WEB FEATURE

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implementing a site-neutral PPS

Congress is considering legislation that would move Medicare to a site-neutral prospective payment system, in which payment would be the same for certain services regardless of whether the services are provided on an outpatient or inpatient basis.

AT A GLANCE

- A bill recently introduced in Congress proposes to implement a site-neutral prospective payment system (PPS) in which certain medical and surgical procedures are paid at the same rate regardless of whether they are delivered on an inpatient or outpatient basis.
- A bill aims to remove financial incentives for healthcare providers to treat patients in the high-cost inpatient setting when the patients could just as well have received the same treatment in the lower-cost outpatient setting.
- The criteria for identifying which MS-DRGs would be appropriately paid under the site-neutral PPS must consider a number of factors, including the presence of major complications or comorbidities and whether treatment in an outpatient setting can be performed without significantly increasing the risk of mortality and morbidity.

A potential change is in the air that demands the attention of finance leaders of healthcare provider organizations. It is important for finance leaders to understand the nature of the prospective changes today to be able to ensure their organizations have a strategy in place to respond to the changes when they become effective.

In November 2014, U.S. Rep. Kevin Brady (R-Tex.), now chairman of the House Ways and Means Committee released The Hospital Improvements for Payment Act of 2014 (HIP), a discussion draft of a bill aimed at modifying the Medicare inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS). The bill would establish a new hospital site-neutral prospective payment system (site-neutral PPS) with equal payments for inpatient short stays and equivalent overnight outpatient stays, thereby eliminating the financial incentive to provide care on an inpatient basis as opposed to an outpatient basis. The bill states the rationale for this change as follows:

"The vast discrepancy in reimbursement between the IPPS and OPPS payment systems for 'short stays' may incentivize hospitals to bill all services on an inpatient basis, even if a procedure is medically appropriate as an outpatient service."

The bill also is indicative of growing interest among members of Congress in finding ways to address significant differences in payment between inpatient and outpatient settings for delivery of the same types of services.

Following the introduction of HIP, now Speaker of the House Paul Ryan (R-Wisc.) introduced the Medicare Crosswalk Hospital Code Development Act of 2015 (H.R. 3291) on July 29, 2015, with the following comments:

"Today, Medicare uses two different payment systems that are completely incompatible. This bill will allow the program to compare what it pays for similar services . . ."

Specifically, H.R. 3291 requires the development of a Health Care Common Procedure Coding System (HCPCS) version of 10 surgical MS-DRGs. The HCPCS version of the MS-DRGs would assign an outpatient surgical claim coded with HCPCS the same MS-DRG as would have been assigned to an identical inpatient claim coded with the ICD-10 Procedure Coding System (ICD-10 PCS). This move will allow costs of and payments for similar services delivered in the inpatient and outpatient settings to be directly compared, and it will provide the basis for implementing a site-neutral PPS.

Background

Critics of the current site-specific payment approach point to a significant problem that it poses: Although outpatient care is beneficial for patients and provides less-invasive treatment in a lower-cost setting, the relative payment and, more important, *profitability* of inpatient care creates a financial incentive to treat patients in an inpatient setting when they just as well could have received the same treatment in an outpatient setting.

The greater payment for inpatient services is intended to account for costs providers do not incur in the outpatient setting, some of which are not directly related to the treatment or procedure in question, such as funding of indigent care and teaching. However, the most significant reason for the difference in payment is that IPPS MS-DRG payments are determined by the combined average of case costs for patients requiring only a one- or two-day length of stay (LOS), who could receive treatment in an outpatient facility, and for more complex patients requiring a longer LOS, who must receive treatment in a hospital.

In its June 15, 2015, *Report to Congress*, the Medicare Payment Advisory Commission (MedPAC) proposed several short-stay policy alternatives, including the equalization of payment across similar case types regardless of site of service. MedPAC's recommendations were consistent with the intent of H.R. 3291, and provide an impetus toward achieving a site-neutral PPS for Medicare as envisioned in HIP.

Design Challenges

MedPAC's recommendations and H.R. 3291 constitute the necessary first step in implementing a MS-DRG-based site-neutral PPS—i.e., identification of MS-DRGs that are appropriate for payment on a site-neutral basis. From a coding standpoint, to operationalize site-neutral payment in these cases, outpatient and inpatient cases will need to be assigned to the same MS-DRGs: Outpatient cases would be assigned to an MS-DRG using the HCPCS version of the MS-DRG while inpatients would continue being assigned to an MS-DRG using the ICD-10-PCS version of the MS-DRG.

The simplest payment design would be to have payment be set at the same, site-neutral amount for all patients assigned to any MS-DRG designated as site neutral. However, some exceptions are necessary to ensure the site-neutral MS-DRGs are sufficiently homogenous in terms of patient resource requirements.

For example, clearly, it is in the best interests of surgical patients with complex comorbid conditions to receive treatment in an inpatient setting. Yet if the site-neutral MS-DRG payment level for such patients is less than the current IPPS payment level, there will be a perverse financial incentive to avoid the higher costs of inpatient care for such a patient and, instead, deliver the treatment in the lower-cost outpatient setting. The most operationally straightforward way of eliminating such an incentive is to pay for

patients with a major complication or comorbidity (MCC), as currently defined in the MS-DRGs, under the IPPS instead of the site-neutral PPS, the rationale being that patients with MCCs should not receive treatment on an outpatient basis in any event, and that payment should take into the higher costs posed by the MCCs for more complex inpatient care. In short, no MS-DRG that has an MCC would be included among the MS-DRGs identified for site-neutral payment, so there would be no incentive to deliver care for these patients in an outpatient facility.

HIP attempted to address the issue of patient complexity by restricting inpatients paid under the site-neutral PPS to short stays. However, LOS is subject to practice pattern variation, and the medical necessity of an additional day of stay is difficult to audit. The presence of an MCC is a more objective and readily audited means of addressing the medical complexity issue.

There can be wide range of medical complexity among different patients in a medical MS-DRG at the time the site of service is selected. Presumably the site-neutral MS-DRG payment level for medical MS-DRGs will be more than the current OPPS payment level to account for the potential for greater medical complexity. To make the site-neutral PPS payment provide a better match to patient resource need, the outpatient visits paid under a medical site neutral MS-DRG could be limited to those patients with greater medical complexity.

The most operationally straightforward way of making this distinction for site-neutral payment would be to restrict the medical outpatients paid under the PPS to those patients who meet existing payment criteria for observation status. Observation care is a well-defined set of clinically appropriate services that include ongoing short-term treatment assessment and reassessment, and that are furnished while a decision is being made regarding whether patients require further treatment as hospital inpatients or are ready to be discharged from the hospital. The OPPS payment system recognizes observation as a payable service after 8 hours and provides guidance to make the decision to admit a patient within 24 hours. The presence of observation in excess of 8 hours thereby constitutes a marker of additional patient complexity. Outpatients in a medical MS-DRG included in the site-neutral PPS who do not meet the criteria for observation status would continue to be paid under OPPS. Although this level of detail is not specified in HIP or H.R. 3291, we believe it is a viable approach to fairly addressing the complexity of medical outpatients in the absence of more detailed outpatient risk classification.

Criteria for Selecting the MS-DRGs Included in a Site-Neutral PPS

To operationalize the intent of HIP and H.R. 3291, we propose the following criteria be used to define the subset of MS-DRGs for which outpatient care is a viable alternative to inpatient care:

- Treatment in an outpatient setting can be delivered without significantly increasing the risk of mortality and morbidity.
- A substantial proportion of inpatients assigned to the MS-DRG have a hospital stay of one or two days.
- A substantial proportion of patients assigned to the MS-DRG are currently being treated on an outpatient basis.
- For medical MS-DRGs, there should be a high degree of certainty that the patient's diagnosis would be known when the decision to admit is made (e.g., allergic reaction) as opposed to requiring significant workup to establish the diagnosis (e.g., Transient Ischemia).

HIP relied solely on inpatient LOS to determine the patients included in the site neutral payment system resulting in all the problems associated with using an arbitrary length of stay cutoff point. The subsequent H.R. 3291 clearly envisioned moving toward an MS-DRG basis for determining inclusion in the site-neutral payment system but did not go into detail on how the site neutral MS-DRGs would be selected. We propose the above criteria as the basis for making the selection of MS-DRGs.

For example, because a substantial proportion of laparoscopic cholecystectomies have a one- or two-day stay and are being routinely performed in an outpatient setting, the MS-DRG for laparoscopic cholecystectomies meets the site-neutral criteria. Conversely, even though many cervical spinal fusion patients have only a one-day LOS, the cervical spinal fusion MS-DRG does not meet the site-neutral criteria because cervical spinal fusions are rarely being performed in an outpatient setting.

The criteria that treatment in an outpatient setting can be delivered without significantly increasing the risk of mortality and morbidity can be operationalized by determining the proportion of patients in an MS-DRG that are actually being treated on an outpatient basis. The possibility of treating only *some* patients in an MS-DRG in an outpatient setting is insufficient justification for including the MS-DRG in the site-neutral PPS. Existing practice patterns should reflect that *a substantial proportion* of the patients in the MS-DRG are actually being treated on an outpatient basis. Simply put, the determination of whether outpatient care is a viable alternative should be determined by current medical practice.

Applying the Proposed Criteria for Selecting Site Neutral MS-DRGs

To illustrate the considerations that must be addressed to apply the proposed criteria for selecting site neutral MS-DRGs, 3M Clinical and Economic research performed a clinician-led review of the 749 MS-DRGs in which the site-neutral criteria were used to identify potential candidate MS-DRGs for inclusion in a site-neutral PPS.

Candidate site-neutral MS-DRGs identified by the physicians included elective surgery MS-DRGs and MS-DRGs for which diagnosis and treatment can be reasonably performed on an outpatient basis. Also included were MS-DRGs such as chest pain that were termed *rule-out MS-DRGs* because effective diagnostic tools are available to quickly rule out major acute illnesses for such MS-DRGs. Malignancies, serious chronic disease (e.g., diabetes), and serious acute diseases (e.g., pneumonia) were excluded because of the wide range of medical complexity within these MS-DRGs.

Quantifying the Criteria for Selecting Site-Neutral MS-DRGs

Although the judgment of the physicians in applying the site-neutral criteria provided a useful point of reference, the operational application of the criteria should be data-driven to the extent possible. In particular, the concept of a "substantial proportion" should be explicitly quantified. The IPPS Medicare Provider Analysis and Review (MedPAR) file and OPPS limited data set data files for FY13 were used to produce data for quantifying the criteria for selecting the site-neutral MS-DRGs.

Surgical MS-DRGs. Because it is necessary to convert the definition of surgical MS-DRGs to be based on HCPCS, nine categories of surgical procedures (comprising 16 MS-DRGs) were selected because the conversion to HCPCS was straightforward. To facilitate testing operational criteria for selecting the site-neutral MS-DRGs, seven of the surgical categories were candidate surgical categories identified by the physicians and two were not. The HCPCS codes that are equivalent to ICD-10 codes in the 16 MS-DRGs were used to create a HCPCS version of MS-DRGs. As shown in the exhibit on page 5 the ratio of outpatient procedures to inpatient procedures and the percentage of inpatients with a one- or two-day stay are reported for each of the nine surgical categories. As previously discussed, surgical inpatients with an MCC were excluded from the counts.

For all seven surgical categories identified as candidates for inclusion as site-neutral MS-DRGs by the physicians, the outpatient volume was substantially greater than the inpatient volume resulting in an outpatient to inpatient volume ratio above 1.0. In contrast, the two surgical categories that were evaluated as non-candidates by the physicians had outpatient volume

OUTPATIENT RATIOS AND PERCENTAGE 1- OR 2-DAY STAYS FOR SELECTED SURGICAL MS-DRGs

MS-DRGs	MS-DRG Description	Count Outpatient	Count Inpatient Without Major Complication or Comorbidity (MCC)	Percentage 1- or 2-Day Stays	Outpatient Ratio*	Candidate MS-DRG
243, 244	Permanent Cardiac Pacemaker Implant w/o MCC	99,687	45,932	37.5%	2.2	Yes
247, 249	Perc Cardiovasc Proc w Stent w/o MCC	105,498	95,912	57.0%	1.1	Yes
251	Perc Cardiovasc Proc w/o Coronary Artery Stent w/o MCC	392	20,945	49.3%	0.0	No
287	Circulatory Disorders Except AMI, w Card Cath w/o MCC	386,181	77,629	50.2%	5.0	Yes
351-352	Inguinal & Femoral Hernia Procedures w/o MCC	92,449	6,998	45.2%	13.2	Yes
354-355	Hernia Procedures Except Inguinal & Femoral w/o MCC	53,111	15,642	34.3%	3.4	Yes
418-419	Laparoscopic Cholecystectomy w/o C.D.E. w/o MCC	82,358	40,652	32.9%	2.0	Yes
472-473	Cervical Spinal Fusion w/o MCC	491	37,728	73.1%	0.0	No
714	Transurethral Prostatectomy w/o CC/MCC	20,807	4,534	78.2%	4.6	Yes

* Count Outpatient ÷ Count Inpatient without MCC

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substantially below inpatient volume, resulting in an outpatient–to-inpatient-volume ratio well below 1.0, confirming the effectiveness of the selection criteria. It is important to note that relying solely on LOS- based criteria, as was proposed in HIP, would result in the majority of patients (73.1 percent) in the MS-DRGs for cervical spinal fusions (472-473) being inappropriately paid under a site-neutral payment system.

The results for MS-DRG 251 (percutaneous cardiovascular procedures without coronary artery stent) may appear inconsistent with the results for MS-DRGs 247 and 249 (percutaneous cardiovascular procedures with stent). However, coronary angioplasties now are rarely performed without a stent, so the volume in MS-DRG 251 is now dominated by the procedure for cardiac mapping, which is primarily an inpatient procedure.

Again, the exclusion of any surgical case with an MCC from the site-neutral payment system is important because such patients are rarely treated on an outpatient basis. For example, the outpatient ratio for laparoscopic cholecystectomy without an MCC (MS-DRGs 418-419) is 2.0, while the outpatient ratio for laparoscopic cholecystectomy with an MCC (MS-DRGs 417) is 0.22.

Medical MS-DRGs. For the four medical MS-DRGs, the exhibit on page 6 shows the percentage of inpatient stays of one or two days, the number of outpatient visits meeting the payment criteria for 8 hours of observation, and the outpatient volume to inpatient volume ratio. For the two candidate medical MS-DRGs identified by the physicians, the ratio of outpatient volume to inpatient volume was greater than 1.0 for only MS-DRG 313 (chest pain).

Although the reviewing clinicians felt that MS-DRG 552 (medical back problems) could be included in a site-neutral PPS, the outpatient to inpatient ratio did not support its inclusion. MS-DRG 552 contains a wide range of medical back problems from lumbago and sciatica to

OUTPATIENT RATIOS AND PERCENTAGE 1- OR 2-DAY STAYS FOR SELECTED MEDICAL MS-DRGs

MS-DRG	MS-DRG Description	Count Outpatient	Count Outpatient w Observation	Count Inpatient without Major Complication or Comorbidity (MCC)	Percentage 1- or 2-Day Stays	Outpatient Ratio*	Candidate MS-DRG
69	Transient Ischemia	44,720	6,826	58,561	61.8%	0.1	No
313	Chest Pain	578,731	116,610	64,662	72%	1.8	Yes
392	Esophagitis, Gastroent & Misc Digest Disorders w/o MCC	1,379,305	36,583	179,701	43.7%	0.2	No
552	Medical Back Problems w/o MCC	1,395,725	15,858	52,656	30.7%	0.3	Yes

* Count Outpatient w Observation ÷ Count Inpatient w/o MCC

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fractured and dislocated spinal vertebra. A restructuring of MS-DRG 552 to isolate the medically complex medical back problems in a new MS-DRG would likely result in a more homogenous MS-DRG that could meet the criteria to be included in a site-neutral PPS.

The two non-candidate medical MS-DRGs had outpatient volume substantially below the inpatient volume resulting in an outpatient ratio well below 1.0, thus appropriately failing the selection criteria.

For all the MS-DRGs evaluated, the percentage of patients with a one- or two-day LOS was consistently above 30 percent. Thus, the percentage of one- or two-day inpatient stays provided no basis for discrimination between which MS-DRGs should or should not be included in a site-neutral PPS. The selection of which MS-DRGs to include in a site-neutral PPS should therefore be solely determined by the outpatient ratio.

In sum, based on results of this review, the appropriate criteria for including a surgical or medical MS-DRG in the site-neutral PPS can be summarized as follows:

- *Surgical MS-DRGs*—inclusion in site-neutral PPS limited to those MS-DRGs that have an outpatient-to-inpatient-volume ratio greater than 1.0, where the inpatient volume of surgical patients excludes patients with an MCC.
- *Medical MS-DRGs*— inclusion in site-neutral PPS limited to those MS-DRGs having an outpatient–to-inpatient-volume ratio greater than 1.0, where the inpatient volume of medical patients excludes patients with an MCC and the outpatient volume includes only patients meeting the criteria for 24 hours of observation.

Determining Claims to Be Paid Under the Site-Neutral PPS

Once the MS-DRGs included in the site-neutral PPS have been determined, the determination of which patients are paid under the site-neutral PPS is straightforward:

- All inpatients assigned to a site-neutral MS-DRG who do not have an MCC are paid under the site-neutral PPS.
- All outpatients assigned to a surgical site-neutral MS-DRG are paid under the site-neutral PPS.
- All outpatients assigned to a medical site-neutral MS-DRG who meet the criteria for 24 hours of observation are paid under the site-neutral PPS.
- All patients not meeting any of the above criteria are paid under IPPS or OPPS depending on their site of service.

Note that, under this proposal, inpatient LOS would not be a factor in determining the claims that will be paid under the site-neutral PPS.

Challenges Facing a Site-Neutral PPS

The major challenge with selecting the MS-DRGs for inclusion in a site-neutral PPS is that MS-DRGs were not constructed for the purpose of identifying patients for whom outpatient treatment is a viable alternative to inpatient care. As a result, many MS-DRGs include both patients for whom outpatient care is a viable alternative and patients for whom it is not. For example, MS-DRG 310 (cardiac arrhythmia and conduction disorders) includes minor heart blocks that can reasonably be evaluated on an outpatient basis and ventricular fibrillation that requires immediate inpatient treatment. Such mixed MS-DRGs cannot be included in a site-neutral PPS. Future MS-DRG updates will need to modify such mixed MS-DRG to create additional MS-DRGs for which outpatient care is a viable alternative.

The creation of a site-neutral PPS will eliminate the need for policies such as the two-midnight rule that are aimed at reducing unnecessary short stay hospital admissions.

Although this article focuses solely on the criteria for selecting the MS-DRG and patients included in a site-neutral PPS, many other design decisions will need to be made, which are beyond the scope of this discussion, including the extent of add-on payment for indirect medical education and disproportionate share, outlier payments, budget neutrality, and computation of relative weights.

Implications for Providers—and for Finance Leaders

Healthcare finance leaders should monitor the status of HIP and H.R. 3291, which—if enacted in their current form—would require the secretary of HHS to develop the CPT version of MS-DRGs by Jan. 1, 2018. Although the final implementation and design of a site-neutral method may vary from that outlined here, the financial and political impetus speeding the transition of inpatient hospital cases to the outpatient setting will grow. Healthcare finance leaders should assess their own reliance upon MS-DRG margins for short-stay inpatient cases that may be significantly impacted by these or similar reforms. Under a site-neutral payment system, revenue cycle management systems will need to be able to determine whether payments are based on IPPS, OPPS, or the site-neutral PPS on a patient-by-patient basis. Adequate planning and preparation will be needed to ensure an orderly transition. ■

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