RESPONDING TO CHANGES IN THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

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On the morning of April 7, healthcare executives began reading over 500 pages of The Healthcare Finance Administration (HCFA: Baltimore, Maryland) ¡ administered Medicare program's final rule that would dramatically change how hospitals get paid for outpatient services. Not only did the regulations differ from previously proposed rules but implementation was scheduled for July 1.

The hospital community didn't expect to be scrambling to implement HCFA's Hospital Outpatient Prospective Payment System (OPPS) in just over 60 days. Not since the 1980's, when Diagnosis Related Groups (DRGs) were introduced as part of the new inpatient prospective payment system (PPS), has such a restructuring changed hospital payment systems. Business relationships between providers, payers, and vendors are affected as the community responds to this economic change.

DRGs vs. APCs

The new OPPS system relies on a system of Ambulatory Patient Classifications (APC) that provide a fixed rate of reimbursement for categories of outpatient services. It was designed to provide a clear economic incentive to hospitals to control the costs of outpatient procedures.

Under the OPPS, outpatient procedures and some medical visits are grouped into 451 APCs. Drawing from the experience of DRGs, APCs will track resource use and generate payments to hospital providers. Both systems are driven by coded data; services are grouped and payments are weighted. Of significance is the difference in how reimbursement is driven in the two systems.

Under DRGs, hospitals are reimbursed for each admission, regardless of number or types of procedures performed. DRG assignment and reimbursement are driven by diagnosis and are reported using the International Classification of Diagnoses (ICD-9) codes. Under APCs hospitals are paid by each encounter. Reimbursements are driven by the services/procedures provided and are reported using two procedural coding systems, Current Procedural Terminology (CPT) and Health Care Procedural Coding System (HCPCS). These systems are used to link actual services/procedures to the correct APCs and associated payments.

Payments

All known outpatient services are grouped into 451 APC groups by CPT or HCPCS code. The APCs are defined by HCFA as being clinically similar and requiring similar resources. National payment rates were established for each APC by calculating a relative value weight based on the median cost of the services included in the APC group. This was largely based on 1996 hospital claims and the most recent cost report data available. Payments are the product of the relative weights and a dollar conversion factor. Additional adjustments are made for geographic

differences, outlier services, and most importantly, a mechanism was established to separately pay for certain devices, drugs and biologics.

Other important rules pertain to "packaged services" and "multiple procedure discounting". Services that previously were reported and reimbursed separately, such as certain supplies, drugs, anesthesia, and recovery and observation room use are now packaged into the APC payment. Certain designated surgical procedures are reimbursed at lower rates when performed during a single encounter than when performed separately. This policy does not apply to most diagnostics.

Immediate Impact to Hospitals
The proper use of CPT and HCPCS procedure codes are central to generating maximum reimbursement under the OPPS system. Unfortunately, hospitals do not have extensive experience in procedure coding, as Medicare's past payment system for outpatient services did not require strict observances of procedure coding to receive reimbursement. OPPS requires some pretty substantial changes to most hospitalsˆ Management Information Services (MIS) systems. These include mapping CPT and HCPC procedure codes into APC categories and retooling the entire billing system to accommodate new (and changing) Medicare billing rules. Reimbursement changes incur real costs to hospitals as personnel must be re-trained to the new coding requirements, new MIS modules must be purchased or developed and implemented, new billing audit standards have to be developed and implemented, and so on. And the retraining doesn't end with billing and administrative staff. Clinical staff must become familiar with CPT and HCPCS coding as these codes affect APC grouping, which in turn affects reimbursement. If the right codes aren't captured and reported, payment can be minimized or worse.

Many hospitals are relying on a three and one half year transitional payment corridor that HCFA established to provide some breathing room as those facilities figure out the ins and outs of the new program. In this transition, HCFA will make additional payments to hospitals if the amounts received under OPPS in relation to hospital costs are less than the hospital's typical reimbursement-to-cost ratio.

Two systems are in place to provide for supplemental payments for drugs, devices and biologics. One is the establishment of a number of new technology APCs that use cost (as opposed to clinical similarity) as the basis for categorization. These cost categories are currently capped at $9,000.

The other payment mechanism is a separate pass-through payment for current orphan drugs; current drugs, biologics, and brachytherapy devices used for the treatment of cancer; current radio/pharmaceutical drugs and biological products; and certain new devices, drugs, and biological agents. Payments are based on cost formulas, with several important limitations.

In each case, HCFA, for a period of two years but no more than three, will collect associated cost data for these technologies to calculate payment rates. At the end of this period the technologies will be assigned to a clinically comparable APC, or a new clinical APC will be established and payments will be rolled into the clinical APC.

The supplemental payment mechanism is a means to insure hospitals obtain reimbursement for technologies not included under APCs. Companies must apply to HCFA to determine eligibility for pass-through payment or assignment to a new technology APC. HCFA released an interim

rule in August revising eligibility criteria for technology pass-through and new technology APCs. The rules remain complex, but they provide greater eligibility for more technologies.

Once approved, HCFA issues a HCPCS code and descriptor by technology brand name and model. Without this designation, hospitals are unable to report the use of the technology, no separate payment is allowed, and the facility cannot capture the cost of the technology. It is critical that medical manufacturers apply for technology pass-throughs immediately if they haven't already done so. Otherwise manufacturers may face sales obstacles as hospitals choose to purchase only those technologies that have been approved in order to obtain the supplemental reimbursement.

To learn if a technology has been assigned a HCPCS code, search HCFA's website, www.hcfa.gov, for Program Memos - Transmittals A-00-42, July 26,2000 and A-00-61, September 6, 2000. HCFA will review applications and release a revised list quarterly. An application can be found at www.hcfa.gov/medicare/passdead.html. The next application deadline is December 1, 2000.

Manufacturers Opportunities

For technology companies, OPPS changes contain both challenges and opportunities. The primary challenge is that uncertainty about the economic consequences of OPPS will stifle customer willingness to buy new technology. This isn't an unreasonable concern because the cost of technology can decrease operating margins for hospitals under OPPS at a time when hospital operating margins are already dangerously compressed. The 2-3 year technology pass-through waiver system mitigates this concern somewhat as many technologies have applied for and received these waivers. However, for those technologies that don't meet the waiver system criteria, and for those who are still fighting the cost-of-technology battle with customers, the OPPS regulations have the potential to dramatically affect sales.

New technologies always impact procedure costs, episode of care costs, or hospital length of stay in some way. They also impact resource allocations and operating efficiencies within hospitals as conventional treatment approaches are supplanted by procedures using new technology. Under Medicare's old reimbursement system, hospitals were able to capture the cost of new technology under existing billing rules. But OPPS has changed those rules with uncertain outcomes. Now, more than ever, hospitals are anxious to know the true cost of technologies. In addition, the OPPS system has the potential to pit companies with older technologies against companies with newer technologies. Since the technology pass-through only applies to devices introduced after 1996, some existing technologies will not be eligible for additional pass-through reimbursement as they compete with newer technologies that do meet pass-through criteria. Hospitals and other purchasers are likely to gear purchases to those technologies that will generate the best reimbursement while meeting physician and patient demand for the "newest and best". This may be a boon to new technologies (at least until the pass-through period expires) at the expense of older technologies.

The opportunity for technology firms rests with the opportunity to support their customers with crucial information during a time of confusion and high potential for poor (or stalled) decision-making. Specifically, there are several gray areas in hospital knowledge where manufacturer diligence in uncovering answers can have a significant pay-off in improved customer relations and product positioning.

Projected OPPS reimbursement for a specific technology, if covered under the transitional pass-through policy Identification of the approximate cost basis for the technology used in the development of the APC reimbursement. Identification of the key coding requirements (combinations of CPT and HCPCS codes) to ensure maximum OPPS reimbursement under a given APC Specific information on policy developments that affect the reimbursement or coding environment of a given APC or technology Data identifying the "true cost" of a technology to the hospital, as opposed to acquisition price. This includes calculating medical cost offsets, improvements in facility efficiencies and potential to generate additional OPPS revenue through the use of technology.

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