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If not, here's what you Should do

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Are You Prepared for APCs?

If not, here's what you should do.

by Mary Lou Bowers, M.B.A.

There has been much talk about how ambulatory payment classification (APC) implementation will dramatically affect outpatient cancer services. Because analyses by ELM Services, Inc., and the Lewin Group showed these impacts, ACCC recently convinced Congress to change the ways cancer drugs will be covered. While it appears this solution will dramatically improve outpatient reimbursement, it is vital that you prepare now for the rapid implementation of the new APC system.

APC categories are the Health Care Financing Administration's (HCFA) attempt to categorize various groups of procedures, and then to pay an average price for all procedures in a given category. (For more information on the potential impact of APCs on cancer programs, see the March/April 1999 *Oncology Issues.*)

One of the most ominous provisions of APCs has been the attempt by HCFA to place chemotherapy and supportive care drugs into categories. Congress recently passed legislation that establishes a complex formula for paying for these drugs. While initial indications are that hospitals will do better than under the original proposal, we cannot be certain until we see the administrative language in February. Updates will be posted on ACCC's web site (www.accc-cancer.org) as they become available.

Although the final numbers and formulas have not yet been decided, the essentials required for hospitals to prepare for APCs are basic, although not necessarily easy.

- Learn everything you can about cost-based reimbursement for outpatient oncology programs.
- Audit your current charge capture and billing processes.
- Make changes to improve current billing.
- Evaluate the charge master.
- Evaluate the financial impact of proposed APC regulations and other options.
- Translate the final rules into program impact.

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FIRST, MAXIMIZE CURRENT REIMBURSEMENTS

Before worrying about APCs, *learn everything you can about cost-based reimbursement for outpatient oncology programs.* Cancer program administrators must take responsibility for billing and cost reporting. If they want their program to succeed, they must ensure that the data produced are accurate.

Those outpatient managers who are not already familiar with reimbursement rules for Medicare and contracted payers under their current systems must learn about them. Many reimbursement problems result from hospital programs not following current rules. For example, a general analysis of data from hospitals shows that from 6.6 percent to 50 percent of billed outpatient services have no CPT codes on the bill; and 8 percent to 53 percent inappropriately use inpatient codes. These are the findings from a study done by CHPS, a consulting center for health policy studies in Columbia, Md. Although HCFA has made many errors in assembling and interpreting the data used to develop the APC system, data from hospital outpatient claims also severely misrepresent services provided.

At this point, it looks like Medicare will rely heavily on CPT codes in the implementation of the APC system. Unlike a cost-based system, a prospective-based system puts a premium on thoroughness and accuracy in the front end of the billing process.

Audit current charge capture and billing processes. Cancer program administrators must have baseline knowledge of the current charge capture, billing, and denial appeals processes. This knowledge comes through a comprehensive audit, either conducted internally or by outside consultants. The audit must include a chart review with claim comparison, a billing process review inclusive of all relevant departments, observation of charge capture processes inclusive of quality control activities, and a denial appeals process review. Consultants are useful in performing an audit because they are outsiders...no internal issues, no favorites, nothing to cover up. Obviously, consultants must bring comprehensive knowledge and skills in hospital outpatient oncology programs. Consultants should quantify the impact of any corrections they recommend. A good report will provide an improvement plan and the additional revenues a cancer program will capture.

Make changes to improve current billing. Once the audit is completed, the cancer program director must take the lead to ensure that a plan for change is developed and implemented. Again, consultants may be useful in assisting with plan implementation, especially if the burden of normal duties means staff cannot take on new assignments in

a timely fashion. Common issues requiring change include:

- pharmacy unit conversion
- proper roll up of CPT codes to Q codes
- ICD-9CM coding
- an appeals process
- matching J and Q codes
- quality control activities
- capture of missed charges
- correct revenue and CPT/HCPCS codes.

TABLE 1. CALCULATING REIMBURSEMENT FOR CHEMOTHERAPEUTIC AGENTS (AND SUPPORTIVE CARE DRUGS*) UNDER APCS

Use data for Medicare patients only. Use data for current cost-report year. Set up a spreadsheet that contains the following items and calculations.

1. Enter the number of units by J code volume.
2. Enter the charge for the J code volume.
3. Enter the cost of the J code volume.**
4. Multiply the number of units (Step 1) by the unit cost (Step 3). This equals the *weighted acquisition cost.*
5. Multiply the charge (Step 2) by the cost-to-charge ratio from the cost report. This equals the *cost based on the Medicare cost report.* Use the charge ratio for pharmacy.
6. Multiply the cost based on the Medicare cost report (Step 5) by the number of units (Step 1). This equals the *weighted cost.*
7. Multiply the APC reimbursement (available from the Health Care Financing Administration) by the number of units (Step 1). This equals the *weighted APC reimbursement.*
8. Subtract the cost based on the Medicare cost report (Step 5) multiplied by the number of units (Step 1) from the APC reimbursement (Step 7). This equals the *APC cost report profit or loss* on total volume.
9. Add **all** the weighted acquisition costs. This equals the cost of purchasing chemotherapeutics for Medicare patients.
10. Add **all** the weighted costs based on the Medicare cost report. This equals the total cost of providing those drugs.
11. Add **all** the weighted APC reimbursement items. Compare this number with those calculated in steps 9 and 10 to evaluate the expected change.

*At this point under the HCFA proposal, there is no payment for supportive care drugs. Thus, the total cost of providing these drugs will be an APC loss. Fortunately, HCFA is required by new legislation to make adjustments to its proposal in February 2000.

** Although it would be ideal to use costs from last year, they may not be available. Pharmacy costs usually change by quarter.

Whatever the APCs system will look like, we know collection of co-payments will be important. Many hospitals have opted not to put resources into collecting oncology co-pays.

Timely implementation of these changes is complicated because they are not centered in one department. Specific process improvement committees can speed up the process of developing action plans. These plans should include: 1) who is responsible for each action, 2) what those actions are, 3) when each action must be completed, and 4) what resources are required. Accountability is the key to successful action plans. Without plans, all you really have are good intentions. Once you have determined the best option for your program, begin to sell that option to senior management and physicians.

Evaluate the charge master. Evaluation of the charge master should begin at the same time as audits of the billing process and development of the improvement plan are proceeding. This evaluation helps to ensure that charges are both adequate to cover costs and competitive in the local market. If claims data (including charges) are reviewed to establish prospective payment, they must cover cost. Our experience shows that in many instances this is not the case. When modeling your program under the APC-proposed payment, benchmark your charges. This is also an opportunity to evaluate your current managed care contract reimbursement.

HOW TO CALCULATE REIMBURSEMENT UNDER APCS

Evaluate the financial impact of proposed APC regulations and other options. Once you have maximized the appropriate reimbursement under the current system, you need to know what services you provide and their costs, and understand what Medicare and other payers are willing to pay. Then you will be prepared to evaluate the final rule changes for APCs when they are issued.

As mentioned earlier, Congress passed and the President has signed legislation that will change APC calculation. HCFA is expected to release a rule in February explaining the payment methodology. Although we do not yet know the exact numbers, we do know the process for calculating APC reimbursement for chemotherapeutic agents and supportive care drugs (Table 1), chemotherapeutic administration and radiation (Table 2). Generally, the health care provider must enter the volume of services, compute current costs under cost reimbursement, and compare these costs to APC payment under prospective payment to determine whether costs are covered for each category of service.

Translate the final rules into program impact. You control your own destiny. You can develop a plan that can be implemented in the worst-case scenario, within a 90-day window between final rule publication of APCs and implementation.

Sitting around saying, "the sky is falling," won't get you there, but being proactive will. So, while the Association of Community Cancer Centers, the American Hospital Association, the American Society for Therapeutic Radiology and Oncology, and others work to make changes in the rules, get busy and make changes that can only help you and your program...no matter which way Congress acts!

TABLE 2. CALCULATING REIMBURSEMENT FOR CHEMOTHERAPEUTIC ADMINISTRATION AND/OR RADIATION

Use data for Medicare patients only. Use data for current cost-report year. First, identify all services currently provided that are assigned to current APC groups.* Set up a spreadsheet that contains the following items and calculations.

1. Enter the number of units of service.
2. Enter the charge for a unit of service.
3. Multiply the number of units (Step 1) by the charge (Step 2). This equals the *weighted acquisition cost.*
4. Multiply the charge (Step 2) by the cost-to-charge ratio from the cost report. This equals the *cost based on the Medicare cost report.* Use the charge ratio for pharmacy.
5. Multiply the cost based on the Medicare cost report (Step 4) by the number of units (Step 1). This equals the *weighted cost.*
6. Multiply the APC reimbursement (available from the Health Care Financing Administration) by the number of units (Step 1). This equals the *weighted APC reimbursement.*
7. Subtract the cost based on the Medicare cost report (Step 4) multiplied by the number of units (Step 1) from the APC reimbursement (Step 6). This equals the *APC cost report profit or loss* on total volume.
8. Add **all** the weighted acquisition costs. This equals the cost of providing these services currently for Medicare patients.
9. Add **all** the weighted costs based on the Medicare cost report. This equals the total cost of providing these services.
10. Add **all** the weighted APC reimbursement items. Compare this number with those calculated in steps 9 and 10 to evaluate the expected change.

*If there is not an APC group, i.e., supplies, multiply the number of units by the charge and cost-to-charge ratio. These 100 percent costs will be losses under APCs.