Legislative Fiscal Bureau

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Medicare Crossover Claims for Outpatient Hospital Services (DHFS -- Health Care Financing -- Payments, Services, and Eligibility)

[LFB 2003-05 Budget Summary: Page 216, #7]

CURRENT LAW

Medicare crossover claims are claims for which MA is required to pay deductibles and copayments on behalf of Medicare beneficiaries with incomes at or below 100% of the federal poverty level (FPL). In 2001-02, MA paid approximately $18.4 million (all funds) for Medicare crossover claims for outpatient hospital services.

Medicare Part B. Under Medicare Part B, beneficiaries receive coverage for a variety of professional medical and other services, including outpatient hospital, physician, ambulatory surgery centers, and durable medical equipment, laboratory services, home health and therapy services. Participants are required to pay a monthly premium to participate in Part B ($58.70 per month in 2003). In addition, participants are required to pay a deductible of $100 for services used under Part B, and after the deductible has been met, coinsurance requirements equal to 20% of the Medicare approved amount.

Before August, 2001, Medicare payments to hospitals for outpatient services were based on a variety of methods, including cost-based reimbursement, maximum fee schedules, and blended payments of costs and a hospitals' charges. Beginning in August, 2001, Medicare changed its method for making payments for outpatient hospital services to a prospective payment system, based on groupings of services provided during an outpatient visit. Under a prospective payment system, hospitals are paid one rate for specific services, rather than payments based on costs or itemized charges. Under the prospective payment system, several payments can be made for services provided during an outpatient visit.

MA and Medicare Beneficiaries. Elderly, blind, and disabled individuals may qualify for both MA and Medicare if they meet the requirements for both programs. These individuals are

considered dually-eligible and are eligible to receive all MA covered benefits. As required under federal law, MA is the payer of last resort. This means that for MA enrollees with other insurance coverage, including Medicare, MA only pays for those MA covered services for which other insurance does not cover, including any required cost sharing. For Medicare beneficiaries, this includes Medicare premiums, deductibles and coinsurance.

In addition, federal law requires state MA programs to pay Medicare Part A and Part B premiums, deductibles and coinsurance for individuals known as qualified Medicare beneficiaries (QMBs). These individuals do not receive MA coverage for any other services. To be considered a QMB, an individual has to be entitled to receive Medicare Part A, have income at or below 100% of the federal poverty level (FPL) and have resources that do not exceed twice the maximum amount established for eligibility for supplemental security income (SSI) benefits, which is currently $2,000 for individuals and $3,000 for a couple. In 2003, the FPL is equal to $12,120 annually for a two-person family.

Medicare Crossover Payments. MA payments for Medicare deductible and coinsurance requirements are referred to as "crossover payments." The minimum amount states are required to pay is the maximum reimbursement paid under MA for the service provided.

Currently, MA payments for outpatient hospital visits are paid based on an outpatient rate for each hospital. This payment represents reimbursement for all of the services provided during the outpatient visit. Crossover claims for outpatient hospital services are limited to the current MA payment for each visit for each of the services reimbursed under Medicare.

GOVERNOR

Reduce MA benefits funding by $8,750,000 (-$3,638,700 GPR and $5,111,300 FED) in 2003-04 and $17,500,100 (-$7,278,300 GPR and -$10,221,800 FED) in 2004-05 to reflect projected savings that would result from changing the method DHFS uses to calculate payment of crossover claims for outpatient hospital services.

DHFS would modify its method of calculating payments to hospitals for Medicare crossover claims so that the maximum amount MA would pay would be limited to the MA rate per visit for the sum of all services received during an outpatient visit rather than limited to the MA rate per visit for each service received during the visit. With this change, DHFS expects that MA would no longer pay crossover claims for most outpatient hospital services, thereby reducing MA payments to hospitals. As required under federal law, providers would be prohibited from charging dually-eligible enrollees and QMBs for the difference between the MA payment and the Medicare cost-sharing requirement.

DISCUSSION POINTS

1. In his March 17, 2003, letter to the Co-chairs of the Joint Committee on Finance, the

DOA Secretary indicated that the administration had reestimated the projected savings that would be realized under this provision. DOA requested that funding in the bill be reduced by $580,000 GPR and $771,700 FED in 2003-04 and $7,400 GPR in 2003-04 and federal funding be increased by $5,300 in 2004-05 to accurately reflect the Governor's intent.

Under the revised estimate: (a) MA benefits would be reduced by $4,245,700 GPR and $5,964,000 FED in 2003-04 and $7,285,700 GPR and $10,216,500 FED in 2004-05 to reflect anticipated savings beginning December, 2003; and (b) $27,000 GPR and $81,000 FED would be provided in 2003-04 to support the cost of contracted programming changes to DHFS information systems that would necessary in order to implement the change. This estimate assumes that the programming changes necessary to implement this change would require at least four months to implement and therefore, it is expected that this change would first apply to crossover payments made in December, 2003.

2. MA crossover claims for outpatient hospital services increased from approximately $18.0 million in 1999-00 and are expected to total approximately $22.7 million in 2002-03. Payments have increased due to changes in the Medicare payment methodology, outpatient hospital rate increases enacted as part of the 2001-03 biennial budget act, and changes in outpatient hospital utilization.

3. The estimated cost savings of this provision, both as reflected in the Governor's bill and the administration's revised request, was based on the assumption that outpatient hospital crossover claims would total approximately $18.4 million in 2002-03. However, based on more recent information, it is estimated that crossover payments for outpatient hospital services will total $22.7 million in 2002-03, which would increase the projected savings of the Governor's provision. Consequently, funding in the bill could be reduced by an additional $1,589,800 GPR and $2,190,100 FED in 2003-04 and $1,740,300 GPR and $2,424,600 FED in 2004-05.

4. It is expected that reductions to each hospital's MA reimbursement would closely correspond to each hospital's share of outpatient hospital services for Medicare beneficiaries. Because most hospitals receive a relatively large share of their revenue from Medicare (approximately 42% on average in 2001), these reductions would be distributed broadly among the state's hospitals. Those hospitals with a relatively small amount of patient revenue from Medicare, such as Children's Hospital in Milwaukee, would not be significantly affected by this change.

5. Changing the methodology for paying outpatient hospital crossover claims under the MA program, which would result in reduced payments to hospitals, could be viewed as an appropriate way to reduce MA benefits spending because crossover claims increased beginning in 2001-02 partly based on changes in the Medicare payment methodology. In addition, these reductions would be relatively broadly distributed among most Wisconsin hospitals.

6. However, it is estimated that on average, MA payments for outpatient hospital services represent between 55% and 60% of hospitals' costs for those services. The portion of hospitals' costs that are unreimbursed by MA are "shifted" to other payers, including commercial

health insurance plans. Reduced MA payment for outpatient hospital services may increase the amount of costs hospitals shift to other payers.

ALTERNATIVES

1. Approve the Governor's recommendation. In addition, reduce funding in the bill by $1,589,800 GPR and $2,190,100 FED in 2003-04 and by $1,740,300 GPR and $2,424,600 FED in 2004-05 to reflect reestimates of the projected cost savings of the Governor's proposal.

Alternative 1	GPR	FED	TOTAL
2003-05 FUNDING (Change to Bill)	-$3,330,100	-$4,614,700	-$7,944,800

2. Delete provision.

Alternative 2	GPR	FED	TOTAL
2003-05 FUNDING (Change to Bill)	$10,917,000	$15,333,100	$26,250,100

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