Florida Agency for Health Care Administration

1st Public Meeting – Outpatient PPS

August 19, 2015
Agenda

1. Outpatient Payment System Redesign Purpose
2. Outpatient EAPG Methodology
3. Design Considerations for Outpatient Prospective Payment System
4. Public Comment

Presenter: Malcolm (Mal) Ferguson, Navigant Healthcare
Outpatient Payment System Redesign
Purpose
Proviso

“From the funds in Specific Appropriation 181, $500,000 in nonrecurring funds from the Medical Care Trust Fund is provided to the Agency for Health Care Administration to contract with an independent consultant to develop a plan to convert Medicaid payments for outpatient services from a cost based reimbursement methodology to a prospective payment system. The study shall identify steps necessary for the transition to be completed in a budget neutral manner. The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than November 30, 2015.”
Current Outpatient System

» AHCA is transitioning its outpatient payment system from the current cost-based per visit rate methodology
  › Current outpatient payment system based on provider-specific cost-based rates, paid for each allowable revenue code in claim detail data
  › Rates updated annually based on cost report data, with retrospective cost settlement (2-3 year process)
  › Lab paid on fee schedule

» Current system relies heavily on cost estimates for both prospective rate setting and retrospective settlements
New Outpatient Prospective System

AHCA is moving to a new **prospective** outpatient payment system and is considering both Enhanced Ambulatory Patient Groups (EAPGs) and Ambulatory Payment Classifications (APCs)

ACHA would prospectively set hospital outpatient rates, without requiring cost report settlements
  - New system rates would be designed to be budget neutral to the modeling period

Target implementation date of new outpatient system is July 1, 2016
  - Navigant report due November 30, 2015
Outpatient Payment System Redesign Purpose

Outpatient Payment Methods Used by Medicaid Agencies

- APCs
- EAPGs
- Fee Schedule or Cost Based Reimbursement

* Indicates Moving Towards / Considering
EAPG Benefits

» Categorizes the amount and type of services used in various ambulatory visits - groups together procedures and medical visits that share similar characteristics and resource utilization

» Generates payments based on average resource utilization

» Allows management of cost of services within a fixed payment structure

» Provides relatively greater reimbursement for higher intensity services and relatively lower reimbursement for lower intensity services

» Provides fair payment across multiple ambulatory care settings (i.e. outpatient department, ambulatory surgery, emergency department, free standing diagnostic and treatment centers)

» Creates a payment structure and language understandable by both clinicians and administrators
### Outpatient Payment System Redesign

**Purpose**

**Tasks February - June**

**Phase I - Payment Policy Design**
- Define payment policy options
- Create simulation dataset
- Perform initial EAPG pricing simulation
- Perform pricing simulations to formulate payment policy
- Determine EAPG payment policy decisions
- EAPG Governance Committee meetings
- EAPG public meetings
- Develop EAPG policy recommendations document
- Submit draft EAPG policy recommendations to AHCA
- Submit final EAPG policy recommendations to Legislature

**Phase II - Payment Policy Design**
- Develop EAPG pricing MMIS requirements document
- Update state plan and provider handbook
- Calc year 1 EAPG rates based on Legislative direction
- Support development of software changes in MMIS

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*Implementation date is not finalized at this time.*
## Guiding Principles for Evaluating Options

<table>
<thead>
<tr>
<th>Principle</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td>Is the option aligned with incentives for providing efficient care?</td>
</tr>
<tr>
<td>Access</td>
<td>Does the option promote access to quality care, consistent with federal requirements?</td>
</tr>
<tr>
<td>Equity</td>
<td>Does the option promote equity of payment through appropriate recognition of recourse intensity and other factors?</td>
</tr>
<tr>
<td>Predictability</td>
<td>Does the option provide predictable and transparent payment for providers and the State?</td>
</tr>
<tr>
<td>Transparency and Simplicity</td>
<td>Does the option enhance transparency, and contribute to an overall methodology that is easy to understand and replicate?</td>
</tr>
<tr>
<td>Quality</td>
<td>Does the option promote and reward high value, quality-driven healthcare services?</td>
</tr>
</tbody>
</table>
Outpatient EAPG Methodology
EAPG Grouper Overview

» EAPG grouper is an outpatient visit-based patient classification system designed by 3M
  › EAPG grouper assigns an EAPG classification to each claim detail line (564 different EAPGs under version 3.10)
  › Services within each EAPG have similar clinical characteristics and similar resource requirements

» EAPGs encompass the full range of ambulatory settings and outpatient services across the all-payer population
  › EAPG classifications are available for all outpatient services (including laboratory and therapies)
  › EAPG classifications are available for all outpatient settings, including same day surgery units, hospital emergency rooms, and outpatient clinics
EAPG Payment Methodology Overview

- EAPG payments are made on a per visit basis, where payment is directed to the main significant procedure or treatment provided during an outpatient visit
  - EAPG payment for the main significant procedure considers the average cost of associated ancillary services
  - Uses packaging and bundling of payment for related services to create incentives to provide services in the most efficient way
  - Allows for higher payment for the main procedure, rather than diluting the payment across individual services
- A separate EAPG code is assigned to each line item on a claim
- Pricing is performed at the line level with interaction between separate lines
Outpatient EAPG Methodology

Three Major Visit Types

» **Significant Procedure** - Main procedure that constitutes the reason for the visit and requires the most resources
  › Example: excision of skin lesion, stress tests

» **Medical Visit** - must have an evaluation and management (E/M) CPT code and usually does not have a significant procedure. ICD diagnosis codes help classify medical visits into clinically appropriate EAPGs.
  › Assigned EAPG describes the patient who receive medical treatment

» **Ancillary Procedures** - ordered by the primary physician to assist in patient diagnosis or treatment
  › Example: immunizations, plain films, laboratory tests
EAPG logic

1. Significant procedures or therapies present
   - YES: Type of procedure or therapy
     - Significant procedure or therapy visit EAPG
   - NO: Medical visit indicator APG present

2. Medical visit indicator APG present
   - YES: Major signs, symptoms or findings present
     - Major SSF EAPG
   - NO: Primary dx code

3. Primary dx code
   - YES: Types of ancillary tests or procedures
     - Ancillary only visit EAPG
   - NO: Ancillary tests or procedures present

4. Ancillary tests or procedures present
   - YES: Error EAPG
   - NO
## Outpatient EAPG Methodology

<table>
<thead>
<tr>
<th>EAPG Type</th>
<th>EAPG Type Description</th>
<th>Number of EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Per Diem</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Significant Procedure</td>
<td>149</td>
</tr>
<tr>
<td>21</td>
<td>Physical Therapy &amp; Rehab</td>
<td>10</td>
</tr>
<tr>
<td>22</td>
<td>Mental Health &amp; Counseling</td>
<td>15</td>
</tr>
<tr>
<td>23</td>
<td>Dental Procedure</td>
<td>27</td>
</tr>
<tr>
<td>24</td>
<td>Radiologic Procedure</td>
<td>27</td>
</tr>
<tr>
<td>25</td>
<td>Diagnostic Significant Proc</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>Medical Visit</td>
<td>191</td>
</tr>
<tr>
<td>4</td>
<td>Ancillary</td>
<td>73</td>
</tr>
<tr>
<td>5</td>
<td>Incidental</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Drug</td>
<td>23</td>
</tr>
<tr>
<td>7</td>
<td>DME</td>
<td>25</td>
</tr>
<tr>
<td>8</td>
<td>Unassigned</td>
<td>3</td>
</tr>
</tbody>
</table>
### Payment with the Three Major Visit Types

<table>
<thead>
<tr>
<th>EAPG Visit Type</th>
<th>Items Included in Base EAPG Payment</th>
<th>Items for which Additional Payment is Permitted</th>
</tr>
</thead>
</table>
| Significant procedure or therapy visit | ▪ Routine ancillaries  
▪ Incidental procedures  
▪ Supplies  
▪ Routine drugs  
▪ Anesthesia  
▪ Additional related significant procedures | ▪ Significant unrelated procedures (with any applicable discounts)  
▪ Non-packaged ancillaries  
▪ Chemo and selected non-routine drugs |
| Medical visit                       | ▪ Packaged routine ancillaries  
▪ Incidental procedures  
▪ Supplies  
▪ Routine drugs | ▪ Non-packaged ancillaries  
▪ Chemo and selected non-routine drugs |
| Ancillary only visit                |                                                   | ▪ All “ancillary only” items are paid separately                                     |
Outpatient EAPG Methodology

Basic EAPG Pricing Formula

- **Provider base rate**: provider-specific rate
- **EAPG relative weight**: each EAPG has a relative weight indicating the acuity, or average resource requirements, for the service
- **Bundling/discounting adjustment**: adjustment factor ranging from 0% to 150% to either discount or bundle ($0 pay) the detail line payment

Pricing example for EAPG 63 LEVEL II ENDOSCOPY OF THE UPPER AIRWAY: ($500 rate) X (4.0952 weight) X (100% adjustment) = $2,047.60 payment (example only)
EAPG Payment Types

» Full Payment – Generally given to the significant procedure or ancillary procedure with the highest EAPG relative weight

» Consolidated – A significant procedure paid at $0 because it was considered sufficiently related to another significant procedure which did receive a non-zero payment

» Packaged – An ancillary procedure paid $0 because it was considered related to a significant procedure which did receive a non-zero payment

» Discounted – A procedure receiving less than 100% of its stand-alone payment

» Per Diem – for partial hospitalization (if used)
Outpatient EAPG Methodology

Bundling/Discounting Adjustments - Procedure Consolidation

» EAPG program designates clinically similar lower-weighted procedures provided during the main visit as “consolidated”
   › Consolidated procedures are “bundled” and do not receive separate payment

» EAPG program contains 3M’s default list of recommended consolidated procedures
   › Consolidated EAPG listed can be customized, but default list considered critical part of EAPG payment method
Bundling/Discounting Adjustments - Ancillary Packaging

» EAPG model recognizes routine ancillary services provided in conjunction with a significant procedure or medical visit by designating these services as “packaged ancillary”

» Routine ancillary services are “packaged” and do not receive separate payment
  › However, the expected resources related to packaged ancillary services are included the EAPG relative weight calculations and are therefore reflected in the significant procedure or medical visit payment

» EAPG grouper contains a default list of 3M’s recommended packaged ancillary services
  › Packaged EAPG list can be customized
Outpatient EAPG Methodology

Bundling/Discounting Adjustments - Procedure Discounting

» Discounting modifies the payment for additional non-clinically related procedures provided during the same visit (non-consolidated)

» EAPG program identifies the following discount types:
  › Multiple Significant Procedure Discounting: multiple occurrences of unrelated procedures during the same visit
  › Repeat Ancillary Discounting: Repeat Ancillary, Drug, and DME EAPGs
  › Terminated Procedure Discounting
  › Bilateral Discounting: bilateral procedures performed on both sides of the body during the same session or on the same day
Outpatient EAPG Methodology

Bundling/Discounting Adjustments - Discounting Factors

- EAPG discount factors must be determined for each discount type
- Example outpatient discounting factors:

<table>
<thead>
<tr>
<th>Discount Type</th>
<th>New York Discount Factor (EAPGs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminated Procedure</td>
<td>50%</td>
</tr>
<tr>
<td>Multiple Significant Procedure</td>
<td>50%</td>
</tr>
<tr>
<td>Repeat Ancillary</td>
<td>50%</td>
</tr>
<tr>
<td>Bilateral (percentage of single service)</td>
<td>150%</td>
</tr>
</tbody>
</table>
## Single outpatient claim example

<table>
<thead>
<tr>
<th>Claim Line</th>
<th>CPT Code</th>
<th>CPT Description</th>
<th>Payment Under Medicare APCs</th>
<th>Payment Under EAPGs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>APC</td>
<td>APC Type</td>
</tr>
<tr>
<td>1</td>
<td>31545</td>
<td>Remove vc lesion w/ scope</td>
<td>0075 - Level V Endoscopy Upper Airway</td>
<td>Significant Procedure</td>
</tr>
<tr>
<td>2</td>
<td>31515</td>
<td>Laryngoscopy for aspiration</td>
<td>0074 - Level IV Endoscopy Upper Airway</td>
<td>Significant Procedure</td>
</tr>
<tr>
<td>3</td>
<td>42405</td>
<td>Biopsy of salivary gland</td>
<td>0254 - Level V ENT Procedures</td>
<td>Significant Procedure</td>
</tr>
<tr>
<td>4</td>
<td>88331</td>
<td>Path consult intraop 1 bloc</td>
<td>0343 - Level III Pathology</td>
<td>Ancillary service</td>
</tr>
<tr>
<td>5</td>
<td>82435</td>
<td>Assay of blood chloride</td>
<td>N/A</td>
<td>Non-APC</td>
</tr>
<tr>
<td>6</td>
<td>93000</td>
<td>Electrocardiogram complete</td>
<td>N/A</td>
<td>Non-APC</td>
</tr>
<tr>
<td>7</td>
<td>00322</td>
<td>Anesth biopsy of thyroid</td>
<td>N/A</td>
<td>Non-APC</td>
</tr>
</tbody>
</table>
Modifiers Configurable to Affect Payment

› 25 – Distinct service
   • Allows reimbursement for a medical visit (E&M) EAPG on the same day as a distinct and separate significant procedure

› 27 – Multiple E&M encounters
   • Allows reimbursement for multiple non-related medical visits (multiple E&M codes) on the same date of service.

› 50 – Bilateral procedure
   • Flags PX code for additional payment – 150%

› 52 – Discontinue service
   • Payment discounted 50%

› 59 – Distinct procedure
   • Bypasses consolidation for line item with modifier
   • Line item paid 50%

› 73 – Terminated procedure
   • Payment discounted 50%

› GN, GO, GP for speech, occupational, and physical therapies

› Anatomical modifiers: E1-E4, F1-F9, FA, LT, RT, T1-T9, TA
Design Considerations for Outpatient Prospective Payment System
## Design Considerations for Outpatient Prospective Payment System

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model Dataset</td>
<td>• Planning to use SFY 2013/14 data&lt;br&gt;• Include managed care encounter data?</td>
</tr>
<tr>
<td>Outpatient grouping/classification system</td>
<td>• EAPGs&lt;br&gt;• APCs</td>
</tr>
<tr>
<td>Provider types included and excluded from new OPPS</td>
<td>• Hospitals, FQHCs, CHDs, Ambulatory Surgical Centers, labs, dialysis center, etc …</td>
</tr>
<tr>
<td>Services included and excluded from new OPPS</td>
<td>• Emergency departments, therapies, drugs, imaging, observation, etc …</td>
</tr>
<tr>
<td>Hospital base rate categories</td>
<td>• One, a few, or many</td>
</tr>
<tr>
<td>Policy adjustors (if any)</td>
<td>• Assigned by category of provider or type of EAPG</td>
</tr>
<tr>
<td>Consideration</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outlier payments (if any)</td>
<td>• How calculated</td>
</tr>
<tr>
<td>Timing of implementation</td>
<td>• Implementation by July 1, 2016 may be challenging for the Fiscal Agent</td>
</tr>
<tr>
<td>Billing rules</td>
<td>• Billing outpatient claims that include multiple days of service</td>
</tr>
<tr>
<td>Discounting factors</td>
<td>• What values</td>
</tr>
<tr>
<td>Acceptable modifiers</td>
<td>• To override discounting</td>
</tr>
</tbody>
</table>
More Information ...

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