August, 2002

AAMC Summary and Analysis

CALENDAR YEAR 2003 MEDICARE OUTPATIENT PPS PROPOSED RULE: PROVISIONS OF INTEREST TO AAMC MEMBERS

On August 9, 2002, the Centers for Medicare and Medicaid Services (CMS) published its calendar year 2003 proposed rule for the Medicare hospital outpatient prospective payment system (outpatient PPS or OPPS). See *Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports.* 67 Fed. Reg. 52092. The proposed rule can be obtained by accessing the AAMC's issue brief on this topic at: http://www.aamc.org/advocacy/library/teachhosp/hosp0046.htm.

Among other items, the proposed rule contains the level of the payment increase (known as the "update factor") for OPPS base payment rates, as well as changes and discussions related to: ambulatory payment classification (APC) groups and relative weights, transitional payments for new drugs and devices, and outlier payment policies.

Comments on the proposed rule are due **October 7, 2002**.[1] If you choose to submit comments, send the original and three copies to:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1206-P
P.O. Box 8018
Baltimore, MD 21244-8018

A number of outpatient data tables are available on the CMS web site at: http://cms.hhs.gov/regulations/hopps/propcy2003.asp

In addition, attached to this memorandum is a table that contains the proposed 2003 APC rates compared to the corresponding final 2002 and 2001 rates.

I. GENERAL BACKGROUND

On August 1, 2000, Medicare implemented a prospective payment system for hospital outpatient services. The outpatient PPS does not affect Medicare physician payments.

The major categories of services subject to the OPPS are:

- clinic visits,
- emergency room visits,

[1] Note this date is different than what was published in the August 9 Federal Register. The date was changed in an August 16, 2002 Federal Register correction notice.

- diagnostic services,
- surgical procedures,
- radiology services, and
- cancer chemotherapy.

In general, the outpatient services excluded from the OPPS are those that already are subject to an existing fee schedule or payment system, for example laboratory services.

Payments under the OPPS are for individual services (as identified by HCFA's Common Procedural Coding System (HCPCS) or Physicians' Current Procedural Terminology (CPT)). Ambulatory Payment Classification (APC) groups are the foundation of the OPPS. In general, hospital outpatient services (as identified by HCPCS/CPT codes) are grouped together according to their similarity in terms of resource costs and clinical indications. In some cases there may be only several services under a given APC while in others there may be 50 or more. Each service within a given APC is paid the same base amount. This amount is adjusted by the FY 2003 inpatient PPS hospital wage index to reflect differences in costs across geographic areas.

II. OPPS CONVERSION FACTOR UPDATE (page 52130)

The proposed rule implements the current law requirement that the base payment rate under the OPPS (known as the "conversion factor") be increased to reflect the full increase in the hospital inpatient market basket, as published in the FY 2003 inpatient PPS final rule. This increase is 3.5 percent.

Analysis—It is beneficial that the payment update will reflect the full market basket increase, as compared to last year when it was reduced by one percentage point. Note, however, that the actual increase to the 2002 conversion factor will only be approximately two percent, from $50.904 to $52.009. This is because budget neutrality factors are applied to the conversion factor to account for wage index changes, and payments for outlier services and new technologies.

III. PROPOSED CY 2003 APC PAYMENT RATES (pages 52093--095, and 52108--114)

Background

An APC payment for a particular outpatient service results from multiplying the APC conversion factor by the relevant APC's payment "weight." This amount is then multiplied by the relevant geographic wage index value.

The APC weight represents the median costs of the services included in that APC relative to the median cost amount of the services included in APC 601, mid-level clinic visits. CMS is required to review the APC weights at least annually.

Proposed Rule

The proposed 2003 APC rates are based on claims data from CY 2001 and hospital-specific department level cost-to-charge ratios (CCRs).[2] According to the proposed rule, many of the 2003 payment rates vary significantly from the 2002 rates, particularly for APCs that include medical devices and drugs. A number of the increases and decreases are more than 20 percent. CMS cites several possible reasons for the payment rate volatility:

- This is the first year that OPPS claims data are used to set payment rates; previous years' rates were based on claims data for periods prior to the implementation of the OPPS;

- More claims data were used to calculate the rates. Up until now, only "single procedure" claims were used to set the rates. CMS has developed a methodology that allowed them to convert 10.7 million multiple procedure claims into single-procedure claims (pages 52108-111). CMS is seeking comments on its methodology for incorporating these additional claims;

- The incorporation of device costs into APC rates for those devices that are no longer eligible for transitional pass-through payments (see below); and

- Changes in APC assignments for a number of outpatient services.

Analysis- The AAMC is concerned about the drastic payment rate changes in the proposed rule. Attached to this memorandum is a spreadsheet that contains 2001, 2002 and proposed 2003 APC rates. Teaching hospitals should review this spreadsheet carefully, particularly for your high volume and/or high cost outpatient services. Compare your costs for these services to the corresponding APC payment rate. While, for a number of reasons, the payment rate is not designed to match providers' costs for services, if the payment rate is significantly lower than what you believe reasonable costs are for the service, this information needs to be conveyed to CMS.

Given that the APC rates are based on 2001 claims data and hospitals' department-level CCRs, it is important to convey to CMS what discrepancies may arise between hospitals' actual costs and the costs derived from CMS' methodology. Another source of discrepancy may relate to the selection of services that are grouped under an APC. The more specific you can be regarding reasons for payment versus costs discrepancies, the more likely the issue will be closely examined by CMS.

Hospitals should also share this information with the AAMC.

[2] Procedure charges from claims data are converted to costs using the CCRs.

IV. TRANSITIONAL PASS-THROUGH PAYMENTS (52117--130)

Background

The OPPS provides that hospitals may receive "pass through" payments for a period of two to three years for specific items. These include:

- Orphan drugs;
- Current drugs, biologic agents, and brachytherapy devices used in cancer treatment;
- Current radiopharmaceutical drugs and biological products; and
- Those new medical devices, drugs, and biologic agents that were not paid as outpatient services as of December 31, 1996 and where the cost of the item is "not insignificant" in relation to the corresponding APC amount.

As mandated by law, in April 2001, CMS established "categories" to determine whether a specific device qualifies for transitional payments (the category designation does not apply to drugs and biologicals). If a category qualifies for pass-through status, then all devices that fall within that category receive transitional payments; individual devices cannot independently be qualified for these payments.

Transitional pass-through payments are available for only for a limited period of time, between two and three years. After that period, the device/drug/biological and its associated costs are "packaged into" a current APC or a new APC is created. The two-to-three year time frame was established because it generally takes CMS this amount of time to collect the claims data and allow Agency staff to analyze the device/drug/biological costs and incorporate those costs into the APC rate calculations.

For drugs and biologicals, the pass-through amount is equal to the difference between 95 percent of the item's average wholesale price (AWP) and the portion of the APC amount determined by CMS to be associated with the item. For devices, the additional payment is the difference between a hospital's charges adjusted to costs and the portion of the applicable APC amount associated with the device. Both of these payment types, however, are contingent on the total monies available for these payments.

Pursuant to current law, the total amount of additional payments available for pass-through payments cannot exceed 2.5 percent of total outpatient payments through 2003; for 2004 and beyond the payments cannot exceed more than 2 percent of total payments. These amounts are funded through a reduction in the conversion factor for all outpatient services. If the amount of pass-through payments exceeds the authorized level (for example, 2.5 percent in 2003) CMS has the authority to make a prospective uniform pro rata reduction to the pass-through payments to ensure that the level is not exceeded.

Proposed Rule

A. Changes to the Transitional Pass-Through List and APC Rate Packaging (pages 52120--130)

CMS proposes to remove transitional pass-through status for 95 device categories (see Table 7, page 52120, for a list of these categories), effective January 1, 2003. Five categories would remain in pass-through status: two existing categories, and three new categories. In addition, a number of drugs/biologicals also will be removed from the pass-through list. (Table X on page 52119 contains the list of device categories, drugs/biologics that comprise the pass-through list.)

For those devices/drugs that are no longer on the pass-through list, their costs will be "packaged" into the costs of the outpatient procedures that use those items. Given that APC rates are based on the procedure costs, the packaging should mean that the APC rates for these procedures will increase (recognizing that there will no longer be a separate pass-through payment associated with the device/drug).

CMS also has proposed to establish separate APCs for certain drugs and biologicals, rather than packaging these items with their associated outpatient procedure. These items include: orphan drugs (that are used solely for orphan conditions) blood and blood products, certain vaccines, and drugs with treatment costs that exceed $150. (Table 8 on page 52125 contains a list of drugs and biologicals that CMS proposes to pay for separately in 2003.)

CMS proposes to package the costs of brachytherapy seeds with their associated procedure when they are used in "remote afterloading high intensity brachytherapy" and prostate brachytherapy. Other uses of the seed will be paid for separately, on a per seed basis, at least through 2003.

Analysis—The packaging of the costs of devices contained in the 95 expired pass-through categories into their associated APC rates is being cited as one reason for the volatility with the proposed 2003 APC payment rates. For example, last year CMS folded into the APC rates 75 percent of device costs (with the remainder being paid as a pass-through). Since CMS had no relevant claims data last year, the Agency determined the cost amounts based on data from device manufacturers. Because relevant claims data were available to CMS this year, the Agency calculated the device costs based on the charge for the device on the claim and individual hospitals' department-level CCRs. CMS stated that this latter methodology results in device costs that often are lower than the manufacturer-provided cost amounts, which can result in lower APC rates in 2003 compared to 2002. Drug cost incorporation faced a similar situation. While drug pass-through payments were based on 95 percent of the average wholesale price (AWP), the cost amounts incorporated into the APC rates were often lower because of the methodology used to convert the drug charges contained on outpatient claims to costs using hospitals' CCRs.

Teaching hospitals should review their outpatient data that contain current pass-through devices and assess the impact of packaging these costs into the 2003 APC rates. Hospitals also should review their systems to make sure that when devices are being used, they are correctly coded. Proper coding is critical to ensuring that future APC rates are as accurate as possible.

B. Pro Rata Reduction (pages 52117--118)

CMS estimates that 2.5 percent of total OPPS spending in 2003 translates into approximately $457 million (page 52118). Thus, CMS will apply a pro rata reduction to the pass through payments if the Agency estimates that transitional pass-through payments will exceed $457 million in 2003.

CMS has not yet made an estimate for 2003 pass-through spending. The proposed rule states that the Agency is still examining the device/drug/biologicals data. In addition, there may be new drugs and/or device categories that receive pass-through status for 2003 that were not reflected in the proposed rule but that will be factored into the 2003 payment estimate.

CMS' proposed methodology for estimating pass-through payments is contained on pages 52117-18 of the proposed rule. CMS is seeking comments on its methodology.

CMS' decision regarding a possible pro rata reduction for transitional pass-through payments will be announced in the final rule.

Analysis--While CMS did not provide an estimate of transitional pass-through payments in the proposed rule, a spreadsheet on the outpatient PPS web site sheds some light on this figure. According to the spreadsheet, 2003 pass-through payment estimates are still "to be determined" for a number of pass-through items. But for those items in which an estimate is provided, total 2003 pass through payments will be approximately $450 million. Given that this estimate is only slightly below the $457 million threshold that would trigger a pro rata reduction, and that additional payments will be added to the estimate, as of now, it appears likely that CMS will impose some level of a pro rata reduction for 2003. In addition, in a telephone call with representatives from hospital associations, CMS Administrator Scully predicted some level of pro rata reduction will be applied to transitional pass through payments in 2003.

The AAMC will be following this issue closely to ensure that any pro rata reduction is fair and based on sound data assumptions.

C. Multiple Procedure Discount and Device Payments (page 52140--141)

Under the OPPS, when two or more surgical procedures are performed together, the highest paying procedure is paid 100 percent of its APC rate, and the additional procedures are paid 50 percent of their corresponding APC rates.

Under current policy, when a device is involved in the additional procedure(s), the methodology is modified such that the payment rate discount is actually less than 50 percent. This modification was in recognition that there are no savings associated with the device costs when multiple devices are used during a multiple-procedure operative session.

In the proposed rule, CMS decided to "revisit" the policy regarding payment discounting when devices are involved. The result is a proposal that applies the 50 percent reduction uniformly when multiple procedures are performed regardless of whether multiple devices are involved.

Analysis—Implementing this proposal would result in less payments when multiple procedures are performed that involve devices. CMS' rationale for its position reversal seems convoluted and unconvincing (see discussion at page 52140). Pending further discussion and analysis, it appears that reason dictates that the proposal be rescinded and current policy retained.

V. CHANGES TO OPPS OUTLIER POLICIES (page 52130)

Background

As with the inpatient PPS, the OPPS makes additional payments for outpatient services that are extremely costly ("outliers"). CMS targeted these payments to be 2.0 percent of total outpatient payments, financed by a corresponding reduction in the APC conversion factor. From the initial date of the system (August 1, 2000) through December 31, 2001, the determination of whether outlier payments would be made was based on the costs of all of the services contained on an outpatient claim. If those costs were 2.5 times more than the sum of the corresponding APC payments plus any transitional pass-through payments, the hospital would receive an outlier payment equal to 75 percent of the costs that exceed the 2.5 times threshold.

Effective January 1, 2002, outlier eligibility is now determined at the individual OPPS service level, rather than claim, level. For 2002, the outlier threshold was changed and set equal to 3.5 times the corresponding APC payment (plus any pass-through amounts) and the payment percentage is 50 percent of the costs in excess of the threshold.

Proposed Rule

CMS proposes to lower the cost threshold for 2003 to equal 2.75 times, rather than 3.5 times, the applicable APC payments. The payment percentage would remain the same—50 percent.

Analysis—Table 11 in the proposed rule (page 52148) displays an estimate of the distribution of outlier payments for 2003. According to that table, while major teaching hospitals comprise only 6 percent of all hospitals, they will receive 32 percent of all

outlier payments. Consequently, outlier payments are an important source of reimbursement for the high cost outpatient services provided by teaching hospitals.

The proposed rule contains no information as to the amount of outlier payments that have been paid to date. Moreover, CMS provides no analytical basis for lowering the cost threshold, other than to say the decision was based on "simulations." Given that the threshold was lowered, it is not unreasonable to assume that CMS is concerned that 2002 outlier payments did not reach 2 percent of total OPPS payments. The AAMC has asked CMS to include more information on outlier payments in the final rule.

Total outlier payments are a function of both the cost threshold and the payment percentage. Consequently, it is important to assess whether the purpose of the outpatient PPS outlier policy is best served by having a lower cost threshold or an outlier payment rate that is greater than 50 percent. The AAMC would be interested in COTH member input on this issue.

VI. CHANGES AND ADDITIONS TO THE APC GROUPS

The proposed rule makes a number of changes to the APC groups, including creating several new HCPCS codes and APCs. Of particular importance to teaching hospitals, CMS proposes to create two new HCPCs codes and a new APC (APC 0656-Transcatheter Placement of Drug-Eluting Coronary Stents) that would be used for payment for drug-eluting stents if and when these items receive FDA approval.

Analysis—The AAMC is pleased that CMS is proposing a distinct APC for procedures involving drug-eluting stents. This will help ensure that these costly stents will receive more appropriate reimbursement.

To review the proposed changes, hospitals should review Tables 1-4 of the proposed rule (pages 52101-105).

VII. INPATIENT-ONLY PROCEDURES (pages 52114--115)

Background

Under the OPPS, there are certain procedures that are deemed "inpatient-only" for which hospitals will not receive an OPPS payment if they are performed in the hospital outpatient department. CMS updates the list periodically, in large part to remove procedures from the list that staff determine can now be safely performed on an outpatient basis. The inpatient-only list was updated most recently in the November 30, 2001 OPPS Final Rule.

Proposed Rule

Under the proposed rule, 41 procedures would be taken off the "inpatient-only" list and paid under the OPPS in 2003. CMS relied on recommendations from its APC Advisory

Panel to develop this list. The Agency also looked at physician outpatient claims and the list of procedures that are paid by Medicare when performed in ambulatory surgical centers. The list of procedures proposed to be taken off the "inpatient-only" list is published in Table 6 of the August 9 rule (page 52115). This table also contains the APC to which the service will be assigned for payment purposes

Analysis—AAMC teaching hospitals should review the list in Table 6, in particular to determine the appropriateness of the APCs to which CMS is assigning the previously "inpatient-only" services. Hospitals also should review the list of services that remain on the "inpatient-only" list (Addendum E) to determine whether any of these can safely be performed in an outpatient setting and, therefore, also should be payable under the OPPS.

The AAMC is troubled by the criteria that CMS is using to determine whether a service should be removed from the "inpatient-only" list. (page 52114). Two of these criteria require that the procedure is being performed in "most outpatient departments" or that "most outpatient departments" are equipped to provide the service. Major teaching hospital outpatient departments are likely the first places to perform services that heretofore have been performed in an inpatient setting. Thus, there likely will be a time gap between when these services are safely performed in teaching hospital outpatient departments and "most" hospitals' outpatient departments. The issue should be whether a procedure can be performed safely in an outpatient department, *not* the number of outpatient departments in which the procedure is occurring.

VIII. HOSPITAL CODING FOR EVALUATION AND MANAGEMENT SERVICES (pages 52131--135)

Background

Currently, hospitals code clinic and emergency room visits using the same CPT codes used by physicians for Medicare payments. Both CMS and hospitals have been concerned that these codes do not aptly describe the range and mix of services provided by hospitals to clinic and emergency patients because they are defined based on physician, not hospital, activity. Because no alternatives were available, CMS required hospitals to create their own internal set of guidelines to determine which code level the hospital would use to assign clinic and emergency room visits.

In a previous rulemakings CMS solicited comments on how to set national guidelines for hospitals to code clinic and emergency visits. The Agency's APC Advisory Panel reviewed these comments.

Proposed Rule

While CMS would still like to achieve national, uniform standards related to emergency room and clinic visit coding, the proposed rule states that the drawbacks of the guidelines that have been suggested to date outweigh the benefits. Thus, the Agency is pursuing an incremental approach, while continuing to examine uniform guidelines.

The proposed rule sets forth new codes for emergency room and clinic visits. In addition, the Agency provides additional requirements related to hospitals' internal guidelines for coding emergency room and clinic visits. While CMS expects to finalize these proposals in the CY 2003 final rule, the new codes and guidelines would not be effective until *January 1, 2004*.

A. Emergency Room Visits

CMS expects that the lowest level code would be used when basic emergency room services are provided, generally to patients who present with minor problems. For higher level codes, CMS continues to expect hospitals to have internal guidelines. However, the Agency believes hospitals' guidelines:

> must be tied to actual resource consumption in the emergency department such as number and type of staff interventions, staff time, clinical examples, or patient acuity. We also propose to require that facilities have documentation guidelines available for review upon request. The guidelines must emphasize relative resource consumption and must not, to the extent possible, set minimal requirements as a basis for determining the level of service (for example, require 30 minutes of staff time or five staff interventions to bill a Level 3 emergency visit.)
>
> (Proposed Rule, page 52134).

B. Clinic Visit Coding

CMS' requirements relating to coding clinic visits parallel the Agency's views regarding emergency room visits. The proposed rule states that for the higher level codes:

> [t]he guidelines must also differentiate the relative resource consumption in the clinic for each level of service sufficiently so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided to validate the level of service provided.
>
> (Proposed Rule, page 52134).

Analysis— While CMS is contemplating coding and guideline changes for 2004, it remains important that hospitals have guidelines in place for determining how they code clinic and emergency room visits currently. Hospitals should review CMS' specific coding proposals at pages 52133-34 and comment accordingly.

IX. MISCELLANEOUS ISSUES

A. Payment for Observation Services (pages 52135--136)

The proposed rule would make several coding changes relating to billing observation services under the outpatient PPS. The major issue relates to when a clinic or emergency room visit must be coded when a patient is admitted directly to observation.

Analysis—This has become a confusing and burdensome area. Hospitals should pay close attention to the rules regarding observation services to ensure that they are providing the necessary coding to receive reimbursement.

B. Performing an "Inpatient Only" procedure on an Emergency Basis

Hospitals have asked how they might get reimbursed when physicians must perform an "inpatient only" service in an outpatient setting because the patient needs stabilization or is in a life-threatening situation and the patient dies before being admitted as an inpatient or is transferred to another hospital.

The proposed rule states that in these situations, the patient's medical record must contain, among other items, an admitting order from the physician. The hospital would then receive a Medicare inpatient diagnosis-related group (DRG) payment or a per diem payment (if the patient is transferred).

Analysis—It is unclear whether obtaining a physician's admit order in these situations is possible or practicable. Hospitals should review CMS' position and comment if CMS' position seems unreasonable.

C. Wage Index

CY 2003 APC rates will be adjusted by the final FY 2003 hospital inpatient wage index.

D. Beneficiary Copayments

As mandated by current law, for CY 2003 the national unadjusted coinsurance for an APC cannot exceed 55 percent. (This level is the same as it was in 2002.)

X. SUMMARY

Outpatient departments and clinics are critical components of teaching hospitals. The 2003 Medicare outpatient proposed rule has a number of important changes that could have a significant impact on teaching hospitals' Medicare outpatient payments and decisionmaking.

If you have any questions regarding the proposed rule or this summary, or have concerns that you would like to discuss for possible inclusion in the Association's comment letter, please contact Karen Fisher at kfisher@aamc.org, or 202-862-6140.