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The Jujitsu of APCs:

Turning Medicare's Outpatient Payment System to Your Advantage

Executive Summary

Medicare's long-awaited and delayed hospital outpatient prospective payment system took effect last August 1. The system changes how Medicare pays for most outpatient services by introducing a methodology—ambulatory payment classifications, or APCs—that has some similarities to the DRG system used for inpatient services. When confronting the challenge of APCs, healthcare executives would be wise to consult the martial art of jujitsu, which emphasizes the re-channeling of aggressive force to a positive outcome.

The Health Care Financing Administration (HCFA) intends the new system to slow growth in Medicare outpatient costs and to create incentives for hospitals to operate more efficiently. HCFA no doubt did not intend the introduction of the system to be as difficult as it is turning out to be. Delays on the agency's part in issuing final rules for the new system had a ripple effect that slowed efforts by fiscal intermediaries and hospitals to update billing software and coding procedures. As a result, one immediate impact on hospitals is higher administrative and coding costs, and a backlog in unpaid Medicare claims. The new system's near-term bottom line impact depends on the volume of Medicare outpatient services a hospital delivers. Its ultimate impact will depend on hospitals' ability to embrace APCs as a tool for collecting detailed information on the cost and efficiency of ambulatory services, then using that information to improve those services. This issue of the *Information Edge* examines how hospitals are coping with APCs so far and how they can turn the demands of the new system to long-term competitive advantage.

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Coding is Key

APCs will influence how hospitals classify and code ambulatory services just as diagnosis related groups influenced the coding of inpatient services, says Peter Boland, Ph.D., a healthcare consultant and author in Berkeley, Calif. "One difference is that the methodology behind APCs is much less sophisticated than DRGs."

Boland urges hospitals to invest the resources necessary to accommodate APCs, "because they're not going away and their financial implications are enormous. As Medicare goes, so go private payers." The only question is how fast. He compares the effect of APCs on hospitals to that of capitation on physicians. "Once a significant percentage of your business, say 20% to 30%, is under a new payment system, you reach a tipping point and you have to change the underlying processes for your entire enterprise, not just how you treat patients covered under the new system."

Bill Sheats, a Vice President with First Consulting Group, agrees that even hospitals that don't have a substantial Medicare business need to pay attention to APCs, since other payers will likely adopt similar payment systems.

Sheats says that the hospitals that are best handling the transition to APCs are those that take a holistic approach to the required changes. "They're not just adding coders to clinics that have a high proportion of Medicare business or revising their encounter forms, although they are doing those things," he says. "Beyond that, they're taking a long-term look at their operations, their organizational structures, and their technology, because they see APCs as part of a larger trend that is changing how outpatient services will be delivered."

APCs will also have an impact on clinical practice, just as DRGs did, Sheats says. For example, the bundling of diagnostic tests in certain ways for purposes of payment creates incentives to provide services in ways that conform to those bundles. Therefore, physicians will need to consider which tests to order and when to order them.

"An obvious point that bears repeating is that coding is going to be key under APCs," says Norbert I. Goldfield, MD, who helped develop the methodology that underlies APCs. Goldfield is medical director of 3M Health Information Services in Wallingford, Conn., which created ambulatory patient groups (APGs), from which APCs were derived.

"The hospital-owned medical group I work with as a practicing internist has already revised its encounter form to account for the added detail needed to bill under APCs," Goldfield says. "Having such an encounter form, and the data-capture capability that flows from it, will be key."

Hospital executives should keep three other key points in mind when thinking about APCs, in Goldfield's view:

- "For a lot of reasons, mainly political, there are fundamental differences between 3M's original APGs and APCs as implemented by Medicare. In many ways, APCs do not truly represent a prospective payment system. They are a detailed fee schedule.
- "The first financial question hospitals want to answer when they deliver a service is, 'How much does the patient owe me at the end of that service?' That's a different question from how much Medicare will pay for that service. It's a question that hospitals should be able to answer using software tools that build on HCFA's office code editor (OCE).

APC Resources:

- At www.hcfa.gov/medlearn/opps3.doc, HCFA has posted a detailed list of 14 glitches that could result in claims processing errors under APCs.
- *Ambulatory Payment Classification: Summary of the Final Rule,* a 32-page booklet by Bonnie Bisol Cassidy, William P. Kelly, Norbert Goldfield; Aspen Publishers, Inc., Gaithersburg, Md., orders (800) 638-8437 or www.aspenpublishers.com
- The American Hospital Association offers an online guide to Medicare's outpatient prospective payment system at www.aha.org/opps/OPPS_home.asp. The site includes news, links, a list of educational programs, and for AHA members, a financial impact guide and other tools.
- The Healthcare Financial Management Association offers a number of APC-related resources, including conferences, links and news at www.hfma.org.

- "Hospital outpatient departments will increasingly compete for business with physician offices and ambulatory surgical centers. Those centers will come under APCs next year. Another possible competitive consequence of APCs is that once hospitals know which APCs are financial winners and losers, they will be able to waive some co-payments to gain competitive advantage."

In Portland, A Rough Ride

Before hospitals can emerge as winners under APCs, they'll have to endure what looks to be a rough first year under the new system. "Our experience with APCs has been very bumpy," says Mary Kjemperud, director of reimbursement and budget at Legacy Health System in Portland, Ore. Legacy is a not-for-profit integrated system of two tertiary hospitals, two community hospitals, a children's hospital and a home health agency. "As of mid-November, we have more than $8 million in Medicare claims pended and waiting." While most of those claims are for inpatient services, Kjemperud is convinced that the time and energy that HCFA has had to put towards the new outpatient payment system is having a ripple effect on the agency and fiscal intermediaries that is also slowing Medicare inpatient payments.

Legacy's issues with APCs stem from changes to Medicare's pricer, the claims processing logic that contains the variables and formulas the health system uses to calculate what it bills Medicare for services. As Medicare tries to fix problems with the pricer, the law of unintended consequences kicks in, and other problems arise.

Legacy's billing personnel are also spending considerable time and energy maintaining and expanding the health system's charge master—the global database containing Legacy's charges to Medicare and other payers for every service and item it provides—to accommodate APCs. Under the old payment system, when a Legacy patient covered by Medicare received a pacemaker as an outpatient surgery, Legacy simply billed for the pacemaker. Under APCs, it must identify the brand and model of the pacemaker, then check to see if that particular model has an APC code. "As new devices come online, we're going to have to make sure they have a code," Kjemperud says. "That adds a new dimension to the work of our purchasing department, which will have to consider whether a product has a code and how much we can bill for that product, before we decide to buy that product."

Another ongoing issue involves changes in how doctors and nurses document what they do. Emergency department clinicians who formerly could simply identify cases as Level 1 through Level 5, based on severity, now must precisely document which procedures and supplies are used. "Capturing this much information is a whole new world to them," Kjemperud says. "Our medical records staff are having to work closely with the ER staff to assure documentation is available for proper billing."

Based on her knowledge of HCFA, Kjemperud expects at least a year, and maybe two, to pass before the outpatient prospective payment system works smoothly. "Even then, from now on, it looks like HCFA will add new APCs that we'll have to keep track of."

Mark Your Calendars: Annual Membership Conference

April 4-6, 2001 Marriott Camelback Inn, Scottsdale, Ariz.

Next year's annual meeting will be held on April 4-6 in Scottsdale, again at the Camelback Inn. The conference is included in your membership fee.

This annual meeting gives us a perfect opportunity to meet and share the findings from the Performance Measurement participants as well as share the data and benchmarks from the IT Cost Benchmarking initiative on Wednesday afternoon, April 4.

Shortly we will be sending you a link so you can enter corporate, regional and site level cost data for IT Cost Benchmarking. There is no charge for this program.

Similarly, several members are beginning the Performance Measurement program. This tool will provide us with a common way to discuss and measure the processes involved in managing IT. Those who represent a leading practice in each area can share your story with your peers at this session.

We look forward to seeing you in April at the conference and at this optional pre-conference session.

Reports From the Field:

APCs' Impact on Scottsdale Institute Members is Mixed

We asked Scottsdale Institute member institutions about their experiences with APCs. Here's a summary snapshot of what our members are saying about the impact so far:

What impact do you expect APCs to have on reimbursement to your organization?

- An increase in year one under APCs of 15%.
- We anticipate a $2,797,000 decrease for FY 2001.
- Our consultant estimated a $500,000 negative impact from Medicare.
- We're not sure yet.
- Our impact is significantly positive.
- Numbers vary but our best guess right now is an 8% decrease in revenue.

What benefits, if any, do you foresee your organization deriving from the switch to prospective payment for Medicare outpatient services?

- An increase in revenue and better cash flow due to a larger amount coming from Medicare as opposed to the beneficiary or supplemental insurer.
- None.
- Revenue predictability after the bugs are worked out.
- We anticipate future benefits from being better able to analyze our case mix and document quality on an outpatient basis.
- We expect delays in reimbursement. Collection of APC supporting data has added significantly to the workload of staff.
- Our ability to analyze costs and reimbursement will be much better than before.

Medicare's problems rolling out APCs are giving private payers pause. "A year or so ago, the local Blue Cross plan said that it would adopt an APC payment system within a year of HCFA going live with APCs," Kjemperud says. "They've been backing off that a bit lately, and now it's likely that they'll wait until a year after the Medicare system is debugged."

Mixed Results in Oklahoma

"The only silver lining with APCs is that I'm 57½ years old, and I only have to deal with it for a few more years before I retire," jokes Richard G. Pearson, vice president of reimbursement at Integris Health, Inc., an 11-hospital system based in Oklahoma City. Integris runs three large urban facilities and eight rural hospitals with less than 100 beds each.

Pearson says that HCFA failed to properly prepare for APCs before launching the system, and should have held it back until it was fully ready. He says another problem with APCs was they arrived just as hospitals were digging out from under other effects of the Balanced Budget Amendment of 1997 (BBA), the law that mandated HCFA to adopt an outpatient prospective payment system. "So many bad things happened as a result of BBA that it was hard to get the attention of top executives and convince them of the need to focus on APCs."

Pearson sees three major systemic flaws in the APC methodology:

- "While I understand Medicare's desire to control the growth in hospital operating expenses, the fact is that APCs will increase our operating expenses. They will increase administrative costs because we will have to add coding staff. Coding for APCs is substantially more complex than anything that came before." Even worse, the work required goes well beyond that traditionally required of coders.
- Pearson finds fault with the results of HCFA's stated goal of bringing down co-payments. "At our rural hospitals, patients who paid 20% of $100 under the old system find themselves paying a $60 co-payment under the new system. Our patients are out there pitching a fit about this change."
- Unless HCFA extends its current two-year exemption that holds small rural hospitals harmless from APCs, the payment system could cripple those facilities. "HCFA continually discovers that payment systems based on national averages, designed to spread risks, have the effect of putting rural hospitals out of business," he says.

Pearson ultimately expects APCs to be a factor that forces hospitals to stop trying to be all things to all people. "Over time, one hospital in a given market may choose to focus on all the inpatient and ambulatory elements associated with cardiology, while a second may focus on cancer care, and a third on gastrointestinal services."

Rural hospitals are not alone in being exempted from APCs. The nation's ten comprehensive cancer centers were also specifically excluded for at least two years, just as they were exempted from DRGs. "We have patients come from great distances who receive massive workups in a very condensed period of time," says Kevin Wardell, COO of the University of Texas M.D. Anderson Cancer Center in Houston. As a result, the averages

that underlie APCs bear little relation to the typical array of services provided by the cancer hospitals.

Know Your Costs

Before hospitals can identify the services that could be winners under APCs, they will have to more fully embrace activity-based cost accounting, says health consultant Boland. "APCs are a step in that direction, and that's important because it brings hospitals closer to knowing their actual costs of delivering care."

The example of pre-surgical screening illustrates how APCs are forcing hospitals to rethink the design and costs of ambulatory services, says Leanne Travers, a healthcare consultant with the Gold Consulting Group in Needham, Mass. Travers has focused on activity-based cost accounting for more than a decade.

"A patient going to a hospital for outpatient pre-surgical screening typically will have a blood test, a chest X-ray, other diagnostic tests and an anesthesiology consult," Travers says. "In the past, all of those elements were billed separately. Now, they're all part of one APC. This creates a demand on hospitals to coordinate all the pieces of that screening and know the cost in time and resources of each component."

The typical pre-surgical screening is "a natural bundle of services, yet most hospitals aren't set up to deliver them as a bundle," says Dan McGaffey, a healthcare consultant specializing in ambulatory services with Talmage & Associates in Norwell, Mass. "So a set of tests that should take an hour and a half eats up four hours." APCs have the potential to cause hospitals to take a hard look at how they deliver such services and find a more rational way to do it, he says. "APCs pay a certain dollar amount for a defined set of services, yet hospitals don't know how often they provide these sets of services as sets. They need to figure that out. Hospitals can save a lot of money by streamlining those services."

Hospitals need to think of outpatient services as a clinical information-gathering system that serves physicians and patients as customers, McGaffey says. Too often, a patient running around to various hospital departments is not managed as a case, and there is a high risk of a breakdown in the information-reporting system.

McGaffey tells of talking with the CIO who had just decided not to buy an automated scheduling system for his 17-hospital health system. The key justification for automated scheduling, McGaffey points out, is that it gives management a chance to recognize and manage the 30-plus percent of ambulatory diagnostic patients who visit two or more hospital departments in a single day or, under the same set of physician orders, over a series of days. Asked why he killed the purchase, the CIO said that none of his constituencies wanted it or asked for it. Who were the CIO's constituencies? The heads of the hospitals' clinical departments. In an outpatient world, hospital department heads need help from top management to expand their view of who they work for to include physicians and patients. To do that requires shedding assumptions based on years of delivering

EHealth Status Report Update:

Expanded Data Now Available for Comparison

Since Scottsdale Institute conducted the eHealth survey in late spring, 2000, FCG has continued to collect survey data from other leading healthcare organizations and has expanded the database of responses. By using a link that we will send to all member CEOs and CIOs shortly, you will be able to update your data and compare your status with this larger sample of industry leaders. During this phase of the project, we will send a report to you as soon as 20 members have entered or updated data.

We encourage you to update your data when we send the link; data over a year old will be deleted from the database, so updating your information will be easier than starting from scratch.

Watch for a link to the data collection tool and the new sample report, and please contact our office with any questions or if you need another copy of the original report.

Welcome New Member

Catholic Health Initiatives!

Not-for-profit Catholic Health Initiatives is the result of a merger of three healthcare systems (Catholic Health Corp. of Omaha, Neb.; Franciscan Health System of Aston, Pa.; and Sisters of Charity Health Care Systems of Cincinnati, Ohio). CHI is one of the largest Catholic, not-for-profit healthcare systems in the country, representing approximately 75,000 employees and annual operating revenues of $5 billion. It includes 70 hospitals, 49 long-term care, assisted-living and residential facilities in 22 states.

Welcome to CEO Patricia Cahill, Executive VP and COO, Kevin Lofton, Senior VP and CMO Hal Ray, M.D., VP Strategic Planning, Bob Cook, CFO Geraldine Hoyler and the entire CHI team.

mainly inpatient care. "Physicians are managing cases in their offices that a few years ago they would have hospitalized," McGaffey says. "In the hospital or not, managing the care of these patients requires diagnostic backup from some source. This is the mission-critical hospital market of the future and it is the market that is being lost to freestanding providers."

Conclusions

The rollout of Medicare's outpatient prospective payment system has been problematic even for hospitals that devoted considerable resources preparing for it. Confusion and uncertainty will continue for the next year or so, as HCFA tweaks its rules, fiscal intermediaries figure out what those rules mean and software vendors develop products to help hospitals revise the way they code and bill for outpatient services. More important in the two to three years that follow is the near certainty that private health insurers will adopt versions of APCs for their own ambulatory payment systems.

Winners under APCs will be those hospitals that can best absorb the initial shock of APCs, then turn the system to their long-term strategic advantage. Hospitals that grudgingly adapt to APCs only because they must will fall behind. Wisely employed, APCs can help illuminate the strengths and flaws in a hospital's outpatient services. Delivery systems that appreciate and exploit the value of the information that must be gathered to bill under APCs will gain competitive advantage.

Strategic benefits that can flow from embracing APC-related changes include:

- **More precise knowledge of the cost of delivering ambulatory care.** The information demands of APCs require hospitals to capture more and better information about the costs of each service and product that is part of ambulatory care. Short term, this knowledge will help hospitals maximize reimbursement from Medicare under APCs.
- **Streamlined design of care.** Once hospitals know their ambulatory costs, they will be better equipped to redesign high-volume services in order to deliver them more efficiently and at lower cost. Delivering common clusters of services as such—rather than as separate pieces—will yield savings.
- **Improved patient satisfaction and management.** Streamlining common clusters of services such as pre-surgical screenings will save time and trouble for patients. It also will enhance clinical support by getting needed information into the right practitioner's hands more quickly.
- **Sharper focus on successful service lines.** Knowledge of the costs and bottom-line benefits of various ambulatory services could spur hospitals to focus on clinically and financially successful services as centers of excellence, while de-emphasizing other services.

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