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AAMC Summary and Analysis

Medicare Prospective Payment System for Hospital Outpatient Services: Interim Final Rule (65 Fed. Reg. 18434 (April 7, 2000))

OVERVIEW

On April 7, 2000 the Health Care Financing Administration (HCFA or the Agency) published an interim final rule that sets forth the requirements for the new prospective payment system (PPS) for the facility payment for hospital outpatient services. The outpatient PPS was mandated by the Balanced Budget Act of 1997 (BBA). The building blocks of the system are ambulatory payment classification (APC) groups, which will determine the hospital's payment amount for each outpatient service subject to the PPS.

The interim final rule reflects changes resulting from over 10,000 comments submitted in response to the proposed rule published September 8, 1998 (63 Fed. Reg. 47552) and the June 30, 1999 correction notice (64 Fed. Reg. 35258), as well as changes mandated by the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. Law 106--13). HCFA will accept comments on interim final rule provisions that were mandated by the BBRA and subsequently issue a final rule.

Additional information relating to the outpatient PPS can be found on HCFA's web site at <http://www.hcfa.gov/medicare/hopsmain.htm>. In addition, Medicare Program Memorandum A-00-23, entitled "*Hospital Outpatient Prospective Payment System (OPPS) Implementation Instructions*" (available on HCFA's web site) also contains detailed information relating to the new PPS.

INTERIM FINAL RULE CHANGES DUE TO THE BALANCED BUDGET REFINEMENT ACT OF 1999 (BBRA)

The BBRA required HCFA to include a number of changes to the PPS. These regulatory provisions are open to comment during a **60-day comment period that will close on June 6**. HCFA will not consider comments on provisions in the interim final rule that were raised in the September 8 proposed rule.

Medicare Outpatient PPS AAMC Summary and Analysis

The major provisions attributable to the BBRA are:

- Transition payments (referred to as “transitional corridor payments” in the interim final rule) that limit losses under the outpatient PPS through 2003;
- Transitional pass-through payments for additional costs of innovative medical devices, drugs, and biologicals;
- Availability of additional payments for high cost cases (“outlier adjustment”); and
- Limitation on the variation of costs of services classified within an APC group.

These provisions are discussed in more detail in subsequent sections of this memorandum.

FINANCIAL IMPACT OF THE OUTPATIENT PPS

In the interim final rule, HCFA presents its estimate of the aggregate financial impact of the outpatient PPS on hospitals (65 Fed. Reg. at 18531). These estimates are by aggregate hospital categories only; in the very near future, HCFA will publish provider-specific impact estimates on its web site at <http://www.hcfa.gov/medicare/hopsmain.htm>.

As expected, the projected impact of the PPS during the three-year transition period is significantly better than when the transition period expires. According to the interim final rule, Medicare outpatient payments to major teaching hospitals (those with 100 or more residents) in 2000 and 2001 will increase by an average annual rate of 2.6 percent compared to pre-PPS payments (see Table 1)¹. Without the transition payments, Medicare outpatient payments to major teaching hospitals would decrease 3.7 percent. With the transition payments, other teaching hospitals and non-teaching hospitals are expected to have average annual gains of 5.0 percent in 2000-2001.

Table 1: Average Annual Impact of Hospital Outpatient PPS in CYs 2000-2001

Hospital Group	Percent change in Medicare outpatient payments <u>excluding</u> transitional corridor payments	Percent change in Medicare outpatient payments <u>including</u> transitional corridor payments	Medicare outpatient payments as a percent of total Medicare payments
All	0.2 %	4.6%	9.9%
Major Teaching	-3.7	2.6	9.1
Other Teaching	1.6	5.0	9.1
Non-Teaching	0.5	5.0	11.3

Source: Outpatient PPS Interim Final Rule, 65 Fed. Reg. at 18534 (April 7, 2000)

¹ It is important to recognize that “pre-pps” payments reflect the payment methodologies in effect as of January 1, 2000 and prior to July 1, 2000. Most importantly, pre-pps payments incorporate previous payment reductions that resulted from a provision in the BBA that changed the methodology for calculating current outpatient payments (prior to PPS) (the so-called “formula-driven overpayment” change). Alone, this change, effective October 1, 1997, resulted in estimated average outpatient payment reductions of 10 percent across all hospitals. Consequently, the payment impact for Medicare outpatient services provided prior to October 1, 1997 and the PPS would be more negative than shown in the interim final rule.

Medicare Outpatient PPS AAMC Summary and Analysis

Analysis—The negative impact of the outpatient PPS on major teaching hospitals is significantly less under the interim final rule compared to the proposed rule. Under the proposed rule, major teaching hospitals were expected to lose 10.6 percent in outpatient payments, compared to 3.7 percent in the interim final rule (without transition payments). The two primary ameliorating factors were 1) a change in how Medicare beneficiary coinsurance payments were calculated (which added 5.7 percent in PPS payments across all hospitals), and 2) provisions in the BBRA, such as outlier payments and transition pass-through payments for certain drugs and devices.

There is still, however, a significant discrepancy in the impact of the system on major teaching hospitals versus other groups of hospitals. This result is especially disturbing when considered in light of HCFA's decision not to include a payment adjustment for teaching hospitals (see discussion under payment adjustments, below). Fortunately, the transition payments will cushion teaching hospitals' outpatient losses for the first three years of the system. However, the AAMC will be closely monitoring the system as it is implemented and performing additional analyses to assess the actual impact of the system on teaching hospitals. HCFA has stated that it will consider changes to the system (including a teaching hospital adjustment) if data under the new system demonstrate financial hardships on groups of hospitals.

DESIGN ELEMENTS OF THE OUTPATIENT PPS

A. Hospitals Subject to the PPS

Highlights:

- Inpatient PPS hospitals as well as hospitals and distinct-part units excluded from the inpatient PPS are subject to the outpatient PPS

The outpatient PPS applies to all hospitals participating in the Medicare program with the exception of hospitals in Maryland, which are under a Medicare waiver,² and critical access hospitals, which are paid based on reasonable costs. PPS-excluded hospitals (cancer, children's, rehabilitation, and psychiatric) and distinct part units (psychiatric and rehabilitation) are included in the PPS.

Analysis—The 10 designated cancer centers are subject to the PPS; however, financially they will be "held harmless" on a permanent basis. This means that these hospitals will receive additional payments to the extent their ratio of outpatient PPS payments to costs falls below their 1996 ratio. A similar provision applies to rural hospitals with less than 50 beds, however, their "hold harmless" provision expires in 2003 (for a more complete discussion, see "transitional corridor payments" below).

² To the extent there are outpatient services included within the scope of the PPS that are not covered under the waiver, those services will be paid under the PPS.

Medicare Outpatient PPS AAMC Summary and Analysis

B. Scope of Hospital Outpatient Services Excluded From/Included in the PPS

Highlights:

- The outpatient PPS will determine hospital payments for clinic and emergency room visits, outpatient surgeries, and radiological services
- Certain implantable devices are covered under the outpatient PPS
- Services designated by HCFA as “inpatient only” will not be reimbursed if performed in an outpatient setting

The major categories of services subject to the outpatient PPS are:

- clinic visits,
- emergency room visits,
- diagnostic services,
- surgical procedures,
- radiology services, and
- cancer chemotherapy.

In general, the outpatient services excluded from the outpatient PPS are those that are already subject to an existing fee schedule or prospective payment system. Some of these items include:

- Physical, occupational, and speech therapies (fee schedules),
- Clinical diagnostic laboratory services (lab fee schedule),
- Orthotics and non-implantable durable medical equipment and prosthetics (fee schedule), and
- Ambulance services (fee schedule)

Finally, services that HCFA determines should be performed only in a hospital inpatient setting will not be reimbursed if they are performed in an outpatient setting. HCFA’s criteria for determining whether a procedure is classified as “inpatient only” include: a) the invasive nature of the procedure, b) the need for at least 24 hours of postoperative recovery/monitoring time, and c) the underlying physical condition of the patient. Examples of these services include certain breast reconstructions, osteotomies of the femur and tibia, and open treatment of certain craniofacial fractures. Addendum E of the interim final rule contains a complete list of “inpatient only” procedures.

Analysis—In the proposed rule, HCFA had proposed to pay for implantable devices and durable medical equipment (DME) under the durable medical equipment fee schedule. HCFA reversed its position pursuant to a requirement in the BBRA. Consequently, implantable prosthetics, and DME and diagnostic x-ray, laboratory, and other tests associated with these implantable items are included in the outpatient PPS.

HCFA received numerous comments on the services it classified as “inpatient only.” In response, HCFA reduced the services on this list from 1,803 to 1,744. HCFA plans to annually review this list in consultation with hospital and physician associations, as well as an outside expert advisory panel, to determine whether the “inpatient only” designation for a particular service continues to be consistent with current standards of practice.

Medicare Outpatient PPS AAMC Summary and Analysis

C. The Payment Unit

Highlights:

- Hospitals will bill and be paid based on CPT/HCPCS codes
- The costs of certain items, such as operating and recovery rooms, will be “packaged” with the primary service and will not be paid for separately

Payments under the outpatient PPS are made for individual services (as identified by HCFA’s Common Procedural Coding System (HCPCS) or the Physicians’ Current Procedural Terminology (CPT)), not an entire encounter or a day of service.

Costs for certain items that HCFA believes are directly related and integral to performing an outpatient service or procedure will be “packaged” with the primary service, and will not be paid for separately. These include:

- Operating, procedure, or treatment rooms;
- Recovery rooms;
- Observation beds;
- Anesthesia;
- Medical and surgical supplies, and equipment;
- Drugs, pharmaceuticals, and biologicals, except those that are paid for under the transitional pass-through (see below);
- Capital-related costs;
- Costs to procure donor tissue, except corneal tissue (which will be paid for separately);
- Intraocular lenses (where applicable); and
- Various incidental services, such as venipuncture.

Analysis—Direct graduate medical education (DGME) costs and education costs for nursing and allied health programs are not included in the outpatient PPS. These costs will continue to be paid for as they are currently. That is, DGME payments for residents training in hospital outpatient departments will be reflected in the hospital’s per resident amounts, and nursing and allied health payments will be made on a cost-based pass-through.

HCFA had originally proposed to packaged corneal tissue costs and costs for blood and blood products into the APC rates. In response to comments, these items will NOT be packaged into the payment rates. Corneal tissue will be reimbursed based on its costs, and separate APCs have been created for blood and blood products.

While, in general, each outpatient service delivered will be paid for separately, when more than one surgical procedure is performed during a single operative session, payments for the additional surgeries will be reduced by 50 percent.

**Medicare Outpatient PPS
AAMC Summary and Analysis**

D. The Ambulatory Payment Classification (APC) System

Highlights:

- 451 APCs compared to 346 in proposed rule
- Clinic and emergency room visit APCs reduced from 121 to 8

Overview

The foundation of the outpatient PPS is 451 APC groups. In general, hospital outpatient services (as identified by HCPCS/CPT codes) are grouped into APCs according to their similarity in terms of resource costs and clinical indications. In some cases there may be only several services in a given APC while in others there may be 50 or more. Each service in a given APC will be paid the same amount.

An example of an APC and the services included in it is APC 0009:

HCPCS Code	Description	APC
11719	Trim nail(s)	0009
11720	Debride nail (1-5)	0009
11721	Debride nail 6 or more	0009

*Analysis--*A number of changes were made to the APC groupings in response to comments. Many other changes, however, were due to a requirement in the BBRA that, with limited exceptions, the most costly service in an APC could not have a median cost more than twice the median cost of the lowest-cost service in the group.

Emergency and Clinic Visit APCs

HCFA had originally proposed to group clinic and emergency room visits according to both the visit's CPT code and the diagnosis code associated with that visit, resulting in 121 APCs. In the interim final rule, HCFA decided to use the CPT code only to assign visits; diagnosis will NOT be considered when assigning a visit to an APC. (Hospitals, however, are still required to code a diagnosis so that HCFA can assess its possible use in the future.)

HCFA has collapsed the 31 CPT codes into 6 APCs: three each for clinic and emergency room visits (low, medium, and high level). 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 APCs (and their unadjusted³ payment amounts) are listed in Table 2.

³ Note that actual payments will be adjusted to reflect the hospital's wage index, see below.

**Medicare Outpatient PPS
AAMC Summary and Analysis**

Table 2: Clinic and Emergency Room APCs under Outpatient PPS

APC	Group Title	Payment Rate
0600	Low Level Clinic Visits	\$47.52
0601	Mid Level Clinic Visits	\$48.49
0602	High Level Clinic Visits	\$80.49
0603	Interdisciplinary Team Conference	\$80.49
0610	Low Level Emergency Visits	\$64.97
0611	Mid Level Emergency Visits	\$102.31
0612	High Level Emergency Visits	\$154.67
0620	Critical Care	\$416.99

Source: Outpatient PPS Interim final Rule, 65 Fed. Reg. at 1855(April 7, 2000).

Analysis— The clinic and emergency room APCs have particular importance for teaching hospitals, as these visits represent a significant portion of overall outpatient service volume. A complete list of the visit CPT codes and their corresponding APC groups are listed in an Addendum at the end of this document.

Commentors expressed concern that the clinic/emergency room CPT codes were developed to differentiate different levels of physician, not hospital, resources levels. In the interim final rule preamble, HCFA acknowledges this difference and directs hospitals to develop a system for mapping provided services to the different levels of effort represented by the visit codes:

“As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill. Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility.” (65 Fed. Reg. at 18451).

Consequently, it is important that hospitals develop protocols to determine how visits will be assigned to particular codes. Hospitals may use the CPT guidelines or other coding structures, such as nursing ratios. Regardless of the method chosen, it should be explained thoroughly to personnel who will be assigning the CPT code to the visit. It also is important for hospitals to code clinic and emergency room visits accurately to ensure that the payment amounts calculated by HCFA can be modified, if necessary.

HCFA’s 1996 database reflects claims from about 1,800 hospitals that coded all of their clinic visits (regardless of acuity) using only the lowest level code, 99201. In developing the payment weights⁴ for clinic and emergency room visits, HCFA excluded the claims from these 1,800 hospitals and derived the clinic visit APC payment amounts from the remaining subset of hospitals that coded a wider range of clinic visits in 1996. The claims from the 1,800 hospitals were excluded because the APC payment for APC 0600 (which contains code 99201) would be overestimated since the hospitals use only code 99201 to describe both low and high level visit resources costs.

Because it was able to only include a subset of hospitals in its clinic visit payment calculations,

⁴ See below for a more complete discussion as to how payment weights are determined.

Medicare Outpatient PPS AAMC Summary and Analysis

HCFA emphasizes in the interim final rule preamble that hospitals should properly assess the intensity of their clinic visits and report these codes properly so that HCFA can revise payment weights accordingly in the future. This is particularly important in the case of distinguishing between low and mid level clinic visits, because there currently is only a \$0.97 difference between their APC payment rates.

New Technology APCs

In the interim final rule, HCFA has included special APCs to pay for new technology services. In contrast to other APCs, these groups reflect only cost similarities, not clinical coherence. The lowest cost group has a payment of about \$25, while the highest cost group has a payment amount of about \$5,500. New technology items that HCFA determines cannot be appropriately placed in an existing APC will be placed in one of the new technology groups for a period of two to three years. During this period, HCFA will collect actual cost information and subsequently move the technology to a clinically-related APC group with comparable resource costs, or create a new APC.

Analysis—These APCs are for items introduced since 1996 (since they are not reflected in HCFA's database), and future technologies yet to be developed. The purpose of the APCs is to ensure appropriate reimbursement so that the APC system does not inhibit the dissemination of new innovations. According to HCFA staff, new technologies will be assigned to the various temporary APCs based on cost information provided by external parties and verified by HCFA internal medical reviewers.

In the interim final rule preamble, HCFA requests that persons who are aware of new technologies that might merit consideration for inclusion in a new technology APC contact the Agency (see 65 Fed. Reg. at 18487). The types of technology services that will be included in these APCs include photodynamic therapy, and positron emission tomography (PET). (Other examples are provided in the interim final rule preamble at 65 Fed. Reg. at 18477.)

E. Transitional Pass-Through Payments for Innovative Medical Devices, Drugs, and Biologicals

Highlights:

- Cancer therapies are covered by the pass-through payments
- New drugs will be reimbursed at 95 percent of their Average Wholesale Price (AWP)
- New devices will be reimbursed at reasonable costs
- A final list of items eligible for pass-through payments will be posted on HCFA's outpatient PPS web site

Medicare Outpatient PPS AAMC Summary and Analysis

The BBRA provides that hospitals may receive “pass through” payments for a period of two to three years for specific items specified in the BBRA. 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, 1996⁵ and where the cost of the item is “not insignificant”⁶ to the APC amount .

For drugs and biologicals, the pass-through amount will be the difference between 95 percent of the item’s average wholesale price (AWP) and the portion of the APC amount determined by HCFA to be associated with the item. For devices, the additional payment will be the difference between a hospital’s charges adjusted to costs and the portion of the applicable APC amount associated with the device. HCFA will collect cost data on these items during the 2-3 year “pass-through” period, after which the item will be packaged into the service with which it is clinically assigned.

Pursuant to the BBRA, 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, these payments cannot exceed more than 2 percent of total payments. These amounts will be funded through a reduction in the conversion factor for all outpatient services. HCFA has the authority to uniformly reduce the pass-through payments (not the reduction to the conversion factor) to ensure that the ceiling percentages are not exceeded.

Analysis—Addendum K of the interim final rule sets forth the items that are eligible for pass-through payments. The vast majority of these items are drugs; no devices are listed. Subsequent to the interim final rule publication, however, HCFA has been reviewing applications for additional items, particularly devices, that should be added to the list in Addendum K. The final list will be posted on HCFA’s outpatient PPS web site, referenced at the beginning of this document.

⁵ New drugs and biologicals are those which are a) not self administered (except for certain cancer agents and other specifically-exempted items), and b) that are “reasonable and necessary for the diagnosis or treatment of disease. . . .” New medical devices are those that, among other criteria, a) are approved by the FDA, b) that are “reasonable and necessary”; and c) are “an integral and subordinate part of the procedure performed, are used for one patient only, are surgically implanted or inserted, and remain with that patient after the patient is released from the hospital outpatient department.” 65 Fed. Reg. at 18480. Devices included under this section DO NOT include “equipment, instruments, apparatuses, implements or items that are generally used for diagnostic or therapeutic purposes, that are not implanted or incorporated into a body part, and that are used on more than one patient (that is, reusable).” (65 Fed. Reg. at 18479). According to HCFA, these latter types of items, however, could possibly be reimbursed under the new technology APCs discussed in the previous section.

⁶ HCFA will use a multiple process to determine whether the cost is “not insignificant” to the APC amount that factors in the item’s cost relative to the applicable fee schedule and the portion of its costs already reflected in the APC rate. See 65 Fed. Reg. at 18481.

Medicare Outpatient PPS AAMC Summary and Analysis

While the general rule is that the pass-through payments for drugs and biologicals will be the difference between 95 percent of AWP and the portion of the applicable APC amount, in the interim final rule APC payments, HCFA removed those drug and biological costs that are eligible for pass-through payments. Consequently, the pass-through payments for these items will be the full 95 percent of AWP.

HCFA does not anticipate that the 2.5 percent pass-through payment ceiling will be exceeded in 2000 or 2001, and consequently will make no uniform reductions to pass-through payments for these periods.

F. APC Payment Calculation and Adjustments

Highlights:

- 2000 conversion factor equals \$48.49
- No special adjustment for teaching hospitals
- No behavioral offset
- No volume control mechanism
- APC payments will be adjusted by the hospital inpatient wage index

In general, the payment that a hospital will receive for a particular outpatient service is a function of a number of factors: the APC relative payment “weight,” the conversion factor, and an adjustment for area wage differences.

1. Payment Weights

Each APC is assigned a relative weight that reflects the relationship between the median cost of the services within the APC (adjusted for geographic wage differences) to the median cost of the services in APC 601 (mid-level clinic visit, with a median cost of \$47.00).⁷ (APC 601 was chosen because it is one of the most frequently performed services.) Consequently, the relative weight for APC 601 is 1.0 and the weights for the other APCs are either higher or lower than 1.0, depending upon whether their median costs are higher or lower than \$47.00.

2. Conversion Factor

The conversion factor is the base payment amount to which the APC payment weight is applied. It is determined by summing the program and beneficiary copayments for all services subject to the PPS for calendar year 1996 (excluding payments associated with the formula-driven overpayment (FDO)—which was eliminated effective October 1, 1997) divided by a wage-adjusted sum of the relative weights for all APCs. The 1996 amount was then updated to 2000. The conversion factor for 2000 is \$48.49.

⁷ As required by the Balanced Budget Act of 1997 (BBA) HCFA calculated outpatient service costs using charge data from the 1996 Medicare outpatient claims and Medicare cost reports that generally began on or after October 1, 1996 and before October 1, 1997 (PPS-14).

Medicare Outpatient PPS AAMC Summary and Analysis

Analysis—The conversion factor is higher than estimated in the proposed rule due to a change in how beneficiary copayments were calculated. This change, mandated by the BBRA, restored about 5.7 percent in outpatient payments to the conversion factor calculation.

3. Payment Adjustments⁸

APC payments (both program and beneficiary coinsurance) will be adjusted to reflect differences in area wages, using the hospital inpatient PPS wage index (post-reclassification, post-floor). HCFA analyses indicated that 60 percent of the hospital outpatient costs are labor-related. Consequently, 60 percent of the APC payment will be adjusted by the hospital inpatient PPS wage index.

Despite having legislative authority, HCFA chose not to include any additional adjustments to the outpatient PPS. Specifically, unlike the hospital inpatient PPS, the outpatient PPS does not include an adjustment for teaching hospitals (such as the indirect medical education (IME) adjustment), or hospitals that treat a disproportionate share of low-income patients (the DSH adjustment).

Analysis—HCFA’s discussion of possible adjustments for classes of hospitals is very brief. HCFA notes that it “reexamined and reestimated” the multivariate regression specifications that it conducted as part of the proposed rule. According to their analyses, there was no statistically significant difference in outpatient costs related to treating a disproportionate share of low-income patients. They did find a statistically significant relationship for teaching hospitals that had ratios of residents to inpatient and outpatient days equal to or greater than 0.28, but stated that the parameter was small and payment was “not greatly improved when a corresponding adjustment was made to these teaching hospitals.”

HCFA states that the “primary reason” for its decision not to include an adjustment for teaching hospitals is the availability of transition payments through 2003. HCFA goes on to say that it will conduct additional analyses when sufficient data under outpatient PPS are submitted and that the Agency will “carefully consider whether permanent adjustments should be made in the system once the BBRA 1999 transition provisions expire.” (65 Fed. Reg. at 18500).

The AAMC is extremely disappointed that a teaching adjustment was not included in the interim final rule. In its comment letter, the Association had advocated for an adjustment that would eliminate the financial disparity between major teaching hospitals and other hospitals. The AAMC had conducted its own regression analyses which showed statistically significant differences for both teaching and low-income share characteristics, as well as a resident to inpatient/outpatient days threshold that was lower than the 0.28 level calculated by HCFA. HCFA did not specifically respond to the AAMC’s findings in the interim final rule.

⁸ Outlier payments and the transitional corridor payments are discussed in subsequent sections.

Medicare Outpatient PPS AAMC Summary and Analysis

While transition payments should help teaching hospitals in the short term, a more permanent solution is needed to fix the discrepancy between the financial impact for major teaching hospitals and other hospitals. The AAMC will be monitoring this situation closely and will continue to conduct its own analyses to ensure that teaching hospitals are treated equitably under the outpatient PPS.

4. Volume Control Mechanism

The BBA required that HCFA develop a method for controlling unnecessary increases in the volume of outpatient services. In the proposed rule, HCFA proposed to establish an expenditure target for calendar year 2000 and to reduce the conversion factor in a subsequent year if the target was exceeded.

In the interim final rule, HCFA states that the outpatient PPS will not include a volume control mechanism for at least two years. HCFA plans to study the issue during this time period. Any volume control policy would be subject to a notice and comment period prior to implementation.

Analysis—The decision to rescind the volume control mechanism is a welcome one. Hospitals need time to adjust to the new system before a mechanism like this is implemented. Moreover, it is unclear how HCFA will be able to appropriately define “unnecessary” increases in outpatient volume. Given the increasing advances in medical practice, an increasing number of services will be able to be moved from the inpatient to the outpatient setting. Such increases are desirable from both Medicare outlay and beneficiary standpoints.

5. Hypothetical Payment Example: HCPCS Code 29815 (Shoulder Arthroscopy)

Below is an example of how payments for a particular outpatient service will be determined:

Step 1: Calculate base APC payment amount:

$$\begin{array}{rclcl} \text{Conversion Factor} & * & \text{Payment Weight (APC 0041)} & & \\ \$48.49 & * & 24.57 & = & \$1,191.33^9 \end{array}$$

Step 2: Apply inpatient PPS wage index to 60 percent of payment amount (assume wage index for hypothetical hospital is 1.1087)

$$(1.1087)(0.60 * \$1,191.33) + (0.40 * \$1,191.33) = \$1,269.03 \quad \leftarrow \quad \text{TOTAL PAYMENT}$$

⁹ This is the amount published in the Federal Register. It is slightly less than the calculated amount due to a rounding of the conversion factor.

Medicare Outpatient PPS AAMC Summary and Analysis

G. Outlier Payments

Highlights:

- Hospitals will receive additional payments for outpatient services with extraordinary costs
- Outlier payments will be financed through a reduction in the conversion factor

The BBRA requires that the outpatient PPS include additional payments for outlier services; these payments were not part of the proposed rule. Like the inpatient PPS, outlier payments are for those services that have extraordinary costs and are financed through a reduction in the APC conversion factor that applies to all cases. The BBRA requires that outlier payments not exceed 2.5 percent of total outpatient PPS payments through 2003, and not exceed 3.0 percent thereafter. For 2000 and 2001, HCFA determined its outpayment methodology such that estimated outlier payments would be 2.0 percent of total PPS payments.

Under HCFA's methodology, when calculated costs of an outpatient service are more than 2.5 times the corresponding APC payment (including pass-through payments, see below), HCFA will make an outlier payment equal to 75 percent of the costs above that threshold.¹⁰

Analysis—This provision should benefit teaching hospitals that provide complex and costly outpatient services. The AAMC is concerned, however, that HCFA chose to set the outlier payment target percentage at 2.0 percent of total PPS payments rather than the 2.5 percent level permitted under the BBRA. HCFA gave no rationale in the interim final rule for establishing the lower level.

Until 2002, the BBRA permits HCFA to identify outliers on a bill basis rather than a service basis and to use an overall hospital cost-to-charge ratio (CCR) to determine costs rather than using department-specific CCRs for each hospital. In this situation, outlier payments will be made when the combined costs of the services on a bill exceed the combined APC payments. After 2002, outliers will be determined on a service-specific basis.

H. Transitional Corridor Payments

Highlights:

- Transition payments will limit outpatient losses until 2003
- Amount of transition payments varies by loss levels and declines over the three-year period

The BBRA requires that the outpatient PPS provide “transitional corridor” payments through 2003 to limit hospitals' outpatient payment losses. The transition amount is based upon a comparison of a hospital's “pre-BBA amount,” and its “PPS amount.” The interim final rule defines these amounts as:

Pre-BBA amount: the amount equal to the product of a) a hospital's reasonable costs for covered outpatient services during the period in question, and b) a hospital's outpatient

¹⁰According to HCFA staff, for purposes of determining whether an outlier payment is appropriate, HCFA will use a hospital's 1996 cost-to-charge ratios inflated to 2000.

Medicare Outpatient PPS AAMC Summary and Analysis

department payment-to-cost ratio for the cost reporting period ending in 1996. (Note that the 1996 payment-to-cost ratio will be calculated to reflect the formula-driven overpayment (FDO) change that became effective October 1, 1997.)

PPS Amount: The amounts payable under outpatient PPS including beneficiary coinsurance and deductibles. (This amount will include the full copayment amounts even if a hospital chooses to reduce the copayment for some or all of the services it furnishes, see below).

With the exception of the 10 inpatient PPS-exempt cancer centers and small rural hospitals, transitional corridor payments decline over the three-year period. The following table sets forth how the transitional payments will be determined for each year:

If the PPS amount compared to the pre-BBA amount is...	Then the hospital will receive an additional payment equal to...		
	Prior to January 1, 2002	Calendar Year 2002	Calendar Year 2003
Less than 100 percent but at least 90 percent	80 percent of the difference	70 percent of the difference	60 percent of the difference
Less than 90 percent, but at least 80 percent	the amount by which 71 percent of the estimated pre-BBA payment exceeds 70 percent of the PPS payment	the amount by which 61 percent of the estimated pre-BBA payment exceeds 60 percent of the PPS payment	6 percent of the pre-BBA payment
Less than 80 percent but at least 70 percent	the amount by which 63 percent of the pre-BBA payment exceeds 60 percent of the PPS payment	13 percent of the pre-BBA payment	6 percent of the pre-BBA payment
Less than 70 percent	21 percent of the pre-BBA payment	13 percent of the pre-BBA payment	6 percent of the pre-BBA payment

Source: Health Policy Alternatives, Inc.

Small rural hospitals (those with less than 50 beds) are guaranteed to receive at least 100 percent of their pre-BBA payments through 2003. The 10 PPS-exempt cancer hospitals are permanently eligible to receive 100 percent of their pre-BBA amounts.

The BBRA requires HCFA to make interim transition payments that will be subject to retrospective adjustments when hospitals submit their cost reports. According to Program Memorandum A-00-23, fiscal intermediaries will be provided with information to calculate the transition payments August 1, 2000 and will begin making payments “before the next month begins” (Program Memorandum. at 14).

Analysis—In essence, hospitals will receive transition payments if their outpatient payments under PPS cover a lower share of their costs than the costs covered by their outpatient payments in 1996.

Unlike other adjustments, the transition payments were funded through additional monies authorized by Congress, rather than through a reduction to the conversion factor. It is important

Medicare Outpatient PPS AAMC Summary and Analysis

to recognize that the transition payment methodology does not take into account outpatient losses that hospitals incur by virtue of the FDO change. Also discussed above, the FDO change alone could reduce outpatient payments significantly for some hospitals.

Transitional corridor payments are critical to teaching hospitals, that otherwise could sustain steep reductions in outpatient payments. Given that the transition period is only three years, it will be important that HCFA monitor the new system carefully to determine whether payment adjustments for certain classes of hospitals, such as teaching hospitals, are needed on a permanent basis.

I. Annual Updates

Highlights:

- BBRA requires HCFA to annual review payment groups, weights, and make other changes as necessary
- First annual update will be January 1, 2002

The BBRA requires HCFA to annually update the conversion factor. As mandated under the BBA, the factor will be updated by the increase in the hospital market basket less one percentage point through 2002, and the market basket increase thereafter. The BBRA requires HCFA to annually review the APC groups, relative payment weights, and wage and other adjustments to take into account changes in medical practice and technology, the addition of new services, new cost data, and other relevant information and factors.

The BBRA also requires HCFA to consult with an expert outside advisory panel of provider representatives when reviewing and updating the APC groups and relative weights.

Analysis—HCFA will initiate the review process for reviewing the APC groups and other components of the outpatient PPS effective January 1, 2002. However, changes to the outpatient PPS likely will occur before this time when HCFA publishes the final rule that will incorporate comments that HCFA will receive through June 6 on the interim regulatory provisions resulting from the BBRA.

It is unclear what was meant in the BBA when it included “new cost data” as one of the factors HCFA must consider when it reviews and revises the APC groups; the interim final rule preamble did not specifically discuss this issue. Whether this means that the APC groups and payment weights will be revised to reflect more recent cost data (the interim final rule used cost report periods ending in 1997) is yet to be seen.

HCFA has not yet identified the outside advisory panel; the formation of this group will be announced through a notice in the *Federal Register*.

J. Beneficiary Coinsurance

Highlights:

Medicare Outpatient PPS AAMC Summary and Analysis

- Coinsurance is initially based on 20 percent of median charges of the services included in an APC
- Coinsurance is reduced gradually over time until it equals 20 percent of the APC payment rate
- Coinsurance is adjusted by the hospital inpatient PPS wage index

For most Medicare services, beneficiaries pay a copayment that is equal to 20 percent of Medicare payments. Under the current outpatient system, however, beneficiaries pay a copayment that is equal to 20 percent of the charges for each outpatient service. Because charges have historically risen faster than payments, the current copayment for most services is often greater than 20 percent of Medicare payments. One of the goals of the outpatient PPS is for beneficiary copayments to eventually equal 20 percent of Medicare payments. As a starting point to achieving this goal, under the outpatient PPS, beneficiary copayments will be set initially at 20 percent of the median charges for each APC group. For those APCs where the copayment is greater than 20 percent of the APC payment rate, the copayment amounts will be frozen until increases in program payments over time reduce the copayment share to 20 percent of total payments.

Pursuant to the BBRA, the coinsurance amount for any individual service can be no more than the hospital inpatient deductible, which is \$776 in 2000.

Hospitals may elect to reduce the copayment amounts for any or all APCs in which the copayment amount is greater than 20 percent of the APC payment rate, and disseminate information on the reduced amounts. Hospitals will not be permitted, however, to reduce the copayment for an individual service within an APC without reducing the copayments for the other services within that same APC. In addition, the coinsurance reductions must remain in place for an entire year and cannot later be treated as bad debt.

Analysis—Because beneficiary coinsurance is based on median charges of services within an APC rather than average charges, overall beneficiary copayments will fall by about 10 percent when the system is implemented July 1.

For competitive reasons, hospitals may choose to reduce the amount of coinsurance that beneficiaries pay. Hospitals wishing to do this for the July 1-December 31, 2000 period must notify their fiscal intermediaries by June 1, 2000. For subsequent years, elections must be made by December 1 for the following year. HCFA Program Memorandum A-00-23 (April 2000), provides a format for submitting coinsurance reduction elections. Essentially, hospitals must identify the APCs and provide the reduced coinsurance levels.

**Medicare Outpatient PPS
AAMC Summary and Analysis**

ADDENDUM

**Clinic and Emergency Room Visits:
CPT/HCPCS Codes and APC Groupings**

APC	CPT/HCPCS	CPT Description	Payment Rate
0600 Low Level Clinic Visits			\$47.52
	99201	Office/outpatient visit, new	
	99202	Office/outpatient visit, new	
	99211	Office/outpatient visit, est	
	99212	Office/outpatient visit, est	
	99241	Office Consultation	
	99242	Office Consultation	
	99271	Confirmatory Consultation	
	99272	Confirmatory Consultation	
0601 Mid Level Clinic Visits			\$48.49
	92002	Eye exam, new patient	
	92012	Eye exam, established patient	
	99203	Office/outpatient visit, new	
	99213	Office/outpatient visit, est	
	99243	Office consultation	
	99273	Confirmatory consultation	
	G0101	CA screen, pelvic/breast exam	
0602 High Level Clinic Visits			\$80.49
	92004	Eye exam, new patient	
	92014	Eye exam and treatment	
	99204	Office/outpatient visit, new	
	99205	Office/outpatient visit, new	
	99214	Office/outpatient visit, est	
	99215	Office/outpatient visit, est	
	99244	Office consultation	
	99245	Office consultation	
	99274	Confirmatory consultation	
	99275	Confirmatory consultation	
0603 Interdisciplinary Team Conference			\$80.49
	G0175	Multidisciplinary team visit	
0610 Low Level Emergency Visits			\$64.97
	99281	Emergency dept visit	
	99282	Emergency dept visit	
0611 Mid Level Emergency Visits			\$102.31
	99283	Emergency dept visit	
0612 High Level Emergency Visits			\$154.67
	99284	Emergency dept visit	
	99285	Emergency dept visit	
0620 Critical Care			\$416.99
	99291	Critical care, first hour	