

CHAPTER

2

**Assessing the design and impact
of the hospital outpatient
prospective payment system**

R E C O M M E N D A T I O N S

2A The Secretary should monitor changes in practice patterns across ambulatory care settings to ensure that differences in payment do not lead to inappropriate shifts in site of care.

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2B The Secretary should study the accuracy of and changes in coding practices with the implementation of the outpatient prospective payment system.

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2C The Congress should enact legislation to accelerate the rate of beneficiary coinsurance buy down under the outpatient prospective payment system and establish a date certain for achieving a coinsurance rate of 20 percent. This date should result in a time frame for implementation consistent with other Medicare payment policy changes.

.....

2D The Secretary should carefully monitor implementation of the outpatient prospective payment system to ensure that:

- it does not have unintended, adverse consequences on beneficiaries' access to care,
- it does not compromise the quality of care delivered, and
- the annual reductions in beneficiary coinsurance as a share of total payment are realized.

Assessing the design and impact of the hospital outpatient prospective payment system

In this chapter

- Evaluating the design of the outpatient prospective payment system
 - Transitioning to the new payment system
 - Updating payments and considering volume control
 - Assessing the impact of the outpatient prospective payment system
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Services provided in hospital outpatient departments represent one of the last major types of care to be shifted from cost-based reimbursement policy by Medicare. The outpatient prospective payment system to be implemented on July 1, 2000 will provide better incentives to control costs in this rapidly growing sector of healthcare, simplify a complex area of payment policy, and begin a gradual decline in the disproportionate financial burden beneficiaries bear for outpatient services. Transitional policies introduced in the Balanced Budget Refinement Act of 1999 will mitigate the potentially negative financial impacts for hospitals of moving to the new payment policy. However, the administrative burden on hospitals of moving to the new system should not be underestimated. The decrease in beneficiary coinsurance and the transitional policies will raise Medicare program costs. MedPAC supports the goals and broad outlines of the outpatient prospective payment system, but has concerns about elements of its design and implementation. Our recommendations highlight the need to monitor shifts in practice patterns across settings, study changes in coding patterns over time, decrease beneficiary financial liability for outpatient services more quickly, and monitor beneficiary access to quality care.

The Health Care Financing Administration (HCFA) will implement the outpatient prospective payment system (PPS) on July 1, 2000, putting in place one of the last major elements of Medicare's transition from primarily cost-based reimbursement to prospective payment for most services. The design of the system has evolved over a number of years, with specific elements mandated by the Congress in the Omnibus Budget Reconciliation Act of 1986, the Balanced Budget Act of 1997 (BBA), and the Balanced Budget Refinement Act of 1999 (BBRA). This chapter evaluates the design of the outpatient PPS, including the classification system, the bundle of services covered by payment, and the setting of payment rates. It then discusses the policies governing the transition to the new payment system and the issues inherent in updating payments and addressing volume growth for outpatient services. The final section assesses the impacts of moving to the outpatient PPS on providers, beneficiaries, and the Medicare program.

The outpatient PPS will pay for facility costs incurred by hospitals in providing outpatient care to beneficiaries. Physicians' services and other professional costs will be reimbursed separately. The outpatient PPS centers on a fee schedule. This approach lets hospitals know their reimbursement in advance, giving them an incentive to keep costs below the fee schedule amount. This represents a fundamental change in the financial incentives facing hospitals. Historically, hospitals were reimbursed for services based on the lesser of their reported costs or charges for delivering care. Higher costs often led to higher payments. In addition, cost-based reimbursement led to large differences in payments among individual hospitals providing the same service. Until the PPS is implemented, Medicare payment for outpatient services will continue to be a mix of cost-based, fee-schedule, and blended payment methods, making it one of the most complicated areas of Medicare payment policy.

Prior payment methods for outpatient department services

Until the prospective payment system (PPS) is implemented, Medicare pays for outpatient services through a mix of cost-based reimbursement methods, fee schedules, and blended payment. The reimbursement method varies based on the type of service provided.

In general, payments for non-surgical procedures and emergency department and clinic visits are equal to the lesser of hospitals' reasonable costs or charges. For surgical services provided in an outpatient department, payments are based on the lesser of hospital costs or charges, or a blend of costs or charges with the ambulatory surgical center payment rate. Similarly, payments for radiology and certain diagnostic services are paid on the basis of costs, charges, and a blend of the lesser of costs and charges with the practice expense component of the physician fee schedule.

Medicare pays for most other services and items provided in the outpatient department according to their own fee schedules:

- clinical laboratory services,
- durable medical equipment, prosthetics and orthotics, and supplies,
- end-stage renal disease services,
- physical, occupational, and speech therapy, and
- ambulance services.

Although these fee schedules and the blended payment method for surgical and radiology services have slowed growth in Medicare payment rates, volume and expenditures have continued to rise, providing an impetus for instituting a PPS. ■

The growth of volume and expenditures for outpatient services is an important impetus for instituting a PPS. Despite a leveling off of growth in the Medicare fee-for-service population in recent years, volume growth has occurred because of increases in outpatient encounters per beneficiary and services provided in each encounter. According to MedPAC's estimates, both measures have increased at an average annual rate of about 3 percent between 1994 and 1997. The effect of volume growth on spending is amplified by the growing intensity of services provided—in other words, services associated with higher resource use and costs are provided more frequently, driving expenditure growth (Miller and Sulvetta 1994). MedPAC estimates that since 1983, expenditures have risen at an average annual rate of more than 12 percent, slowing slightly to

10 percent annually between 1993 and 1998. Medicare expenditures for outpatient services are estimated to be about \$18.6 billion in 1998, making outpatient payments nearly 17 percent of total payments to hospitals.

Moving to a PPS will accomplish a number of goals. First, prospective payment will provide hospitals with better incentives to control costs. Second, the use of a fee schedule will give the Medicare program better tools for containing overall costs for outpatient services. Third, the use of a fee schedule will simplify a complex payment system and make payments more predictable and more equitable across hospitals. The outpatient PPS, in conjunction with policies included in the BBA and BBRA, will also reduce beneficiary financial liability for outpatient services to a degree,

and move slowly toward a more equitable distribution of payments among the program and beneficiaries. In designing and carrying out the PPS, HCFA must ensure adequate payment levels so that beneficiary access to care and quality of care are not compromised.

Evaluating the design of the outpatient prospective payment system

MedPAC supports the goals of the outpatient PPS. The final rule presented by HCFA provides a unified payment system that moves the Medicare program toward fully prospective payment. We commend HCFA for its substantial efforts in designing and refining the PPS. MedPAC's comments and recommendations center on specific elements of the payment system and implementation issues.

Classifying services

Under the PPS, outpatient services are classified into Ambulatory Payment Classification (APC) groups, which are intended to combine services that are clinically similar and require comparable resources. In response to legislation and comments from industry and other groups, HCFA made many changes to the APC classification system originally set out in its proposed rule (HCFA 1998). HCFA incorporated these changes into its final rule (HCFA 2000b). One major legislative requirement was the BBRA provision that limited the range of costs between the most and least expensive services in a given APC group to a factor of two: The median cost of the most expensive service in the group cannot be more than double the median cost of the least expensive service in the group, with some exceptions.

The final rule includes 451 groups, while the proposed rule included about 350 groups. However, the extent of change in

the classification system is greater than these numbers might suggest. The proposed rule included more than 100 groups for emergency department and clinic visits, using a matrix definition that included diagnosis as part of the classification system. That system has been dropped, at least for now, resulting in fewer than 10 groups for emergency and clinic visits. Many services were reclassified into new groups and a number of services were added to the outpatient PPS that were previously to be paid for only when provided in the inpatient setting. These services include, but are not limited to, some insertions, removals, and replacements of pacemakers; transluminal balloon angioplasty; bone marrow transplantation; and surgical laparoscopies, including cholecystectomies. Finally, HCFA has created a set of new technology APC groups that will temporarily combine new services based solely on costs. New services will not be immediately placed into clinically related, existing groups as previously proposed.

In many ways, the expanded classification system improves on the system originally proposed by HCFA. Limiting the variation in costs within an APC should lead to a more accurate payment system. The median cost of services in a group is closer to the cost for each service in the group. Therefore, there is less risk of underpaying (overpaying) facilities that consistently provide services that are among the higher-cost (lower-cost) elements within a group. In addition, having a larger number of groups may facilitate consistency of payment across sites of care. The Commission continues to be concerned by large differences in payment for the same service provided in different settings.

Although increasing the number of groups has benefits, including fewer services in each group may create problems. Hospitals may have incentives to upcode, to the extent that clinically related services

are now in separate groups due to differences in costs. Increases in coding intensity for non-clinical reasons have been documented in the inpatient PPS (Carter et al. 1991). A smaller number of services per group also complicates the placement of new and low-volume services. HCFA has previously argued that existing cost data do not support creating separate groups for these services, and setting payment rates for single services or small groups implies a level of precision that is not warranted (HCFA 1998).

Defining the appropriate bundle of services

The outpatient PPS provides incentives to control costs by incorporating payment for incidental ancillary services and items into the payment amount for a given service. For example, payment for surgery covers the hospital's costs for the operating and recovery room, medical and surgical supplies used in the surgery, anesthesia, most drugs, and other incidental costs. Previously, each item was paid for separately on a reasonable-cost basis or according to the appropriate fee schedule. Bundling payment for incidental services provides incentives to control the use of such services and items because hospitals retain any payments in excess of costs. Increasing volume of incidental services is thought to have played an important role in the rapid rise in expenditures for outpatient services in the 1980s (HCFA 1998).¹

The bundle of incidental services and items included within the payment for the primary service has become smaller than originally proposed because of provisions in the BBRA and decisions made by HCFA. Specifically, blood and blood products will now be paid for separately, rather than as part of the bundled payment. HCFA has also created separate categories for casting, splints and strapping services, and certain high-cost drugs. Corneal tissue acquisition will be

¹ HCFA uses the term "packaging" to describe the set of inputs covered by the payment for a service. For consistency with other MedPAC reports, we use the term "bundling."

paid for on a reasonable-cost basis. In addition, some drugs, biologicals, and medical devices will be subject to additional pass-through payments—additional amounts above the group payment rate—in the short term; thus, although these items remain in the bundle of services, payment above the APC group rate is possible.

Including fewer ancillaries in the payment bundle for a given service may reduce the incentives for efficiency. Additional payments for certain drugs and devices may undermine the goal of creating incentives for efficient use of these services which underlies the use of bundling. The ability to bill separately for additional incidental items and services, such as casts and splints, could lead to increased use of these services.² However, the effect of this type of unbundling on use depends on the relationship between the payment for the item or service and the marginal cost of providing it. If the payment is equal to marginal cost, there are no incentives to either over- or under-use an item or service. If the payment is above marginal cost, there is an incentive to increase use. If the payment is below marginal cost, there is an incentive to stint on services by decreasing use. MedPAC takes the position that Medicare should pay the marginal cost of the efficient provider, but recognizes the difficulty of determining that cost.

Setting payment rates

All services in an APC group have the same payment rate. Payment is derived from the product of a measure of the expected cost of the APC group relative to the average costliness of all services (the relative weight) and a factor that translates the relative weight into a dollar amount (the conversion factor). The process HCFA used to calculate relative weights for the APC groups and the conversion factor used in setting payment rates was

established by statute. It relies on historical cost and charge data to set payment rates. After the conversion factor is determined, it is reduced to accommodate two budget-neutral payment adjustments: outlier payments and pass-through payments for new and innovative technologies. The conversion factor is \$48.49 in 2000. (See Appendix A for more detail on elements of the outpatient PPS.)

This approach to setting payment rates focuses only on the outpatient sector. However, changes in technology, practice patterns, and the organization of medical services have led providers to offer the same services in multiple ambulatory settings. Ensuring consistency of payment across sites of ambulatory care, therefore, becomes an important issue. MedPAC continues to be concerned with the differences in payment rates for the same service provided in alternative settings. The financial incentives inherent in payment differences could lead to inappropriate decisions about where care is delivered.

RECOMMENDATION 2A

The Secretary should monitor changes in practice patterns across ambulatory care settings to ensure that differences in payment do not lead to inappropriate shifts in site of care.

Table 2-1 provides examples of the differences in payment for the same service in alternative settings for the year 2000. Under the outpatient PPS, hospitals will receive \$387 for a diagnostic colonoscopy. If this procedure were performed in a physician's office, the practice expense base rate—the component of the physician's fee analogous to the hospital outpatient facility fee—would be \$192. If performed

in an ambulatory surgical center (ASC), the facility payment would be \$425. ASC payments are moving to a PPS, and the transition to fully prospective payment for physician practice expenses will be completed in 2002. Therefore, payment rates are anticipated to change in these settings. Nevertheless, monitoring payment differentials will remain important.

These differences may represent underlying cost differences among settings, such as levels of staffing and critical care facilities provided or the case mix of patients receiving services in the different settings. Alternatively, they may be anachronistic differences due to the manner in which payment rates were set historically. If the latter is true, differences in payment across settings could lead to shifting care among ambulatory settings for financial rather than clinical reasons. Such differences may also provide incentives for a facility to change the way it is identified for the purposes of billing Medicare, in order to receive higher payments.³ Analysis is needed to determine the magnitude of these differences, the extent to which they reflect underlying differences in the costs of providing services in each setting, and their impact on decisions regarding the site of care.

Transitioning to the new payment system

Moving to a fully prospective payment system for outpatient services will change the payments hospitals receive for the services they deliver. Instead of receiving payments based on their own reported costs, all hospitals will be paid the same base amount for a particular service, adjusted for geographical differences in input prices. Hospitals will fall along a continuum with respect to their financial

2 Providers' responses to financial incentives are also influenced by the extent of their control over the product, related potential costs (loss of reputation, for example), the likelihood of oversight by physicians or others, and personal and professional ethics and values.

3 These incentives have been recognized by HCFA. The final rule for the outpatient PPS includes a discussion of the requirements that must be met for a facility to be considered "provider based," and hence eligible for payment under the outpatient PPS. A facility must be an integral and subordinate part of a main provider in order to be considered provider based.

**TABLE
2-1**

Comparison of payment rates across settings for selected high-volume ambulatory care services, 2000

Type of service	HCPCS code	Description	OPD base rate	ASC base rate	Practice expense base rate*
Surgery	43239	Upper GI endoscopy with biopsy	\$347	\$425	\$139
	45378	Diagnostic colonoscopy	387	425	192
	45380	Colonoscopy with biopsy	387	425	209
	45385	Colonoscopy with lesion removal	387	425	260
	66984	Extract cataract, insert lens	1,287	934	—
Radiology	71010	Chest X ray, one view	38	—	21
	71020	Chest X ray, two views	38	—	26
	73510	X ray of hip	38	—	25
	70450	CAT scan of brain/head	237	—	188
	76091	Mammography, both breasts	34	—	56
Diagnostic	93005	Electrocardiogram, tracing	18	—	17
	93017	Cardiovascular stress test	79	—	63
	93307	Echo exam of heart	213	—	171
	93880	Duplex scan of extracranial arteries	132	—	150
Clinic visit	99201	Office or outpatient visit, new patient	48	—	23
	99213	Office or outpatient visit, established patient	48	—	22

Note: HCPCS (HCFA Common Procedure Coding System), OPD (outpatient department), ASC (ambulatory surgical center), GI (gastrointestinal), CAT (computerized axial tomography).

* Practice expense base rates are for services provided in non-facility settings.

Source: HCFA 1999b, HCFA 2000a, HCFA 2000b.

gains or losses from moving to a new system. Some will have a PPS payment about equal to what it would have been under prior law, and a fair number can be expected to have greater payments under the PPS. Other hospitals, however, may receive PPS payments below previous levels.

In the short term, these changes could present financial challenges to hospitals that receive less under the PPS than they would have under the existing payment system. To soften the impact for such hospitals, the Congress included transitional corridor payments in the BBRA. The corridors are designed to make up part of the difference between payments that would have been received under the old payment system compared with the outpatient PPS.

To provide incentives for efficiency, the full difference between PPS payments and

the estimate of what payments would have been under prior law is not compensated.

The amount of transitional corridor payment varies with the extent of the difference between PPS payment levels and estimates of payment under prior law, and the time since implementation of the PPS. The first efficiency incentive provides a greater degree of subsidy to hospitals with costs closer to parity with PPS payments. Thus, to the extent that the PPS payment amounts reflect the cost of an efficient provider, more efficient providers are given greater financial protections. The second factor serves as a transition over time, with declining subsidies provided over the period 2000–2003. The text box on p. 40 explains the transitional corridors in more detail, and Figure 2-1 illustrates the effect of the efficiency incentives by showing

the impact of the transitional corridor payments on total payments to a hospital.

HCFA projects that the transitional corridors will raise total payments to hospitals by 4.4 percent annually in 2000 and 2001 (HCFA 2000b). Total transitional corridor payments will decrease in 2002 and 2003, and end in 2004.

MedPAC concurs with the need for a transitional policy. Although it is complex, the approach laid out in the final rule provides some cushion for hospitals while maintaining incentives for efficiency. Monitoring access to care will be necessary, however, to ensure that beneficiaries remain able to obtain needed services as the PPS is carried out.

The BBRA also provided transitional policies for incorporating innovative and new drugs, biologicals,⁴ and medical

4 Examples of biologicals include blood products, hormones, and antibodies.

Calculating transitional corridor payments

The Balanced Budget Refinement Act established transitional corridors to partially offset losses hospitals might experience as a result of the new outpatient prospective payment system (PPS). The amount of the transitional adjustment depends on the difference between PPS payments and what payments for services provided in the current year would have been under previous payment policy. HCFA determines what would have

been paid under previous payment policy by establishing a hospital-specific payment-to-cost ratio based on 1996 cost reports.⁵ The ratio is then applied to current-year reasonable costs.

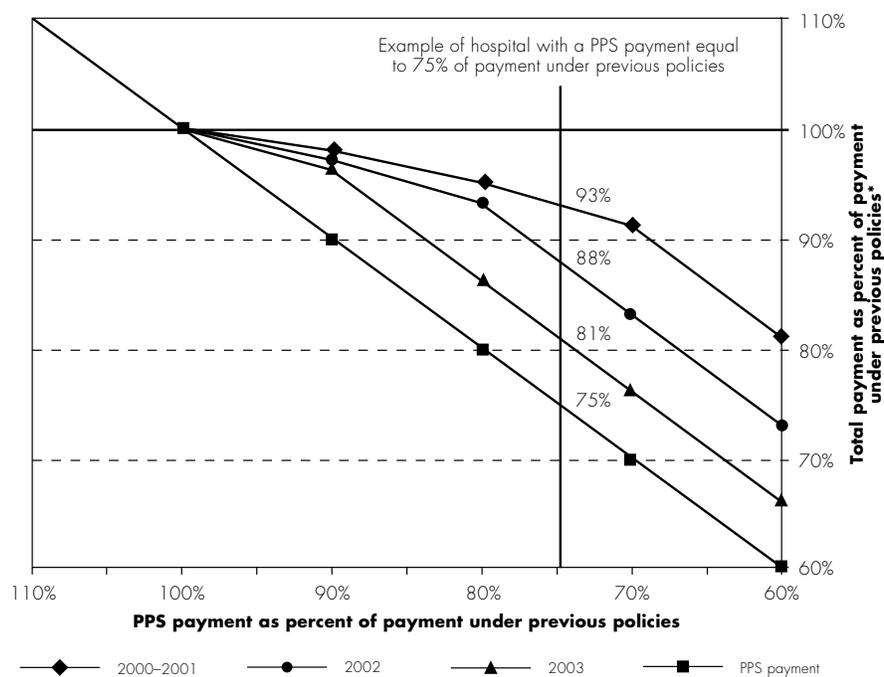
In 2000 and 2001, for the first 10 percentage points of difference between PPS payments and what payment would have been under previous payment policy, an additional payment of 80 percent of the loss is made. For the second 10 percentage points of difference, an

additional payment of 70 percent of the loss is made. For the third 10 percentage points of difference, an additional payment of 60 percent of the loss is made. If the difference between PPS payments and payments under previous policy exceeds 30 percent, no additional compensation is received. In years 2002 and 2003, the percentage of the difference subject to additional payments, and the percent of the loss paid, declines.

Figure 2-1 illustrates total payments—the PPS amount plus the transitional corridor adjustment—for those hospitals that are paid less under the PPS than they would have been otherwise. The longest diagonal line shows the relationship between the PPS amount and what payment would have been under previous policies. Hospitals will fall along a continuum, represented by the x-axis. Some will have PPS payments equal to or greater than 100 percent of payment under previous policies. For these hospitals, no adjustment is made. Other hospitals will have PPS payments below the level of previous policies, and will experience losses mitigated by the transitional adjustment. The vertical line demonstrates the transitional adjustment for hospitals where PPS payment is 75 percent of what it would have been under previous policies in each year. In 2000 and 2001, the transitional adjustments bring hospital payments up from 75 percent to 93 percent of what payments would have been under previous policies. A smaller adjustment is received in 2002 and 2003, bringing total payment up to 88 and 81 percent of what payments would have been under previous policies, respectively. ■

FIGURE 2-1

Effect of transitional corridors on total payments to hospitals, 2000–2003



Note: PPS (prospective payment system).

*Total payment equals PPS payment plus transitional corridor adjustment.

Source: MedPAC analysis of BBRA legislative language.

5 This ratio incorporates the elimination of formula-driven overpayments, which were excessive payments made to hospitals under blended payment methods that failed to adequately account for beneficiary coinsurance.

devices into the outpatient PPS. Unlike the transitional corridors, which address hospital financial performance, these provisions allow for additional payments above the APC group payment rate—termed pass-through payments—for specific classes of items that are generally included in the bundled payment. HCFA has put forth detailed criteria to establish items as eligible for pass-through payments and to determine payment amounts (see Appendix A for additional detail on the transitional pass-throughs).

Although the transitional pass-through payments may help to ensure access to new and innovative technologies, they may also dilute the ability of the prospective payment system to provide incentives for efficiency and cost control. The mechanisms for establishing the pass-through payments introduce cost-based pricing into the PPS. Because data collected during the pass-through process will be used to establish future PPS payment amounts, hospitals and manufacturers have an added incentive to inflate the prices of these products: both current and future payments will increase as a result.

The BBRA stipulates that the transitional pass-throughs be applied in a budget-neutral fashion—increased payments for new technologies must be offset by decreases in total payments for outpatient services. This provision raises a concern. Most studies have shown that new technologies increase costs. Much of the growth in spending for medical services is tied to new technologies (Newhouse 1993). The pass-through payments for new technologies pay hospitals for the increased costs of these technologies but do not account for their cost-increasing nature. The budget-neutrality provision leads to redistribution of payments among services, rather than the provision of new funds, when pass-through payments are authorized. This approach is likely to have a differential impact on hospitals by type; community and rural hospitals will likely see decreased payments, while teaching, specialty, and large urban hospitals will receive increased payments for new

technologies as they are introduced. The impact on rural and community hospitals will depend on the extent to which the update process takes into account costs of new technologies.

Updating payments and considering volume control

As required by the BBRA, the outpatient PPS will be subject to an annual review of classification groups and payment weights. Based on these reviews, HCFA will recalibrate the system and modify groups at its own discretion. Decisions on the payment groups and weights will be made in consultation with an expert, external advisory panel, similar to the Relative Value Scale Update Committee, which advises HCFA on changes to the physician fee schedule. Detailed information on the structure of the advisory panel and its level of authority is not available, although the group is expected to assist in a review of payment groups and weights in 2001.

Beyond establishing a schedule and mechanism for reviewing payment groups and weights, the process for updating payments under the outpatient PPS remains uncertain. By law, an update of the hospital market basket index minus 1 percent can be used by the Secretary through 2002. The Secretary has stated her intention to do so, although she may also design an outpatient-specific update factor.

Careful consideration must be given to the design of future update mechanisms. Options include an expenditure target system, which would limit total spending for outpatient care, and an update framework, which would consider the individual factors influencing the costs of providing care. However they are structured, updates to the outpatient PPS should take into account changes in the underlying costs of providing care, the costs of new technologies, coding changes, and changes in complexity. The

update mechanism must also balance the need to provide adequate payments to ensure access to care with the obligation to control costs by maintaining incentives for efficiency.

In its March report, MedPAC recommended that Congress refrain from establishing a single expenditure target to determine updates for physician services and ambulatory care facilities (MedPAC 2000). Although the goal of consistency in updates across settings is desirable—and speaks to the Commission's concerns regarding differences in payment rates across settings—a global expenditure target is unlikely to accommodate the complex and variable shifts in practice patterns from inpatient to ambulatory settings. Given the potential for shifts of services among ambulatory care settings, the Commission also stated that the Secretary should not establish setting-specific expenditure targets.

Designing an update mechanism is related to the issue of ensuring volume control. MedPAC has previously noted the delicate balance required to develop an update mechanism that counters the incentives to increase use inherent in a fee schedule, while also remaining flexible enough to accommodate clinically appropriate shifts in the site of care. As medical technology advances, more surgical and diagnostic services are provided on an outpatient basis. Thus, some increases in outpatient volume may be appropriate. However, a fee schedule provides incentives to increase the volume of services delivered as a way to maximize payments. In the case of payments to hospital outpatient departments, this incentive is softened by the central role of physicians. Although payments to hospitals will increase if volume increases, physicians—not hospitals—order the diagnostic tests, surgeries, and other procedures that make up the bulk of outpatient services. It is likely, however, that hospitals have some indirect influence on the volume of outpatient services through hospital policies and the direction provided by medical staff.

In the short term, no volume control mechanism will be implemented for outpatient services. The law does, however, allow the Secretary to modify updates in response to unnecessary increases in the volume of services provided. HCFA is currently assessing alternative volume control mechanisms for future implementation. Options presented in the proposed rule included variants on the expenditure target approach used for physician services, whereby future payment updates are reduced in response to excessive increases in volume, defined as increases that take total expenditures beyond the target amount.

Evaluating the nature of changes in the volume of services delivered is complicated by the incentives to improve coding accuracy under the outpatient PPS. Previous payment systems were not always tied to the service codes reported by hospitals; therefore, hospitals did not have an incentive to code accurately. Under the PPS, however, payment will be tied to such coding and improved coding can be anticipated.

Improved coding accuracy may lead to an increase in coding intensity, in which procedures related to greater resource use may be coded more frequently than clinically similar procedures related to lesser resource use. For example, coding for hospital inpatient evaluation and management services has shown an increase in intensity during 1993–1998 (MedPAC 2000). Lower-intensity visits were coded less frequently and higher-intensity visits more frequently over time. This increase in coding intensity may reflect actual changes in the case mix of the Medicare population, changes in coding and administrative practices, or both.

RECOMMENDATION 2B

The Secretary should study the accuracy of and changes in coding practices with the implementation of the outpatient prospective payment system.

Previous research conducted on the inpatient setting indicates that changes in coding practices do significantly contribute to changes in measured case mix. In 1987–1988, the Medicare program's case-mix index (based on diagnosis related group (DRG) data) increased by about 3.3 percent. However, approximately 50 percent of that increase was attributed to changes in coding behavior by hospitals and carriers (Carter et al. 1991). More recent analyses by MedPAC have assessed coding changes in inpatient services by examining data collected by HCFA. A HCFA contractor had independent reviewers assign DRG codes to abstracted medical records for fiscal years 1996–1999. Comparing these independent codes to those assigned by hospitals provides additional insight into how coding changes occur over time. The study found hospital coding to be more intensive than that assigned by the independent reviewers in 1996–1997, but less intensive than the independent coding in 1998.⁶

Because coding behavior is anticipated to change with the implementation of the outpatient PPS, similar analyses are needed for outpatient services to separate which changes in measured service mix are attributable to true changes in resource use versus changes in coding practices. Although inpatient services are reimbursed based on diagnosis or DRG information, outpatient services are reimbursed based on service use or APC information. Measuring service-mix change based on the APC system may present some challenges, due to the unavailability of APC group data until the PPS is implemented. Also, because APC group data are not tied to diagnosis, as the DRG system is, analysis of coding changes may require other approaches.

MedPAC will be considering options for analyzing changes in coding intensity during the coming year. MedPAC also strongly encourages the Secretary to conduct analyses similar to those performed on the inpatient side to tease

out changes in service mix attributable to coding and administrative practices versus changes in the underlying resource use.

Assessing the impact of the outpatient prospective payment system

The outpatient PPS will affect hospitals, beneficiaries, and the Medicare program in different ways. Hospitals face the administrative challenges of revising billing systems and adapting to a new payment system during a short time frame. While they make this transition, the inclusion of transitional corridors will soften the financial impact of moving to a PPS for hospitals that suffer losses under the new system. Beneficiaries will see a decrease in coinsurance payments, but will still pay a disproportionate share of total payments for outpatient services well into the future. Medicare program payments will increase as some costs are shifted from beneficiaries to the program and as cost-increasing transitional policies are carried out.

Impact on hospitals

Although the outpatient PPS has been under discussion for more than a decade and a proposed system was laid out in 1998, there is little time between the release of the final rule in April 2000 and implementation of the new system on July 1, 2000. In that time, hospitals must revise their information management and billing systems and train staff to use them. In addition, in some areas in which payment was not previously tied to coding, such as clinic and emergency visits, physicians as well as hospital staff will need to be trained how to properly code visits and procedures. Some of the provisions of the PPS will be difficult to administer, such as the calculation of separate coinsurance amounts for each APC group. Given the short time frame, industry representatives fear that hospitals and HCFA's intermediaries will not be sufficiently prepared (Pollack and Scully 2000).

⁶ See the discussion of changes in inpatient PPS case mix in Chapter 5 for more detail.

However, the industry is working closely with HCFA to undertake training and minimize disruptions as the new system is instituted. HCFA has launched training activities for both intermediaries and hospitals.

Under the outpatient PPS, hospitals will operate in an environment that rewards efficiency more directly than in the past, but they will also face financial risk if they cannot control costs adequately. The overall effect of the new payment system on individual hospitals will depend on their ability to adapt. The experience from inpatient PPS implementation suggests that hospitals can rapidly modify behavior in response to new payment rules (Altman and Young 1993, Russell 1989). Behavior changes that might influence the impact of the outpatient PPS on individual hospital financial performance include improved coding and increased efficiency (such as limiting labor, supply, and overhead costs incurred in providing outpatient care). As hospitals make these changes and adapt to the new policies, the transitional corridors will provide respite from severe financial losses.

Two classes of hospitals are protected from the potentially negative effects of moving to the outpatient PPS: rural hospitals with up to 100 beds and cancer hospitals.⁷ Total payments to these hospitals for covered services must be at least equal to 100 percent of what they would have been under previous payment policy.⁸ If outpatient PPS payments are lower than they would have been, then additional payments will be made. No adjustments will be made if outpatient

PPS payments are above the pre-BBA amount. This “hold harmless” provision applies to small rural hospitals through 2003, and is permanent for cancer hospitals. These provisions are not required to be budget neutral.

MedPAC has previously recommended that adjustments to payment rates, where feasible, be based on patient characteristics, rather than facility characteristics. The final rule governing the PPS does not include patient-level adjusters. We reiterate our concern that facility-level adjustments, such as those for small rural and cancer hospitals, provide differential treatment by hospital class that is not necessarily tied to underlying differences in the populations served by these facilities. As required by the BBRA, MedPAC will study the appropriateness of using the outpatient PPS for payments to cancer hospitals and certain rural hospitals.

HCFA estimates that some classes of hospitals will fare better under the outpatient PPS than others. Table 2-2 presents estimates of annual changes in total outpatient payments to hospitals under the PPS, with and without the transitional corridors, for 2000 and 2001.⁹ The distributional impacts excluding the transitional corridors provide an understanding of the effect of the PPS alone. This is the system that will remain in place after the transitional corridors end in 2004 and shows the distributional impacts of the long-term policy change. Without the transitional corridors, overall hospital payments would increase slightly under the PPS (0.2 percent) due to the

hold-harmless provisions for cancer hospitals.¹⁰ The estimates show that large urban hospitals would have seen a small (0.3 percent) annual decline in total payments, and rural hospitals would have experienced a larger, but still small, decline of 1.8 percent. Among rural hospitals, those with fewer beds could be expected to experience large annual decreases in payments (8.5 percent for 1–49 beds and 2.7 percent for 50–99 beds), while rural hospitals with 150 or more beds would experience increases of about 2.5 percent. In urban areas, only hospitals with 500 or more beds are projected to suffer losses (2.9 percent) under implementation of the PPS in the absence of the transitional corridors. Considering the estimates by teaching status, major teaching hospitals would have experienced a reduction in total payments of 3.7 percent if the outpatient PPS were implemented without the transitional corridors. Cancer hospitals are expected to experience a slight increase in total payments (0.8 percent) due to the hold-harmless provisions.

In the short term, the distributional impacts of moving to a PPS are muted by the transitional corridors. After accounting for the transitional corridors, most of these estimated decreases become increases. For all hospitals, annual payments will increase by 4.6 percent in 2000 and 2001. For hospitals also subject to the inpatient PPS, the impacts are all positive, with slight variations by location, bed size, teaching status, and ownership. For hospitals exempt from the inpatient PPS (referred to as TEFRA hospitals¹¹), the impacts range from small, negative

7 HCFA's impact estimates under the proposed rule indicated that these hospitals would be severely affected by the PPS, with Medicare outpatient payments declining by 32 percent for cancer hospitals, 14 percent for rural hospitals with fewer than 50 beds, and 8 percent for rural hospitals with 50–99 beds (HCFA 1999a).

8 Payment under previous policies is defined as the hospital's reasonable costs for providing covered outpatient services in the current year, multiplied by a base payment-to-cost ratio for the hospital for 1996. The payment-to-cost ratio is determined after the elimination of formula-driven overpayments, which were excessive payments made to hospitals under blended payment systems that failed to adequately account for beneficiary coinsurance.

9 The PPS will be operating for only six months in 2000, so the actual impact for that year is half of that reported. Numbers are estimated impacts based on claims data from 1996. In estimating the impacts, HCFA made no adjustments for future changes in volume and intensity or coding behavior.

10 For the impact estimates, HCFA included the hold-harmless provisions for small rural hospitals in the transitional corridors because they expire in 2004. The hold-harmless provisions for cancer hospitals, however, are not included in the transitional corridors because they are permanent. The impact of other provisions of the BBA, such as formula-driven overpayment elimination, on hospital financial performance are discussed in Chapter 5.

11 TEFRA hospitals are paid according to rules established by the Tax Equity and Financial Responsibility Act of 1982 and modified by the Social Security Amendments of 1983. See Chapter 6.

**TABLE
2-2**

Projected impact of outpatient prospective payment system on payments to hospitals, 2000–2001

Hospital group	Number of hospitals	Percent change in total Medicare outpatient payments excluding transitional corridors*	Percent change in total Medicare outpatient payments including transitional corridors [§]
All hospitals	5,362	0.2%	4.6%
Non-TEFRA hospitals	4,828	0.1	4.6
Urban [#]	2,665	0.6	4.6
Large urban (>1 million)	1,505	-0.3	4.3
Other urban (<1 million)	1,160	1.8	5.1
1–99 beds	672	0.6	4.6
100–199 beds	924	1.3	5.2
200–299 beds	533	0.8	4.4
300–499 beds	399	1.8	5.2
500+ beds	137	-2.9	2.8
Rural	2,160	-1.8	4.4
1–49 beds	1,170	-8.5	3.3
50–99 beds	615	-2.7	4.4
100–149 beds	223	-0.2	3.8
150–199 beds	81	2.5	5.5
200+ beds	71	2.7	6.1
Teaching status			
Minor	821	1.6	5.0
Major	269	-3.7	2.6
Nonteaching	3,738	0.5	5.0
Ownership status			
Voluntary	2,816	0.6	4.7
Proprietary	752	-0.1	4.7
Government	1,260	-2.3	3.6
Cancer	10	0.8	0.8
TEFRA hospitals			
Rehabilitation	147	-9.4	1.7
Psychiatric	281	21.3	27.9
Long-term care	65	-15.3	-1.7
Children's	41	-11.9	-3.2

Note: TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

* Includes all BBRA provisions except the transitional corridor provisions that expire January 1, 2004.

[§] Estimates of change compared with prior policy payments, which reflect the payment methodologies in effect as of January 1, 2000, and prior to July 1, 2000.

[#] Does not include the impact of reclassifications as allowed under section 401 of the BBRA.

Source: Adapted from HCFA 2000b.

impacts for long-term care and children's hospitals to a large, positive impact on psychiatric hospitals. However, HCFA states that the estimates for these hospitals may be affected by differences in coding and billing procedures for TEFRA hospitals.

Impact on beneficiaries

The outpatient PPS carries out provisions of the BBA designed to decrease beneficiary financial liability for outpatient services. Historically, beneficiary coinsurance was based on hospital charges, and Medicare program payments were based on reasonable costs

minus beneficiary deductibles and coinsurance. As hospitals' charges have increased more rapidly than costs over time, beneficiaries' coinsurance payments have come to represent an increasingly large share—currently around 50 percent—of the total payment that hospitals receive. The BBA mandated that

beneficiary coinsurance eventually equal 20 percent of the payment rate under the outpatient PPS, similar to the coinsurance rate in other areas of the program. However, the process for achieving a 20 percent coinsurance rate—referred to as the beneficiary coinsurance buy down—is gradual and could take decades to achieve. MedPAC has previously recommended that Congress pass legislation to increase the rate of the beneficiary coinsurance buy down, thereby allowing for a more equitable distribution of payments. We reiterate that recommendation here.

RECOMMENDATION 2C

The Congress should enact legislation to accelerate the rate of beneficiary coinsurance buy down under the outpatient prospective payment system and establish a date certain for achieving a coinsurance rate of 20 percent. This date should result in a time frame for implementation consistent with other Medicare payment policy changes.

Under the outpatient PPS, beneficiaries will, as a whole, pay a smaller share of total outpatient payments than they did under prior law. Historically, beneficiaries' coinsurance amounts were specific to the hospital in which the service was provided. Under the outpatient PPS, however, all beneficiaries will face the same schedule of coinsurance amounts, adjusted to reflect geographic wage differences.¹²

The method used by HCFA to calculate the coinsurance amounts leads to a reduction of about 10 percent in beneficiary coinsurance overall (HCFA 1999a). Those savings for beneficiaries will be shifted to program spending; they will not become net reductions in

payments to hospitals. The outpatient PPS also limits beneficiary coinsurance amounts for a given service to the amount of the inpatient hospital deductible (\$776 in 2000). About 15 APC groups have national unadjusted coinsurance amounts that meet this limit in 2000. Given that the coinsurance amounts are frozen, the only additional services that could be subject to the limit will be new, expensive ones.¹³

As mentioned previously, the outpatient PPS also implements the buy-down provisions of the BBA. The buy down of the beneficiary coinsurance rate will occur on a service-by-service basis. Analysis of the copayment amounts by APC in the final rule indicates that when the outpatient PPS is first implemented, beneficiary coinsurance will represent, on average, 47 percent of the payment rate for a service.¹⁴ Buying this percentage down to 20 percent is projected to take 45 years, on average (see text box, p. 47). In contrast, the inpatient PPS for hospitals' operating expenses was phased in over four years, while the move to the physician fee schedule took five years. A more gradual, 10-year transition period was used to adopt prospective payment for hospitals' capital expenses under the inpatient PPS.

The average time to achieve the coinsurance rate of 20 percent masks considerable variation in the rate of beneficiary coinsurance buy down among services (Table 2-3). A few services, including outpatient visits and new technology APCs, will have coinsurance amounts already limited to 20 percent of the base payment amount. For these APCs, there is no buy-down period. For other services, achieving a coinsurance rate of 20 percent will take decades.

MedPAC estimates that buying down the coinsurance payment for computerized axial tomography scans (APC group 0283) will take 71 years. For an upper gastrointestinal endoscopy (APC group 0141), the buy down will take 52 years. As discussed in the text box, these estimates are dependent upon assumptions regarding annual update amounts.

Impact on the Medicare program

The Medicare program will benefit from a simplified payment system that allows for more predictable costs and better cost-control measures. However, establishing the PPS will lead to increased program costs, even without increases in the volume of services provided, partly due to the shift in costs from beneficiaries to the program. The transitional corridors and hold-harmless provisions will also increase spending.

HCFA projects that costs will increase by \$490 million in fiscal year 2000 and \$3 billion in fiscal year 2001, and by a total of \$16 billion for fiscal years 2000 through 2004 (HCFA 2000b). The Office of the Actuary estimates that about 20 percent of this increase is due to the transitional corridors and hold-harmless provisions. Almost 40 percent is due to the one-time shift in costs from beneficiaries to the program, which results from the method HCFA used to calculate the base coinsurance amounts for each APC group. Approximately 1 percent is due to the limit on beneficiary copayments. The remainder (about 39 percent) represents increases in costs due to the buy down of beneficiary coinsurance over time and anticipated increases in the volume of services provided (Warfield 2000). These

12 Note that the relationship between previous coinsurance amounts and PPS coinsurance amounts for a given beneficiary will vary with a hospital's historical charge structure. If the hospital's charge was above the median, the PPS coinsurance amount will be less than before; if the historical charge was below the median, beneficiaries may actually face a higher coinsurance amount. Hospitals have the right to waive a portion of the coinsurance amount above 20 percent of the PPS payment rate for an APC group, as long as they do so for all beneficiaries and for all services in the group.

13 The limit on coinsurance will be applied only after coinsurance amounts are subject to geographic wage adjustments. Thus, the services affected by the limit may vary by location.

14 This figure is derived by dividing the unadjusted national coinsurance amount by the APC payment rate for each service. The percent coinsurance is then averaged over all services. A coinsurance amount of \$776 is used for services for which the unadjusted national coinsurance is above \$776. This calculation is distinct from the share of total payments paid by beneficiaries, because the latter is influenced by volume and service mix.

**TABLE
2-3**

Years required to buy down beneficiary coinsurance to 20 percent of payment, for selected high-volume ambulatory payment classification groups

Type of service	APC group	Group title	Payment rate	Coinsurance amount	Initial coinsurance share	Years to achieve 20 percent coinsurance*
Surgery	0141	Upper GI procedures	\$347	\$185	53%	52
	0143	Lower GI endoscopy	387	199	51	50
	0246	Cataract procedures with IOL insert	1,287	624	48	47
Radiology	0260	Level I plain film except teeth	38	22	57	56
	0283	Level II computerized axial tomography	237	179	76	71
	0271	Mammography	34	19	57	56
Diagnostic	0366	Electrocardiogram	18	16	85	77
	0097	Cardiovascular stress test	79	62	79	73
	0269	Echocardiogram except transesophageal	213	114	53	52
Clinic or emergency visit	0600	Low-level clinic visits	48	10	20	0
	0601	Mid-level clinic visits	48	10	20	0
	0610	Low-level emergency visits	65	21	32	25

Note: APC (ambulatory payment classification), GI (gastrointestinal), IOL (intraocular lens).

* The estimated years to achieve 20 percent coinsurance is based on an assumed update of 1.9 percent. A higher update assumption yields a lower estimate. See text box, p. 47, for more information on the beneficiary coinsurance buy down.

Source: MedPAC analysis of Addendum A, HCFA 2000b.

estimates include the compounded costs of increased payments over time. They are associated with implementation of the outpatient PPS, but do not represent all of the changes to outpatient payments under the BBA. Other policy changes, such as the elimination of the formula-driven overpayment and the extension of capital and operating cost reductions, reduced outpatient payments substantially.¹⁵

Although program costs for outpatient services will increase, the program should benefit from moving to a unified, simpler payment system. Achieving the goal of simplicity is hampered, however, by layers of complexity introduced in the BBRA. Considerable administrative resources will be required to process the outlier payments, pass-through payments, transitional corridors, and hold-harmless adjustments. In addition, the administrative burden of setting up and maintaining new claims processing systems will be significant for HCFA, its fiscal intermediaries, and hospitals.

Ensuring beneficiary access to quality care

The move to a prospective payment system represents a significant change in how Medicare pays for outpatient services, including the introduction of a grouping methodology for payment, an expanded list of outpatient procedures, and a change in beneficiary coinsurance amounts. In addition, the time allowed for implementing the changes is short, leading to significant administrative challenges for hospitals. Given the scope of the changes and the limited time frame, the Commission strongly recommends that the Secretary monitor various aspects of the PPS to ensure continued beneficiary access to quality services.

RECOMMENDATION 2D

The Secretary should carefully monitor implementation of the outpatient prospective payment system to ensure that:

- **it does not have unintended, adverse consequences on beneficiaries' access to care,**
- **it does not compromise the quality of care delivered, and**
- **the annual reductions in beneficiary coinsurance as a share of total payment are realized.**

The Commission's concerns about access arise from structural aspects of the payment system, the financial and administrative impacts of the PPS on individual hospitals, and the relatively complex process for reducing beneficiary financial liability for outpatient services.

The use of a grouped classification system provides incentives to limit the use of

¹⁵ See Chapter 5 for a discussion of the impact of these reductions on hospital outpatient margins.

Beneficiary coinsurance buy down

Under the outpatient prospective payment system (PPS), each Ambulatory Payment Classification (APC) group has a unique rate of coinsurance derived from historical experience. The average coinsurance rate across APC groups is 47 percent. The Balanced Budget Act of 1997 established a system for buying the beneficiary coinsurance share of total payment down to 20 percent over time. This buy down will be achieved separately for each APC group. To reach a coinsurance amount of 20 percent, the coinsurance amount for an APC group is frozen, while the total payment rate increases with the annual updates. For example, if an APC group has a total payment of \$1000 and a coinsurance amount of \$470, coinsurance equals 47 percent of total payment. Assuming an annual update of 1.9 percent, total payment would be \$1019 in the next year and coinsurance would remain at \$470, which is now 46 percent of total payment. Once the coinsurance rate is 20 percent, the coinsurance amount will also increase by the annual update.

The buy-down mechanism may be stated as the following mathematical relationship:

$$\frac{\text{Coinsurance amount}}{\text{Total payment} \times (1 + r)^t} = 0.20$$

Where r is the annual update rate of growth and t is the number of years required to achieve beneficiary coinsurance liability of 20 percent. This equation is then solved for t .

In Table 2-3, r is assumed to be 1.9 percent, HCFA's estimate of the hospital market basket for 2001 minus 1 percentage point. The outpatient PPS payment rates will be updated by the hospital market basket minus 1 percentage point in 2001 and 2002.

The estimate of the years required to achieve the beneficiary coinsurance buy down is sensitive to the growth rate assumption. For this example, if a growth rate of 3 percent is assumed, then the average number of years required to achieve the buy down drops to 29. ■

outcomes of care for beneficiaries receiving outpatient services previously limited to the inpatient setting is necessary. HCFA has indicated that the use of observation beds will be monitored to ensure that patients receiving these services are not kept in observation beds for an extended period instead of being admitted to the hospital. However, to ensure adequate quality, monitoring should go beyond the extent to which hospitals use observation beds after these procedures are performed to include analysis of the outcomes of care.

Finally, the process for buying down beneficiaries' disproportionate share of payments for outpatient services is relatively complex. Each APC group has its own coinsurance amount, based on historical charges. The reduction in beneficiary payments as a share of total payment takes place as the outpatient PPS payment rates are updated each year. As previously noted, the time taken to reach a coinsurance rate of 20 percent varies by APC group. Hospital representatives have suggested that the APC-group-specific changes in coinsurance amounts could generate confusion for hospital billing clerks and beneficiaries. Educational efforts are needed to inform hospitals and beneficiaries about the changes in coinsurance over time.

The limits placed on balance billing by physicians in the early 1990s provide an example of implementing a policy meant to limit beneficiary coinsurance. Physician compliance with the balance billing limits was a concern; non-compliance was found to be primarily due to physicians' poor understanding of the law. Congress passed clarifying legislation allowing HCFA to enforce the limits and impose sanctions if necessary (PPRC 1996). Given the complexities of the buy down and given previous experience with implementing restrictions on balance billing by physicians, it will be important to monitor whether beneficiaries realize the reductions in financial liability over time.

The Secretary has noted her intention to evaluate the operation of the outpatient

higher-cost services within a payment group, even when they may be more clinically appropriate than lower-cost services in the group. Although this incentive is diminished by the limitation in cost variation among services in a group, one service in a group may still be twice as expensive as another. In addition, the bundling of ancillary services and items for payment may lead to stinting on ancillary services and items. Financial losses and/or the administrative burdens resulting from transition to the PPS might also lead hospitals to limit access to all or some outpatient services for Medicare beneficiaries. Although the transitional corridors will minimize financial losses, individual hospitals may still find it difficult to contain costs and, consequently, may limit the provision of outpatient services to Medicare

beneficiaries. The phasing out of the transitional corridors by 2004 increases the potential for future access problems. The administrative burden of carrying out a new payment system in a short period of time may also lead to access problems.

In addition to concerns about access, some elements of the PPS raise quality concerns. Expanding the list of services that can be provided in an outpatient setting to include services such as insertion and removal of pacemakers, surgical laparotomies, and bone marrow transplantation entails an obligation to ensure adequate quality of care for beneficiaries receiving these services in this setting. Although HCFA states its expectation that only the least intensive cases would be treated in an outpatient setting, careful monitoring of the

PPS, but provides no specific plans to monitor beneficiary access to care as the PPS is implemented. Given the magnitude of the change, significant resources should be devoted to monitoring access. Access and quality indicators that might be developed include:

- changes in the provision of services in outpatient departments overall and by hospital type,
- shifts in the settings in which care is delivered,

- differential outcomes of care among settings and pre- and post-PPS,
- post-procedure admission rates for services that shift from inpatient to outpatient settings,
- changes in hospitals' willingness to provide outpatient services to Medicare patients,
- rates of decrease in beneficiary coinsurance amounts, and
- other measures that could indicate compromised access.

This recommendation is consistent with our March report to the Congress, which recommended that the Secretary make a greater effort to ensure that the considerable changes occurring in the Medicare program not compromise beneficiaries' access to quality care (MedPAC 2000). MedPAC will work to develop appropriate methods for assessing the adequacy of access to quality outpatient services. ■

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