

ANALYSIS OF MEDICAID EMERGENCY ROOM REIMBURSEMENT POLICY

(FY2008 Appropriation Bill - Public Act 123 of 2007)

September 30, 2008

Section 1657: (1) Reimbursement for medical services to screen and stabilize a Medicaid recipient, including stabilization of a psychiatric crisis, in a hospital emergency room shall not be made contingent on obtaining prior authorization from the recipient's HMO. If the recipient is discharged from the emergency room, the hospital shall notify the recipient's HMO within 24 hours of the diagnosis and treatment received. (2) If the treating hospital determines that the recipient will require further medical service or hospitalization beyond the point of stabilization, that hospital must receive authorization from the recipient's HMO prior to admitting the recipient. (3) Subsections (1) and (2) shall not be construed as a requirement to alter an existing agreement between an HMO and their contracting hospitals nor as a requirement that an HMO must reimburse for services that are not considered to be medically necessary. (4) Prior to contracting with an HMO for managed care services that did not have a contract with the department before October 1, 2002, the department shall receive assurances from the office of financial and insurance services that the HMO meets the net worth and financial solvency requirements contained in chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580.

*Michigan Department
of Community Health*



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Report on Medicaid Payment Policies in the Emergency Department Boilerplate Report Section 1657

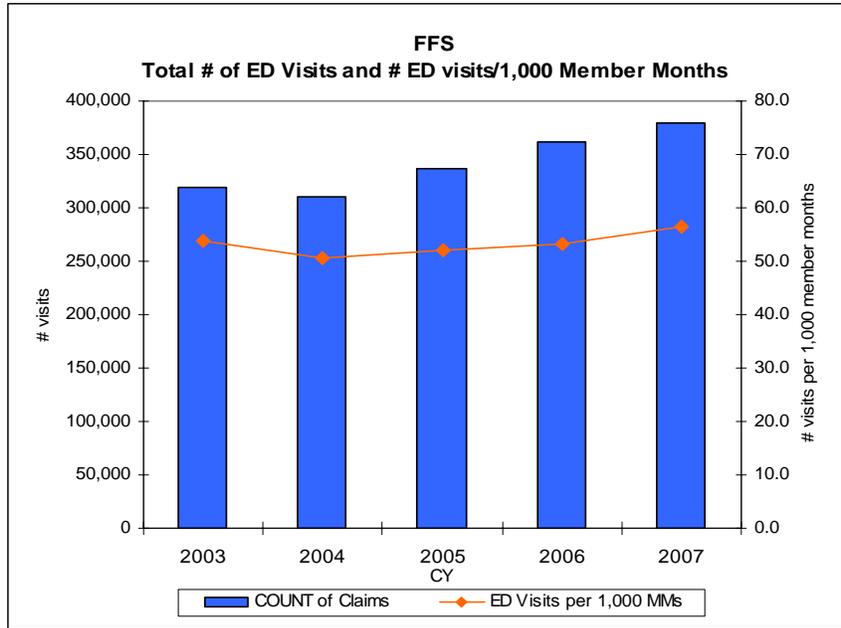
Medicaid physician payment policy regarding recipients treated in emergency room departments has undergone a number of changes since 2000. The current Medicaid ER case rate policy is a two-tiered policy where physician reimbursement is based on whether the patient was released following ED services or admitted as an inpatient (UD and UA modifiers). Additionally, ancillary services are excluded from the case-rate and are billed separately. The current two-tiered payment rate system creates an incentive for health facilities to admit beneficiaries seeking care in the emergency department to inpatient care given the higher reimbursement (\$104.81 vs. \$45.50) for ED patients that are admitted as inpatients. Whether this is actually influencing physician decision-making in terms of admitting or releasing ED patients is the question of interest.

Fee for Service claims data as well as Managed Care encounter data from calendar years 2003 to 2007 were analyzed. Analysis included examining:

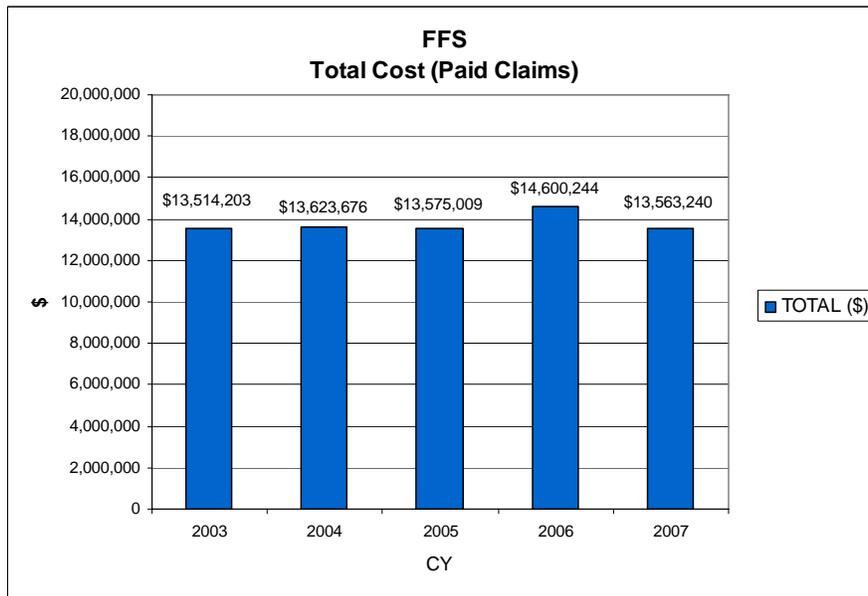
- The number/cost of ED visits calculated by counting claims/encounters and their related cost for 99281-99285 (cost not calculated for Managed Care).
- The ratio of ED visits per 1,000 member months was calculated by dividing the total number of ED visits by the total number of member months for a given calendar year.
- In order to calculate a rough approximation of the number of ED visits that resulted in inpatient admissions, a count of claims that originated in the ED and included the modifier UD (discharge) or UA (admit) was calculated.

Trends in FFS ED Visits, Costs, and Inpatient Admissions

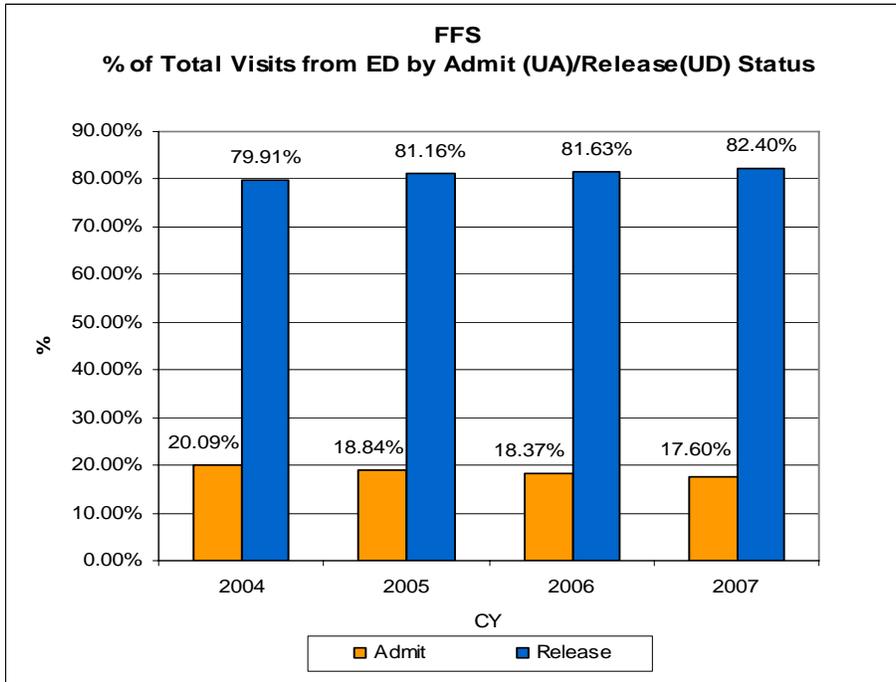
Since 2003, there has generally been an increase in the number of ED visits from 318,860 to 378,944 visits. This growth is at least partially attributable to increased Medicaid enrollment and that is reflected in the visits/1,000 eligible month metric.



When calculating the total cost associated with these procedure codes (99281-99285), costs have remained fairly stable since 2003.

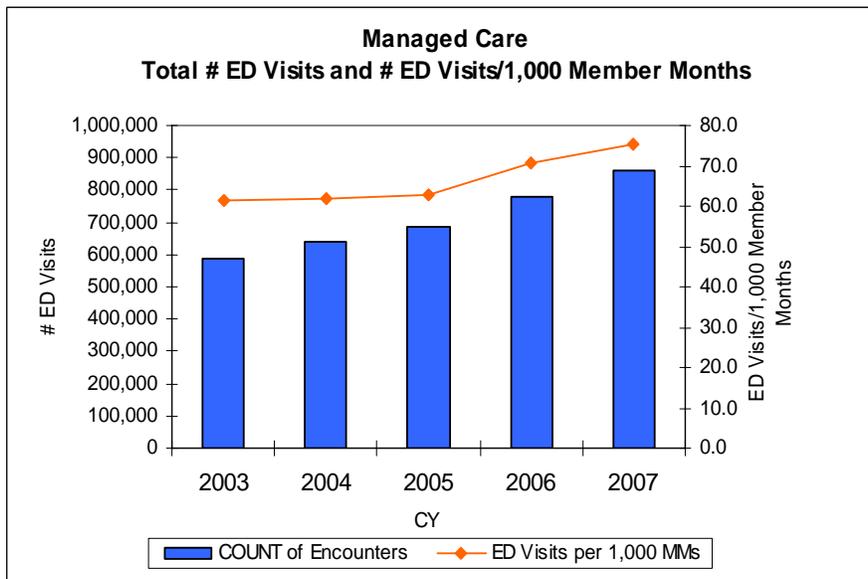


The proportion of inpatient admission of visits originating from the ED has remained relatively stable for FFS patients, and has actually been decreasing.

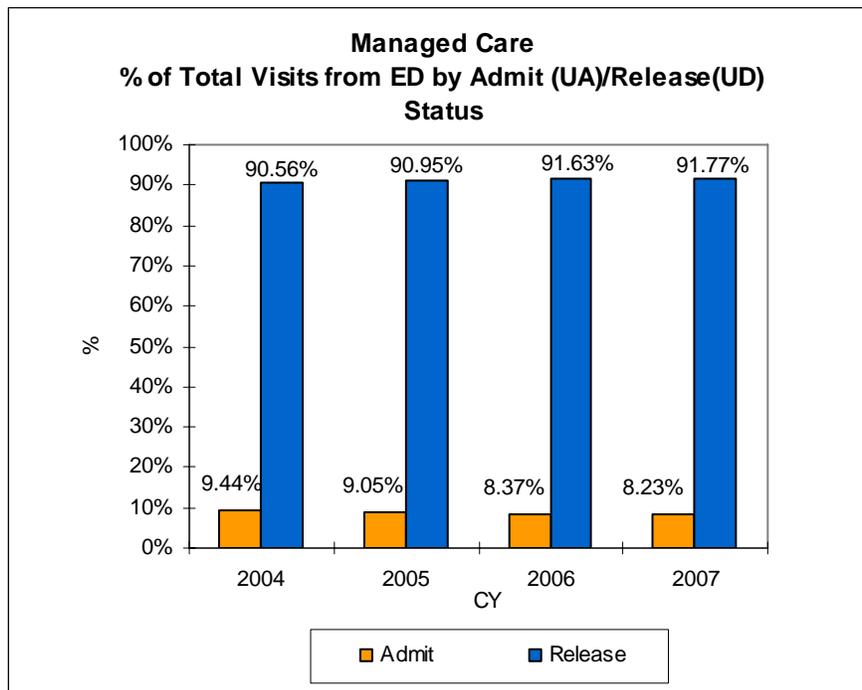


Trends in Managed Care ED Visits, Costs and Inpatient Admissions

A count of ED visits for managed care beneficiaries also shows an increase in the number of ED visits since 2003. The number of ED visits per 1,000 member months has also increased. Again, Medicaid enrollment growth explains some of this increase.



The proportion of inpatient admission of visits originating from the ED has remained relatively stable for managed care patients, and has decreased since 2004.



Medicaid ER Case Rates Payment Policy Background

MSA issued a bulletin (00-12) in December 2000 on changes related to the Physician Emergency Room Case Rate. Following workgroup recommendations, an all-inclusive, two-tiered case rate was developed for hospital emergency room services where the level of reimbursement was based on whether a patient received treatment and was released or treated and admitted/transferred. The rates went into effect (January 1, 2001) for services for all Medicaid, CSHCN, and State Medicaid program beneficiaries enrolled in either a health plan or fee for service.

The 1/1/01 changes were recommended by a DCH/industry workgroup. The workgroup was formed at the direction of the legislature because of cumbersome billing disputes between HMOs and emergency room physicians related to the level (intensity) of the visit encounter. The two-tiered case rate solution simplified the reimbursement process and provided concrete criteria for the rate differential. It should be noted that this solution has retained its effectiveness relative to the presenting problem.

Two years later MSA reexamined the rates and issued another bulletin (02-12) that included modifications to the Physician Emergency Room Case Rate. The new policy became effective on January 1, 2003. In order to be HIPAA compliant, the designations of "treat and release" and "treat and admit/transfer" for level of payment were eliminated. The physician was reimbursed without regard to whether the patient was released or admitted or whether the medical screening resulted in the service being deemed an emergency or not, and ancillary services were excluded from the case rate. The reimbursement rate became dependent on the level of ED E&M service the physician billed; \$50 for procedure codes 99281-99284 and \$120 for procedure code 99285.

On January 1, 2004, in response to ER physicians concerns; DCH converted back to the release/admit tiered structure but continued to exclude ancillary services. Fee screens remained the same. In 2005, the rates were lowered to \$45.50 and \$104.81.

Conclusion

Although the structure of the two-tiered emergency room case rate does provide more reimbursement to physicians for patients admitted to the hospital from the emergency department, evidence from the past five years shows no apparent impact on the behavior of physicians in their admission practices. The current system has resolved past billing issues and provided a reimbursement differential for more complex cases, typically those requiring admission to the inpatient hospital.

This conclusion is focused narrowly on physician incentives for admitting patients to hospitals from the ED. Other attendant problems associated with the ED, such as high overall utilization and heavy use for non-emergent visits, continue to be structural problems that plague both Medicaid and the health care system generally. The underlying causes are multiple and complex and there is no easy solution in spite of many ongoing efforts to address these issues. The pressures felt by primary care physicians and hospitals contribute to the difficulty in gaining ground. The increasing workload of primary care physicians and the anticipated reduction in the number of physicians entering primary care will exacerbate problems with high ED utilization. Further, while the practice has diminished, hospitals have marketed their services by highlighting ED access in their efforts to compete for patients. These pressures have contributed to higher utilization.