

# District of Columbia Medicaid

## A New Outpatient Hospital Payment Method

### *Frequently Asked Questions*

*Version Date: January 28, 2014*

*Please note that details of the payment method shown in this document remain subject to change before the implementation date.*

#### OVERVIEW

##### **1. What change is being made?**

The DC Department of Health Care Finance (DHCF) will change its current payment method for outpatient hospital services from a cost-based, hospital-specific visit rate and a fee schedule for some services, to a new method using Enhanced Ambulatory Patient Groups (EAPGs). EAPGs are a visit-based patient classification system designed by 3M Health Information Systems to characterize the amount and type of resources used in a hospital outpatient visit for patients with similar clinical characteristics. The use of EAPGs will result in higher payments for higher intensity services and lower payments for lower intensity services.

##### **2. Why change to a new payment method?**

The current outpatient payment method is based upon hospital specific costs with an enhanced rate for emergency services, while some services are paid by a fee based on the procedures billed. Today, the reimbursement rate is 131.1% of base year, hospital-specific costs, with a 50% add-on for emergency room visits. Laboratory and radiology services are paid using fee schedules. A flat visit rate of \$50 is also paid in certain instances, for example, for emergency room visits considered non-emergent. Outpatient surgery services are paid by flat rates based on groups of HCPCS procedure codes. Based upon this payment methodology, hospitals currently are reimbursed at 44% of their costs for outpatient services. This payment methodology results in underpayment for outpatient services and does not take into account the clinical complexity of the patient and the resources needed to appropriately diagnose and treat that patient.

### **3. What are the goals that DHCF hopes to achieve by implementing a new outpatient payment methodology?**

Goals of the new outpatient hospital payment method include:

- ***Implement a sustainable payment method.*** The District needs an outpatient payment method that is sustainable over time, promotes quality of care and is flexible enough to accommodate changes in payment policy and federal regulatory requirements.
- ***Increase fairness.*** Today, different hospitals are often paid very different amounts for the same or very similar care to similar patients based upon historic differences in the cost of providing care. We believe it is fairer to have payment reflect resources currently available and the reasonable costs of providing care based on patient needs rather than the individual hospital's historic experience in providing care.
- ***Reduce administrative burden.*** One component of the current payment method relies on diagnosis codes defined as emergent for an add-on ER payment. Maintaining this list of emergent diagnosis codes will present an administrative burden when ICD-10 coding is implemented in October 2014. The EAPG grouper is compliant with ICD-10 coding.
- ***Improve purchasing clarity.*** It is currently very difficult to understand how much Medicaid is paying for specific types of outpatient services. The District wishes to align its payment methodology with prevailing methodologies used by other Medicaid programs and private payers that improve purchasing clarity and encourage hospital efficiency.

### **4. What is the target date for implementation?**

The target date for implementation is October 1, 2014.

### **5. What providers and services will be affected?**

The new payment method will apply to outpatient hospital services provided by:

- In-District general acute care hospitals and specialty hospitals (psychiatric, rehabilitation, and children's hospitals) and
- Out-of-District hospitals, except for Maryland hospitals.

### **ENHANCED AMBULATORY PATIENT GROUPS (EAPGS)**

### **6. Why were EAPGs chosen? Why not the Ambulatory Payment Classification groups (APCs) that Medicare uses?**

The District conducted an assessment of various options available for payment of outpatient hospital services, including Medicare's APCs. EAPGs were chosen because they are more suitable for use with the Medicaid population. Medicare APCs were designed for the Medicare population in support of Medicare policies. EAPGs are designed for an all-patient population. EAPGs reflect the relative intensity of the entire visit allowing providers and payers to more accurately account for resources and for payment. EAPGs reward hospitals for providing efficient access to a wide variety of increasingly clinically complex outpatient hospital services in a more appropriate manner.

As opposed to Medicare's APC mixed fee schedule approach, EAPGs are an outpatient visit grouping system, which places patients and services into clinically coherent groups. EAPGs do rely on the CPT/HCPCS procedure code but also use diagnosis codes and other clinical and demographic factors to determine appropriate EAPG assignment. And while APCs generate payment based on volume of codes submitted, EAPGs are more clinically driven and are designed to generate payments that reflect the relative resource intensity of the entire visit. Therefore the use of EAPGs will result in higher payments for higher intensity services and lower payments for lower intensity services.

**7. In general, how will the new payment method impact hospitals?**

In general, the new payment method will provide rational incentives for the provision of outpatient hospital services:

- There will be a more direct link between the level of payment and the complexity of the service provided. Efficiency and cost containment will be rewarded. Hospitals that provide similar services will be paid similarly.
- Complete and correct coding of claims will become more important, and will have an effect on claim payment, although there may be an adjustment period for the hospitals as the effect of the new method is realized.

**8. What other payers use EAPGs?**

Medicaid programs currently using EAPGs include: New York, Virginia and Wisconsin for payment, Maryland and Massachusetts for service-mix adjustment. Medicaid programs with planned EAPG implementations for outpatient hospital services are: New Hampshire, Illinois and Washington in 2014. Commercial payers currently using EAPGs include: Oklahoma BlueCross BlueShield, Minnesota BlueCross BlueShield, and Wellmark in Iowa and South Dakota.

**9. Will my hospital be required to purchase EAPG software in order to receive payment under the new method?**

No. The EAPG grouper/pricer specific to DC Medicaid will assign the EAPGs to the claim lines and calculate the payment. The DC Medicaid claims processing system will then adjudicate the claim for final pricing. Hospitals may choose to purchase grouping software allowing them to project revenue.

**10. Will my hospital have to start collecting additional data to use 3M EAPGs?**

No. The data elements needed for EAPGs use the information hospitals already submit on the paper and electronic standard institutional claim forms. For example, diagnosis codes, CPT/HCPCS procedure codes, revenue codes, line item dates of service, age and gender.

## PAYMENT CALCULATIONS

### 11. NEW - How is EAPG payment calculated?

Each CPT/HCPCS procedure code on a claim line is assigned to the appropriate EAPG at the line level. Each EAPG has an assigned relative weight. This relative weight is adjusted by the various payment mechanisms as applicable such as discounting, packaging and consolidation. The adjusted relative weight is multiplied by a conversion factor or base rate to yield the EAPG payment amount.

Table 1 EAPG Payment
EAPG payment = Adjusted EAPG relative weight * conversion factor
Adjusted EAPG relative weight = EAPG relative weight * multiple significant procedure discount * bilateral procedure discount * terminated procedure discount * repeat ancillary procedure discount * other discounts

### 12. NEW - What EAPG relative weights will be used to calculate EAPG payment?

DC Medicaid will use version 3.8 of the national relative weights available from 3M Health Information Systems. The EAPG national relative weights are calculated by 3M based on Medicare claims data, comprising approximately 55 million claims from FY 2010.

After examining the available options, the District opted to use the national relative weights because statistically valid District-specific relative weights are not feasible due to the District's small volume of Medicaid claims. The national relative weights are updated annually by 3M and use EAPG default settings which align more closely with the District's overall approach and goals. Other Medicaid programs also use or plan to use the national relative weights for their EAPG-based payment method.

### 13. NEW - What conversion factor or base price will be used in EAPG payment?

DHCF will use two conversion factors: one for in-District and out-of-District hospitals and one that is 2% higher for United Medical Center (based on its geographic location in an economic disadvantage zone). The value of the final conversion factors will be determined during the ratesetting phase using historical claims data from the District's fiscal year 2013.

### 14. NEW – What version of EAPGs will be implemented?

DHCF will implement version 3.8 of EAPGs, which was released in January 2013. EAPG payment simulations and final rates will be done using version 3.8.

### 15. NEW - Will there be regular updates to the EAPG Grouper/Pricer software?

Yes. DHCF plans to perform EAPG quarterly updates, which generally involve staying current with CPT/HCPCS coding updates. The grouper version will be updated at a minimum every two years, which may involve changes in grouper logic, enhancements and updates to EAPG settings.

**16. NEW - Will any outpatient hospital services be paid based on a fee schedule under EAPGs?**

No. Outpatient hospital services will be paid based on EAPGs. No services have been identified for payment by fee schedule at this time.

**17. Will outlier payments be included in the new payment method?**

Outlier payment provisions are typically made for cases that are unpredictably expensive. The District's analysis of claims data performed to date does not indicate extreme variation in claim charges or cost, typically associated with outlier cases. An outpatient cost outlier payment policy will not be used, unless a need is identified in claims data during the ratesetting process.

**18. Will EAPG payment be capped to the lower of the EAPG payment or billed charges?**

The current outpatient hospital payment method limits payment for some services to the lesser of the calculated amount or billed charges. Limiting payment to billed charges is typically used to control costs, particularly when the payment method is based on a percent of charges. EAPGs are a visit-based patient classification system designed to link the level of payment with the complexity of the service provided. When a sophisticated grouping algorithm is used to price claims, such as EAPGs, the result is that a hospital may be paid more than its charge on a specific claim or line and significantly less than its charge for others due to payment bundling techniques (packaged services and discounting). However, on balance the payment method is expected to be fair. A charge cap to limit payment to billed charges will not be imposed.

**19. Will the change affect payments from Medicaid managed care plans?**

No. Payments to hospitals from Medicaid managed care plans are outside the scope of this project.

**20. Will the change affect how Medicare crossover claims are paid?**

No. The payment logic for Medicare crossover claims will not be affected by EAPGs. DC Medicaid will continue to pay the lesser of these two amounts on an outpatient crossover claim:

- a. The Medicaid allowed amount minus the Medicare paid amount
- b. The Medicare co-insurance amount plus Medicare deductible amount

**COVERAGE AND PAYMENT FOR SPECIFIC SERVICES**

**21. What changes, if any, will be made to prior authorization policy?**

The Department uses prior authorization to help control inappropriate utilization of services. While there are no changes contemplated that are specifically related to the implementation of EAPGs, changes in the Department's prior authorization policy are made from time to time to address new coverage policies, new technologies or to address areas of potential fraud, waste and abuse.

**22. How will payment be made for laboratory and radiology services?**

Laboratory and radiology services will be processed and paid by EAPG, with some services paid zero when subject to consolidation, packaging or discounting.

**23. How will payment be made for physical, occupational, and speech therapy?**

Physical therapy, occupational therapy and speech therapy procedures will be processed and paid by EAPGs, subject to consolidation, discounting and packaging.

**24. How will dental services provided in an outpatient hospital setting be paid?**

Outpatient hospital dental services will be processed and paid by EAPGs. The procedure codes and payment are for the facility services, not for the professional services provided by the dentist. Professional services provided by dentists (e.g., pedodontist) are not included in the EAPG payment method and would continue to be billed separately and paid by fee schedule.

**25. Will payment for vaccines and vaccine administration be affected?**

DHCF will continue its existing policy and make no payment for vaccines available through the Vaccines for Children (VFC) Program. VFC vaccines are not payable under Medicaid because these vaccines are federally funded and available at no charge to providers for Medicaid eligible children.

Other vaccine and vaccine administration procedure codes currently covered for adults and children will be processed through the EAPG grouper. The payment for vaccine administration codes for adults and children will be bundled when a significant procedure is billed on the claim.

**26. NEW – What changes, if any, will be made to observation room services policy?**

DHCF will change its current policy and pay separately for observation room services under certain specific conditions.

- Observation room services begin at the time that the physician writes the order to evaluate the patient.
- The new DHCF policy states that observation services must be at least 8 hours and not more than 48 hours.
- Payment for observation services is based on the EAPG, regardless of the number of units (hours) billed as long as units billed are at least 8. If units are not at least 8, the line will group to EAPG 999 and pay zero.
- Observation room services are always packaged when a significant procedure is also billed.

Under the new payment method, observation room services may be identified by HCPCS code G0378 which groups to EAPG 450. The relative weight for this EAPG reflects the national average units (hours) greater than 8. (For details on the observation logic, please see EAPG Information handout question #11)

**27. NEW – What changes, if any, will be made to partial hospitalization program (PHP) services policy?**

No change in current policy for partial hospitalization program (PHP) services is expected due to the new payment method. Consistent with the District Medicaid State Plan, PHP services are not a covered outpatient hospital service, except as part of waiver services. PHP services will not be paid under the new payment method based on EAPGs.

## **BILLING AND EDITING**

### **28. What billing practices will be important for hospitals to follow?**

The EAPG grouper relies on revenue codes, procedure and diagnosis codes and patient demographic information to accurately group and price claims. Hospitals are asked to ensure that these fields are coded completely, accurately and defensibly on their outpatient claims. We encourage hospitals to continue to include all diagnosis and procedure codes on their outpatient hospital claims.

### **29. How will the National Correct Coding Initiative edits apply under the new payment method?**

DHCF will continue to identify and edit claims where coding methods do not adhere to these federal guidelines under the new EAPG payment method. The National Correct Coding Initiative is a federal requirement for all Medicaid programs under the Affordable Healthcare Act.

### **30. How will payment for professional fees revenue codes be affected?**

Professional fees revenue codes will not be eligible for payment under the EAPG payment method when billed on outpatient hospital claims (UB-04). These professional services should continue to be billed on professional claims (CMS-1500).

### **31. How will an outpatient hospital visit be defined under EAPGs?**

An outpatient hospital visit is defined as all services billed on a single claim regardless of the service date. Generally speaking, DC Medicaid does not pay separately for multiple dates of services on a hospital outpatient claim.

### **32. NEW - How will medical visits be paid under EAPGs?**

Lines billed with HCPCS/CPT codes that are designated by the EAPG grouper as medical visit indicator EAPGs will be packaged in the presence of a significant procedure. If a claim is billed with a medical visit HCPCS/CPT code and no significant procedure is present, then the EAPG for that line will be assigned based on the principal diagnosis. Most of the HCPCS/CPT codes designated as medical visit indicator codes are evaluation and management codes.

### **33. Will DC Medicaid implement an inpatient-only list? Is the list the same as that maintained by Medicare for APCs?**

Yes. The EAPG list of inpatient-only services will be applied under the new payment method. The list of procedures is similar but less restrictive than the Medicare list.

**34. What bundling or packaging methods will DHCF implement with EAPGs?**

Bundling or packaging refers to grouping different services provided into a single payment unit. A bundled or packaged service receives no separate payment. DHCF will implement the following bundling methods with EAPG payment:

Packaging/Bundling	Description
Packaged Services	<ul style="list-style-type: none"> <li>• A standard list of packaged EAPGs is built into the grouper.</li> <li>• Packaging occurs in the presence of significant procedure visits or medical visits.</li> <li>• Packaging applies only to procedures that group to ancillary, drug and DME EAPGs.</li> <li>• If a significant procedure or medical visit is not present on the visit, items on the standard packaging list <i>may</i> be paid separately.</li> </ul>
Significant Procedure Consolidation	<ul style="list-style-type: none"> <li>• Consolidation refers to the collapsing of significant procedures into a single EAPG - when one significant procedure is performed, additional significant procedures may require minimal additional time or resources.</li> <li>• The procedures are ranked based on the relative weight of the EAPG.</li> <li>• There are two types:                             <ul style="list-style-type: none"> <li>• Same significant procedure, which applies to procedures that group to the same EAPG.</li> <li>• Clinically related significant procedure, which applies to related EAPGs.</li> </ul> </li> </ul>
Discounting Multiple Significant Procedures	<ul style="list-style-type: none"> <li>• This type of discounting refers to a reduction in the payment for an EAPG – when an unrelated significant procedure is performed multiple times during the same visit.</li> <li>• Multiple significant procedure discounting is applied to procedures within the same EAPG type and across EAPG types.</li> <li>• The procedures are ranked based on the relative weight of the EAPG.</li> <li>• Discounting level percentages will be applied: 100, 50 and 25 percent for the first, second, third and subsequent procedures.</li> </ul>
Discounting Repeat Ancillary/Drug/DME Procedures	<ul style="list-style-type: none"> <li>• This type of discounting refers to a reduction in the payment for an EAPG – when non-routine ancillary procedures are repeated on the same visit.</li> <li>• Discounting is applied to repeat procedures for ancillary, drug and DME procedures within the same EAPG.</li> <li>• Discounting level percentages will be applied: 100 percent for the first non-routine ancillary, 50 for the first repeated ancillary and 25 percent for the second, third and subsequent repeated non-packaged procedures, respectively.</li> </ul>
Notes:	
<ol style="list-style-type: none"> <li>1. There are six EAPG significant procedure types subject to consolidation and discounting: significant procedure, physical therapy and rehabilitation, mental health and counseling, dental procedure, radiologic procedure, and other diagnostic procedure.</li> <li>2. 3M Health Information Systems, <i>Definitions Manual</i>, Version 3.8.13.1, January 2013</li> </ol>	

**35. What modifiers will impact payment under EAPGs?**

The EAPG grouper recognizes a number of modifiers which may potentially impact payment. Some modifiers are used to increase or decrease the payment amount. Some modifiers are informational and will not affect payment. However, hospitals should continue to bill using standard coding conventions.

Modifier	Description	Effect on EAPG Payment
Therapy modifiers GN (speech and language), GO (occupational), GP (physical)	Identify whether the therapy services were for speech, occupational or physical therapy services.	<ul style="list-style-type: none"> <li>No effect on payment.</li> </ul>
Anatomical modifiers and other select modifiers (E1–E4, F1–F9, FA, LT, RT T1–T9, TA, 76, 77, 91, RC, LC, LD)	Used to report procedures performed on paired organs or specific sides of the body, (e.g., eyelids, fingers, toes, arteries, kidneys, lungs, right, left) or to report the same procedure was performed more than once by the same or different physicians.	<ul style="list-style-type: none"> <li>No effect on payment.</li> </ul>
Modifier 25 Distinct service	Used to report significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day as a significant procedure or other service.	<ul style="list-style-type: none"> <li>Medical visits will be payable with a significant procedure in the presence of this modifier.</li> </ul>
Modifier 27 Multiple outpatient hospital E/M encounters	Used to report multiple outpatient hospital E/M and emergency room visits on the same day to indicate that the E/M service is a separate and distinct E/M encounter.	<ul style="list-style-type: none"> <li>Lines billed with this modifier may be payable unless a significant procedure is present on the visit.</li> </ul>
Modifier 59 Distinct procedural service	Used to report procedures not normally reported together, and are distinct or independent from other services performed on the same day.	<ul style="list-style-type: none"> <li>Lines billed with this modifier will not be subject to same significant procedure consolidation.</li> </ul>
Modifiers 73 and 52 Terminated procedures	Used to report that the procedures or services were not completed so that the service provided was less than usually required for the procedure as defined by the CPT/HCPCS code.	<ul style="list-style-type: none"> <li>Lines billed with these modifiers will be discounted by 50%</li> <li>If the line is subject to both multiple significant procedures discounts and modifiers 73/52 discount, the modifier discount will be based on the adjusted weight that results after the significant procedure discount is applied.</li> </ul>

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Modifier	Description	Effect on EAPG Payment
Modifier 50 Bilateral procedure	Used to report any bilateral procedures that are performed at on both sides at the same operative session as a single line item (except when 'unilateral' or 'bilateral' is in the CPT/HCPCS description).	<ul style="list-style-type: none"> <li>Lines appropriately billed with this modifier will be discounted by 150%.</li> <li>If the line is subject to both multiple significant procedure discounts and modifier 50 discount, the modifier discount will be based on the adjusted weight that results after the significant procedure discount is applied.</li> </ul>
Item at no cost or reduced cost to provider modifiers (FB, FC)	Used to report a device associated with a surgical procedure and furnished to the hospital without cost or at reduced cost (e.g., covered under warranty, replaced due to defects, samples)	<ul style="list-style-type: none"> <li>No effect on payment.</li> </ul>
Never Events modifiers PA (wrong body part), PB (wrong patient) or PC (wrong surgery)	Used to report erroneous surgical or invasive procedures.	<ul style="list-style-type: none"> <li>DC current policy continues for non-payment of never event procedures and related services, as required by federal law.</li> </ul>
<p>Note</p> <p>The list of bilateral procedure codes subject to discounting are identified in the Medicare Physician Fee Schedule.</p>		

## OTHER

### 36. How will hospitals be kept informed and involved during the development of the prospective payment system?

<b>FAQ</b>	This FAQ document which provides DC Medicaid policy, payment and billing information about the new outpatient hospital payment method. FAQs are periodically updated and distributed to hospitals.
<b>EAPG Information</b>	A separate document which provides general information about EAPGs.
<b>Provider information sessions</b>	To be held periodically to keep providers informed of data, decisions and the progress of the project.
<b>Training sessions</b>	Planned for July/August 2014

**37. Who can I contact for more information?**

<i>Policy questions contact</i>	Claudia Schlosberg, Department of Health Care Finance Director, Health Care Policy and Research Administration Tel: 202-442-9107 • Email: <a href="mailto:Claudia.Schlosberg@dc.gov">Claudia.Schlosberg@dc.gov</a>
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