Ambulatory Care Payment Reform in Medicaid: APGs and HIV Care

Franklin Laufer, PhD

AIDS Institute

NYS Department of Health

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Presentation will…

- Outline reasons for Medicaid payment reform
- Introduce APGs
  - As a classification system
  - As a payment system
- Describe implementation in context of Medicaid ambulatory care payment reform and HIV-related care

Medicaid Reform

- Reallocate funds from inpatient to outpatient services
- Invest in ambulatory care to encourage outpatient service provision
- Payment based on service intensity rather than flat rate
- Other objectives
  - Primary care enhancements
  - Physician reimbursement enhancements

Where we are now

- 5-tier rates for Primary Care Program and designated AIDS centers (DACs)
  - HIV counseling & testing, initial/annual evaluation, HIV monitoring
- 7-tier rates – DACs
  - Initial, annual, intermediate, routine, therapeutic, infusion
- Carve-outs – viral load, resistance testing, tropism assay
- General clinic rates – all facilities (hospitals and free-standing clinics)

Ambulatory Patient Groups

- A visit classification system designed to explain the amount and type of resources used in an ambulatory visit and that is used to determine payment for ambulatory service(s)

- Prospective payment system – sets payments in advance of service provision

APG Payment

- Utilizes standard claims information to assign APG(s)
- Intended to reflect the diversity, intensity, and variation in costs of services provided by assigning multiple APGs when appropriate
- Also groups services into single payment unit to 1) provide incentives for efficiency and 2) to minimize “upcoding”

Ambulatory Payment Groups

- Significant Procedures, Therapies, or Services
  - APG 089 – Level I cardiothoracic procedures
  - APG 136 - Colonoscopy
- Ancillary Tests and Procedures
  - APG 397 – Level II microbiology tests
  - APG 415 – Level I immunization
- Medical Visit
  - APG 880 – HIV infection
  - APG 881 - AIDS

APG Assignment

- Unlike under the DRG system, a patient can be assigned to more than one APG to describe the service(s) rendered to the patient
- Patient has visit with a clinician, who orders a chest X-ray as the clinician suspects community-acquired pneumonia
  - Results in two APGs assigned to that visit:
    - APG 573 – Medical visit for community-acquired pneumonia
    - APG 471 – Plain film

Grouping APGs

- Not all APGs are used to compute payment

- Three “grouping” techniques:
  - Significant procedure consolidation
  - Ancillary packaging
  - Discounting

Significant Procedure Consolidation

- Collapsing multiple *related* significant procedures, recognizing that some significant procedures are integral to the primary procedure and require minimal additional time and resources
  - Laryngoscopy done with aspiration (APG 62) and also with removal of a non-neoplastic lesion from patient's vocal cord (APG 63)
  - Payment will be 100% for the procedure to remove the lesion as the primary procedure, and 0% for the aspiration

Ancillary Packaging

- Include certain ancillary services in the APG payment for a significant procedure or medical visit.
- Cost of a “packaged” ancillary included in the payment for the significant procedure or medical APG
  - Chest x-ray is packaged with the payment for the medical visit for pneumonia

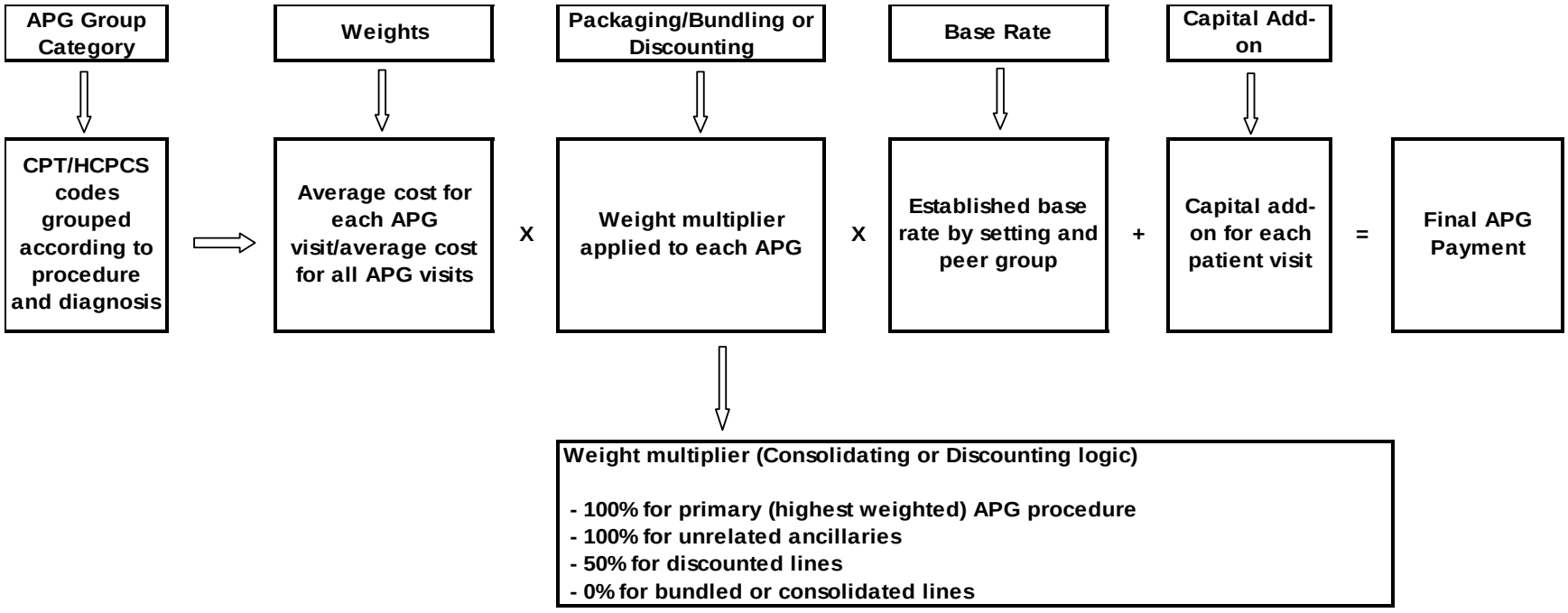
Ancillary Packaging

- Costs for packaged ancillaries are included in the medical visit they accompany, based on the frequency with which they are ordered
- Examples:
  - Thyroid activity - CBC
  - Urinalysis - EKG
  - Blood chemistry - PPD
  - Hepatitis C antibody - Syphilis/RPR

Discounting

- Reduction in the standard payment rate for an APG when, during a single visit, either
  - Multiple significant *unrelated* procedures are performed or
  - The same procedure or ancillary service is provided several times
- Marginal cost of providing a second procedure or additional ancillary is less than its full cost (i.e., the cost of providing the procedure by itself).

APG Payment Methodology



APG Example
7-Tier HIV/AIDS High Intensity
(All procedures are grouped based on the same Date of Service)

HIV/AIDS Initial Visit (Equivalent to 7 Tier - High Intensity)										
CPT Code	**CPT Description**	**APG**	**APG Descp**	**Payment Element**	**Payment Action**	**Full APG Weight**	**Percent Paid**	**Allowed APG Weight**	**Sample Base Rate**	**Paid Amount**
99213	E & M, est. pt., low complexity (15 mins.)	881	AIDS	Medical Visit	Full payment	0.9932	100%	0.9932	$ 202	$ 201
99403	Preventive Counseling (Case mgmnt not mappable)	491	Medical Visit	Medical Visit	Packaged	1.1276	0%	0.0000	$ 202	$ -
71020	Chest x-ray	471	PLAIN FILM	Ancillary	Packaged	0.6885	0%	0.0000	$ 202	$ -
80074	Hepatitis B panel	403	ORGAN OR DISEASE ORIENTED PANELS	Ancillary	Full payment	0.3618	100%	0.3618	$ 202	$ 73
80061	Fasting lipid profile (incl cholesterol)	403	ORGAN OR DISEASE ORIENTED PANELS	Ancillary	Discounted	0.3618	50%	0.1809	$ 202	$ 37
86360	CD4 count	395	LEVEL II IMMUNOLOGY TESTS	Ancillary	Full payment	0.3007	100%	0.3007	$ 202	$ 61
36415	Venipuncture	457	VENIPUNCTURE	Ancillary	Full payment	0.0675	100%	0.0675	$ 202	$ 14
87490	Chylmd trach, dna, dir probe	397	LEVEL II MICROBIOLOGY TESTS	Ancillary	Full payment	0.2270	100%	0.2270	$ 202	$ 46
86777	Toxoplasma antibody	395	LEVEL II IMMUNOLOGY TESTS	Ancillary	Discounted	0.3007	50%	0.1504	$ 202	$ 30
81000	Urinalysis	410	URINALYSIS	Ancillary	Packaged	0.1139	0%	0.0000	$ 202	$ -
82955	Glucose-6-phosphate dehydrogenase level	401	LEVEL II CHEMISTRY TESTS	Ancillary	Full payment	0.2411	100%	0.2411	$ 202	$ 49
	Total Payment					**4.7839**		**2.5226**		**$ 510**
	Current Payment (Rate Code 2940: downstate excluding capital)									**$ 501**
	Net Difference									**$ 9**
	Percent Difference									**2%**

Note: APG weights and base rates shown are for illustrative purposes only. The primary diagnosis was AIDS (ICD-9 042). For this visit, the following carved-out services were billed to the Laboratory Fee Schedule: 87900 ($80), 87901 ($350), and 87903 ($675).

APG Example
7-Tier HIV/AIDS Low Intensity
(All procedures are grouped based on the same Date of Service)

Routine Visit (Equivalent to 7 Tier - Low Intensity)										
CPT Code	**CPT Description**	**APG**	**APG Descp**	**Payment Element**	**Payment Action**	**Full APG Weight**	**Percent Paid**	**Allowed APG Weight**	**Sample Base Rate**	**Paid Amount**
99213	E & M, est. pt., low complexity (15 mins.)	881	AIDS	Medical Visit	Full Payment	0.9932	100%	0.9932	$ 202	$ 201
85025	CBC w/diff	408	Level I Hematology Tests	Uniformly Pkgd Ancillary	Packaged	0.0857	0%	0.0000	$ 202	$ -
80076	Hepatic function panel	403	Organ or Disease Oriented Panels	Ancillary	Full payment	0.3618	100%	0.3618	$ 202	$ 73
90740	Hepatitis B vaccinations	416	Level III Immunizations	Ancillary	Full Payment	0.4323	100%	0.4323	$ 202	$ 87
36415	Venipuncture	457	Venipuncture	Ancillary	Full Payment	0.0675	100%	0.0675	$ 202	$ 14
	Total Payment					**1.9404**		**1.8548**		**$ 375**
	Current Payment (Rate Code 2942: downstate excluding capital)									**$ 146**
	Net Difference									**$ 229**
	Percent Difference									**157%**

Note: APG weights and base rates shown are for illustrative purposes only. The primary diagnosis was AIDS (ICD-9 042). For this visit, the following carved-out services were billed to the Laboratory Fee Schedule: 87900 ($80), 87901 ($350), and 87903 ($675).

General Payment Reform Issues

- Implementation
  - Hospital OPDs and free-standing D&TCs transition to APGs over 3 years
    - Year 1 (December 1, 2008 – December 31, 2009): 75% current / 25% APGs
      - DTCs: transition period compressed to begin March 2009
    - Year 2 (calendar year 2010): 50% current / 50% APGs
    - Year 3 (calendar year 2011): 25% current / 75% APGs
    - Year 4 (beginning January 1, 2012): 100% APGs

Payment during Transition

- APG portion – Percentage of what the grouper produces as summed APG payment
- Non-APG portion – Percentage of facility's 2007 billings in the aggregate
  - Weighted average of all billings, including for HIV-related visits
    - Validated with each hospital
  - Frozen during transition

HIV-Specific Issues

- Replaces 5- and 7-tier pricing for most services
  - Counseling and testing and therapeutic (case management) visits carved out
  - Billing under APGs is optional for FQHCs
- Higher payment weight for the medical visit APG reflects higher complexity and packaged ancillaries
- Separate medical visits with another practitioner on the same day of service is accounted for using billing modifier

Supporting Materials

- Available on the DOH website
  - Implementation Schedule
  - APG Documentation
  - Payment Examples
  - Uniformly Packaged APGs
  - Inpatient-Only Procedure List
  - “Never Pay” and “If Stand Alone, Do Not Pay” Lists
  - Carve-Outs List
  - List of Rate Codes Subsumed in APGs
  - Paper Remittance
  - Frequently Asked Questions

www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm

Contact Information

- Grouper / Pricer Software Support

  3M Health Information Systems

  - Grouper / Pricer Issues 1-800-367-2447
  - Product Support 1-800-435-7776
  - http://www.3mhis.com

- Billing Questions

  Computer Sciences Corporation

  - eMedNY Call Center: 1-800-343-9000
  - Send questions to: eMedNYProviderRelations@csc.com

- Policy and Rate Issues

  New York State Department of Health

  Office of Health Insurance Programs

  Div. of Financial Planning and Policy 518-473-2160

  - Send questions to: apg@health.state.ny.us