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Outpatient Ambulatory Payment: Understanding EAPG Transition

Three Perspectives on implementing EAPG: State, consultant & payer

Dan Jenkins, Illinois Department of Healthcare and Family Services
Mal Ferguson, Guidehouse Healthcare
Adam Proctor, Nebraska Total Care

July 26, 2022

Health Policy Executive Summit 2022

Meet the speakers

Dan Jenkins
Deputy Administrator of Rates and Finance for the Illinois Department of Healthcare and Family Services

Malcolm (Mal) Ferguson
Associate Director with Guidehouse Healthcare

Adam Proctor
Sr. Vice President of Operations for Nebraska Total Care.

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Illinois: The state's perspective, by Dan Jenkins.

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State of Illinois hospital outpatient reimbursement

Illinois Outpatient Hospital Landscape

- 218 cost reporting hospitals
  - General Acute Care
  - Psychiatric
  - Rehabilitation
- Over 5 million OP claims annually (FFS and MCO)
- Over $1.8 billion in OP claims payment annually (FFS and MCO)

History of state of Illinois hospital outpatient reimbursement

Late 1990's : Homegrown Ambulatory Procedure Listing (APL)

6 APL Groups:

-Surgical -Observation Services -Diagnostic and Therapeutic -Psychiatric Services

-Emergency Room Procedures -Rehabilitation Services

- Each procedure code is grouped into 1 of the 6 APL groups
- Claim paid according to the highest group on the claim
- Labs, X-rays, DME considered professional services: billed on a professional claim

State of Illinois hospital outpatient reimbursement

July 2014: Transitioned institutional claims to EAPG

- Months of industry and community stakeholder meetings
- Established EAPG rates for Acute, Psych, and Rehab categories of service
- Established an increase to rates for high outpatient volume hospitals

Illinois updates to EAPG reimbursement

July 2018: Expensive drugs and devices add-on

- Claim lines with certain EAPG or EAPG/Revenue Code assignments
- Calculation much like an inpatient cost outlier calculation

July 2020: Moved non-institutional claims to EAPG

- Labs, X-rays, DME, historically paid via fee schedule
- Educating providers on reimbursement changes

Illinois EAPG reimbursement lessons learned

Positive move:

- More precise payment for each line
- Grouper updates keep reimbursement in line with industry changes
- Better data analytics capabilities

Issues encountered:

- Changes in relative weights when updating grouper versions
- ASTC that specialized in certain service
- DME lines packaging to zero reimbursement

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Guidehouse: The consultant's perspective, by Mal Ferguson.

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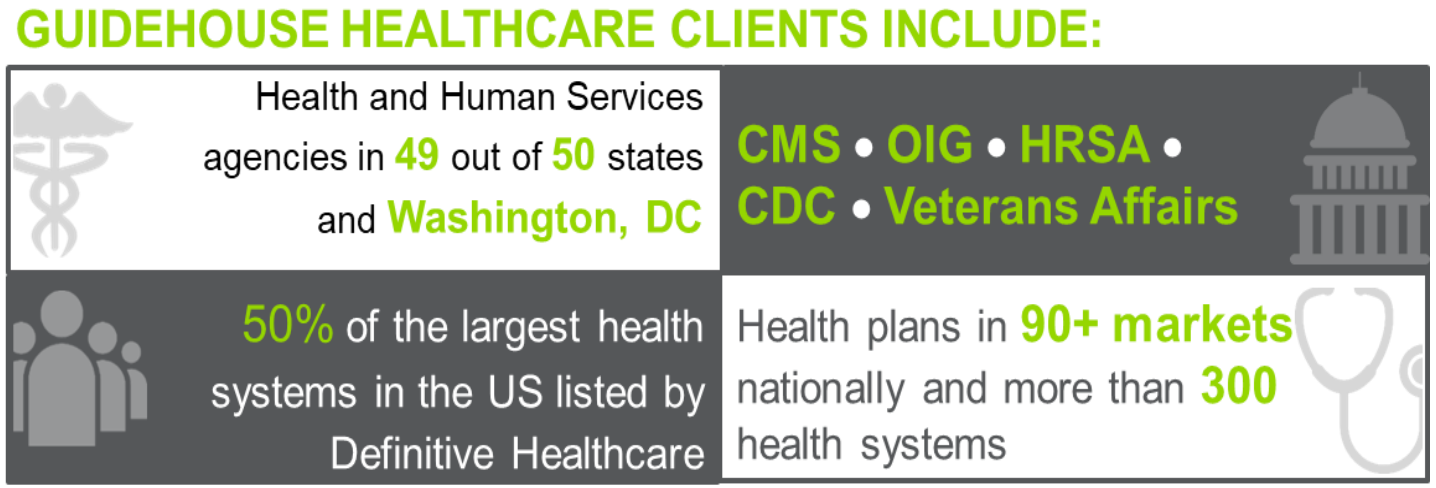
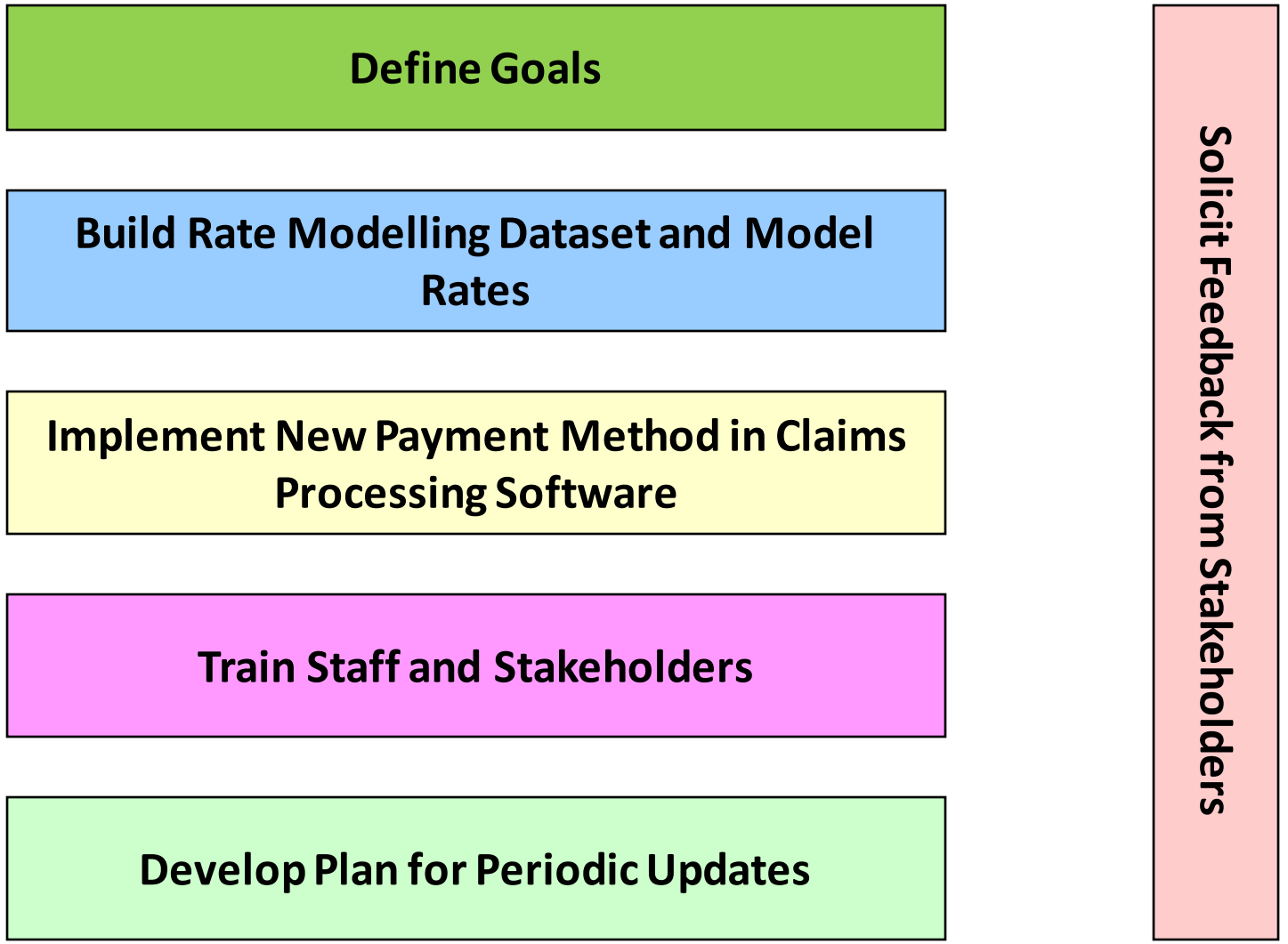
Introduction to Guidehouse

- Headquartered near Washington, D.C., the company has more than 12,000 professionals in more than 50 locations globally.



- Supported several Medicaid agencies with implementation of EAPGs including Florida, Illinois, Nebraska, Washington, and Wisconsin. Also supported Blue Cross and Blue Shield of Alabama with an EAPG implementation.

Basic process flow for conversion to EAPGs

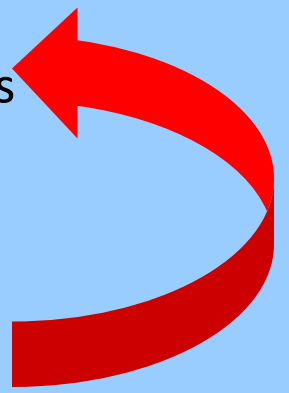


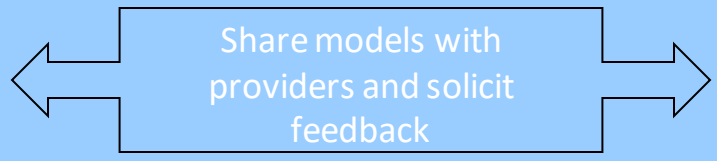
Define goals

- Budget – generally set based on spend in historical dataset
- Providers to include
  - Hospitals
  - Ambulatory surgical centers
- Services to include
  - EAPGs will cover all services provided in a hospital outpatient setting
  - Some payers carve out drugs and biologicals
  - Some payers carve out therapies
- Communicate goals to stakeholders and solicit feedback

Build rate modelling dataset and model rates

- Determine timeframe of historical claims
  - Desired claim volume is at least 100,000
  - Should data from timeframe of Public Health Emergency be included?
  - Claim service lines must include procedure codes
- Determine EAPG version and group claims under that version
- Calculate Base Rate(s) (a.k.a. Conversion Factors) and potential other payment factors
  - Possible policy adjustors
  - Possible outlier payments
- Determine model impact – Compare historical payment to proposed new payment
  - By provider
  - By provider category
  - By type of service





Implement new payment method in claims processing software

- Grouping requires software from 3M
- Pricing can be done with internal logic or using 3M logic
- EAPG grouping and pricing is performed at the claim service line level, but data billed on one line can affect pricing on other lines
  - Denied claim lines should not be sent to the grouper
  - Claim lines denied after grouping / pricing have potential to generate inaccurate pricing

Train staff and stakeholders

- Communicate timing of payment change
- Communicate rates
- Provide examples with training – EAPG pricing has a learning curve

Develop plan for periodic updates

- EAPG software ideally is updated quarterly and should be updated at least annually to enable processing of newly defined CPT and HCPCS codes
  - ➢ This does not require updates to Base Rates and other payment parameters

- Ideally, the version of EAPG codes and relative weights applied to claims is updated annually, but at least should be updated every 3 years.
  - ➢ This does require updates to Base Rates and other payment parameters because the EAPG relative weights change

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Nebraska Total Care: The payer's perspective, by Adam Proctor.

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3M’s new outpatient methodology

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Improving Patient Safety : Ambulatory Potentially Preventable Complications

Flora Coan, 3M Regulatory and Government Affairs

July 2022

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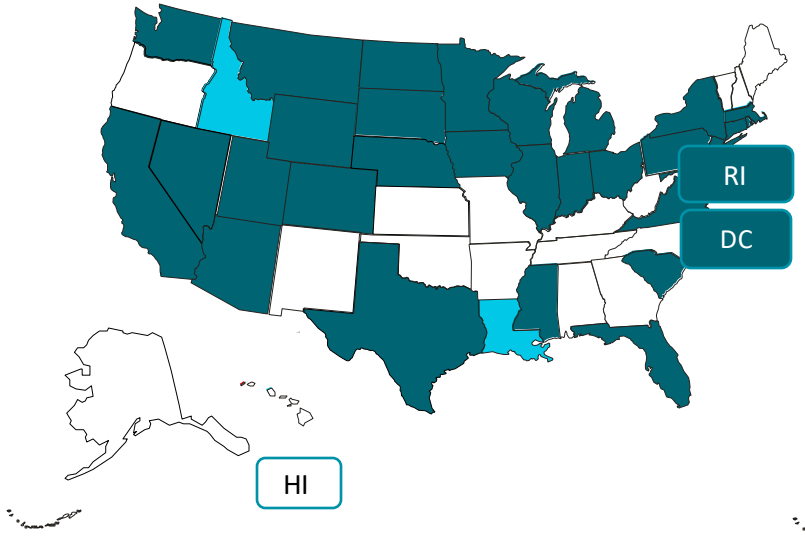
3M HIS leadership across: Inpatient, outpatient and VBC payment federal, state agencies and blues

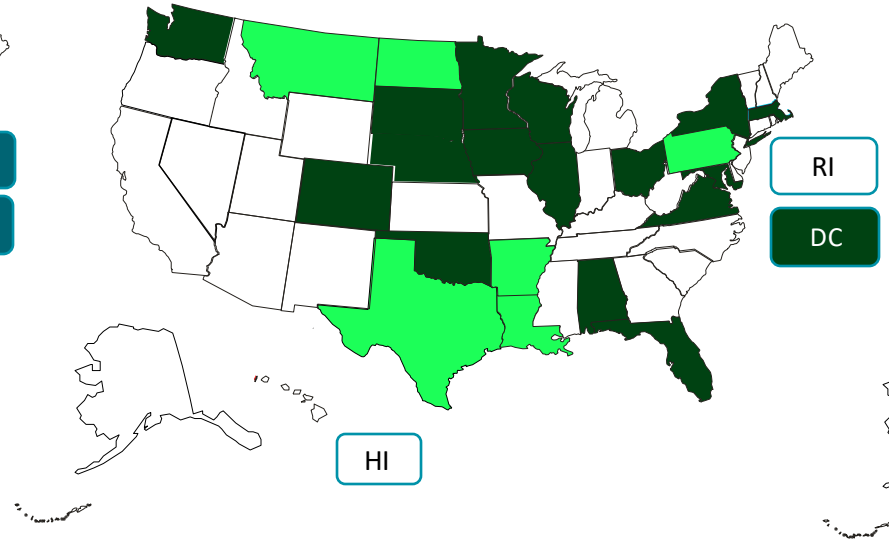
CMS Medicare Inpatient (MS-DRG) and Medicare Outpatient (APCs), Tricare and VA Inpatient and Outpatient Payment

3M Inpatient Payment



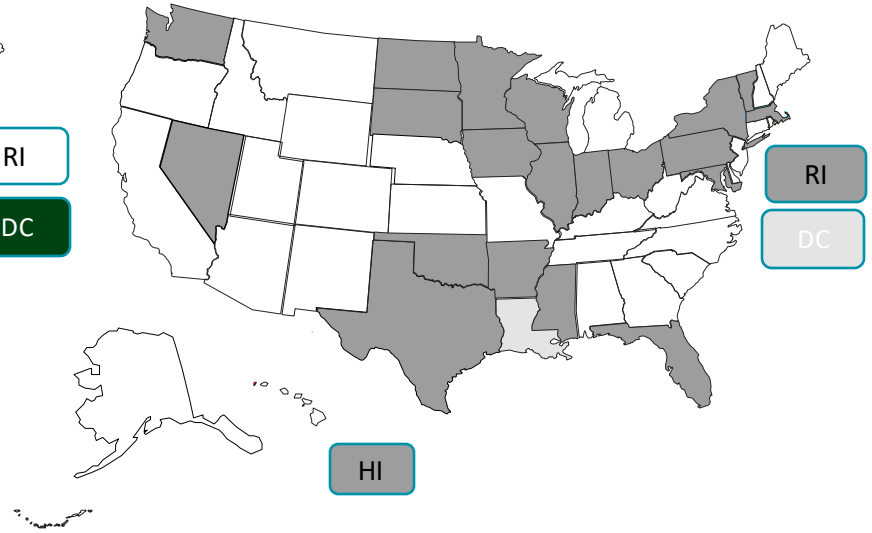
Implemented
State Agency (29)
Commercial (10)

3M Outpatient Facility



Implemented
State Agency (14)
Commercial (6)

3M VBC and Quality



Implemented
State Agency (36)
Commercial (6)

As of March 2022-- Publicly Announced

Background: Outpatient procedures and quality

80% procedures performed in outpatient settings

Limited outcomes/quality measurement systems

3M building first comprehensive quality outcomes system for ASC/HOPD procedures

Also providing benchmarks against regional/national performance; by sites, service lines, physicians for reducing variation and targeting poorer outcomes

Ambulatory complications solution description

- Aggregate procedure Groups developed specifically for procedures of interest
- Supports procedure code, service line, site of service, and physician level detail to target improvements
- Only use claims data
- Extends expertise gained building inpatient complication measures

Procedure Groups

- **91 procedure groups representing > 2500 procedures**
- All HCPCS codes on encounter
- Inclusion Logic
- Procedure Group Assignment

Complication Types

- **23 complication groups representing 1500 unique complications**
- Monitor subsequent events
- Complication Flag based on procedure and timing

Complication Setting

- Unscheduled admissions within 30d
- ED visit rate post procedure
- OP Encounter to address complication
- 72 hour admission post procedure

2020 Medicare FFS hospital outpatient facility data:

Preliminary draft sample findings - Procedure groups and complication rates

- ~5 Million Procedures at risk for complication
- ~175,000 Potentially Preventable Complications Identified
  - ~30,000 occurring in ED
  - ~65,000 occurring in Hospital Inpatient Setting
  - ~ 80,000 occurring in Outpatient Setting
- At risk cases are with Expected: Observed complication ratios ranging from .5 – 1.5

High Complication Rates

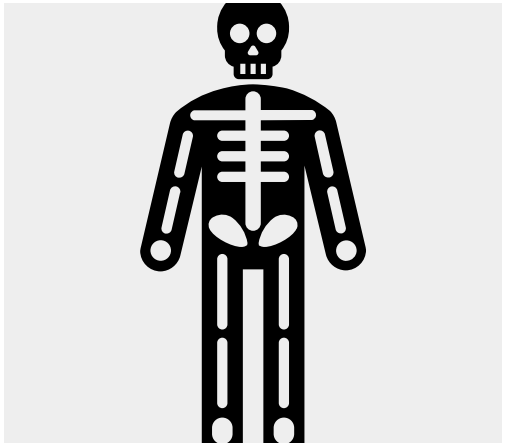
Procedure Group	Complication %
Upper Genitourinary Catheter (Percutaneous) Procedures	18.29%
Laparoscopic Procedures with Insertion or Revision of Intraperitoneal Catheter	15.11%
Cardiothoracic - Thoracoscopy Procedures	14.6%

Low Complication Rates

Procedure Group	Complication %
Hand and Wrist Arthroscopy Procedures	0.73%
Shoulder and Elbow Arthroscopy Procedures	0.91%
Strabismus and Extraocular Muscle Procedures	0.92%

Medicaid/3M HIS beta partnership

- Partnership Access Package
- Research team support on set-up, output, configuration
- Variation analysis feedback



- Review Actual over Expected complication rates by sites, service lines, physicians

- Feedback from management, sites, service lines, physicians on findings
- Type 4 complication – 72-hour admissions feedback

- Participation in Product Launch
- Thought Leadership

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Questions?