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Paying for Hospital Outpatient Services

A Guide for Medicaid Programs

This reference guide covers the many ways Medicaid programs can pay for hospital outpatient services. It includes options of adapting Medicare's APC method or 3M's EAPG method to Medicaid. We welcome suggestions for future versions.

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Introduction

Hospital outpatient care has become steadily more important during the last 20 years, with Medicaid payments for such care costing roughly $16 billion a year.1 Many states' Medicaid programs find it to be among the most problematic areas of payment policy, because payment methods have not kept pace. Today's methods are confusing, offer inappropriate incentives and do not sufficiently explain the solutions that Medicaid is purchasing.

In 1997, faced with these same problems in the Medicare program, Congress directed the program to implement a new approach to paying for hospital outpatient care. CMS (then HCFA) awarded a contract to 3M Health Information Systems to develop an outpatient prospective payment system. The result was the Ambulatory Patient Groups (APG) grouper.[2]

After a complex set of events and debates in Washington, however, what Medicare actually implemented was not APGs, but rather Ambulatory Payment Classification (APC) groups.[3]

In 2007, 3M made significant changes to APGs to reflect current coding and billing practices, as well as to describe a broader, non-Medicare population. The resulting product of these revisions is Enhanced APGs (EAPGs).

Many Medicaid programs are now considering whether they should implement a new payment method based on APCs or EAPGs.

This guide compares these methods and introduces some questions Medicaid programs must address in adapting these methods to their own use.

Traditional Payment Methods for Outpatient Care

Though states vary widely in their methods of purchasing outpatient hospital care, the most common approach has been a combination of cost reimbursement and fee schedules.[4]

For example, a state's basic approach might be to reimburse a hospital for its reasonable costs of care. It does this by making interim payments at a percentage of charges, and then retroactively adjusting payments to reflect settled cost reports.

This approach is often supplemented with fee schedules for lab services and perhaps imaging services, therapies and/or surgical procedures. Fees may be based on:

- Medicare fees (for lab)
- Medicaid physician fee schedules (for imaging and/or therapies)
- Historical charges

Dissatisfaction with the traditional approach stems from several sources:

- As Medicare and other payers have moved away from charge-based payment, Medicaid programs have become increasingly vulnerable to charge inflation. Nationwide, hospital charges are now three times higher than hospital cost, and the gap is larger for outpatient care than inpatient.[5] Even when payment is retrospectively adjusted to cost, Medicaid effectively provides an interest free loan to hospitals during the cost settlement process, which can take several years.
- Reliance on Medicare cost reports creates vulnerability for Medicaid. Because few of the program's payments now depend on cost reports, Medicare audits only 15 percent of cost reports nationwide.[6] Moreover, auditors focus on areas most important to Medicare – which often differ from those most important to Medicaid.[7]
- Different hospitals are paid different amounts (sometimes dramatically so) for providing the same service – often with no evidence that aligns costly care with sicker patients or better outcomes.
- Because there is no clinically relevant way to categorize outpatient cases, Medicaid programs often don't really know what they're paying for.
- For therapy services, Medicaid may pay hospitals more than it would pay community based therapists for the same treatment.
- In 2008, Medicare changed its ambulatory surgical center (ASC) payment method to better align with the hospital outpatient prospective payment method and use more clinically meaningful groups.

About Ambulatory Payment Classification (APC) Groups

APCs are essentially line-level fee schedules by CPT or HCPCS procedure code. Each CPT or HCPCS code is assigned to one of hundreds of individual APCs. For a single outpatient visit, the hospital usually receives several separate APC payments.

Since Medicaid programs typically haven't required hospitals to provide the line-level detail that APCs (and EAPGs) require, a first step is usually for Medicaid to put such a requirement in place.

Here's how it breaks out:

- For services that are always "packaged" (bundled), such as anesthesia and recovery room, procedure codes are not necessary on the line.
- For services that are sometimes packaged and sometimes paid separately, such as drugs and devices, the procedure code is not required. But hospitals have a strong financial incentive to provide it.

EAPGs are clinically meaningful groups. They give hospitals incentives to manage the number of ancillary services they provide by using extensive packaging and discounting of multiple services.

- For all other services, especially visits and procedures, a CPT or HCPCS code must be present. If it is not, payment for that line will be zero, regardless of charges. For almost every APC, the fee equals a relative weight multiplied by a conversion factor.

For example, the 2016 relative weight formula for APC 5362 (Level II laparoscopy) is:

	Relative Weight	$93.0608
x	National Conversion factor:	$73.725
=	National Medicare Fee	$ 6,860.91

Of special interest is the fact that payment for emergency department and clinic visits depend solely on the procedure code assigned by the hospital.

A Level IV ED Visit (HCPCS code G0383), for example, has a 2016 relative weight of 2.6619, so its national Medicare fee is $196.25.

Although there are specific national guidelines for how physicians should assign visit levels, no similar guidelines exist for hospitals to use. Instead, CMS advises each hospital to create its own guidelines and use them consistently.

When multiple procedures are performed on the same day on the same patient, payment for additional procedures may be discounted to 50 percent of the otherwise payable fee.

Discounting applies most often to surgical procedures; X-rays, CT scans and other imaging procedures are not discounted.

Diagnosis has no impact on any APC pricing. "Outlier" payments are made if the hospital's estimated cost of a specific procedure meets specific criteria.

About Enhanced Ambulatory Patient Groups (EAPGs)

EAPGs are a visit-based payment methodology intended to reflect resource utilization of outpatient encounters. It factors in CPT-4 procedures codes, HCPCS procedure codes and ICD-10-CM diagnosis codes.

EAPGs are clinically meaningful groups. They give hospitals incentives to manage the number of ancillary services they provide by using extensive packaging and discounting of multiple services.

As with APCs:

- More than one EAPG may be payable during a single visit.
- Each EAPG has a relative weight that is multiplied by a single conversion factor to yield the EAPG payment rate.
- By EAPG grouping logic, patient encounters are first classified by the presence/absence of CPT codes designated as significant procedures. If a significant procedure is absent but a medical visit (E&M) code is present, then the logic looks for diagnoses on a list of "major signs, symptoms and findings."
- If such a diagnosis is present, the logic assigns a "Major SSF" EAPG.

- If there is no diagnosis, the logic assigns one of a number of medical visit EAPGs defined by principal diagnosis.
- If there is no medical visit indicator, the visit is considered "ancillary only," and EAPGs are assigned to the various services provided.

Importantly, the payer chooses the level of packaging of ancillary services for the different types of visits.

Switching to APCs or EAPGs

Medicaid programs considering a switch to an APC or EAPG-based method should evaluate the advantages and disadvantages of each.

Under both methods, payment rates are set by Medicaid not determined by costs or charges – giving Medicaid more control over outpatient spending.

We have no financial interest in either alternative. In advising Medicaid programs on the choice of grouping algorithm, we usually find that states take into account the following factors:

- Familiarity. Since Medicare adopted APCs in 2000, this method is very familiar to hospitals. Many state Medicaid programs (Iowa, Maine, Michigan, Minnesota, Montana, North Dakota, Utah, Vermont and Wyoming), some Blue Cross plans and commercial payers use APCs.
- Bundling. APC-based methods are more unbundled than EAPG-based methods. As a result, financial incentives to provide more services, especially diagnostic tests, are sharper under APCs. Incentives to provide fewer services are sharper under EAPGs.
- Purchasing clarity. With APCs, payment for specific services can be analyzed, but minimal use of diagnostic information is an obstacle to analyzing resource use by patient characteristics. EAPGs, by contrast, are designed to be clinically meaningful.
- Proprietary software. APCs are in the public domain, although its software is not "plug-and-play" for a Medicaid program. EAPG software is owned by 3M Health Information Systems.
- Coding. APC-based methods use evaluation and management (E&M) codes to establish payment levels for emergency department and clinic visits.

Some payers are concerned that the lack of national guidelines for hospital use of E&M codes leaves hospitals to subjectively define visit levels. EAPG's reliance on diagnosis coding for visits is less open to judgment.

Adapting APCs or EAPGs to Medicaid

Although the choice of APCs or EAPGs is the single most important decision for a state considering a new outpatient payment method, several other payment policy decisions need to be made. These include:

- Affected providers. The first question is whether to include all hospitals and/or certain non-hospital provider types. Medicare's APC based method, for example, excludes critical access hospitals, but it includes ambulatory surgical centers and community mental health centers.
- Covered services. Where Medicaid coverage policy differs from Medicare, adaptations to APCs or EAPGs may be necessary for services such as preventive care, immunizations, family planning and mental health. For example, Medicare pays for psychiatric partial hospitalization using APCs on a per-diem basis – which Medicaid programs may or may not want to adapt.
- Conversion factor. Setting a conversion factor to meet Medicaid budget targets requires a thorough simulation using a dataset of paid claims.
- Medicare crossovers. Medicaid programs may choose to run Medicare crossover claims through the Medicaid pricing logic, either for purposes of analysis or for calculating Medicaid payment under a "lower of" pricing method for crossovers.
- Discounting factors. When related surgical or imaging procedures are performed within the same visit, prudent purchasers reduce payment to reflect economies in hospital costs. Details can be intricate, however.
- Outliers. Outlier payments are intended to help compensate hospitals for exceptionally costly services. Some payers, however, believe they're unnecessary in the outpatient setting.
- Geographic differentials. Some 60 percent of Medicare's APC conversion factor varies by locality across the U.S. to reflect differences in local-area wages. (The other 40 percent is a fixed amount.) Medicaid may want to use a single set of statewide APC or EAPG rates, or vary rates by locality.
- PA, SURS, DSS, MARS. To make maximum benefit of a new hospital outpatient payment method, states usually need to change other systems and business practices. These may include:
  - Prior authorization
  - Surveillance and utilization review
  - Decision support
  - Management administrative reporting subsystem
- Code editing. Payers typically edit claims to ensure correct coding and billing practices have been followed. Examples include edits that identify inappropriate unbundling of services, or to enforce maximum units. Medicare's APC software includes the Outpatient Code Editor (OCE). It's also possible to build an APC payment method without the OCE but including National Correct Coding Initiative edits (NCCI). The EAPG software includes similar edits. In light of Sec. 6507 of the Patient Protection and Affordable Care Act mandating state use of NCCI effective 10.1.2010, a state would want to review their policies.

- Lab and therapy services. Lab and therapy services are two leading examples of outpatient services that Medicare reimburses outside the APC payment method. These services are included within EAPG-based payment methods.
- Transition. The question of whether to use transitional payment rates before full implementation has significant policy and MMIS implications.
- Provider relations. Hospitals are keenly interested in payment method changes and can offer valuable advice. Successful projects usually include comprehensive consultation and education efforts with hospitals and other interested parties.
- MMIS implementation. Implementing a new outpatient payment method is a major enhancement to a Medicaid Management Information System (MMIS). It typically requires more than 1,000 hours of coding and testing.
- Updating and maintenance. Both APC and EAPG-based payment methods require code updates and policy reviews at least annually. For APC-based methods, other, minor updates are also recommended on a quarterly basis.
- Policy documentation. A new outpatient payment method typically requires a Medicaid state plan amendment and changes in regulation. States operating under a 111.5 waiver may require an amendment. Depending on the state, it may also involve a change in statute or submission of an advanced planning document to CMS.

Case Study: APC Success in Montana

In 2002, Montana Medicaid became one of the first Medicaid programs to decide to implement an outpatient prospective payment system for hospital care, based on Medicare APC groups.

Montana chose Conduent to design the new method and to implement it in the MMIS. Traditionally, Medicaid programs contracted with consultants who lacked real-world experience in processing claims and working with providers.

But Montana Medicaid saw that Conduent had intimate familiarity with its claims data and detailed knowledge of program rules and the Montana hospital industry.

The design work was done by a small team that included specialists in payment method development as well as MMIS programmers. When needed, the team drew on the expertise of their Conduent colleagues, including a health information administrator, a technical writer, provider relations specialists and additional MMIS programmers. The same programmers then implemented the new method in the MMIS.

Throughout the project, Conduent staff worked closely with Montana Medicaid staff. Since APCs were primarily designed for use in the Medicare program, substantial adaptations were necessary to ensure that the APC-based method met the policy and budget needs of Montana Medicaid.

Other challenges that were successfully met included adjusting to changing Medicare rules, incomplete APC documentation, integrating Medicare's Outpatient Code Editor edits into the MMIS, and creating extensive simulations of impacts on hospitals and the Medicaid budget.

APCs were implemented August 1, 2003, on schedule and on budget. State staff praised Conduent for one of the smoothest implementations of a major change they had ever seen. Hospitals welcomed the new method.

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For more information about our solutions, please visit www.conduent.com/medicaid.

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