APPENDIX A

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In Chapter 2, we discuss the design and impact of the new payment system for outpatient departments (OPDs), which begins July 1, 2000. Like most prospective payment systems (PPSs), the outpatient PPS classifies covered services and determines payment. This appendix reviews the components of these functions.

Classifying covered services

The outpatient PPS covers a specified scope of services, determines a unit of payment for those services, and institutes a classification system by which to group them. Defining the scope of services determines the services paid for under the outpatient PPS. Defining the unit of payment allows the Health Care Financing Administration (HCFA) to determine which services will be paid for separately and which will be included in a "bundled" payment. Finally, a classification scheme allows HCFA to categorize services that are similar clinically and with respect to resource use.

Included services

The Balanced Budget Act of 1997 (BBA) gave the Secretary discretion to determine the services included in the PPS. However, HCFA was not permitted to include services already paid under separate fee schedules.[1] The PPS includes outpatient services such as surgical procedures, certain preventive services, diagnostic tests, clinic and emergency department visits, chemotherapy services for cancer patients, and radiology services. The Secretary was also required to include partial hospitalization services provided by community mental health centers, as well as psychiatric services provided in an OPD. HCFA has expanded the number and type of services covered by the outpatient PPS to include a number of services traditionally provided in the inpatient setting. Future migration of services from the inpatient to the outpatient setting will be evaluated by HCFA in consultation with professional organizations and an external advisory panel.

Unit of payment

Medicare pays for outpatient services based on the individual service or procedure provided, as identified by a HCFA Common Procedure Coding System (HCPCS) code. The payment to hospitals covers institutional or facility costs; physician and other professional costs are paid separately. HCFA bundles integral services and items into the costs of the primary service.[2] For example, bundled services include operating and recovery room charges, most pharmaceuticals, anesthesia, and surgical and medical supplies.

In deciding which services to bundle and which to pay separately, HCFA made efforts to consider comments from various interests. In response to these comments—specifically regarding cost variation concerns—HCFA unbundled certain items. For example, HCFA separated corneal tissue acquisition, maintenance, and distribution from services requiring corneal tissue use. Similarly, HCFA separated payments

[1] Ambulance services and physical, occupational, and speech therapies are paid under separate fee schedules. Chronic renal dialysis is paid under the composite rate for end-stage renal disease beneficiaries. Clinical diagnostic laboratory services and nonimplantable durable medical equipment (DME), prosthetics, orthotics, and supplies are paid under their respective fee schedules. Implantable prosthetics, implantable DME, and implantable items used during certain diagnostic procedures are no longer covered under a separate fee schedule but under the OPD PPS.

[2] Bundled services usually can be thought of as those services that a patient would not enter an OPD just to obtain; for example, one would not go to an OPD just to receive anesthesia. HCFA uses the term "packaged" to describe the set of inputs covered by the payment for a service; MedPAC uses the term "bundled."

under the PPS for casts and splints. Additionally, in response to the Balanced Budget Refinement Act of 1999 (BBRA), HCFA also unbundled blood, blood products, and plasma-based and recombinant therapies.

Unlike all other services included in the outpatient PPS—for which the unit of payment is the service or procedure provided—partial hospitalization services for psychiatric services will be paid on a per diem basis. These intensive outpatient psychiatric services may be provided by an OPD or by a community mental health center, and the per diem payment rate represents facility costs associated in providing a day of care.[3]

Classification system

To group services for payment, the Secretary developed the Ambulatory Payment Classification (APC) system, which includes 451 groups. The APC groups classify the full range of ambulatory services—including procedures represented by more than 5,000 HCPCS codes—based on similarity of resource use, clinical similarities, the number of providers who make the services available, and the volume of services. Additionally, the agency strived to minimize opportunities for upcoding (coding for a service that may be clinically similar but which has higher payment than the service actually provided) by grouping clinically similar services in the same APC group.

The BBRA limited the variation of service costs within an APC group to a factor of two. To accommodate this requirement, the Secretary recalibrated the APC system, increasing the number of APC groups, combining certain groups, and dividing others.[4]

HCFA also created "new technology" APCs. HCFA will classify new technology services that do not qualify for transitional pass-through payments (special payments provided for certain new technologies by the BBRA) into these groups. These groups are similar in terms of costs or resource use but, unlike other APCs, do not necessarily represent clinically similar services. The payment rate for all the services or items within a particular group will be the midpoint of that group. To qualify for classification within a new technology APC, the services must be covered by Medicare, be underrepresented in the 1996 data used to set payment rates, have a HCPCS code, and be deemed a reasonable and necessary service for treating an illness or improving an impaired function. HCFA will group qualifying new technologies or services within new technology APC groups for at least two but no more than three years, before assigning these services to existing or new groups. This mechanism should allow HCFA to pay for new technologies shortly after they arrive on the market and qualify for Medicare outpatient payments. It will also allow HCFA to collect clinical and cost data and further refine, expand, and update the APC classification system.

Determining payment

The outpatient PPS establishes mechanisms to determine payments to hospitals, rate adjustments, beneficiary copayments, and periodic updates. Each of these components allows HCFA to reimburse facilities for outpatient services while maintaining a predictable level of payment for the Medicare program, hospitals, and beneficiaries. Adjustment and update mechanisms are intended to allow the PPS to adjust for regional, facility-level, service-specific, and inflationary costs.

Payment rates

HCFA pays the same rate for all services in an APC group. The prospective payment rate for each APC group is the product of the relative weight for each APC group and the conversion factor, a constant that converts the relative weight into a payment rate. To determine individual payment rates, relative weights must be established.

Relative weighting is intended to capture variation in cost among APC groups. To calculate relative weights for each APC group, HCFA first determined the costs for each outpatient service. The agency aggregated the costs of inputs to be bundled with the payment for the primary procedure or medical visit. By adjusting 60 percent of the resulting unit cost by the hospital wage adjustment factor, HCFA accounted for local input prices. Each procedure, taken from 1996 claims data, was matched to the corresponding APC group. The median cost for each APC group was weighted by the volume of services in each group. To arrive at the relative weight, the median cost for each group was divided by the median cost for a mid-level clinical visit (APC 0601, with a weight of 1.0).

To calculate the conversion factor, total payments to hospitals are divided by the sum (over all APC groups) of the volume of services multiplied by the relative weight for each APC group. The conversion factor was adjusted to account for budget-neutral provisions of the BBRA, making it $48.49 in 2000.

As stipulated by law, HCFA calculated the total payment to equal program payments plus beneficiary copayments actually charged in 1996, minus the formula-driven overpayments (payments resulting from anomalies in the payment calculation methods for certain surgical, radiological, and diagnostic services).

[3] Payments for clinical social workers, occupational therapists, and support staff whose services are considered to be partial hospitalization services are also included in the per diem rate.

[4] HCFA was permitted to make exceptions to this provision if deemed appropriate. Exceptions were made for certain categories of services, such as the simpler levels of casting, splinting, or strapping; ventilation initiation and management; and non-coronary angioplasty. These groups were considered exceptions because they contained low-volume procedures or suspect or incomplete cost data, or presented concerns about inaccurate coding or clinical considerations.

Rate adjustments

Payment rates under the outpatient PPS will be adjusted for local wage differentials and outliers. Cancer hospitals and rural hospitals with up to 100 beds are held harmless from financial losses under the outpatient PPS. In addition, adjustments called transitional pass-through payments will be made for new and innovative technology services.

To adjust for local wage differentials, the agency applied the fiscal year 2000 inpatient PPS wage index to 60 percent of the national median for each APC group. HCFA will annually update this adjustment with the updates of the inpatient PPS wage index.

Outlier adjustments in the outpatient setting are made for those services or procedures with extraordinarily high costs, compared with the payment rates for the same APC group. Outliers are defined as those that exceed the PPS payment rate by a factor of 2.5. Hospitals will be reimbursed 75 percent of the differential. Total funds for outlier payments are limited to 2.5 percent of total program payments for all covered services through 2003, and 3 percent thereafter.

The BBRA mandated that cancer hospitals and outpatient departments of small rural hospitals (less than 100 beds) be held harmless from financial losses under the PPS.[5] These hospitals will be paid according to the PPS payment rates, but will be retrospectively reimbursed based on costs if PPS payments are below what they would have been under previous payment policies. Additionally, they will also receive interim payments on a quarterly basis. Cancer hospitals will be permanently held harmless; small rural hospitals are held harmless through 2003. HCFA intends to analyze the costs and payment differentials among classes of hospitals to propose and determine potential payment adjustments.

Transitional pass-through payments

New and innovative medical services, drugs, and biologicals will receive additional pass-through payments for at least two but no more than three years, as mandated by the BBRA. These payments will be made to account for technological advances. Total payments under this provision are limited to 2.5 percent of total program payments through 2003, and 2 percent thereafter. If these limits are exceeded, all pass-through payments will be reduced. Total payments must remain budget neutral. The BBRA specified the items and services that qualify for additional pass-through payments:

- current drugs, biologicals, and brachytherapy[6] used in cancer therapy,
- current orphan drugs,[7]
- current radiopharmaceutical drugs and biological products used in diagnostic, monitoring, and therapeutic nuclear medicine procedures, and
- new medical devices,[8] drugs, and biologicals[9] first paid as outpatient services after 1996.

"Current" technologies are those that will be paid for as of July 1, 2000, with the implementation of the OPD PPS.

In order to define which items qualify for transitional pass-through payments, HCFA determined that cost must be "not insignificant" in relation to the portion of the APC payment rate associated with the technology. This cost criterion was established to ensure that reimbursement is provided for only those new technologies that are substantially more expensive than the existing payment rate—so expensive that hospitals face incentives to make these services unavailable to beneficiaries. Additionally, HCFA sought to ensure that the administrative costs of making additional payments would not be greater than the applicable fee schedule amount. For example, the cost of the technology must exceed 25 percent of the relevant APC payment rate.

As required by the BBRA, pass-through payments for each drug, biological, and radiopharmaceutical will be based on the difference between 95 percent of its average wholesale price and its payment rate under the PPS as determined by the Secretary. To the extent possible, HCFA will use OPD claims data to determine the payment rates under the PPS.

Pass-through payments for qualifying devices are based on the difference between the hospitals' charges (adjusted to costs, using each hospital's cost-to-charge ratio) and the portion of the payment rates under the OPD PPS associated with the device, as determined by the Secretary.

Beneficiary copayments

The BBA changed the way in which beneficiary copayments would be calculated. The law enacted a buy-down

[5] Other hospitals do not come under the OPD PPS, including certain Maryland hospitals (covered under the state's payment system) and critical access hospitals (paid under a reasonable cost-based system required by the BBA).

[6] Brachytherapy is radiotherapy in which the radiation source is placed within the body.

[7] Orphan drugs are products used to treat diseases that affect fewer than 200,000 people in the United States.

[8] The following types of medical devices do not qualify for transitional pass-through payements: equipment, instruments, implements, and items used for diagnostic or therapeutic purposes; devices that are not implanted; and those items used on more than one patient. Because these materials are included within capital expenses, HCFA maintains they are reflected in the APC payments.

[9] Biologicals include items such as blood products, hormones, and antibodies.

method that froze the copayment rate at 20 percent of the national median of charges until annual updates bring the payment rate to a level at which the copayment amount equals 20 percent of the payment rate. The BBRA limited beneficiary copayments to an amount equal to the inpatient hospital deductible, which is $776 for calendar year 2000. MedPAC's analysis of the copayment amounts by APC group indicates that when the outpatient PPS is first implemented, beneficiary coinsurance will represent, on average, 47 percent of the payment rate for a service. According to MedPAC estimates (see Chapter 2), reducing the coinsurance to 20 percent is projected to take an average of 45 years, assuming an annual update of 1.9 percent.

Payment updates and volume control methods

HCFA will update payment rates annually using the hospital market basket index minus 1 percent for each year through 2002. Update methods beyond 2002 have not been determined.

The BBA mandated the Secretary to examine and institute a mechanism to curtail unnecessary growth in the use of outpatient services, if such a mechanism was deemed appropriate. However, HCFA has decided to postpone its decision on this topic and to delay implementing a volume control mechanism. The Secretary will continue to study the issue and publish a proposal seeking public comment before making a final decision. ■