

Utilizing Enhanced Ambulatory Patient Groups in Ambulatory Prospective Payment

Ambulatory prospective payment is a means of organizing services and payments in outpatient hospital settings and other ambulatory facilities (such as free standing surgical, dialysis, and diagnostic service centers). Similar to Diagnostic Related Groups (DRGs) used for inpatient payment, ambulatory prospective payment uses 3M™ Enhanced Ambulatory Patient Groups (EAPGs) to provide a product definition for outpatient services inclusive of incidental and frequent ancillary services routinely provided with those services.

Private sector interest in outpatient payment has led to the development of systems that emphasize fee schedules for ambulatory services. Most payers and providers are aware that these limited systems need to be replaced with those of greater sophistication, more specifically, greater potential for payment equity across providers based upon the complexity and resource consumption of the services provided. Private payers and their providers are utilizing data obtained through ambulatory prospective payment to provide a framework for understanding differences in costs in the effort to develop more equitable payment systems. While traditional methods of reimbursement rely on disjointed bits of information provided through individual procedure codes, ambulatory prospective payment includes a classification that aggregates procedures and visits, providing a comparative base meaningful from both a financial and a quality perspective.

Enhanced Ambulatory Patient Groups (EAPGs)

As the case with DRGs, EAPGs have the potential to bring about fundamental and beneficial changes in management, communication, cost accounting and planning within hospitals, hospital systems, and freestanding ambulatory facilities. To maximize these benefits, conversion to EAPGs would require that the methodology meet the following key goals of an ambulatory classification and payment strategy.

The classification strategy should:

- Be clinically meaningful, comprehensive and flexible, describing every patient in the outpatient setting;
- Be simple and cost-effective to develop, implement and maintain, as well as communicate in a transparent and tangible manner;
- Minimize the administrative burden for both payers and providers;
- Promote incentives that encourage a balance between cost-effective and quality-based access to services;
- Be flexible in meeting unique community reimbursement goals;
- Ensure that providers, who control treatment resource decisions, share equitably in the financial implications for those decisions; and,
- Meet purchaser's demands for reports on outpatient services purchased for their employee and dependent populations.

The key characteristics of 3M™ EAPGs enable a high functioning classification system. They are as follows:

- Ambulatory visits reflect similar resource use;
- Patients in each EAPG have similar clinical characteristics because EAPGs relate to organ systems (etiology), thereby establishing a medical rationale for differences in resource use;
- EAPGs encompass full range of ambulatory care settings including same day surgery units, hospital emergency departments, outpatient clinics;
- EAPGs differentiate facility costs, not professional costs; and,
- EAPGs provide a tangible structure for payment development that allows payers to be transparent in communicating changes in policy to providers.

The Centers for Medicare and Medicaid Services (CMS) implemented their version of OPPTS on August 1, 2000 for Medicare financed hospital outpatient services. The Medicare prospective payment system utilized the design of an earlier version of ambulatory patient groups (APGs) as a starting point for its program. Under pressure from special interest groups and under-prepared fiscal intermediaries, CMS revised the methodology to include over four times the number of potential groups. This new program was termed Ambulatory Payment Classification (APC). Despite the emergence of APCs as a government reimbursement tool, the industry is realizing the shortcomings APCs in meeting broader goals for payment system re-engineering and that the design and application of EAPGs provide a better fit in the following ways:

- *Comprehensiveness:* EAPGs are comprehensive. They were developed to encompass all types of outpatient services and procedures conducted in outpatient settings. On the other hand, APCs exclude specific services such as DME, orthotics, prosthetics (all paid per fee schedule) as well as pass-through services paid outside of the APC system.
- *Flexibility:* EAPGs offer more flexibility in the level of packaging and consolidation than under APCs.
- *Efficiency Incentives:* EAPGs encourage efficient resource use through the use of packaging, significant procedure consolidation and discounting.
- *Outcomes Management:* The comprehensive design and clinical relevance of EAPGs provide useful data for analyzing and predicting the utilization and cost of outpatient services in a variety of settings.
- *Episodes of Care:* The policy decisions involved in the development of EAPG payment systems provide the foundation for developing episodes of care.

Since it implemented APCs in 2000, CMS has articulated what it believes to be the shortcoming of the APC based payment system; that is, APCs focus on service level

payment rather than provide efficient delivery of services through visit based service payment or payment for episodes of care. By encouraging a focus on individual services, CMS has determined that the system has created fiscal incentives for providers to over-utilize healthcare resources. Furthermore, CMS believes that the granular nature of the APC groups has enabled upcoding and overcharging. Because of these and other similar issues, CMS has concluded that modifications to its implementation of ambulatory prospective payment are needed. CMS is proposing changes that will expand its use of packaging and consolidation as well as group

related services along more clinically meaningful lines similar to EAPGs.

~For Consideration~

The shift in focus to visits from services promotes a fundamental shift in incentive that encourages utilization management at the time of service and on the part of the provider, minimizing the need for retrospective utilization management on the part of the payer.

Policy and the Design of EAPG Payment Systems

A number of policy decisions must be addressed prior to the development of an EAPG payment system. The major goals of outpatient payment policy should be reflected in its programmatic design.

Since the 3M™ EAPG payment system is built around a *unit of service*, an EAPG system should define what constitutes a unit and what is included within it. Factors such as payment windows, packaging of ancillary services, significant procedure consolidation, and discounting multiple procedures represent individual sets of policy decisions.

~For Consideration~

*A **unit of service** may be comprised of one service, one visit or multiple visits depending on the overall goal of the healthcare encounter. Early application of EAPGs for payment should focus on a visit as the unit of service, broadening this definition in future enhancements once providers and payers acclimate to the new model. The broader the definition of a **unit**, the closer the system comes to defining **episodes of care**.*

The payment window defines the duration of a visit. Payment windows associated with EAPG-based systems generally range from 24 to 72 hours, although longer time frames have been considered. All services related to a specific patient during the specific period are considered part of the visit. The longer the payment window, the more services will be consolidated, packaged, and discounted. Longer windows also increase the administrative burden to both payers and providers in reconciling payment for services associated with a visit.

Ancillary packaging is the decision logic by which an outpatient classification system links ancillary services with procedure or medical visit units for payment. Generally, the lower cost ancillaries, routinely associated with a procedure or medical service, are packaged with the service, and the price is set to reflect their inclusion. Different from the typical practice of line editing, where packaged items may be discarded and not paid, the 3M™ EAPG process allows for the cost of the packaged ancillaries in the weights. Ancillaries that are not normally

~Best Practice~

*EAPG payment systems are built around a **unit of service**. To maximize value, routine ancillary services (minor laboratory, radiology services), anesthesia and supplies should be packaged into significant procedures for payment purposes.*

provided in conjunction with a procedure or medical service are not packaged but are treated as a separate unit for payment purposes.

Significant procedure consolidation is the decision logic by which an ambulatory classification system determines whether procedures within a visit should be paid as separate units or combined with one or more other units into a single unit. Procedures that are consolidated are considered to require minimal additional time or resources and therefore, no additional payment is made for the additional significant procedure. If multiple procedures are performed during a visit (or payment window), and they are not consolidated, they may still be discounted. Similarly, if multiple ancillary services are performed during a visit, and they are not packaged, they may still be discounted. It is believed that providing multiple services in a single visit is less costly than providing each service separately due to the fixed costs that occur only once during the visit and increase incrementally with the number of procedures performed. Discounting the rates for additional services in a visit is intended to result in payment of the marginal cost of those services.

~Best Practice~

It is recommended that payment systems be developed utilizing the clinical logic for significant procedure consolidation that EAPGs provides since its development involved detailed, clinical reviews of related services.

Another key issue facing payers in designing and implementing 3M™ EAPG payment system is the decision on which types of providers and services should be covered. This decision should consider the differences

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It is recommended that discounting be applied to multiple significant procedures, repeat ancillary, bilateral and terminated procedures.

in cost, service mix, and volume of providers. Characteristics such as *type of facility* (hospital outpatient departments (HOPD), free standing ambulatory service centers, and provider offices), *location* (urban, rural) and *mix of services* (volume differences in surgical, ancillary and emergency department) should be considered since such differences may produce varied cost structures. Instead of omitting providers based upon their differences, some payers have opted instead to vary base rates based upon some or all of these characteristics.

Payers implementing EAPG payment systems need to decide what types of services (if any) should be excluded

for reasons including low volume of services, services with wide variation in costs, non-covered services. Ambulance services provide a good example of services for which unit cost variations make inclusion less than straightforward. Partial hospitalizations (most commonly used in mental health treatment) have a wide variation in costs due to the variation in the number of patient days under treatment and have been commonly excluded due to the fact that reliable payment rates were difficult to develop. One of the enhancements included within EAPGs, is a method to customize the recognition of a partial hospitalization thereby lowering the occurrence of large cost differences.

~For Consideration~

*Variation in the cost of services can be accounted for while through the development of **peer groups**. Peer groups can be assigned base rates commensurate with their commonality in the mix of services and the variation in cost that they represent.*

Determining Payment in an EAPG Payment System

Once outpatient payment policy decisions have been made, the process of constructing the payment system can begin. *Figure 1* illustrates the process that is followed to do so.

3M™ EAPG payment system is constructed around one set of relative weights. These weights can be based upon charges, allowed payments or costs. Because of the variability in charges and payments, payers are utilizing cost as the basis for establishing relativity between services. Each EAPG is assigned a weight which is the average derived cost mean resource consumption for all cases in the EAPG divided by the mean resource consumption for all cases in all EAPGs. The weight for a specific EAPG can be described as a measure of the percentage of the average weight for all cases.

Weights are based upon costs instead of charges which are frequently used in payer payment systems. Charges have significant shortcomings as accurate measures of resource consumption due to biases resulting from random differences in hospital charge structures. Reliance on charges to create relative weights is likely to introduce inappropriate access to care in an outpatient payment system. If payment rates are set too high for some procedures or services and too low for others, the balance in access to these services may be disrupted. In order to prevent such occurrences, there is a need to gain an increased understanding of outpatient service costs and their relationships to charges for specific procedures and services. A facility's cost to charge ratio can be used to gain this understanding and adjust the weights. Costs are derived by computing ratio of costs to charges from the Medicare Cost Report (MCR) for each cost center. These RCCs are then exported to the corresponding revenue center on the Payer's line level claim records. Cost per case is then estimated by multiplying the RCCs by the charges for each line.

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There should be one set of relative weights developed for the entire payment system. These weights should be based upon costs due to the variability in charges between facilities.

Relative weights reflect the average resource consumption for a specific EAPG and are applied to a base rate to determine service payments. It is important to understand that packaged ancillary services become part of a significant procedure or medical visit and should be included in the unit price; therefore, relative weights used in implementation should be calculated based on the payment policies to be implemented. If packaging and consolidation are implemented in the payment system, the cost of all packaged and consolidated services should be included in the cost of the associated significant procedure or medical visit and the additional cost should be reflected in the relative weight.

It is important to determine if there are insufficient claims data to develop reliable weights for every EAPG category. The process of calculating relative weights cannot begin until a useful outpatient claims database has been prepared. The database must include a sufficient number of coded claims to provide a reasonable representation of all outpatient activities. It is likely that a large number of categories will have too few claims to assign a weight, based on charge or cost data alone. In this case, benchmark data should be used to provide an estimate.

Treo has developed a benchmark dataset for use in establishing relative weights. This dataset represents claims from over 8 million covered lives in the Northeast, Mid-Atlantic, and Midwest from 2005 through 2007. Claims data are adjusted to account for cost differences based on geography to create a robust, geographically

neutral data set that calculates average costs for a full, comprehensive list of outpatient procedures. In addition to creating valid weights for procedures with insufficient volume, the benchmark data set can also be used to validate existing plan data, examine the impact of payment decisions, check for monotonicity and relativity between procedure codes, and provide weight adjustments as needed.

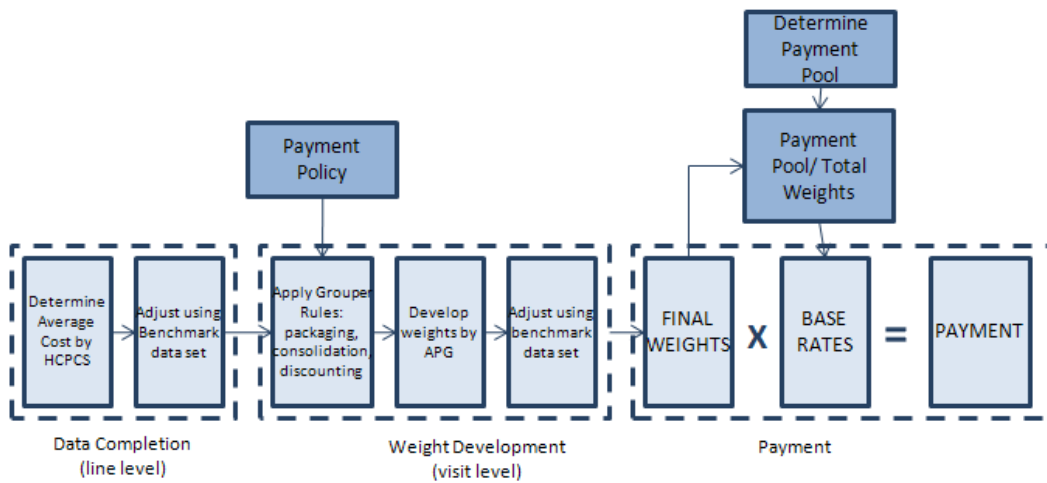
After the weights have been determined, payment for each EAPG is calculated by multiplying the weight times the base rate (also commonly identified as a conversion factor). This base rate represents the payment for a service with the relative weight equaling 1.0. Although the process for determining the base rate is a simple mathematical formula (total payment pool / total weights), a policy decision on the value of the total payment pool is needed. This decision may be based upon budget neutrality provisions, variation in payment levels between providers or groups of providers, trend factors, or differences in payment by service category. Determining the level and composition of the payment pool will depend upon each payer's contractual requirements.

The amount of financial savings that are obtained through the implementation of the 3M™ EAPG payment systems

is factor of both policy goals and program design. Savings can be realized through a discretionary control of the trend on the total payment pool either through immediate reductions in pool dollars or reductions in future growth. This type of savings is achieved through the development and trending of the base rate. Savings may also be achieved through the application of payment rules (such as packaging, consolidation and discounting) which may be more robust than previous adjudication rules. In either case, changes in payment levels should be modeled and the impacts on individual providers should be understood and shared before implementation to avoid undesirable outcomes on access to care.

In order to account for changes in outpatient health care delivery, the 3M™ EAPG payment system should be updated annually. These updates should, at a minimum, include calculating new relative weights. By completing this process, the payment system will reflect the constant realignment in the cost of individual outpatient procedures as well as account for new procedures that were not previously provided in the outpatient setting. Additional maintenance items may include revision of allowed outpatient services, composition of payment pool (base rates), and trend factors.

Figure 1: Determining EAPG Payment



Using Ambulatory Prospective Payment in Outcomes Management

Payers have utilized data obtained through ambulatory prospective payment to provide a framework for outpatient utilization review. Traditional methods of review such as preadmission review and concurrent review, as well as provider profiling, lack the in-depth insight into case distribution and practice patterns that ambulatory classification provides. While traditional methods of review rely on individual procedure codes, ambulatory classification systems group procedures and visits to provide a comparative base for case tracking and outcomes review which is more equitable across a variety of provider practices.

Within the 3M™ EAPG payment system, the shift in focus to visits from services promotes a fundamental shift in incentive that encourages utilization management at the time of service and on the part of the provider, minimizing the need for retrospective utilization management on the part of the payer.

Ambulatory perspective payment systems provide both payers and providers with a unique opportunity to organize data in a manner that allows for accurate and equitable reviews and comparisons of outpatient

services. Data obtained from the system can be used in the following manner:

- Report on levels and types of ancillary services;
- Report on services by site of service such as emergency department, hospital outpatient departments, and ambulatory surgery centers as an alternative to provider office sites; and,
- Report on differences in market basket of services by type of service or visit.

Some or all of this data should be shared with the provider community in a collaborative and transparent effort to improve the overall efficiency of health care delivery.

Private payers also use ambulatory classification systems to create meaningful reports for their customers. Most employers are now demanding information on the services that they are purchasing for their employees. Relevant data collected through ambulatory prospective payment include the following:

- Provider comparisons that could be used to establish and improve network performance; and,
- Comparison of the costs and volume of outpatient and inpatient care.