



Paying for Hospital Outpatient Services

A Guide for Medicaid Programs

For the information of Medicaid programs, ACS has prepared this discussion of paying for hospital outpatient services, including the options of adapting Medicare's APC method or 3M's APG method to Medicaid. We welcome suggestions for future versions.

ACS Government Healthcare Solutions can assist Medicaid programs with the design, implementation and maintenance of payment methods for hospital outpatient care and other health care services. For further information, speak to your ACS account manager or contact Kevin Quinn, director of payment method development, at 406-457-9550 or kevin.quinn@acs-inc.com. See also www.acsstatehealthcare.com/pay_method.html.

Introduction

Many states find the hospital outpatient setting to be among the most problematic areas of payment policy. This setting has become steadily more important over the last 20 years, with Medicaid payments nationwide now exceeding \$12 billion a year.¹ Payment methods have failed to keep pace, however. Too often, Medicaid programs feel that their hospital outpatient payment methods are confusing, offer inappropriate incentives, and do not enable understanding of the "products" that Medicaid is purchasing.

Faced with the same problems in Medicare, Congress in 1997 directed Medicare to implement a new approach to paying for hospital outpatient care. CMS (then HCFA) awarded the contract to develop an outpatient prospective payment system to 3M Health Information Systems. The result was the Ambulatory Patient Groups (APG) grouper.² After a complex set of events and debates involving Congress, the Administration and several lobby organizations, what Medicare actually implemented in 2000, however, was not APGs but rather Ambulatory Payment Classification (APC) groups.³

Many Medicaid programs are now considering whether they should implement a new payment method based on either APCs or APGs. This guide compares these methods and discusses some of the 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. This is put into practice by making interim payments at a percentage of charges, then retroactively adjusting payments to reflect settled cost reports.

The basic approach is often supplemented with fee schedules for lab services and perhaps also imaging services, therapies and/or surgical procedures. Fees may be based on Medicare fees (as for lab), Medicaid physician fee schedules (for imaging and/or therapies) or historical charges. Fee schedules for surgeries in particular may be based on the groups that Medicare used to pay ambulatory surgical centers (ASCs) before January 2008.

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. For years, hospitals have increased charges faster than costs. Nationwide, hospital charges are now three times higher than hospital



cost, and the gap is larger for outpatient care than inpatient care.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 Medicare payments now depend on cost reports, Medicare audits only 15% of cost reports nationwide.⁶ Moreover, auditors focus on the areas most important to Medicare—which often differ from the areas most important to Medicaid.⁷
- Different hospitals are paid different amounts—sometimes to a surprising degree—for providing the same service, often with no evidence that more costly care is associated 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, sometimes much more, than it would pay community-based therapists for the same treatment.
- The previous Medicare ASC groups used by some states excluded many obstetric and pediatric procedures and were not clinically meaningful. Effective January 1, 2008, Medicare has changed its ASC payment method to use APCs. States that used the previous ASC surgery groups now must decide what to do next.

Ambulatory Payment Classification (APC) Groups

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

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

For services that are always “packaged” (the outpatient prospective payment word for bundling), 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 required for some codes but is otherwise optional.

For all other services, especially visits and procedures, a CPT or HCPCS code must be present. If it is not, then payment for that line will be zero regardless of charges.

For almost every APC, the APC fee equals a relative weight times a conversion factor. For example, the 2008 relative weight for APC 131 (Level II Laparoscopy) is 43.5488, which when multiplied by the national conversion factor of \$61.47 equals the national Medicare fee of \$2,676.86.

Importantly, payment for emergency department and clinic visits depends solely on the procedure code assigned by the hospital. A level 4 ED visit, CPT code 99284, has a relative weight of 3.4163 and therefore a national Medicare fee of \$209.99. Although specific national guidelines exist 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% of the otherwise-payable fee. Discounting applies most often to surgical procedures; x-rays, CT scans and other imaging procedures are not discounted.

The only instance where diagnosis affects Medicare payments is for observation bed services, where



Medicare will pay a separate observation fee if a patient has a diagnosis of chest pain, congestive heart failure, or asthma. If such a diagnosis is not present, payment for observation is considered packaged into payment for other services provided.

“Outlier” payments are made if the hospital’s estimated cost of a specific procedure exceeds a specific threshold.

Ambulatory Patient Groups (APGs)

APGs are a visit-based payment methodology intended to reflect resource utilization of outpatient encounters by factoring CPT-4 procedure codes, HCPCS procedure code and ICD-9-CM diagnosis codes. APGs are clinically significant groups designed to give hospitals incentives to manage the volume of ancillary services they provide by utilizing extensive packaging and discounting of multiple services. As with APCs, more than one APG may be payable during a single visit. Also in common with APCs, each APG has a relative weight that is multiplied by a single conversion factor to yield the APG payment rate.

The APG grouping logic first classifies patient encounters by the presence or 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 present, the logic assigns a “Major SSF” APG. If absent, the logic assigns one of a number of medical visit APGs defined by principal diagnosis. If there is no medical visit indicator, then the visit is considered “ancillary only” and APGs 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 APGs

Medicaid programs considering a switch to an APC- or APG-based method should evaluate the

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advantages and disadvantages of these methods. Under both methods, payment rates are set by Medicaid and are not determined by costs or charges, thereby giving Medicaid more control over outpatient spending.

ACS has 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 familiar and well accepted by most hospitals. APGs are used for calculating Medicaid payment in Iowa, Maryland and Massachusetts but, in general, are much less known than APCs.
- *Bundling.* APC-based methods are more unbundled than APG-based methods. Financial incentives to provide more services, especially diagnostic tests, are therefore sharper under APCs while incentives to provide fewer services are sharper under APGs.
- *Purchasing clarity.* APCs enable analysis of payment for specific services, but the minimal use of diagnostic information is an obstacle to analyzing resource use by patient characteristics. APGs, by contrast, are designed to be clinically coherent.
- *Proprietary software.* APCs are in the public domain, although the software is not “plug and play” for a Medicaid program. APG 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. The APG reliance on diagnosis coding for visits is less open to judgment.

Adapting APCs or APGs to Medicaid

Although the choice of APCs or APGs 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.* Whether to include all hospitals and/or certain non-hospital provider types. Medicare's APC-based method, for example, excludes critical access hospitals but includes ambulatory surgical centers and community mental health centers.
- *Covered services.* Where Medicaid coverage policy differs from Medicare, adaptations to APCs or APGs 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.* What discounting to use for which procedures when performed multiple times.
- *Medicaid adaptations.* Whether to adapt certain Medicare policies to Medicaid policy needs. For example, the Montana and Wyoming Medicaid programs have added obstetric diagnoses to the list of Medicare diagnoses for which observation services will be paid under APCs.
- *Outliers.* Outlier payments are intended to help compensate hospitals for exceptionally costly services, although some payers believe they are unnecessary in the outpatient setting.
- *New technology.* Whether the payment method should have specific provisions to pay for new drugs and devices.
- *Geographic differentials.* 60% of Medicare's APC conversion factor varies by locality across the U.S. to reflect differences in input prices. (The other 40% is a fixed amount.) Medicaid may want to use a single set of statewide APC or APG rates or may want to vary rates by locality.
- *Code editing.* Payers typically edit claims to ensure correct coding and billing practices have been followed. Examples include edits to identify inappropriate unbundling of services or to enforce maximum units. Medicare's APC software includes the Outpatient Code Editor (OCE). The APG software includes similar edits. In either case, a Medicaid program would want to review the edits in light of its own policies.
- *Lab and therapy services.* Lab and therapy services are the two leading examples of outpatient services that Medicare pays for outside the APC payment method. These services are included within APG-based payment methods.
- *Transition.* Whether to use transitional payment rates before full implementation.
- *Provider relations.* How to involve and inform hospitals and other interested parties in the development of the new method.
- *MMIS implementation.* Implementation of a new outpatient payment method is a major enhancement to a Medicaid Management Information System that typically requires more than a thousand hours of coding and testing.
- *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, including those for prior authorization, surveillance and utilization review, the decision support system and the management administrative reporting subsystem.



- *Updating and maintenance.* Both APC-based and APG-based payment methods require major code updates and policy reviews at least annually. For APC-based methods, more 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. Depending on the state, a change in statute or submission of an advanced planning document to CMS may also be involved.

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About ACS

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ACS Government Healthcare Solutions is an ACS unit that assists over 30 Medicaid programs with fiscal agent services, pharmacy benefit management, decision support systems, managed care, enrollment brokering, eligibility determination, or other services. See www.acsstatehealthcare.com for more information.

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 ACS 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 ACS 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 ACS 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, ACS 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 ACS for one of the smoothest implementations of a major change they had ever seen. Hospitals have welcomed the new method.

For more information on APCs in Montana, go to www.mtmedicaid.org; choose "Resources by Provider Type" then "Hospital Outpatient." Key information is in the hospital outpatient manual (especially "How Payment Is Calculated"), the APC fee schedule and the outpatient hospital payment summary.



Notes

¹ Nationwide Medicaid payments for hospital outpatient care in FFY 2005 were \$12.3 billion (CMS-64 data).

² Richard F. Averill, Norbert I. Goldfield, Laurence W. Gregg and others, *Development of a Prospective Payment System for Hospital-Based Outpatient Care* in Norbert I. Goldfield., ed., *Physician Profiling and Risk Adjustment*, 2nd ed.. (Gaithersburg, MD: Aspen Publishers, 1999), pp. 281-350.

³ Barbara O. Wynn, *Medicare Payment for Hospital Outpatient Services: A Historical Review of Policy Options*, Report to the Medicare Payment Advisory Commission (Santa Monica, CA: Rand Corporation, 2005).

⁴ Mark Merlis, *Medicaid Reimbursement Policy* (Washington, DC: Congressional Research Service, 2004).

⁵ Gerard F. Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing," *Health Affairs* 26:3 (May/June 2007), p. 783.

⁶ CMS, "Revision to Hospital Inpatient Prospective Payment Systems," Final Rule, *Federal Register* 71:160 (Aug. 18, 2006), p. 47893.

⁷ CMS, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates," Final Rule, *Federal Register* 72:162 (Aug. 22, 2007), p. 47196.