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## Chairperson’s Corner

by *Bernie Rabinowitz*

**T**he entire Health Section Council, including myself as the incoming chair, look forward to serving you this year. First, welcome to our newly elected Council members: Tony Wittmann, Bob McGee, Dan Skwire and Mary Ratelle; and also welcome to our other new team members: Jeff Miller, newsletter editor, and Darrell Spell, annual meeting program coordinator.

The major challenge facing our profession is to provide the actuary with the technical skills, professional

*(continued on page 3, column 1)*

## APCs - They’ll Change Outpatient Hospital Contracting

by *Pat Dunks & Nick Ortner*

**M**edicare’s Ambulatory Payment Classification (APC) system could become the reference standard for the majority of non-capitated outpatient hospital contracts, much like RBRVS has for physician contracts. Numerous parallels between the planned APC implementation and RBRVS’s implementation exist.

Medicare requires use for reimbursement under the original Medicare fee-for-service program. Providers nearly

always know what Medicare pays them for a given service and readily understand reimbursement that is a multiple of Medicare reimbursement.

Prior to APCs and RBRVS, providers in the same geographic area often received different reimbursement for the same service. Health plans had difficulty in comparing providers using Medicare reimbursement as a reference, because Medicare reimbursement could differ for each of their providers.

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## APCs — They'll Change Outpatient Hospital Contracting

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Under APCs and RBRVS, providers in the same geographic area receive the same reimbursement for the same service. Health plans learn area Medicare reimbursement levels quickly and can now easily compare providers using Medicare reimbursement as a reference.

Prior to APCs and RBRVS, health plans provider contracts often based reimbursement on fee schedules (home-grown or otherwise) or discounts from billed charges. Fee schedules offered protection against billed charge inflation but were routinely criticized by providers and were expensive to implement and maintain.

Under APC- and RBRVS-based reimbursement, health plans can deflect relative value complaints from providers by pointing out that HCFA sets them and can also rely on HCFA to update the schedules for appropriate reasons (e.g., changes in technology, inflation). Medicare increases will be based on Medicare indices or other formula-driven mechanisms. Historically, Medicare fee increases have been lower than commercial group fee increases.

Because APCs, in a nutshell, form a fee schedule for most hospital outpatient services, health plans will realize APCs' relative ease of use and inflation-controlling nature. We expect many health plans will push to implement APCs as soon as possible.

### What is the APC System?

The most recent version of the proposed outpatient hospital payment system consists of 345 Ambulatory Payment Classifications (APCs) that are determined by procedure code (CPT or HCPCS) and, for hospital clinic and emergency room visits, by diagnosis (ICD-9 CM). The APCs grouping procedures are comparable both clinically and with respect to resource use.

The APC system covers facility charges only and is, essentially, a fee schedule that specifies maximum allowable payments for each of the 345 APC groups. When a claim is received, each procedure code or diagnosis is mapped

into the appropriate APC group. If multiple procedures are performed during a single visit to the hospital, more than one APC may be identified, with each APC generating a payment.

While the APC system has been described as a prospective payment system (PPS), we believe that label can be misleading. On the one hand, the APC system determines payment for a given classification regardless of a specific hospital's costs and doesn't pay any more if certain packaged ancillary services are performed. On the other hand, the proposed APC system pays hospitals based on individual services performed. Except for the packaged ancillary services, a hospital will get paid more for doing more for a given patient. Certain charges such as those for operating room, recovery room, anesthesia, and various other services are packaged together.

### Scope of APC Services and Providers

The APC system encompasses the majority of outpatient hospital facility services and expenses including:

- Surgery
- Diagnostic testing
- Radiology
- Certain pathology procedures
- Clinic and ER visits
- Partial hospitalization
- Psychiatric visits
- Rehab
- Chemotherapy and chemotherapy drugs

Other outpatient hospital charges will continue to be paid according to non-APC methods, including:

- Ambulance services. Paid by fee schedule, starting as soon as operationally possible after the proposed fee schedule is received (its deadline is February 15, 2000). Current payments are based on reasonable costs or charges.
- Physical and occupational therapy. Paid by fee schedule.

- Speech-language pathology. Paid by fee schedule.
- Services covered under end-stage renal disease composite rates.
- Lab services paid under the clinical diagnostic lab fee schedule.
- Mammography screening. Paid at the lesser of billed charges or a national rate.
- DME, orthotics, and prosthetics currently paid under the DMEPOS fee schedule.
- Certain APC services furnished to inpatients of skilled nursing facilities (SNFs), when covered under the inpatient PPS or the SNF PPS, and billable only by the SNF.
- Costs associated with allied health professionals training. Such costs will be covered on a cost-pass-through basis, as is done under the inpatient PPS.

The APC PPS will apply to the vast majority of hospitals, including those excluded from payment under the inpatient PPS (e.g., cancer hospitals). In addition, certain other types of providers will be included to achieve consistency in payment rates among different sites of service. Providers paid under the APC PPS will include:

- All hospitals, with these exceptions:
  - Critical Access Hospitals will continue to be paid under a reasonable cost-based system.
  - Certain hospitals in Maryland will continue to be reimbursed under the state's payment system.
- Other hospital-based providers (e.g., hospital-based clinics). The new rules define hospital-based providers for the first time.
- Certain services currently paid on a cost-based system when provided by comprehensive outpatient rehabilitation facilities (CORFs), home health agencies, hospices, and community-based mental health treatment centers.

While the APC PPS will apply to most hospitals, the Medicare, Medicaid, and Balanced Budget Refinement Act of 1999 (MMBBA99) holds the following

categories of hospitals harmless (i.e., their payments will be at least at pre-APC levels, in aggregate):

- Rural hospitals with less than 100 beds (until 2004)
- Cancer hospitals

### Payment Mechanism Explained

The proposed APC system details were published in the June 30, 1999 *Federal Register*. In general, the payment amounts for a specific claim are determined as follows:

- The claim is mapped to an APC based on its CPT or HCPCS procedure codes and ICD-9 diagnosis codes.
- National APC rates are used as the starting point.
- The national rates are adjusted based on the geographic location of the provider, using the geographic wage indices that are also used for Medicare inpatient PPS.
- Beneficiary co-payments are determined by formula but are limited to the inpatient deductible amount. For each APC, 60% of the national payment rate is adjusted for wage level variations.

Two examples are included:

- Example #1 on page 26 is relatively simple, with just two HCPCS codes generating one payment from a single APC group (see page 26)
- Example #2 on page 27 is a bit more involved, mapping four HCPCS codes into three APC groups, one of which is defined by a combination of a procedure code and diagnosis code (see page 27)

Please note that the examples do not reflect changes that will occur in response to MMBBRA99. HCFA has not yet announced the details of the expected modifications.

### Expected APC System Modifications

In response to MMBBRA99, we expect several changes to the proposed APC system:

- APC implementation will be revenue neutral. In other words, the total pay-

ments to all hospitals will be the same as if APCs were not implemented.

Under the current version of APCs, total Medicare outpatient hospital payments were projected to be a 5.7% reduction.

- APC implementation will be delayed until 2001 and phased in over a three-year period.
- Beneficiary coinsurance limits will be effective July 1, 2000.
- An outlier provision may be added.
- A transition mechanism for new choices, drugs, and biologicals may be added.
- APC classifications may be refined in response to congressional concerns noted in MMBBRA99.
- A mechanism may be added to update the APCs annually.

### Implications and Issues

#### *Modified Payments to Provider:*

HCFA projects modifications in payments for outpatient hospital services that will vary significantly according to number of variables, including type of hospital, geographic location, case mix, and the proportion of revenue generated from inpatient versus outpatient services.

In a given geographic area, the same payment will be made for the same services; therefore, hospitals with charge levels higher than other hospitals in the same geographic area should expect a greater reduction in reimbursements.

Outpatient payments to certain types of specialty hospitals may also be significantly affected, including those of urban teaching/non-disproportionate share hospitals, rehab hospitals, psychiatric hospitals, and children's hospitals.

#### *Beneficiary Coinsurance Limits*

The coinsurance limits are effective July 1, 2000. The limits are defined by APC but the APC system won't be implemented until 2001. Will hospitals and Medicare Supplement carriers have to determine APC groupings using the most recent version or will HCFA restate the limits by HCPCS code?

#### *Cost-Shifting Increases, Procedure-Shifting Decreases*

HCFA estimates that the reduced payments to hospitals will result in a 10% "behavioral offset" by the hospitals. This offset could occur through increases in utilization or billed charge levels, both of which could potentially affect non-Medicare patients as well.

Reduced profits on outpatient procedures may also reduce a hospital's incentive to encourage the appropriate shifting of procedures from inpatient to outpatient.

#### *Increases Indexed*

Annual conversion factor updates will be made according to changes in a specified market basket index, less 1%, in each of the years 2000, 2001, and 2002, as required by the Balanced Budget Act (BBA).

#### *Administrative Requirements*

To receive full reimbursement, hospitals will need to assign HCPCS codes to all services. Under the current reimbursement system, full reimbursement can often be achieved without coding every service associated with a case. HCFA also expects to revise the UB-92 claim form so that a diagnosis code can be reported for each line item.

While hospitals may be less than enthusiastic to implement APCs unless it is financially advantageous for them, we believe pressure from non-Medicare insurance organizations, greater understanding by hospitals that the APC system does not necessarily mean reduced reimbursement levels, and expected APC system enhancements will lead to APC-based reimbursement becoming common when contracting for outpatient services.

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## APCs — They'll Change Outpatient Hospital Contracting

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### Example #1

Case Description: Patient has outpatient arthroscopic knee surgery to repair a torn ligament.  
 Provider Location: Seattle, Washington  
 Part B Deductible Previously Paid: \$40  
 Remaining Part B Deductible: \$60

<u>Service</u>	<u>HCPCS Code</u>	<u>APC Group</u>
Arthroscopically aided anterior cruciate ligament repair / augmentation or reconstruction	29888	286 – Arthroscopically-aided procedure
Anesthesia for arthroscopic procedures of knee joint	01382	N/A – Packaged Service

(a) APC Payment Rate*	\$1,423.82
(b) National Unadjusted Coinsurance Amount*	\$ 791.90
(c) National Unadjusted Coinsurance Percent [(b) / (a)]	55.62%
(d) Program Payment Percentage [1 - (c)]	44.38%
(e) Geographic Wage Index	1.1375
(f) Labor-Related Portion of Expenses	60%
(g) Area-Adjusted APC Payment Rate [(a) x (e) x (f) + (a) x (1 - (f))]	\$1,541.29
<b><u>Total Payment Received by Hospital</u></b>	
(h) Part B Deductible Paid by Beneficiary	\$ 60.00
(i) Medicare Payment [(d) x ((g) - (h))]	\$ 657.40
(j) <u>Beneficiary Copayment [(g) - (h) - (i)]</u>	<u>\$ 823.89</u>
(k) Total Payment Received by Hospital [(h) + (i) + (j)]	\$1,541.29

\*

The APC Payment Rate and National Unadjusted Coinsurance Amount were taken from Addendum A of the June 30, 1999 *Federal Register*. For a given APC, Addenda A and B of the *Federal Register* may show slightly different dollar amounts. This is true for many of the APCs, and we expect that these discrepancies will be remedied in the final version of the APC payment system.

**Example #2**

Case Description: Patient presents to hospital-based clinic with symptoms suggesting acute lower respiratory illness.

Provider Location: Seattle, Washington

Part B Deductible Previously Paid: \$0

Remaining Part B Deductible: \$100

Diagnosis Code: 466.0 – Acute Bronchitis

MDC: 33 - Respiratory System Diseases

<u>Service</u>	<u>HCPCS Code</u>	<u>APC Group</u>			
Office or Other Outpatient Visit	99214	91533** - High Level Clinic Visits, Respiratory System Diseases			
Complete Blood Count	85022	N/A – Paid Under Laboratory Fee Schedule			
ECG Recording	93270	956 – ECG Recording			
Chest X-Ray	71010	700 – Chest X-Ray			
		<u>APC</u>	<u>APC</u>	<u>APC</u>	<u>Total For</u>
		<u>91533</u>	<u>956</u>	<u>700</u>	<u>All APCs</u>
(a) APC Payment Rate*		\$74.04	\$56.05	\$41.14	\$171.23
(b) National Unadjusted Coinsurance Amount*		\$14.81	\$54.47	\$22.37	\$91.65
(c) National Unadjusted Coinsurance Percent [(b) / (a)]		20.00%	97.18%	54.38%	53.52%
(d) Program Payment Percentage [1 – (c)]		80.00%	2.82%	45.62%	46.48%
(e) Geographic Wage Index		1.1375	1.1375	1.1375	
(f) Labor-Related Portion of Expenses		60%	60%	60%	
(g) Area-Adjusted APC Payment Rate [(a) x (e) x (f) + (a) x (1 – (f))]		\$80.15	\$60.67	\$44.53	\$185.35
<b><u>Total Payment Received by Hospital</u></b>					
(h) Part B Deductible Paid by Beneficiary		\$80.15	\$19.85	\$ 0.00	\$100.00
(i) Medicare Payment [(d) x ((g) – (h))]		\$ 0.00	\$ 1.15	\$20.31	\$21.46
(j) <u>Beneficiary Copayment [(g) – (h) – (i)]</u>		<u>\$ 0.00</u>	<u>\$39.67</u>	<u>\$24.22</u>	<u>\$63.89</u>
(k) Total Payment Received by Hospital [(h) + (i) + (j)]		\$80.15	\$60.67	\$44.53	\$185.35

\*

The APC Payment Rate and National Unadjusted Coinsurance Amount were taken from Addendum A of the June 30, 1999 *Federal Register*. For a given APC, Addenda A and B of the *Federal Register* may show slightly different dollar amounts. This is true for many of the APCs, and we expect that these discrepancies will be remedied in the final version of the APC payment system.

\*\*

The APC group for the clinic visit is a concatenation of a three-digit APC group (915) that is defined by the HCPCS code and the two-digit MDC (33). HCFA expects to re-number the APCs in the final version of the system so that all codes will be three digits.