Medicare Outpatient PPS

Apr 01 2000

Practice Area: Health Law

Although HCFA posted an early release version of the Outpatient Prospective Payment System regulations (Outpatient PPS) on its web site on March 31, 2000, the final regulations were not officially published in the Federal Register until Friday, April 7, 2000. In addition to implementing Outpatient PPS, the regulations include the rules for determining when operations qualify for provider based status, that is, treated as part of a hospital or other applicable provider. Outpatient PPS is arguably the biggest Medicare development affecting hospitals since HCFA implemented inpatient PPS in 1984. The provider based requirements will also have a substantial impact on the industry. Following is a general overview of key parts of the regulations.

OUTPATIENT PPS

Basics: The regulations will be effective for services provided on or after July 1, 2000. Outpatient PPS will apply to all hospitals, including hospitals that are excluded from inpatient PPS, and community mental health centers that provide partial hospitalization services. The only exception is for critical access hospitals and hospitals located in Maryland, which are paid under a statewide waiver from HCFA.

Unlike inpatient PPS, Outpatient PPS will have a single rate covering both operating and capital related costs. The rate is intended to pay for costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. Included in these costs are: use of an operating suite or treatment room, recovery room, observation bed, anesthesia, certain drugs, medical and surgical supplies, equipment and incidental services. Costs specifically excluded from Outpatient PPS include: professional component services, ambulance services, prosthetic and orthotic devices and supplies, take home DME, clinical diagnostic lab services, medical education costs for approved nursing and allied health programs, and services provided to a SNF resident.

Payment: Outpatient PPS payment rates will be based on the 3M-Health Information System Ambulatory Patient Groups (APG) version 2, with revisions by HCFA using more recent Medicare data. The APG system consists of mutually exclusive service categories which contain multiple procedures that are consistent in terms of clinical characteristics and resource costs. HCFA has established relative payment rates for each covered group of outpatient services (Ambulatory Payment Classification Groups – APC) based on 1996 claims data adjusted forward.

For each APC group the regulations identify the relative weight (equivalent of the inpatient DRG weight). To obtain the APC payment rate (APC Rate), the relative weight is multiplied by the conversion factor (equivalent of the inpatient standardized amount). The conversion factor (payment for an APC with a relative weight of 1.0) is $48.487 for 2000. The APC Rate includes both the Medicare program and the beneficiary coinsurance amounts. The method for determining the coinsurance amount is described below. In most cases, it will not equal 20% of the APC Rate during the initial years of Outpatient PPS. The regulations include tables identifying: the APC category for each HCPCS code and the HCPCS codes included in each APC.

The APC Rate for each category will be subject to a wage adjustment. The wage adjustment will be based on the inpatient PPS wage index and applied to 60 percent of the APC Rate (therefore affecting both the Medicare payment and coinsurance portions). Payments will be also subject to outlier adjustments where charges, adjusted to costs, exceed 2.5 times the sum of: the APC rate and any transitional pass through payments for innovative devices, drugs, and biologicals.

In situations where more than one surgical procedure is performed during a single encounter, Medicare will pay the full amount of the procedure having the highest rate, and one-half of the amount forall other covered procedures. The reduced payment will also apply to the coinsurance amount chargeable to the beneficiary. Where a surgical procedure is terminated prior to completion, payment will be at the full amount of the specified rate if the procedure is discontinued after induction of anesthesia or the procedure is started, or one-half of the rate if the procedure is discontinued prior to that time. The regulations also provide for a transitional pass through for the additional costs of new services, drugs and biologicals.

Coinsurance: Outpatient PPS will have a significant effect on the system and mechanics for charging coinsurance to beneficiaries. Instead of coinsurance being based on 20 percent of actual charges, the regulations specify the coinsurance amounts for each APC category. Eventually, the nationally specified coinsurance amount will equal 20 percent of the APC Rate for each category. However, this system will not be fully implemented immediately.

Initially, coinsurance amounts will be based on 20 percent of the national median charges billed during1996 for the services in each payment category, indexed forward to 1999. This amount is listed in the regulations as the national unadjusted coinsurance. The regulations also list the minimum unadjusted coinsurance, which is equal to 20% of the APC Rate. In most cases the national unadjusted coinsurance is greater than the minimum. The national unadjusted coinsurance amount (based on 1996 median charges) will not be indexed forward annually, unlike the APC Rates (and therefore the minimum coinsurance). Therefore, 20 percent of the APC Rate will eventually exceed 20 percent of the national unadjusted coinsurance. However this will occur at different times for different APCs.

Hospitals are eligible to file an election with their intermediary to reduce their coinsurance charges from the national unadjusted coinsurance amounts to amounts not lower than the unadjusted minimum coinsurance. The election must be filed by June 1, 2000, for services provided from July 1 through December 31, 2000. Thereafter, the election must be made on a calendar year basis by December 1 of the prior year. The election must apply to all services provided within an APC. Properly electing hospitals are allowed to advertise these discounts.

Unbundling Prohibition: The final regulations include a prohibition against unbundling of hospital outpatient services. Medicare will not cover any services that are furnished in a hospital (including critical access hospitals) to an outpatient unless the services are furnished by the hospital or by another party under arrangement with that hospital. The following services are excluded from the bundling requirement: physician and certain other allied health professional services, DME furnished by the hospital, services furnished to SNF residents, and diagnostics services ordered during an encounter in the hospital but furnished outside of the hospital. Penalties for violating the bundling rule include a civil monetary penalty of up to $2,000 for each improper bill, and possible exclusion from the Medicare and Medicaid programs.

Transitional Corridors & Hold Harmless: The final regulations include a transitional rule for all hospitals and several hold harmless rules for certain hospitals. Cancer hospitals are eligible for a permanent hold harmless provision which ensures that their Medicare payments will be the greater of the PPS amount or costs. Rural hospitals having 100 or fewer beds are eligible for the greater of the PPS amount or costs for services provided prior to January 1, 2004.

PROVIDER BASED STATUS

Process Requirements: The provider based provisions of the final regulations do not take effect until October 10, 2000. *Any* provider that creates or acquires a facility or site after October 10, 2000 that: (1) is located off campus; or (2) would increase costs of the main provider, as reported on its cost report, by at least 5 percent; will be required to obtain advance approval from HCFA before it can bill for services at that facility or site as provider (hospital) services. Any provider that has one or more provider based sites, even those created or acquired before October 10, 2000, must report to HCFA any material changes in the relationship between it and the provider based sites that could affect the facility or site's provider based status.

The final regulations contain no grandfather rule for sites in existence prior to October 10, 2000, that have been treated as provider based, even in situations where a provider obtained prior approval from HCFA (even though not required to do so). The regulations state that if HCFA learns that a provider has treated a facility or site as provider based and the provider has not obtained a HCFA determination of provider based status, HCFA will review the situation to determine whether provider based status is appropriate.

If HCFA determines that provider based status was not appropriate, HCFA will recover the difference between the amount of payments actually made and the amount that would have been made in the absence of provider based status. However, recovery will not be made for any period prior to October 10, 2000, if during that period management made a good faith effort to operate the site as provider based. The good faith exception will be met if: the requirements regarding licensure and public awareness in the final regulations were met, all facility services were billed as if furnished by a department of provider; and all professional services on site were billed with the correct site of service indicator.

Requirements for Provider Based Status: The final regulations effectively adopt the prior standards established by HCFA program memoranda and those contained in the proposed regulations with the following significant additions or changes.

Campus: The term campus is now defined to mean the physical area immediately adjacent to the provider's main buildings and structures that are not contiguous to the main buildings but are located within 250 yards, and any other areas determined on an individual basis by the HCFA regional office.

Same License Requirement: The proposed regulations would have required that a site be operated under the same license as the main provider. In recognition of the differences in state licensure law, HCFA backed away from an absolute licensure requirement in the final regulations. A site must be operated under the same license as the main provider, except in circumstances where state law does not permit licensure of the site as part of the hospital, or requires separate licensure. In states with a rate setting commission, the site must be treated as part of the provider for rate setting purposes. HCFA commentary indicates that if common licensure is possible under state law then the provider must obtain it to be provider based.

Location in Immediate Vicinity: The final regulations add an objective test for determining whether off-campus sites may be treated as provider based.

The provider must be able to demonstrate that the site serves the same patient population by showing that for the 12-month period prior to filing a provider based application (and each subsequent annual period), at least 75 percent of the patients served by the site reside in the same zip code areas as at least 75 percent of the patients served by the main provider. Alternatively, at least 75 percent of the patients served by the site who required the type of care furnished by the main provider received that care from the main provider. For sites not in operation for the prior 12 months, the regulations state that the site must be located in a zip code area included in those that accounted for at least 75 percent of the patients served by the main provider.

Same State Requirement: HCFA also backed away from the requirement in the proposed regulations that a site must be in the same state as the main provider. Under the final regulations, a site cannot meet the location requirement unless it is located in the same state as the main provider, *or where consistent with the laws* of both states, an adjacent state

Obligations of Provider Based Sites: The final regulations specifically identify the obligations applicable to sites that are determined to be provider based to a hospital. These sites must:

- comply with the anti-dumping requirements;
- bill physician services with the correct site of services indicator;
- comply with all terms of the hospital provider agreement;
- comply with the nondiscrimination provisions applicable to physician services;
- treat all Medicare patients at the site as hospital outpatients;
- comply with the DRG payment window provisions;
- provide notice that patients will be liable for coinsurance for a facility visit as well as for physician services; and
- comply with all applicable Medicare hospital conditions of participation.

CONCLUSION

Besides gearing up billing systems and procedures to handle Outpatient PPS on July 1, 2000, hospitals will need to carefully assess the implications of the final regulations relative to the bundling rules, pass-through payments, coinsurance rules and elections, and eventually the transitional and hold harmless rules to ensure compliance with legal requirements. The provider based rules necessitate that every provider assess their compliance with the new requirements at existing off campus sites and ensure that operations at those sites satisfy the obligations of provider based departments. In some cases, an application for provider based status may be appropriate.

There are many aspects of the final regulations which will require more detailed explanation and analysis than is contained in this general overview. Watch for follow-up Health Law Bulletins regarding issues presented by: the bundling rule, the coinsurance provisions, transitional corridors and hold harmless rules, pass-through payments, and the provider-based requirements.