hospital Safety Net
- Payment reduction calculations are based on the APC payment method which was utilized by the agency prior to July 1, 2014.
- No payment impact due to the implementation of EAPG can be calculated until a full year's worth of data is available
- Managed care encounter data used was submitted to ProviderOne, and has not been verified by HCA's actuaries for completeness or accuracy
- Savings figures were not increased or decreased based on contract payments between the Managed Care Organizations and hospitals
- Reductions do not apply to Critical Access Hospitals (CAH), FQHC, or RHCs
- Reductions apply to both off-site and on-site hospital clinics
- Payment amounts were trended from SFY 2013 at a rate of 2.10 percent per year, resulting in a cumulative trend of 1.06 percent for SFY 2016 and 1.09 percent for SFY 2017

Part VI: GLOSSARY OF TERMS

Ambulatory Payment Classification means (APC) – an OPPS method used by the agency prior to July 1, 2014

Center of Medicare and Medicaid Services (CMS) – the federal agency that administers the Medicare program and works with state agencies to administer the Medicaid program

Critical Access Hospital (CAH) – a hospital that is approved by the Department of Health (DOH) for inclusion in the critical access hospital program and approved by the agency for CAH payment

Enhanced Ambulatory Patient Groups (EAPG) – the OPPS method used by the agency effective July 1, 2014

Facility Setting – the setting for care that is performed in a hospital, ambulatory surgery center, or other medical facility

Non-facility Setting – the setting for care that is performed in a clinic or physician’s office

Hospital - an entity that is licensed as an acute care hospital by the Department of Health

Hospital-Based clinic - a clinic or physician’s office that is owned and operated as part of a hospital or hospital system

Medical visit - a visit during which medical treatment was received but no significant procedure was performed, such as preventive care visit.

Medicare – the Federal program responsible for health care for citizens aged 65 and over, or citizens with chronic disabilities

Medicare Payment Advisory Commission (MedPAC) – an independent federal commission created to advise congress on financing and administering the Medicare program

Observation services - health care services furnished to an outpatient client to evaluate their condition or determine the need for possible inpatient admission

Outpatient - a patient who is receiving health care services outside of an inpatient hospital setting, including services such as emergency room visits

Outpatient hospital - a hospital authorized by the department of health to provide outpatient services.

Outpatient Prospective Payment Systems (OPPS) – a method used to determine payment for outpatient services based on average resource use and intensity of services performed

Part VII: Further Information

Code of Federal Regulations, 42 CFR 413.65, Requirements for a determination that a facility or an organization has provider-based status. <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec413-65.pdf>

HCA's FY 2015-2017 policy-level decision package on hospital-based clinic services. http://www.hca.wa.gov/Documents/budget/15-17_PL-A0_Hospital_Based_Clinic_Services.pdf

MEDPAC June 2013 Report, Chapter 2, Medicare payment differences across ambulatory settings. http://www.medpac.gov/documents/reports/jun13_ch02.pdf?sfvrsn=0