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HCFA's Outpatient PPS: Finally Ready to Roll?

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A discussion featuring

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HCFA's Outpatient PPS

Hospital outpatient services are slated to go under the Medicare prospective payment system (PPS) on July 1, 17 years after enactment of legislation mandating PPS for hospital inpatient services. Despite some providers' earlier dire predictions about the impact of applying PPS to the hospital outpatient department (OPD), implementation seems to be on a steady course. When the PPS inpatient provisions became law, policymakers expected to include almost all Medicare services in PPS fairly swiftly. Indeed, the Omnibus Budget Reconciliation Act (OBRA) of 1986 called for the Health Care Financing Administration (HCFA) to develop an OPD PPS. But it was not until the late 1990s, with the passage of the Balanced Budget Act of 1997 (BBA) and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), that the legislative and executive branches moved to put outpatient and most post-acute services under the system, thereby approaching the original all-inclusive PPS goal.

The rationale behind the goal was—and is—to move from cost-based, hospital-specific reimbursement to predetermined payment rates for Medicare services, in order to assure more accurate, equitable, and predictable, as well as less complicated, payments.[1] While the rates for hospital inpatient services are based on diagnosis-related groups, those for hospital outpatient services—according to a final regulation published by HCFA in the April 7 *Federal Register*—are based on an ambulatory payment classification (APC) system. The system divides all covered outpatient services into 451 groups, each of which includes clinically similar services that require comparable resources.

The OPD PPS regulation appeared in proposed form in the *Federal Register* on September 9, 1998, a time of bitter complaints from providers and their trade associations about Medicare cost reductions in the BBA. Originally intended to be implemented in 1999 but postponed to 2000, the provisions proposed in 1998 added fuel to the protest fire over BBA changes in Medicare graduate medical education, disproportionate-share hospital, and post-acute-care payments. Congress responded to providers' complaints by requiring HCFA, in the BBRA, to make a number of changes in the OPD PPS. Since the final, revised regulation was issued, along with a HCFA statement that hospitals on average would receive 4.6 percent more in payments as a result of the new system, providers have complained little about HCFA's policy stance, preferring instead to focus on what they see as the time-consuming and costly process of getting the new APC system up and running.

This Forum session will explore both the OPD PPS policy and the process of implementation. It will trace the origins of the policy, the provisions that define it, and the challenges that it brings. The session also will provide perspective on the policy as one of the last remaining pieces of an overall PPS strategy for Medicare.

BACKGROUND

When the Medicare program was first established in 1965—as Title XVIII of the Social Security Act—it relied upon cost-based reimbursement. The overriding goal was to provide public insurance to persons 65 and older and to younger persons with disabilities, with a related goal of racially integrating provider facilities, which had to fulfill certain criteria in order to become "participating providers" in the Medicare program. As the rate of increase for Medicare services rose to double-digit percentages in the 1970s, the federal government strove to contain the program's cost inflation. For example, President Carter put forth a legislative proposal (introduced as the Hospital Cost Containment Act of 1977) to impose mandatory controls on inpatient hospital costs; it was gutted by an amendment authorizing voluntary restraints. However,

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the Reagan administration's Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provided for cost "caps" on hospital and hospital distinct-part services on a per-discharge basis.

The provider-supported Social Security Amendments of 1983, the legislation that created the Medicare PPS program, offered providers a way out from under the TEFRA caps, at least for hospital inpatient services. (Certain services provided in distinct parts of hospitals—such as medical rehabilitation and psychiatric care—remained under the TEFRA limits.) Hospital OPD services were at first on a "lesser of costs or charges" basis, offering little incentive for cost restraint. Gradually, some services—such as those of clinical laboratories—became subject to fee schedules, as did durable medical equipment.

During the latter part of the 1980s and the 1990s, hospital care underwent a shift from inpatient to outpatient, so that today outpatient services, on average, make up more than half of hospital revenues. While much of the shift from inpatient to outpatient is due to advances in medical science, some is a result of providers' preference for offering Medicare services in a fee-for-service environment rather than in one with set prices. During the same period, Medicaid moved toward managed care contracts for its beneficiaries under Section 1115 waivers in some states, and then, as a result of the BBA, without waivers, thereby increasing the number of states. This added to the cost pressure. Private payers, too, sought discounted prices under managed care arrangements and—because costs for given procedures or treatments are generally lower in outpatient settings than in inpatient beds—provided incentives to their enrollees to get care as outpatients when appropriate.

HCFA has the responsibility for administering Medicare outpatient services not only in hospital OPDs but also in physician offices and freestanding facilities, such as ambulatory surgery centers (ASCs). In 1992, the agency instituted a fee schedule called the resource-based relative value scale (RBRVS) for physician services. It grouped ASC services (certain surgical procedures provided in hospital-based and freestanding settings) in four and later in eight categories. HCFA indicates that it plans to include ASC procedures in PPS—based on approximately 100 APCs—after it has implemented the OPD PPS.

In summary, OBRA 1986 directed HCFA to develop an OPD PPS. The BBA mandated that HCFA establish the OPD PPS effective in 1999, but the date was delayed to 2000. The BBRA loosened the BBA provisions by easing hospitals' transition to the OPD PPS through 2003 and making certain other changes, indicated in the "Provisions" section. The BBRA also put 4.6 percent of Medicare funds back into the system by cutting back on a planned payment reduction.[2]

PROVISIONS

Table 1, which draws on an analysis of the April 7 HCFA regulation by Lawrence Goldberg, director of national affairs (health) for the accounting firm Deloitte & Touche LLP,[3] outlines the new OPD PPS policy.

CHALLENGES

While hospitals have expected the OPD PPS regulation since 1986 and have been able since September 1998 to assess the proposed regulation, some providers have strong concerns about the changes it will mean and the preparations it requires. Some of the concerns include the following:

Coding and Other Process Issues

The various steps that need to be taken to put the OPD PPS into operation are major concerns for some hospitals. For example, the American Hospital Association indicated to HCFA in April that it was worried about the timetable HCFA would have to follow in order to put the system into place by July 1. The association cited ten items. "Many of the items concerned potential software and claims-processing glitches, hospital payments, the readiness of fiscal intermediaries to operate the payment system, and whether there will be adequate time to test the system before it becomes operational."[4]

Coding seems to be a major worry. HCFA utilizes the HCPCS coding system, consisting of the international ICD-9-CM for inpatient services and the American Medical Association's (AMA's) CPT for outpatient services. According to the OPD PPS, services are grouped into APCs according to clinical indicators and resource costs and identified by HCPCS/CPT codes. A specific APC may cover several or dozens of services. For example, to cite an example used by the American Association of Medical Colleges (AAMC), for emergency and clinic visits, "HCFA has collapsed . . . 31 CPT codes into 6 APCs: three each for clinical and emergency room visits (low, medium, and high level)." In addition, "there also will be a distinct APC for critical care visits, and a distinct APC for consultation services when three or more health professionals confer." The AAMC, noting that teaching hospitals have

Table 1
Provisions of the Outpatient Department Prospective Payment System Regulation, Scheduled to Be Implemented by HCFA, July 1, 2000

Provision	Description
Classification System	A total of 451 ambulatory patient classifications (APCs) that use HCFA's Common Procedural Coding System (HCPCS), with billing according to the HCPCS codes
	Packaging into the APC payment rates for given procedures or services any costs incurred to furnish the following items or services: (1) use of an operating suite; (2) use of a procedure or treatment room; (3) use of a recovery room or area; (4) use of an observation bed; (5) anesthesia, as well as medical and surgical supplies and equipment; (6) surgical dressings; (7) supplies and equipment for administering and monitoring anesthesia or sedation; (8) intraocular lenses; (9) capital-related costs; (10) costs incurred to procure donor tissue, other than corneal tissue; and (11) various incidental services such as venipuncture; also (12) packaging of the costs of drugs, pharmaceuticals, and biologicals into the APC payment rate for the primary procedure or treatment with which they are used
Applicability	Any hospital participating in the Medicare program, except for critical access hospitals, hospitals in Maryland that are paid under a cost containment waiver, and Indian Health Service hospitals
	A community mental health center that provides partial hospitalization services
	A distinct part of a hospital that is excluded from the inpatient PPS to the extent that the distinct part furnishes outpatient services
Excluded Services	Physician, nurse practitioner, clinical nurse specialist, physician assistant, certified nurse-midwife, qualified psychologist, anesthetist, clinical social worker, outpatient therapy, and ambulance services
	Prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices, except those considered implantable, as provided by the BBRA
	Durable medical equipment supplied by the hospital for the patient to take home
	Clinical diagnostic laboratory services (except when part of an implantable procedure, an exception made by the BBRA)
	Services for patients with end-stage renal disease
	Services and procedures the HHS secretary designates as requiring inpatient care
	Hospital outpatient services furnished to skilled-nursing facility (SNF) residents which are part of a patient's resident assessment or comprehensive-care plan and therefore part of the SNF PPS
	Services furnished by a comprehensive outpatient rehabilitation facility (CORF) that fall within the definition of CORF services
	Services provided by a hospice within the scope of the hospice benefit
	Services furnished by home health agencies within the scope of the home health benefit
	Services not covered by the Medicare law
	Services not reasonable or necessary for the diagnosis and treatment of an illness or disease

(Table 1 continued on following page)

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Payment	As indicated, APC rates, with billing according to HCPCS codes
	Payment amounts determined by multiplying a conversion factor ($48.487 in 2000, based on 1996 data and updated for inflation) and relative weighting factors for each APC and HCPCS code
	Payments adjusted by the hospital PPS area wage index to reflect local labor differences
	Discounting of surgical procedures (if more than one surgical procedure is performed during a single surgical encounter)
	Special APC groups to accommodate payment for new technology services
	Additional payments (pass-throughs) for a period of at least two but not more than three years for innovative medical devices, drugs, and biologicals (a BBRA provision)
Beneficiary Co-Payment	At the start, 20 percent of the national median of charges billed in 1996 and trended to 1999
	Intended over time to equal 20 percent of the prospectively determined APC payment rate (not to exceed the hospital inpatient deductible)
Hospital Election to Offer Reduced Co-Payment	Code-specific option for hospital to reduce the beneficiary coinsurance amount (except for a screening sigmoidoscopy, screening colonoscopy, or screening barium enema), subject to DHHS approval by June 1, 2000, and, after that, by December 1 preceding the calendar year
Outlier Payment	Budget-neutral payment adjustments of 75 percent of the excess costs for cases falling outside the norms—when calculated bill costs exceed PPS payments on a claim by more than 2.5 times—not to exceed 2.5 percent before 2004 and 3.0 percent for 2004 and later (a BBRA provision)
Transitional Payments	Through 2003, a non-budget-neutral payment adjustment (based on the difference between the hospital's PPS amount and its pre-BBA amount) for an individual hospital, according to a schedule
Special Provisions	Exemption for rural hospitals with fewer than 100 beds through 2003 (a BBRA provision)
	Permanent hold-harmless clause for 10 cancer centers that are excluded from the inpatient PPS (a BBRA provision)
Determination of "Provided-Based Status"	New requirements as to whether a facility or organization has such status
Annual Update	Annual review and revision of the APCs, payment weights, and wage and other adjustments to take into account changes in medical practice, technology, and the addition of new services, cost data, and other relevant information

significant emergency room and clinic volume, points to the need for the hospitals it represents to "develop protocols to determine how visits will be assigned to particular codes" and explain them "thoroughly to personnel who will be assigning the CPT code to the visit."

The AAMC also stresses that it "is important for hospitals to code clinic and emergency room visits accurately."[5] With undercoding sure to result in underpayment, and with upcoding—at a time of heightened anti-fraud and -abuse activity by the DHHS inspector general and the Department of Justice—likely to lead to legal action, there obviously is a lot at stake. In its analysis, the association points out that accuracy is essential to future modification, if necessary, of the payment amounts calculated by HCFA, because "HCFA's 1996 database reflects claims from about 1,800 hospitals that coded all of the clinic visits (regardless of acuity) using only the lowest level code, 99201."[6]

Getting up to speed in coding, billing, service, and financial operations implies orienting practitioners, training personnel, coordinating data systems, and conducting myriad other tasks. In recognition of this, numerous consultants have stepped forward to offer their services to hospitals preparing for the OPD PPS. HCFA has also scheduled training sessions and provided various materials on its Web site, www.hcfa.gov. Various companies are offering hospital billing system grouper and pricing modules to help hospitals assign codes and calculate payments.

The switch to APCs for hospital outpatient services by Medicare is expected to affect the commercial insurance and health plan sector, according to a Bureau of National Affairs analysis. "Although APCs started with Medicare, they appear to be garnering the interest of major health plans across the country." Examples cited include Blue Cross and Blue Shield plans, Wellpoint Health Networks, Health Partners, and Kaiser Permanente. According to consultants with DeMarco and Associates, APCs are being used to fine-tune reimbursement for internal and external contracting because the groupings "offer a standardized federal definition of the service, allow for individual service area distinctions using localized unitization inputs, and [have] a payment conversion factor to arrive at alternative payments." Claimed advantages include "the bundling of services to receive packaged payment on a prospective basis," reduction of administrative burdens, and restraint of the rising costs of outpatient services.[7]

PPS Strategy

"It is necessary to focus on PPS rather than cost-based strategies," Goldberg indicates in his analysis of the regulation for Deloitte & Touche clients. "The outpatient PPS has aligned Medicare outpatient payment objectives with inpatient payment. The BBA and BBRA eliminate most, if not all, cost-based reimbursement approaches." While he points out that "hospital payment is fee-schedule driven and will require a major refocus of payment objectives," he says there is one cost-based element remaining. "This is the three-year transition payment corridor, which is based, in part, on a hospital's payment-to-cost ratio. Hospitals should not use this tool to ignore the real issue of being paid under PPS."[8]

"It's a really fundamental shift from a cost-based reimbursement methodology to one that's driven by coding," KPMG health care consultant Rajan Patel told *Modern Healthcare*.[9] It offers providers the means to track their costs and manage the outpatient services they offer, says Kim Sheets, an expert on ambulatory patient groups (APGs) at 3M, which developed APGs, the forerunners of APCs.[10]

Redistribution of Payments

From the onset, Medicare PPS was touted as a competitive system, meant to lower the rate of increase in health care costs by encouraging providers to offer the highest quality services at the lowest cost. Each PPS regulation has meant winners and losers, and OPD PPS is no exception (see Table 2).

Table 2
Projected Increase in Medicare Outpatient Payments, Effective July 1

Hospital Type	Increase (in percent)
All hospitals	4.6
Psychiatric hospitals	27.9
Eye and ear specialty hospitals	20.2
Rural hospitals with 200 or more beds	6.1
Urban hospitals with 100-199 beds	5.2
Nonteaching hospitals	5.0
Rural hospitals under 50 beds	3.3
Urban hospitals with 500 or more beds	2.8
Major teaching hospitals	2.6

Source: Health Care Financing Administration, DHHS

Various factors figure into how different types of hospitals, as well as individual hospitals, will fare under the new system. For instance, hospitals with high outpatient volume, such as those in rural areas, where outpatient revenue tends to account for a greater proportion of overall revenue, may do better. (Small rural hospitals are temporarily exempt from the new system.) Designated cancer hospitals that are held harmless under the new system are expected to do well. So are hospitals using high volumes of new drugs and technologies that will remain cost-based. On the other hand, major teaching hospitals, which will not receive the payment adjustment for medical education costs they desired under the OPD PPS, are likely to be worse off than nonteaching and specialty hospitals. The predictability of payments under the OPD PPS has been a major concern of hospitals, despite various projections of how they will do.

One point that gets scant mention is the practice of some providers, since the inception of inpatient PPS, to assign more overhead costs to the cost-based outpatient side. Now that outpatient costs will be subject to predetermined rates, providers that engaged in that practice may experience greater upheaval in their cost ledgers. Not only cost allocation but also service mix—for instance, among surgical, medical, and ancillary services—will be crucial when the APCs are implemented. Another point is the definition of "provider-based entity," which is a response from HCFA to post-PPS incentives for providers to affiliate (for instance, to gain control of physician offices) in order to game the PPS system.

Beneficiary Co-Payments

While some hospitals are seeking a delay in the July 1 implementation date, groups such as the American Association of Retired Persons want HCFA to move full speed ahead because of the regulation's beneficiary co-payment provisions. The BBA not only required HCFA to replace its cost-based system for outpatient services with the PPS but also "changed the way beneficiary coinsurance is determined for services under the PPS. Generally, under the new PPS, coinsurance amounts will be based on 20 percent of the national median charge billed by hospitals for the service."[11] The coinsurance for each APC will be frozen at 20 percent of the 1999 median charge until it is 20 percent of the APC rate. A hospital may discount the beneficiary coinsurance, but not beyond 20 percent, and the discount must apply to all procedures within a given APC. So any delay in implementation would delay the freeze in beneficiary co-payments, as well as the discounting of such co-payments by hospitals that choose to do so to compete for Medicare patients.

THE FORUM SESSION

This Forum session will look at the OPD PPS as part of the federal government's overall PPS strategy and as a contrast to the handling of outpatient services under cost-based reimbursement. It also will consider the OPD PPS relative to both the BBA and BBRA and the positions of providers, consumers, and payers on the provisions of the final regulation. It will raise the following questions:

- With the inclusion of Medicare outpatient services in PPS, is the prospective system fulfilling its original goals?
- What Medicare services remain outside PPS and why?
- Is the fact that various Medicare services are subject to different base years a potential problem? (For example, payment for outpatient services will be based on 1996 cost data when they go into effect July 1.)
- What are the incentives of the OPD PPS for efficient care? Cost-effective services? Volume management?
- What impact will the OPD PPS have on providers? What behavioral changes, if any, are expected?
- What are the complaints of providers and interest groups? How valid are they?
- How will the beneficiary co-payment provisions work? From a policy perspective, what are the ramifications of provider discounting of beneficiary coinsurance?
- Since codes determine payment, what will adoption of the APCs mean for HCPCS? For the AMA, which operates the CPT coding system? For insurers and health plans in the private sector?

This Forum session will be a briefing on the OPD PPS, both as an expansion of the federal government's strategy to move from cost-based to prospective pricing and as a payment system in itself for a defined set of services. The session will also take into account the differences between the October 1998 proposal and the final regulation and the implications for various providers of outpatient services. During the discussion period following the briefing, there will be dialogue on the

potential effects of the OPD PPS relative to other provisions in the BBA and the role the OPD PPS played in campaigns to ameliorate the BBA that led to enactment of the BBRA.

Steven H. Sheingold, Ph.D., director of HCFA's Division of Program Analysis and Performance Measurement, Center for Health Plans and Providers, will open the session with a review of the OPD PPS's salient provisions and HCFA's expectations of its impact upon hospitals. He also will place it in context relative to other types of Medicare services covered under PPS. Previously, he was director of HCFA's Technology and Special Analysis Staff, responsible for technology assessment information, analysis, and payment and coverage policy development. Before he joined HCFA, he was a research scientist for Battelle's Human Affairs Research Centers and a principal analyst for the Congressional Budget Office.

Hal Cohen, Ph.D., will examine the challenges to providers that the regulation poses and other issues that implementation of the OPD PPS raises. President of Hal Cohen, Inc., a health care consulting firm, he has experience with ambulatory groups in Maryland and with PPS issues there and throughout the country. He was a member of Maryland's Health Care Access and Cost Commission from 1972 to 1987. During the 1980s, he served on the Prospective Payment Assessment Commission (an organization since merged into the Medicare Payment Advisory Commission) and chaired the panel's Subcommittee on Hospital Productivity and Cost Effectiveness. He also has been a member of both the National Advisory Committee on Rural Health and the National Committee on Vital and Health Statistics.

ENDNOTES

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5. Association of American Medical Colleges (AAMC), "AAMC Summary and Analysis—Medicare Prospective Payment System for Hospital Outpatient Services: Interim Final Rule" (65 Fed. Reg. 18434 [April 7, 2000]), 6-7, handout at April 10 meeting of the association on the OPD PPS.

6. AAMC, "Summary and Analysis," 7.

7. Arnesa Howell, "Larger Health Plans Expected to Be First in Adopting APCs for Commercial Members," *BNA's Medicare Report*, 11, no. 16 (April 21, 2000): 397–98.

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