WORKING
PAPER

Medicare Payment for Hospital Outpatient Services

A Historical Review of Policy Options

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HEALTH

SUMMARY

The Medicare prospective payment system for hospital outpatient services has been subject to continuing debate since it was implemented August 1, 2000. Policy issues directly related to how payment is determined under the under the current system include:

- The ambulatory payment classification (APC) system used to group procedures for payment purposes,
- The items and services that are packaged into the APC payment,
- The methodology used to determine the costliness of one APC relative to other APCs, and
- The treatment of new technology and high cost drugs.

In addition, there are concerns over using different payment methodologies across ambulatory settings and the lack of an effective mechanism to control aggregate Medicare expenditures for ambulatory services.

The purpose of this study was to identify the alternative approaches that were considered for payment of hospital outpatient services when the outpatient prospective payment system (OPPS) was designed and to consider their relevance today.

STUDY APPROACH

The study focuses on the policy development period preceding the initial implementation of the OPPS. It begins with the first mandate for a prospective payment system for hospital outpatient services in the Omnibus Budget Reconciliation Act of 1986 (OBRA-86) and ends with the implementation of the OPPS in August 2000. A two-fold approach was taken to identifying the issues and policy alternatives that were considered during the period. First, government documents and research reports dating from this period were collected and reviewed. Second, individuals who were involved at various stages and in different roles in the development and implementation of the OPPS were interviewed.

SUMMARY OF FINDINGS AND IMPLICATIONS

The rapid growth of hospital outpatient services following the implementation of the PPS for acute care hospital inpatient services in 1983 led to interest in creating payment incentives to promote more efficient delivery of outpatient services. Most hospital outpatient services were paid the lesser of the hospital's reasonable cost or customary charges for services furnished to Medicare beneficiaries. Over time, service-based payment methodologies were developed for certain types of services, including fee schedules for clinical laboratory tests and for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Payments for ambulatory surgical procedures and for radiology and other diagnostic tests were based on a blend of the hospital's aggregate Medicare costs for these services and Medicare's payments for similar services in other ambulatory settings. In all, there was a confusing mix of at least eight different payment methodologies by the time the OPPS was implemented in 2000.

OBRA-86 spurred the development of an OPPS. The legislation required the Department of Health and Human Services (HHS) to develop and report to Congress on a fully prospective payment system for hospital outpatient services in two stages. The first stage was to focus on ambulatory surgical procedures and, to the extent practical, was to provide for an all-inclusive rate for the services. The second stage was to develop a model system for other hospital outpatient services. Subsequent legislation provided additional requirements for the full OPPS. The final statutory requirements for the OPPS were established by the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999 (BBRA).

Reports to Congress by the HHS Secretary and the Prospective Payment Assessment Commission (ProPAC) articulated common policy goals for the OPPS.[1] The overall goal was to provide incentives for the efficient delivery of high quality medically necessary outpatient care to Medicare beneficiaries. Other important attributes were whether the system provided similar financial incentives for care across ambulatory

[1] ProPAC was one of the predecessor agencies to the Medicare Payment Advisory Commission (MedPAC).

settings, administrative simplicity, predictability, limited opportunities for "gaming", and incentives for controlling total program expenditures.

The policy debate in the reports to Congress on the OPPS raised three basic issues related to defining the unit of payment:

- *Grouping*. One issue was the extent to which clinically similar procedures should be grouped for payment purposes and the logic that should be used for the groupings. The advantages of grouping were that it created a manageable number of units of payment and provided a method for pricing low-volume procedures. Commonly cited disadvantages were that it created units of payment that were inconsistent with the procedure-level fee schedules already in use in other ambulatory settings and reduced procedure-level payment accuracy for higher volume procedures.
- *Packaging*. A second issue was the extent to which ancillary services associated with a significant procedure should be packaged into a single payment for the procedure. Packaging was seen as a way to create incentives for efficiency. Commonly cited disadvantages of extensive packaging were that it was inconsistent with the fee schedules already in use in other ambulatory settings, reduced payment accuracy, and potentially created incentives for "gaming" by shifting the delivery of packaged ancillary services to other settings.
- *Bundling*. The third issue was the extent to which multiple significant procedures related to an outpatient encounter or to an episode of care should be bundled into a single unit of payment. This issue included the question of whether services prescribed during an outpatient encounter but furnished in a non-hospital setting should be bundled into the payment. Bundling was seen as a way to create incentives for efficiency comparable to the inpatient PPS. The policy disadvantages were similar to those applicable to packaging. The technical policy issues related to developing and implementing a bundling policy

that involved services provided over a span of time and by different providers made bundling a long-term policy objective.

A prospective payment system relies on an "averaging" concept, so that payment may be more or less than the estimated costs of providing particular services, but on average it is adequate to assure access to high quality care. The policy decisions regarding grouping, packaging and bundling involved a trade-off between establishing incentives for efficiency through larger units of payment and payment accuracy. Different aspects of payment accuracy were raised in the OPPS policy debate:

- One aspect relates to establishing an accurate payment rate for unit each of payment. Here, a major issue is the use of *accounting costs* to reflect differences in resource costs. Accounting costs refers to a method of determining the costs of outpatient services using annual cost reports filed by hospitals. Direct and indirect costs are allocated to each ancillary service department through a cost finding methodology and then apportioned to Medicare based on a ratio of Medicare charges to total charges for the ancillary service department. The methodology relies on accurate cost finding and on charges that are consistently related to costs. Other issues include: the use of median or mean costs to determine payment rates; the reliability of cost data for low-volume procedures; assigning ancillary procedures when multiple significant procedures are performed; and, combining services that were separately billed into a single unit of payment.
- A second aspect relates to the amount of cost variation within the payment groupings. There is variation across hospitals in the cost of providing a particular procedure. Additional variation is introduced through broad procedure groupings, packaging of associated ancillary services with the primary procedure, and bundling of multiple procedures related to an outpatient encounter into a single payment (or bundling of all procedures performed over a period of time into a single per

episode of care payment). Here, the issue is the likelihood that on average the payment will be accurate given the amount of cost variation within the grouping. Increased cost variation does not necessarily reduce payment accuracy at the hospital-level unless there are systematic differences across hospitals in the services included in the unit of payment. However, it reduces service-level payment accuracy and could create inappropriate incentives for "gaming" by shifting higher cost services to alternative ambulatory settings.

The two aspects of payment accuracy are somewhat inter-related. If the unit of payment is relatively large, there is more room for balancing inaccuracies in establishing the cost of the services covered by the rate than if the rate covers a small unit of payment such as an individual procedure.

The HHS report to Congress on the OPPS was issued in 1995. The report recommended using Ambulatory Payment Group (APG)-like procedure groupings as the basic unit of payment (which the Health Care Financing Administration (HCFA) later called APCs). The groupings consisted of procedures that were similar clinically and with respect to resource costs. Four general areas were identified as requiring additional research: defining the unit of payment (bundling and packaging policies), determining how well accounting costs reflect resource costs, examining use of the procedure groupings in other ambulatory settings, and accounting for legitimate cost differences across classes of hospitals. The report indicated that as further research was completed and better data became available, the OPPS could evolve to include more extensive packaging of ancillary services and to cover services in other ambulatory settings. The report made no recommendations regarding mechanisms to control aggregate expenditures.

The 1995 HHS report to Congress also raised a major concern with beneficiary coinsurance. The law required that beneficiaries pay 20 percent of submitted charges for hospital outpatient services paid on a cost-related basis. Hospital charges substantially exceeded Medicare's

cost-based payment amount. As a result, beneficiaries typically paid substantially more than 20 percent of Medicare's payment amount.

The beneficiary coinsurance issue created an impetus for adopting an OPPS as soon as possible. Adopting policies that were technically feasible to implement in the short-run and were unlikely to involve protracted policy development and debate became overriding considerations in the initial PPS design. Articulated policy goals that were deferred as implementation became the paramount concern were:

- Creating financial incentives for the efficient use of ambulatory services through packaging and bundling policies;
- Establishing consistent payment policies across ambulatory settings; and,
- Controlling aggregate expenditures for hospital outpatient services.

The perceived advantages and disadvantages of alternative policies that were considered when OPPS was initially implemented generally remain relevant. However, as the OPPS has evolved, concerns over the payment accuracy for services furnished to particular patients have been given precedence over creating incentives for efficient delivery of care. The "averaging" concept that underlies the inpatient PPS and the initial OPPS-construct has eroded as the OPPS payments have become increasingly less packaged and the procedure groupings have narrowed. Arguably, unpackaging further increases the importance of payment accuracy since there is increasingly less room within the payment to offset higher costs for some items and services with lower costs (or no usage) for others.

Goals such as administrative simplicity and financial incentives for efficient use of ancillary services have been given less attention in the post-implementation period. At the same time, the OPPS payment policies increasingly resemble those for other ambulatory settings. Indeed, the more fee schedule-like appearance of the OPPS rates coupled with other developments——such as growth of ambulatory surgical center (ASC) services, implementation of the resource-based relative value scale for the practice expense component of the physician fee schedule,

improved coding on hospital outpatient claims—suggest that progress might still be made on rationalizing the payment systems across ambulatory settings. Updating the research on differences in resource costs for high volume procedures across ambulatory settings should be considered as part of this initiative. In using accounting costs to set the APC relative weights, the OPPS depends on hospital charges being consistently related to costs. Hospital charges have been increasing rapidly relative to costs and there is evidence of substantial differences in hospital markups across hospitals and by type of services. Current hospital charging practices challenge more than ever the assumption that accounting costs accurately reflect a hospital's costs for specific items and services.

Several issues that have created extensive policy debate during the post-implementation stage—new technology, devices and expensive drugs—received minimal attention in the initial PPS development. As a result, there is little information on alternatives that were considered for new technology during the OPPS design period.

The reports produced by HHS and ProPAC during the pre-implementation period envisioned that work would proceed towards the longer-term policy goals after the initial PPS was implemented and that the payment system would evolve to include more packaging and to expand to other ambulatory settings. However, other priorities and the resource demands imposed by the current system over the years, particularly with continuing legislative changes, interfered with research and policy development activities on the longer-term goals. When the OPPS is viewed independently, the individuals that were interviewed for this study seemed to believe that for the most part the OPPS payment system was maturing and stabilizing. However, when OPPS is considered within the broader context of ambulatory care payment, the goals of rationalizing payment methodologies across ambulatory settings and using financial incentives to control aggregate ambulatory expenditures remain important but unrealized.