CHCPP NEWS
COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

HCFA Publishes Proposed Rule On Hospital Outpatient Prospective Payment System

In September the Health Care Financing Administration (HCFA) published the proposed rule for a prospective payment system (PPS) for hospital outpatient departments.[1] The rule will replace the current cost-based system with one using ambulatory payment classifications (APCs). The outpatient PPS will affect about 5400 hospitals nationwide, and along with several related payment reductions, will save $6.66 billion from fiscal year 1998 through fiscal year 2003.

The average hospital will see its outpatient Medicare payments reduced 3.8% under the proposal and its total Medicare payments cut 0.4%, according to HCFA. The new system redistributes the current total Medicare payments, based in part on cost-based payments and in part on blended amounts, across all services. Hospitals, in the aggregate, will receive proportionately less for currently cost-based services and more for services that had been paid under blended payment methods.

Responding to the Balanced Budget Act of 1997, the rule will eliminate formula-driven overpayment for certain outpatient hospital services and extend reductions in payment for costs of hospital outpatient services. The rule also establishes PPS regulations for hospital outpatient services.

Areas that will continue to be paid under the old cost-based system include laboratory services that were paid under the clinical diagnostic-laboratory fee schedule, durable medical equipment, ambulance services, physical and occupational therapy, speech-language pathology and some end-stage renal disease services.

Following are key elements of the proposed rule.

Delay in implementation. The effective date for implementation had been January 1, 1999, but year 2000 computer system problems at HCFA have delayed implementation until after January 1, 2000. Rates will be based on those that would have been in effect on January 1, 1999, updated by the increase in the hospital marketbasket minus one percentage point. HCFA reports no negative impact on hospitals from the delay in implementation.

Elimination of formula-driven overpayment. Effective October 1, 1997, payment for radiology and other diagnostic services under blended payment methods will be calculated by subtracting the full amount of copayment due from the beneficiary (based on 20% of the hospital's billed charges). Before enactment of the Balanced Budget Act under the blended payment formulas for radiology and other diagnostic tests, the physician fee schedule portion of the blends was calculated as if the beneficiary paid 20% of the physician fee schedule amount instead of the actual amount paid, which was 20% of the hospital's billed charges.

Hospital Outpatient PPS. The new system will use 346 APC groups to pay hospitals for outpatient services delivered to Medicare beneficiaries. The groups' composition is based on the premise that procedures within each group must be similar clinically and have similar resource costs. The Society, which has played an active role in proposing APCs for nuclear medicine, recommended 10 classifications to HCFA. HCFA has accepted nine: standard and complex nonimaging; standard and complex planar; standard and complex SPECT; standard and complex therapy; and PET, wherein standard and complex procedures were collapsed into one APC.

In addition, all nuclear medicine APCs are considered "significant procedures" and are not subject to the "multiple procedure reduction" policy

Radiopharmaceutical costs bundled into the APC. Medicare has traditionally reimbursed for radiopharmaceuticals separately from nuclear medicine procedures, while the HCFA proposal bundles radiopharmaceutical costs into the APC procedure payment. The agency defines packaged services as those that are recognized as contributing to the cost of the service in an APC but which are not paid for separately, such as supplies and radiopharmaceutical costs. SNM has expressed concerns about bundling radiopharmaceutical costs into the procedure APC.

HCFA reports that it gathered aggregate cost data on all drugs billed with HCFA Common Procedure Coding System (HCPCS) codes and those billed with revenue center codes, whether or not an HCPCS was entered. After reviewing payment rates for nuclear medicine APCs, the Society believes there were errors in HCFA's methodology and that claims data from 1996 for radiopharmaceuticals were not complete or accurate in constructing nuclear medicine APC weights. During a recent telephone conference, representatives of HCFA agreed that its data might not have captured all the alphanumeric HCPCS codes. The agency will review the data and reanalyze the nuclear medicine groups to ensure that all HCPCS codes from 1996 were captured.

Another problem specific to nuclear medicine is that Medicare policies on billing and coding for radiopharmaceuticals changed frequently and significantly during 1994–1996, the time when HCFA collected claims data to develop the proposed rule. As a result, reported data from hospitals on radiopharmaceuticals may not accurately reflect reasonable costs associated with these products.

Lastly, HCFA created separate (unpackaged) groups for various chemotherapeutic agents because some agents had high costs that would not be recognized if those drugs were packaged into the median cost for chemotherapy administration. Since this argument is similar to that for the wide range of costs for radiopharmaceuticals,

SNM is reviewing the feasibility of separate radiopharmaceutical APCs.

Methodology. In developing the new system, HCFA matched the database of 98 million hospital outpatient claims paid in

[1] *Federal Register* September 8, 1998.

Table 1
Nuclear Medicine-Related APCs

APCs	Group Title	Relative Weight	Payment Rate
761*	Standard Non-Imaging	2.04	$103.37
762*	Complex Non-Imaging	1.78	$90.19
771	Standard Planar	3.78	$191.53
772	Complex Planar	4.22	$213.83
781	Standard SPECT	5.26	$266.52
782	Complex SPECT	9.28	$470.21
791*	Standard Therapy	15.83	$802.10
792*	Complex Therapy	4.80	$243.21
760	PET Scans	17.26	$874.55

*These groups are anomalous because the "complex" group in each case has a lower weight than the one entitled "standard" owing to the cost of the procedure itself compared to the cost of the radionuclide involved. SNM is working with HCFA to correct these anomalies.

1996 to the most recent cost reports to determine median costs for services and procedures within each APC group. The relative payment weights are based on median hospital costs. To calculate median costs for services within an APC, HCFA used only single-procedure bills. HCFA notes that using such procedures to compute a weight for services that are not typically billed as a single procedure could result in rates that are not accurate for these services. The multiple-procedure bills were used in the service-mix calculations, regressions and impact analyses.

HCFA then assigned to each APC group an appropriate weighting factor to reflect the median costs for the services within the APC group compared to the median costs for the services in all APC groups.

Adjustments were made to standardize costs for geographic wage variation (labor-related costs). All adjustments were budget neutral. HCFA reported that adjustments to eliminate outliers and adjustments to certain classes of hospitals were not necessary to ensure equitable payments. Therefore, no adjustments were made for disproportionate-share patient percentage, teaching intensity or rural locations. HCFA notes that some hospitals, particularly low-volume rural facilities that are sole-community or Medicare-dependent, will be hit harder under the proposal. The agency is considering options to decrease the impact, such as gradual phasing-in.

In addition, HCFA scaled all the relative payment weights to APC 91336, a mid-level clinic visit for cardiovascular services, which has a relative payment weight of 1.0. This adjustment will assist hospitals in comparing the relative relationship of one APC to another.

An APC payment rate is determined by multiplying the relative weight by the conversion factor. (The adjusted 1999 conversion factor is $50.67. See Table 1 for the nuclear medicine APC groups, relative weights and payment rates.)

Updating APC groups. The Balanced Budget Act of 1997 gives the Secretary of Health and Human Services the authority to periodically review and update APC groups, relative payment weights and wage and other adjustments that are components of the outpatient PPS. The review would respond to changes in medical practice and technology, the addition of new services, new cost data, and other relevant factors.

HCFA intends to update the wage-index values used to calculate program payment and copayment amounts on a calendar-year basis. The conversion factor will be updated annually, although recalibration of all APC group weights will not be. HCFA is accepting comments on this issue but supports a five-year review process.

Revisions to APC groups. HCFA expects the composition of all APC groups to remain intact from year to year with the exception of the few changes as a consequence of annual revisions to HCPCS and ICD-9 codes. The agency does not plan to routinely reclassify services and procedures from one APC to another. All changes in APC groups must continue to be budget neutral.

Volume control. The Balanced Budget Act requires development of a method for controlling unnecessary increases in the volume of covered outpatient services. If the volume of paid-for services increases beyond a determined amount, then the conversion factor will be adjusted in the following year. Pending completion of further analyses for determining expenditure targets, HCFA will propose an appropriate method beginning in 2001 and for subsequent years. Options for 2001 include expanding the sustainable growth rate (SGR) for physician services to take into account hospital outpatient services; expanding the SGR system for physician services to include all ambulatory services, and to use this to establish updates for ambulatory facility payments as well as for physician fee schedule updates; or modifying the physician SGR method and incorporating it into the hospital outpatient payment system. HCFA is accepting comments on the future methodology but notes that the last option appears most feasible at this time. The growth rate system would be used in setting annual updates to the conversion factor for hospital outpatient services.

Physician Supervision. The proposed outpatient PPS minimally requires a general level of physician supervision—and in some cases direct or personal physician supervision—when diagnostic tests are furnished at a hospital outpatient department or clinic. HCFA states that physician supervision is reasonable and necessary to ensure that patient health and safety are protected and that diagnostic tests are safe and effective at such sites. The levels of supervision for each CPT code have not been determined by HCFA, although instructions for physician supervision of diagnostic tests are being developed. Instructions will contain revisions in supervision levels required for many ultrasound services, stress tests, and some other services from the 1998 Physician Fee Schedule final rule (see *Federal Register,* October 31,1997).

Prohibition against unbundling of hospital outpatient services. The proposed rule recommends a more limited approach to the issue of bundling health care ser-

vices because the new PPS will cover fewer services than HCFA estimated when it first addressed the bundling issue in a 1988 proposed rule. The rule cites a $10,000 penalty for unbundling outpatient services to increase Medicare reimbursement.

Correct Coding Initiative. HCFA will apply the Correct Coding Initiative (CCI) to hospital outpatient claims to ensure that the most comprehensive of a group of codes is billed instead of the component parts. The CCI also checks for mutually exclusive code pairs.

Extension of cost reductions. Hospital outpatient operating costs will be reduced by 5.8% and capital costs by 10%. These reductions were scheduled to end in fiscal year 1998, but the Balanced Budget Act has extended the reductions through December 31, 1999.

New method for calculating beneficiary copayment. Under the current system, beneficiary liability for outpatient services is based on 20% of charges, rather than on 20% of actual program payments, as is the case for other Medicare services. Because charges generally are substantially greater than payments, beneficiaries on average have been paying up to 50% of the costs of outpatient care. The year 2000 delay in implementation will cost beneficiaries $570 million.

To obtain a copy of the September 8th *Federal Register*, contact the Superintendent of Documents at (202) 512-1800. Readers may download the proposed rule by accessing the *Federal Register* (http://www.access.gpo.gov/su_docs/aces/aces140.html) and searching "Federal Register," date "09081998," keyword "Medicare."

SNM and the Nuclear Medicine APC Task Force

SNM is a member of the Nuclear Medicine APC Task Force, headed by Kenneth McKusick, MD (see "Commentary," following this article). As well as SNM and the SNM Technologist Section (the section is represented by Denise A. Merlino, MBA, CNMT), the task force includes the American College of Nuclear Physicians (represented by Robert E. Henkin, MD) the American Society of Nuclear Cardiology (William A. Van Decker, MD), and the Council on Radionuclides and Radiopharmaceuticals (CORAR, represented by Jack Slosky, PhD, MBA, and Gordon Schatz, Esq.). Working with HCFA officials over the last year, the group has been successful on two of the three most important issues: increasing the number of nuclear medicine APCs from four to nine and ensuring that all nuclear medicine procedures are considered significant ones not affected by the multiple-procedure reduction policy. The task force will ensure that HCFA corrects anomalies in nuclear medicine APCs and that the agency reimburses radiopharmaceutical costs fairly.

"Black Box" Commercial Coding Edits Now in Effect

Responding to congressional pressure to conserve Medicare funds, HCFA recently instituted 220 Commercial Correct Coding (CCC) edits. The agency compared its current National Correct Coding Initiative (NCCI) codes with 500 proposed codes in a side-by-side trial in Iowa before coming up with the reduced number. Although the aim appears to be to further improve Medicare's rebundling policy, the CCC coding combinations will remain unknown to physicians requesting Medicare reimbursement. Only when the physician receives a denial will he or she know that a certain combination isn't allowed under the new edits. According to Medicare officials, physicians calling to inquire about denials will be given explanations drawn from the carrier manual, which gives the rationale for prohibited code combinations. Carriers have been instructed to call a help desk set up by the contractor that created the edits for any questions they can't answer by referring to the manual. One reason given for "black-boxing" the new CCC edits is they are "proprietary" and will not be published by the National Technical Information Service.

HCFA says its goal is to chart additional cost-savings earned by the CCC edits. The money saved from the commercial edits will be tracked separately from the money saved by the NCCI edits

The American Medical Association and SNM are opposed to these new proprietary edits. Physician specialty organizations, like SNM, were not allowed to participate in the development of these edits, which will have a significant impact on specialty physician reimbursement.

For more information on APCs, contact Wendy Smith (703-708-9000 ext. 242, or by e-mail: wsmith@snm.org). Also contact Ms. Smith if you are affected by a "black box" coding edit and to report the code pairs involved. SNM will attempt to determine code edits that affect nuclear medicine and communicate these to its membership.

—Wendy Smith, MPH, is the SNM director of health care policy

Congress

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sion stipulates that radiopharmaceuticals and PET radiopharmaceuticals will be excluded from regulations concerning pharmacy compounding. "I thought that the FDA was not being realistic," said Stupak. "The FDA felt that radiopharmaceuticals injected into the body to diagnose tumors needed to be proven safe and effective in the same manner as drugs used to treat tumors. I felt there needed to be a distinction between diagnostic agents and therapeutic drugs."

In recent legislation, Stupak was also a co-sponsor of the patient's bill of rights, which would require managed care companies to reimburse for the costs patients incur when they enter a clinical trial using an experimental treatment. This could be useful for trials involving alpha emitters or radio-labeled monoclonal antibodies for the treatment of cancer. "Nuclear medicine is on the cutting edge of technology," said Stupak. "Why not allow patients to have coverage for these treatments and get some practical use out of the research?"

Supporting Players: With Stupak, Representative Tom Coburn (R-OK) co-authored the FDA reform bill's radiopharmaceutical provisions. Senator Ted Kennedy and Senate Minority Leader Tom Daschle (D-SD) plan to reintroduce the patient's rights bill in the Senate.

—Deborah Kotz