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Medicare Reimbursement Methodologies and Cost Trends

Track: Health

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Summary: What's happening in the world of Medicare reimbursement? Diagnosis Related Groups and Resource Based Relative Value Scale are now old news, but what about Ambulatory Payment Classes and Resource Utilization Groups? Panelists examine:

- *Recently developed reimbursement methodologies*
- *Updates on existing methodologies*
- *Historical and projected cost trends*

Mr. Anthony J. Wittman: It has become more and more important over the years for health actuaries to have a firm understanding of the methodologies used by Medicare to pay providers and the cost trends associated with those payment methodologies, both from the Medicare side and the commercial side, in terms of potential applications and the cost shifting effects. Diagnosis Related Groups (DRGs) and Resource Based Relative Value Scale (RBRVS) have been a part of the universal language of provider reimbursement for years now. Ambulatory Payment Classifications (APCs), Resource Utilization Groups (RUGs) and Home Health Resource Groups (HHRGs) have now arrived and are also necessary tools with which health actuaries must become skilled. We have a distinguished panel of experts here today to share their insights on these methodologies, both the historical methodologies and the current updates to those methodologies as well as the newer mechanisms.

First we'll have Greg Savord, who is the special assistant to the chief actuary for the Health Care Financing Administration (HCFA). Greg has almost 25 years of U.S. Government experience. Greg works with Medicare issues, including the inpatient Prospective Payment Systems (PPS) and DRG case analysis. He also worked on estimates for the Health Security Act and spent a lot of time recently working on estimates for the current Medicare prescription drug proposals. Greg is an FSA and earned his B.S. in Math at Bowling Green State University. Greg will be

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giving us an overview of Medicare expenditures, expand on physician reimbursement, and provide a background on the cost-based methodology. Kevin Kenny is a consultant in the Irvine, California office of Milliman & Robertson. He's been consulting with clients on health-care issues since 1984. Kevin's consulting expertise covers the entire spectrum of health-care financing issues. Recent projects include design of provider compensation systems and analysis of provider contracts, both of which are pertinent to this topic. Kevin is an FSA and earned his B.S. in Math and Economics at John Carroll University. Kevin will focus on inpatient hospital reimbursement and also talk about the skilled nursing and home health categories, which are both undergoing significant changes right now.

Also, I would like to welcome our guest, Pete Frank, who is no stranger to actuaries or actuarial work. He's a senior consultant with Reden and Anders, Ltd. Pete graduated from Duke University with a B.A. in Math and then pursued a career in group insurance with the Prudential where, among other things, he took care of a large block of guaranteed-issue Medicare supplemental products (the AARP block). Since joining Reden and Anders, Pete's been involved in many aspects of managed care consulting with a concentration in Medicare+Choice and Medicare supplemental products. He's become "distressingly" familiar with outpatient hospital costs. Pete will cover the outpatient category with an emphasis on APCs, which is a current hot topic and something Pete's been working on a lot lately.

Mr. Gregory J. Savord: First, I want to talk about the penetration of the Medicare program in the general economy. The Trustees' Report examines Medicare expenditures as a percent of gross domestic product. In 1980 Medicare was about 1.3% of the GDP, but in 1990 it reached 2%. There was a slow down or, actually, a decline in benefits in the late 1990s. We do not expect this trend to continue. We expect an upward trend again, driven by demographic factors, inflation and utilization increases. By 2025 we expect Medicare expenditures to reach 4% of the GDP.

When we look at per capita expenditures by type of service we see that inpatient expenses are the highest, although it's not the most popular benefit among beneficiaries. In the later half of the 1990s, there is a slow down, an actual decline, in some of the benefits, particularly in the home health area. There was a mammoth decrease in home health in the late 1990s. Inpatient and physician numbers never did decline. Skilled nursing did decline as did home health and outpatient costs.

Medicare does not operate in a vacuum. I think the major political issues today are privatization and choice. We have many examples of these issues: the Breaux-Frist bill, the competitive defined-benefit concept, Medicare+Choice, which is managed care by private organizations. We had premium support proposals, such as federal employees' health benefits (FEHB) plans, medical savings accounts, and provider service organizations. Medicare actually has a private, fee-for-service plan run by Sterling Insurance, which will be starting soon. Of course, one of the major issues is prescription drug coverage for Medicare beneficiaries. We have no idea if we'll get a benefit this year. If we do, what will it look like? Who will be covered? Stay tuned.

The final thing is everybody wants to increase benefits and reduce expenditures. Many politicians have their own magic formulas that they are convinced will work. I think you will know better and see through the smoke screen on these proposals. If you want to be a hero, come up with a proposal that actually will achieve these goals.

The program is administered by HCFA, but it does not pay the benefits directly to the providers. We use contractors, intermediaries, which pay institutional providers and carriers, which pay the physicians and other practitioners. HCFA administers program policy within the confines of the law and contracts with intermediaries and carriers. Some intermediaries and carriers still do program integrity, but HCFA also has payment safeguard contractors who look at fraud and abuse. Payment safeguard contracts were specified in the HIPAA legislation, and it looks at the enforcement of Medicare secondary payer provisions, review claims, audit providers, and does a lot of program integrity checks. HCFA also performs research and analysis.

We can finally get into Medicare payment methodologies. I break payment methodologies into two major groupings: physicians and practitioners. They are paid individually by service. In the past they were paid under a charge-based system. Currently they're paid under a fee schedule. Institutions, which are the other major group, include hospitals, skilled nursing facilities, and home health agencies. They could be paid in the aggregate for their cost, called cost reimbursement, or they could be paid by service, such as under the PPS. More and more cost-based providers are moving to the PPS.

The physicians are not a small factor in Medicare. They are 21%, almost a quarter of the program. They are second after inpatient, which is 46% of the total.

Physician reimbursement has changed over time. The old method was the usual-customary-reasonable or UCR that was used prior to 1992. In 1992 we implemented the RBRVS, which was given to us by Congress. Under the old UCR method, we paid the lowest of the submitted charge from the physician, the customary charge (which was just a median charge from that physician for that procedure), or the prevailing charge (which was the 75th percentile of customaries). Because the prevailing charge grew too rapidly, Congress froze it at one point in time and updated it by the economic index. In this situation, if the expenses or charges are growing faster than the economic index, the prevailing charge doesn't stay at the 75th percentile, but keeps declining. Under the UCR method, the carrier determined the screens or limitations. There were separate prevailing charge screens by procedure, locality, and physician specialty. The carrier determined the localities.

Under the current system we use the RBRVS, which is broken into three components. First is the work component, which is based on the work that the physician does, and is actually resource-based determined by surveys and analysis. The work component has been resource based since 1992. Second, the practice expense, or you might want to call it overhead, which used to be based on physician charges, but now is being converted to a resource base, based on surveys. Third, malpractice expenses, which is still based on charges, and is based on malpractice premiums.

Under the current RBRVS system, in contrast to the prior system, the relative values for each procedure are the same for all specialties and they are adjusted by a geographic practice cost index, or GPCI. We actually have three separate GPCIs: one each for work, malpractice and practice expense. The value scale is not the payment amount. We need to multiply the relative value times the conversion factor, which will give us the payment amount. The conversion factor for 2000 is 36.614. Prior to the Balanced Budget Act of 1997, we actually had three conversion factors. We had factors for primary care-type procedures, procedures deemed to be surgery, and all other procedures. Post BBA, we have one conversion factor for all procedures. It is updated by the Medical Economic Index plus the Sustainable Growth Rate (SGR), which is an adjustment based on how the physicians' expenses compare to a benchmark—or sometimes Congress just tells us what the update is.

The revised Relative Value Units (RVUs) for individual procedures are usually in an upward direction but can go down. If RVUs increase, on average, overall payments will be higher. We don't want to do that so we have a budget neutrality adjustment.

Mathematically you could apply the budget neutrality adjustment either on the RVUs or you could apply it on the conversion factor. Both methods have been used. The physicians would prefer that we would adjust only the conversion factor because so many private insurers also use the RVUs and RBRVS. If we lower all the RVUs, payments from private insurance for procedures will decline and physicians don't particularly care for that. If we apply the budget neutrality adjustment to the conversion factor and the average RVU ends up higher, then private insurance will actually be paying more—so you may want to keep attuned to what Medicare is doing and respond appropriately.

The SGR does go up with real per capita GDP, but it's also adjusted for volume and intensity. As this is an aggregate measure, we also must adjust it for fee-for-service enrollment changes. Recent developments under the Balanced Budget Act gave us one conversion factor. The SGR replaced the Medicare Volume and Performance Standard (MVPS). The problem with the MVPS was that it was "re-based" or adjusted every year. If the physicians came in high, that just got built into the base with a 2-3 year time lag. It did not keep the expenses under control, which is what Medicare wanted to see.

The SGR has a benchmark and it's a cumulative update. There was a problem with the SGR in that it had an unstable update capability. It either would set a very high increase, which would run into the billing limitation, or a very low increase, which would trigger the minimum update. If the MVPS didn't have a minimum, it eventually would have gone down to zero, which would have been very beneficial for Medicare because we would get the services for nothing, but not very good for the physicians because they need payment for services. The Balanced Budget Refinements Act fixed that problem by blending the factors. Also, the Balanced Budget Act specified the use of the resource-based practice expense rather than the charge-based practice expense.

If we plot the growth in per capita physician expenditures from 1991 to 2005, we can see that the benefits have steadily increased every year. The increases have varied from close to zero (from 1995-97) to almost 10% (between 1993-95). We do not expect a decline in these payments.

The next major category I will discuss is institutional reimbursement. We have two major categories, cost reimbursement and PPS. Inpatient PPS for operating expenses started in fiscal year 1984 and has, with transition over the years, been rolling along merrily. The inpatient capital related expense portion started in 1992 with a ten-year transition. We'll enter the tenth year of the transition next October. PPS for skilled nursing facilities started in 1998. Outpatient PPS is scheduled to start July 1, 2000, and home health will start October 1, 2000. I will not say any more about PPSs because Kevin and Pete will be talking about them.

Next I'll talk about cost reimbursement. Very simply, under cost reimbursement we tell the providers "provide the service, tell us how much it costs and we will pay you." The problem is what does it cost? The principles I will talk about will apply to any cost reimbursement provider, inpatient or outpatient.

For cost reimbursement purposes, we divide the institution into departments. We have two types of departments—ancillary departments and general routine departments. We determine total cost through accounting techniques for each department. Examples of general routine, which are pretty complete here, are room, board and general nursing. These are the services one would expect for every inpatient admission, and we expect these expenses to be relatively the same for all beneficiaries. Examples of ancillary departments include operating room, anesthesia, radiology, pharmacy, lab. There are quite a number of them. The list can go on and on, and hospitals can make up their own ancillary departments. Ancillary services would vary with each admission. Most patients would not use all ancillary services and they'd use them in varying degrees.

To pay for general routine expenses, take from the accounting system the total routine dollar costs for the hospital and multiply it by the ratio of Medicare's inpatient days to all inpatient days. That’s not a very complicated calculation, except that you must run it through the cost report. Under the ancillary department we have the concept of the Ratio of Charges to Charges Applied to the Cost (RCCAC). Now, how is that actually done? It's done using a formula that is not complicated. This is done for each department. Take the total cost for the department and multiply it by the ratio of Medicare charges to total charges. When I talk about total charges, that's total charges for the institution, which would include both inpatient and outpatient services.

This was not simple enough for Congress. Congress, at one point, saw problems with certain providers getting some extravagant reimbursements under the system in effect. In 1972 Congress implemented Section 223 of the Social Security amendments, which essentially said that the then Secretary of Health, Education and Welfare, now Health and Human Services, could define reasonable costs. That's what the Secretary did—he defined reasonable cost. What happens is that a tool is there, expenses are still running "out of control," you start to use Section 223 as a savings management tool. You start gradually tightening the definition of reasonable cost. Congress got into the act in 1982 and passed the Tax Equity and

Fiscal Responsibility Act (TEFRA), which implemented a per admission limit. TEFRA took a peer group of hospitals and set the limit at, I think it was, 115% of the mean, and said that it will not pay more than this amount. That was not good enough. TEFRA also implemented a rate of increase limit that said your reimbursable costs should not increase any more than a certain percentage. TEFRA did case-mix adjust the percentage of the mean limit. TEFRA initiated the first use of DRGs. Although TEFRA was specified for three years, most hospitals used TEFRA for only one year because the PPS replaced TEFRA for fiscal 1984.

When services are provided under cost reimbursement, the intermediary pays an estimate of what it thinks that particular admission costs, or that particular service costs. The intermediaries don't care if they are exact on a particular service, just so that over all services they come out close to what should be paid. If so, they're doing a good job. Total payments are never exact, so the hospital or other institution files a cost report to determine the exact cost that should be paid and the differences are settled.

Here are a few Internet resources you may find useful. Many of them are from HCFA, which is www.hcfa.gov/pubforms/pubforms.htm. The *Federal Register* also has a good site, which is www.access.gpo.gov/su_doc/aces/aces140.html. And sources of legislative information are located at thomas.loc.gov/. Feel free to use these resources. HCFA does have some free data on their site. They also have data that you can purchase.

Mr. Kevin Kenny: I will talk about the PPSs for three types of institutional providers under the Medicare program: inpatient hospital, skilled nursing facility (SNF) and home health agency (HHA). The PPSs for these three provider types are somewhat comparable, so I will start with a review of the inpatient system that most of you are already familiar with. Then we will go through the new systems for SNF and home health and compare and contrast with the existing inpatient DRG system for inpatient care.

First, here’s a definition. Prospective Payment means that payment rates are established before care is provided. Prospective Payment doesn't describe the structure of the rates—it just means that the prices are determined in advance.

The greatest advantage of Prospective Payment over cost-based reimbursement is that the provider has an increased responsibility for managing costs. This is because the provider receives a fixed payment amount and receives no extra compensation for any cost overruns. Despite this advantage, Prospective Payment does not solve all of the financial and utilization problems that affect the system. Even though payment rates are set in advance, treatment decisions are still made by patients and physicians, and those treatment decisions still have great influence on payment amounts and total costs.

While PPS does give providers a financial incentive to manage costs efficiently, efficiency is still very difficult to achieve. We'll look at some numbers that suggest it may be a long-term process to really manage costs down to efficient levels. Quality of care can also be a concern when providers are financially motivated to manage costs efficiently. Providers must keep in mind the need to provide adequate care for their patients. Administration is a major problem with all new

PPSs, at least initially. There are numerous difficulties with respect to data collection, reporting, and administration systems.

The first PPS I'll address is the inpatient system. Inpatient care is the largest component of Medicare costs, accounting for about 46 cents of every dollar spent on benefits. That percentage was as high as 70% about 25 years ago, but the inpatient share of total Medicare costs has been declining steadily for a variety of reasons, including the effect of the PPS. Prospective Payment was implemented 16 years ago for inpatient services with hospital reporting periods beginning October 1984. The main structural feature of the inpatient PPS is that providers are reimbursed based on case rates designed to cover all costs associated with a patient during the time that he is in the hospital.

It is not practical to use a single case rate for all patients, because patients differ greatly with respect to the amount of health care resources required. To deal with this issue, Medicare adopted a case-mix-adjustment system known as DRGs. DRGs are groups of clinically and financially similar patients. Each hospital inpatient discharged is categorized into one of currently 511 DRGs in 25 major diagnostic categories. The patient is assigned to a DRG primarily based on International Classification of Diseases, 9th Revision (ICD-9) data with respect to the procedures and diagnoses associated with the hospital stay.

To give an example, I'll discuss two examples of DRGs covering different types of heart disease patients and the typical Medicare reimbursement rates for patients in each of these DRGs. A patient with simple heart failure may require only one or two days in the hospital and would produce a reimbursement of $4,000. A heart transplant patient might require 40 or 50 days in the hospital and would produce a much greater reimbursement amount—about $82,000. This is the adjustment method used in the DRG system to account for differences in patient characteristics, and these examples illustrate the range of the adjustments. The dollar amounts vary by hospital and by year, so these numbers should be considered illustrations only.

Factors that drive hospital inpatient costs include admissions, treatment decisions, length of stay, and the cost of medical services. Under a cost-based system, there is no financial incentive for the provider to efficiently manage any one of those factors because any money spent can be billed to the payer. Under Prospective Payment, there is still no financial incentive for the provider to manage admissions and treatment decisions efficiently because the provider is reimbursed for each admission and is reimbursed greater amounts for more complex treatments. But PPS provides a distinct financial incentive to effectively manage length of stay and cost per service. Providers are paid the same DRG amount regardless of length of stay or cost and, therefore, are able to increase their profits by the amount of any cost savings they are able to generate.

With those financial incentives, there has been some downward pressure on hospital inpatient costs in the Medicare program. A long-term comparison of Medicare inpatient costs shows that prior to the adoption of PPS, hospital cost trends were generally more than 10% per year. Since PPS was introduced, trends have been less than 10% per year. There are many other factors that influenced

those trends, but the trends do provide evidence that, to some extent, PPS is having the desired financial effect.

Similar results can be found in the trends in length of stay. Prior to the adoption of PPS, hospital lengths of stay were already declining, slowly. In the years after adoption of PPS, the decline in length of stay has accelerated. At the time PPS was introduced, in 1984-85, length of stay dropped almost overnight by a day or two, so it is clear that some of the desired effects have been realized. It seems equally clear that it's a slow, long-term process to improve costs and lengths of stay to efficient levels.

Another way of looking at this issue is by comparing lengths of stay by state. We see some western states with an average length of stay as low as five days. However, in the Mid-Atlantic states, with exactly the same PPS payment structure, lengths of stay are more than 50% higher (7.2-7.7 days). In all states, lengths of stay remain substantially higher than the best-observed practices from Milliman & Robertson's database.

The next PPS I will address is for SNFs. SNF currently accounts for about 7% of Medicare benefit costs. Prospective Payment has just been implemented for Skilled Nursing Facilities over the last two years. The PPS became effective for cost reporting periods beginning in July 1998.

The SNF PPS structure is a little different from the inpatient approach. The SNF PPS is based not on case rates but on per-diem payments. The rates are established prospectively, but are intended to cover each day of care rather than an entire stay in the facility. Along with prospective payment, Medicare introduced several other changes, including a requirement for consolidated billing of most expenses associated with SNF patients. In addition, the new reimbursement system was designed to produce some cost savings by reducing the normal trend increases for some future years.

The SNF PPS incorporates several adjustment factors, some similar to those in the inpatient PPS. For example, the SNF PPS includes geographic adjustments that are very similar to the corresponding inpatient adjustments. There is also a three-year transition period. Although prospective payment was fully implemented in the 1998-1999 time frame, during the three-year transition period the amount of the prospective payment was based partly on the facility's own cost experience. By the end of the transition period, the facility cost experience is phased out and payment is based entirely on the federal rates.

There is also a need for a case mix adjustment on the SNF PPS. Just as inpatient cases differ in complexity, nursing facility residents differ—some require far more extensive resources than others do. The case-mix adjustment used for the new PPS for SNF is called RUG-III, or Resource Utilization Groups, Version 3. The RUGs are based on a new assessment that every SNF is required to perform on each patient, as many as five times during the patient's stay. The patient may move from one RUG to another during his stay as his needs change over time.

The patient assessments are based on the Minimum Data Set (MDS), under which the facility is required to capture information regarding the level of resources

required by the patient, some specific diseases that impact those resource levels, and information regarding the patient's functional status. This data allows Medicare to group patients into 44 different groups in seven categories for reimbursement purposes. Each of these 44 RUGs includes clinically similar patients with reasonably similar resource requirements.

The seven major categories of RUGs include rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavioral problems, and reduced physical function. Patients requiring extensive amounts of rehabilitation in multiple disciplines require the most resources, while patients with limited behavioral problems or reduced physical function are much less costly. The highest-cost RUG, ultra-high rehab, pays $384 per day. Low-level rehab care is $179 and impaired cognition is $142. The lowest-cost RUG, reduced physical function, pays $117. The RUGs have a narrower range of payment amounts than the DRGs. While the RUG payment amounts appear much smaller than the hospital inpatient amounts, these are per-diem rates rather than case rates.

The SNF PPS, like the hospital inpatient PPS, provides new incentives to the provider to manage costs. There is no financial incentive to manage SNF length of stay, because the reimbursement is structured as a per diem payment.

If you look at an illustration of previous trends in SNF costs, you'll see the dramatic impact of the new PPS. For a variety of reasons, cost trends were very high in the early to mid- 1990s, averaging 30-40% annually. Under PPS, there has been a significant reduction in costs, with cost trends ultimately falling between 5% and 10% after 1994.

The last PPS system that I will discuss is the Home Health Agency PPS. Medicare currently estimates home health at 6% of benefit costs. Three years ago that number was as high as 10%. Although PPS has not yet been implemented for home health, a stringent interim payment system was introduced late in 1997, reducing payments by about 40%.

This drastic reduction has led to significant disruptions in the home health industry, even more severe than those previously seen in the SNF industry. It is generally recognized that Medicare's home health costs have been excessive and so, to some extent, these disruptions are necessary and appropriate.

PPS for home health agencies will become effective on October 1, 2000. The payment structure is different from both the SNF and inpatient systems. For home health, the prospective payment will be based on a 60-day episode of care. At the time the patient is referred to home care, he is evaluated and the home health agency is paid a lump sum to cover the next 60 days of care. If more than 60 days of home care are needed, the agency can apply for another 60-day period. The PPS reimbursement formulas are designed to reduce the payment limits from the interim payment system by another 15%. And, as with SNF, there is a new consolidated billing approach.

The home health PPS includes several adjustments—most of them similar to those used in the other PPS systems. One adjustment unique to home health is the reduction for patients receiving four or fewer visits. This provision would seem to

provide home health agencies with a strong financial incentive to make sure that patients are seen at least five times, when at all possible.

The case-mix adjustment for home health is based on the new Home Health Resource Groups (HHRGs). The HHRGs are based on patient assessments using the Outcome and Assessment Information Set (OASIS). There are 80 HHRGs reflecting different levels of clinical severity, patient functional status, and levels of services provided.

Each HHRG is defined based on the three indicators: severity, function, and services. So C0F0S0 reflects a minimal clinical severity, minimal change in patient's functional status, and minimal service levels, which yields a per diem rate of $1,075. But HHRG C2F2S2, for example, reflects moderate clinical severity, moderate patient functional status, and moderate service levels for a per diem cost of $3,723. And high and maximum indicators have a per-diem rate of $5,236.

Prospective Payment does appear to provide incentives for efficiency improvement for both service duration and cost per service. In particular, home health agencies can benefit from reductions in the costs of their services. In addition, within the 60-day episode of care (but after the 5th visit), there is an incentive to reduce the duration of service.

Medicare cost projections for home health show the drastic reductions of the past several years (since PPS began in 1994), followed by significant cost increases, over 10% per year, for the next few years (since 1998) as the PPS matures and providers gain experience under the new system. Although the transition to PPS is extremely painful for some providers, the PPS is expected, in the long term, to produce cost efficiency improvements similar to those seen previously for inpatient hospital care.

Mr. Peter M. Frank: Similar to Greg and Kevin, I'm going to talk a bit about the topic with respect to financial history and then go into the new payment method and how it will impact the future. One thing I will try to do a little differently is to discuss the total payment, considering both changes in the beneficiary liability and the Medicare liability. The two don't necessarily move in the same direction, and so I am going to try and discuss it in terms of total payment, rather than just Medicare payment.

If we look at what's been paid historically, in 1983 Medicare charges were over $3 billion, but by 1997 they swelled to almost $15 billion. There would be an even larger increase if you look at per capita charges. We looked at fee-for-service charges. Considering the fact that managed care was growing during the 1990's, the growth in per capita charges would have been even greater than what actually occurred. The total payment grew more gradually to $22 billion. Charges covered by Medicare grew to about $12 billion.

If you look early on, in the 1980s, most of the payment was coming from Medicare. The beneficiaries were contributing something, but not a great percentage. The further on we look, the greater the proportion of total payment that is coming from the Medicare beneficiaries. In 1985, the coinsurance represented about 25% of the Medicare payment. As we reach 1997, when the

Balanced Budget Act was enacted, the beneficiary coinsurance was more than half of the Medicare payment. On an overall basis, close to 40% of the dollars paid were coming from beneficiaries rather than from Medicare. For most of the other services that Medicare covers, the beneficiary liability is a much smaller piece of the pie than that.

When I'm referring to outpatient hospital services, I'm speaking a little more broadly than just outpatient services provided in a hospital setting. I'm including those things that Medicare would consider outpatient hospital. These items include payments to Ambulatory Surgical Centers, dialysis centers, rural health clinics, and other settings that are in the overall outpatient hospital umbrella for Medicare. The 7% represents only the Medicare portion. If you include beneficiary coinsurance, the outpatient services represent closer to 9%. If we look at how payment was made prior to BBA, there was a fee schedule for lab. Other services would be paid at the lower of cost or charge, except for radiology, surgery and other diagnostic procedures. They were paid on the lower of cost, charge, or a blend. A piece of the weighting for the blend is lower of cost and charge. The other piece of the weighting is a function that's related to the physician fee schedule for that particular type of service.

As Greg mentioned in his presentation, all of these services are reimbursed using the interim payment method with a later final settlement. The intermediary pays based on individual claims but then a final aggregate adjustment is made at the end of the cost-reporting year. For surgery, radiology and other diagnostic procedures, the blend payment was what would be used in most cases. For those procedures, Medicare wouldn't pay the difference between the total allowable amount and the coinsurance. Medicare would pay 80% of the allowed amount but the beneficiary would pay 20% of charges.

If you look at what was paid in total for the facility for that claim, the facility would usually get 80% of the blend amount from Medicare plus 20% of the actual charges from the beneficiary. From a hospital perspective with respect to these procedures, if you increased charges you got paid more. The increased beneficiary liability was not offset with a lower payment from Medicare. That's why we saw such a rapid growth in Medicare charges. Higher hospital charges most times went directly to the bottom line.

Now we get to the point where the BBA and the Balanced Budget Refinement Act (BBRA) are going to start to impact things. The BBA lowered allowable costs for capital by 10% and operating costs by 5.8%. The other big change was elimination of formula driven overpayments (FDOs). The FDO is the situation where the facility was getting 80% of the blended amount from Medicare plus 20% of charges from the beneficiary. With the formula driven overpayments going away, the total amount the hospital would get would be the allowable amount. Now if the hospital increased its charge, the beneficiary would pay more, but the increase would be offset for the hospital by a lower payment from Medicare.

From third quarter '97 until the mid-2000 advent of the Ambulatory Payment Classifications (APCs), that's the process that went into place. The elimination of formula driven overpayments coupled with the reductions in allowable and capital costs represented significant cuts for the hospitals. The overall reduction is about

12%, but that's 12% on total payments including both the beneficiary payments and the payments from Medicare. If you looked at just the payments that were coming from Medicare and consider the fact that lab isn't being affected and dialysis isn't being affected, many payments were being reduced by more than 20%.

In July 2000 outpatient PPS will arrive. It will apply to all Medicare hospitals excluding Maryland hospitals and critical access hospitals. Initially it will not apply to Ambulatory Surgical Centers. Congress prohibited HCFA from applying APCs to ASCs until after completion of an updated cost study. It doesn't look like, given all the administrative complexity, HCFA had resources to implement APCs for ASCs initially anyway. When outpatient PPS does become implemented for ASCs, it will probably be a blend of the APC methodology with the existing method of paying ASCs.

What are APCs? They are, to some degree, similar to DRGs except that there is no intensity of service component. APCs are groupings of clinically similar kinds of services that, according to HCFA's cost records, require similar resource use. I counted 451 of them in the final rule. What are they used for? They're used for services such as emergency room visits, clinic visits, surgery, radiology, and diagnostic procedures. They do not apply to DME, therapy, ambulance or laboratory services. In terms of the way they work, each procedure code maps into an APC. Each of those APCs is paid separately. There is packaging. Different revenue codes may be packaged, depending on the type of service. As an example, APC payments for surgery codes will include operating room, recovery room, anesthesia, drugs and supplies that are furnished in relation to that surgical procedure.

Packaged services are reimbursed as part of the APC rate, and no separate payment will be made for them. That's not terribly different than the existing situation with respect to surgery, but it is very different with respect to other services. For example, in an emergency room situation you will be charging for a visit, but that cost will include drugs and supplies that previously could have been billed and paid for separately. There is also an outlier payment process similar to what is done for inpatient DRGs. If the total amount of costs defined using the cost-to-charge ratio for the hospital exceeds 2½ times the APC, an outlier payment equal to 75% of the excess will be paid in addition to the APC amount. There are also pass-through payments for defined drugs and devices. For a drug that is one of the defined drugs, the payment will be 95% of the average wholesale price.

HCFA's rate development of APCs was done with the drugs removed. In terms of how APCs will end up moving forward for new technology, initially there are new technology APCs where, if something comes in as a new type of service, HCFA will evaluate it. It will get a code and be initially thrown into one of the new technology APCs. Within two to three years it will end up getting pulled out and reworked as part of the annual review of APCs that HCFA is going to do. The same type of process will apply to new drugs.

In terms of how the payment actually works, HCPCS codes map into an APC amount and the only other real variable is the wage index for the hospital. The wage index is going to be based on the hospital's geographic area. A discount would apply, both for terminated procedures and for ambulatory surgical

procedures. If you have a number of surgical procedures that are delivered at the same time, the highest one is going to get paid at 100% and the others would end up getting paid at 50% of the amount.

As part of the APC development, HCFA followed the BBRA requirements to establish national coinsurance amounts that apply to each APC. These coinsurance amounts are based upon the 1999, projected median co-insurance for the services that make up that APC. The thing that is a little different about the coinsurance than in the existing system is that, for any given service or APC, the coinsurance percentage is going to be the same no matter where it's delivered in the country. In the existing system, the coinsurance is a percent of total Medicare payment, and could vary substantially depending on the relationship between the cost structure and the charge structure in that particular geographic area. Currently there are large differences in what coinsurance actually represents from a geographic basis. As we go forward, the coinsurance for an APC is going to vary only by the amount of the wage index. If the deductible applies, it will reduce both the payment and the coinsurance.

We can use an MRI of an arm as an example. The payment rate is $388.87 and the national unadjusted coinsurance is $257.39. The coinsurance is 66% of the total. While that percentage seems high, it also mirrors the median of what beneficiaries currently pay for that kind of procedure. If we assume that the hospital is located in an area with a geographic wage index of 1.02, the total payment is going to be weighted 60% by the wage index and 40% with a weighting of one, producing a total of $393.54. The coinsurance is going to be the national coinsurance amount, weighted the same way, producing a total of $260.48. The Medicare payment is going to equal the total payment less the coinsurance amount.

In terms of how APCs are going to be updated over time, HCFA is going to revise the groups and weights each January 1st. An expert panel will have to convene to advise HCFA on making sure that the groups and weights make sense. Control of the overall cost of APCs will probably eventually work in a fashion analogous to the physician fee schedule. There is going to be a control on cost per service, but initially there is no control on volume of services or intensity of services provided. The BBRA does provide that there will be a volume control mechanism, but the method for doing that and the implementation and time frame are still under study. The coinsurance amounts are going to remain fixed. Congress was very concerned about getting APCs implemented in part because beneficiary coinsurance had gotten so high. It would be unworkable from a budget standpoint to immediately reduce the beneficiary coinsurance to 20%, but coinsurance will now remain fixed. Future trend on outpatient beneficiary coinsurance is going to be strictly volume and utilization instead of having a cost component along with it.

Part of the final rule on PPS is many pages on hospital-based providers and what is necessary to be a hospital-based provider. If you want to know exactly what defines a hospital-based provider, you should be looking for a convention of lawyers. The basic idea is the hospital has to have direct control, but it is more complicated than that.

Clinical coding edits. In the past there hasn't been a whole lot of incentive for hospitals to code outpatient services accurately because they got paid on a cost

basis. What they coded didn't make too much difference to reimbursement for a lot of services. It is going to make a big difference in reimbursement under outpatient PPS. As a result, HCFA is going to be doing a lot more editing of codes. As an example, hospitals currently may code all of their ER services with 99201. They have one visit code that they use for all ER. Under the outpatient PPS, there are many different visit codes. There is a much greater requirement to code accurately because reimbursement will vary depending on what has been coded. Because of this, HCFA will be paying much more attention to outpatient coding practices. Hospitals may reduce coinsurance down to 20% if they choose to do so. If they do, they have to be consistent about it. They can't pick and choose and they have to notify HCFA in advance.

Transition payments are a big issue for outpatient PPS. A lot of facilities might otherwise take a really big hit under outpatient PPS, especially if they are not very good with their coding and it takes them awhile to get up to speed. The transition process provides some protection to 2003. The payment is based on a formula that depends on how much of a hit the facility would take, absent the transition payment. If a hospital elects to reduce coinsurance, HCFA isn't going to give any credit for that. They'll calculate the transition payment as if the coinsurance had not been reduced.

In terms of how the transition payment would actually work, if a facility would have taken a 20% hit under the outpatient PPS prior to 2002, HCFA will make up 15% of that 20%. The facility would in essence only lose 5% prior to 2002. In 2002 the transition payment decreases, and if a facility hasn't adjusted by 2003 then its reimbursement may reduce substantially. The form of the transition payment is important because it will not affect the way individual claims are paid. The intermediary is going to look at what a facility was paid in the months preceding the benchmark for making a payment and then, if the facility qualifies, there will be a lump-sum payment. The intermediaries are not going to build something into each individual bill or each individual payment. What gets paid under outpatient PPS in terms of claim by claim will be on the same basis both during and after the transition process.

If we look at anticipated Medicare outpatient hospital payment trends from the Trustee's Report, you would see in both 1998 and 1999 the impact of the formula driven overpayment reductions (-8.4% and –2.5% respectively). The big numbers in 2000 and 2001 (15.9% and 16.1%) have to do with the transition payment itself as well as the fact that Medicare is picking up some of the slack for the fact that beneficiary coinsurance is going down. Beyond 2001, the projected trends are lower (5.1% to 10.8%). Given the history of major Medicare payment transitions, I wouldn't necessarily regard any of these projected numbers as fact. Until there is a volume and intensity control mechanism, there are incentives on the upside for the hospitals, but not as much of a downside.

What will happen with contracting because of this? As with other Medicare payment methods, Outpatient PPS will probably find its way into contracting between managed care organizations and hospitals. Even if contracting doesn't occur, the standardization in the way APCs are developed will give managed care organizations a way to benchmark different kinds of contracts even if they are not paying based on APCs. The third way of viewing this from a contracting perspective

is that APCs could be substituted for existing reimbursement in developing standardized population studies.

From the Floor: Has there been a quantification of the amount of APC payments that will be attributed to outliers? As a gut reaction, 75% in excess of 2.5 times the APCs sounds kind of generous to me.

Mr. Frank: In the HCFA analysis that was used to develop the outlier payments it was assuming that it was 2.5%. It did the development based on single procedure claims. It looks like the outliers will be administered on a total claim basis, so it's not clear whether or not the 2.5% will hold up. But I wouldn't expect it to be off very much.

Mr. Joseph N. Romano: Each of you have talked about reimbursement mechanisms that are vertical off of different types of service. I'm curious if there have been any studies that look at the continuum of care as to how this reimbursement has affected a person who tracks through the system as he moves from inpatient into SNF, home health or inpatient into outpatient, or outpatient into home health settings.

Mr. Kenny: I don't have any specific studies to cite, but certainly the numbers we saw earlier indicate that the PPS for inpatient care, the DRG system, had a major impact on utilization of SNF and home health. The increases in those two services seem to have been due in large part to the changes in the inpatient reimbursements. So yes, we do see those ripple effects.

Mr. Romano: I would point out that, from the point of view of a managed-care organization, looking at the total continuum of care, adopting various pieces to study and compare costs, this would be an important aspect to try to understand as opposed to fragmentary vertical looks at it.

Mr. Savord: I would say this does need more study. When the hospital PPS system started way in back in 1984, there was some talk about a payment for an episode of care, but I haven't heard talk about that in a long time and you would need studies like this to come up with a payment mechanism like that.

Mr. Brian R. Lewis: I basically have three questions about the RUGs, the categories for SNF. The first question is, it seems like there is a lot of crossover in the different categories of SNF. I was wondering if you could comment on some of the criteria for setting those categories. The second question is about the per diem. Is that an all-inclusive per diem or is it room and board only? The third question is, can you answer any of my questions by referring me to a public or private resource? I would appreciate that.

Mr. Kenny: That's a very good observation. There is significant crossover and overlap among some of the SNF RUGs and, in fact, HCFA is currently proposing to substantially revise the 44 RUGs that we discussed earlier. The proposed new system contains 178 RUGs, some of them reflecting overlapping categories, such as rehabilitation for patients with clinically complex conditions.

The per diems are intended to include, with few exceptions, all of the services to be provided to residents in the facility. They exclude physician services and a few other items.

A helpful resource on these questions is the current and proposed PPS rules, which are published in the *Federal Register*. The latest HCFA proposals for the SNF PPS are in the *Federal Register* for April 10, 2000.

From the Floor: I have a clarifying question for Greg about RVUs. In 1998 I was under the impression that they moved the RVUs to have a facility-based and a non-facility RVU, and you didn't discuss that at all. Did BBA amend that?

Mr. Savord: I didn't discuss that. Medicare had previously included a site of service differential, which reduced practice expense RVUs by 50% for certain services when performed in a facility setting. With the implementation of resource-based RVUs for practice expense, separate RVUs reflecting actual resources used in a facility and non-facility setting have been developed. The resource-based RVUs for practice expense are being phased in from 1999 to 2002.

Mr. Wittman: Question for Kevin and possibly Pete. What are the applications on the Commercial side with respect to provider contracting for the new home health and SNF reimbursement methodologies?

Mr. Kenny: I don't think that the implications for Commercial contracting are dramatic. But I would suggest that for most commercial Medicare plans they are worth taking a look at, particularly home health. It's at least worth running the numbers on a PPS basis, to see how they compare with current reimbursement levels. I don't expect large numbers of health plans to quickly implement similar PPS methodologies. But I do think it's helpful to analyze the results, see how they compare with Medicare, and make sure that you avoid cost shifting.

Mr. Wittman: How about on the APCs. In your opinion, can they be directly implemented at this point?

Mr. Frank: Theoretically they could be, but I haven't seen a lot of people moving to try and get there right away. I imagine that within a year or two, once the methodology is administratively clearer, there will be more people interested in doing that. It's not a foregone conclusion that APC contracting will be done heavily because it is a fee-schedule type of system, and anybody who contracts that way is going to give up some utilization and intensity control.