

October 8, 2004



Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: CMS-1427-P; Medicare Program, Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Rates; (*Federal Register*, August 16, 2004)

Dear Dr. McClellan:

The Wisconsin Hospital Association (WHA), on behalf of our more than 140 hospitals and health systems, welcomes the opportunity to comment on the proposed Calendar Year (CY) 2005 Medicare Outpatient Prospective Payment System (OPPS) rule.

WHA is concerned that in the proposed 2005 OPPS, many ambulatory payment classification (APC) rates continue to fluctuate dramatically, with payments much lower or higher in 2005 than in 2004. These changes make it extremely difficult for hospitals to plan and budget from year to year. In addition, a separate payment-to-cost analysis of the OPPS that the American Hospital Association (AHA) performed using the 2003 Hospital OPPS Limited Data Set revealed troubling issues. Among them are more than 60 “broken” APCs that resulted in hospital losses of more than \$1.4 billion in payments in 2003. Even more troubling, several of the evaluation and management (E/M) services APCs – clinic and emergency department visits – were among the most “broken,” resulting in losses of more than \$700 million. Also, there is a tremendous degree of variation across APCs in terms of payment-to-cost ratios. We would expect that three years after the implementation of the OPPS, these payment to cost ratios would be much more stable. Such dramatic variation in payments compared to costs puts full-service hospitals and their communities at risk because limited-service, or “niche,” providers can easily identify and redirect patients with more lucrative APCs to their facilities, leaving full-service hospitals with a disproportionate share of patients with underpaid APCs.

Further, the entire OPPS is underfunded, paying only 87 cents for every dollar of hospital outpatient care provided to Medicare beneficiaries. Hospitals must have adequate funds to address critical issues like severe worker shortages, skyrocketing

liability premiums, expensive drugs and technologies, aging facilities, expensive regulatory mandates and more.

Wage Index (*Federal Register page 50541*)

CMS indicates that the final inpatient wage index will be used in the outpatient final rule. However, CMS does not mention the one-year temporary relief provided in the inpatient final rule for hospitals harmed by the redefinition of wage areas. Under this relief, hospitals experiencing a wage index decrease due to labor market changes receive a blend of 50% of the wage index based on the new definitions and 50% based on the old boundaries.

We urge CMS to specify that the OPSS wage index will include the one-year temporary relief for facilities that experienced a loss caused by geographic redefinitions, which was provided under the federal fiscal year (FFY) 2005 Medicare Inpatient Prospective Payment System (IPPS).

Outlier Payments (*Federal Register page 50542*)

CMS proposes to require that costs must exceed 1.5 times the Ambulatory Payment Classification (APC) rate and exceed a \$625 fixed-dollar threshold to qualify for outlier payments. This would eliminate outlier payments for low-cost services and provide higher outlier payments for relatively expensive procedures. **WHA supports the continued need for an outlier policy in all prospective payment systems, including the OPSS, and supports revisions that better target outlier payments to unusually high cost services.**

However, we are concerned that the proposed thresholds for outlier payment may be too high. In the proposed FFY 2005 IPPS rule, CMS suggested a substantial increase in the outlier threshold based on inflated charge estimates that did not take into account the charge decreases that many hospitals implemented in 2003 and 2004. In 2003, CMS issued a rule requiring the use of data that are more up-to-date when determining a hospital's cost-to-charge ratio (CCR); specifically, a hospital's most recent final or tentatively settled cost report. It also instructed fiscal intermediaries, in certain situations, to retrospectively reconcile outlier payments when a hospital's cost report is settled. Because of these changes, many hospitals decreased their charges and the overall rate of increase declined. In response to comments, CMS lowered its charge increase assumptions substantially in the inpatient final rule.

CMS states that the new methodology will continue to pay 2% of total OPSS payments as outliers. However, CMS does not provide details of this estimate. **WHA urges CMS to provide details of the assumptions used to set the outpatient outlier thresholds. CMS should review assumptions regarding charge increases to ensure that they do not inappropriately inflate charges in setting the OPSS outlier thresholds.**

In addition, we join the American Hospital Association (AHA) in advocating an outlier

policy that would consider costs at the claim level, rather than at the individual service level. This would be easier to administer and would result in payments that are more equitable for high cost patients.

Cost-to-Charge Ratios *(Federal Register page 50527)*

CMS uses default CCRs for hospitals that are determined to have invalid CCRs. These include new hospitals, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds, or hospitals that have recently given up their all-inclusive rate status. CMS is proposing to update the default CCRs for CY 2005 based on the most recent available cost reports (2002 cost reports for most hospitals). Under the proposal, most areas would experience a decrease in the default CCR. The lower CCRs would result in decreased payments for hospitals using the default.

The default CCRs often result in inequitable payments for hospitals that have recently given up their all-inclusive rate status. **CMS should instruct fiscal intermediaries to work with those facilities that have given up their all-inclusive rate status to quickly determine an appropriate CCR that will provide an accurate estimate of costs for each facility.**

Blood and Blood Products *(Federal Register page 50521)*

CMS proposes to set payment rates for all blood and blood products based on a facility's CY 2003 claims data, utilizing an actual or simulated hospital blood-specific CCR to convert charges to costs for blood and blood products. For certain low volume products, CMS would combine claims data for CYs 2002 and 2003. While this approach results in modest payment increases for many blood and blood product-related APCs, payment rates for most low volume APCs will decline significantly under this methodology.

WHA recommends that CMS freeze the reimbursement rates for 2005 at the current 2004 levels for those low-volume blood products (as reported on Table 31 of the proposed rule) that experience a rate decrease. WHA believes this is necessary to ensure continued beneficiary access to these blood products.

New Technology APCs *(Federal Register page 50468)*

CMS indicates that a number of positron emission tomography (PET) scans currently classified into New Technology APC 1516 have sufficient data for assignment to clinical APCs. However, this would reduce payments for PET scans and CMS is concerned that this might hinder beneficiary access to this technology. Therefore, CMS is considering three options as the proposed payment for PET scans in CY 2005:

- Option 1: Continue in CY 2005 the current assignment of the scans to New Technology APC 1516 before assigning to a clinical APC. APC 1516 has a rate of \$1,450.00.

- Option 2: Assign the PET scans to a clinically appropriate APC priced according to the median cost of the scans based on CY 2003 claims data. Under this option, PET scans would be assigned to APC 0420: PET imaging, with a rate of \$898.64.
- Option 3: Transition assignment to a clinical APC in CY 2006 by setting payment in CY 2005 based on a 50-50 blend of the median cost and the CY 2004 New Technology APC. CMS would assign the scans to New Technology APC 1513 for payment with a rate of \$1,1150.00.

WHA agrees that the substantial payment decreases that would result from Option 2 could hinder beneficiary access to necessary care. Option 3 limits the decrease but still results in a 20.7% rate reduction. **WHA supports the continued assignment of PET scans to APC 1516 as proposed under Option 1 until CMS can determine an equitable rate for these services.**

Observation Services (*Federal Register page 50532*)

CMS established separate payment for observation services under the OPSS for three medical conditions: chest pain, congestive heart failure, and asthma. A number of accompanying requirements were established, including provision of specific diagnostic tests to beneficiaries based on their diagnoses. CMS has responded to comments from the hospital community by proposing to eliminate the requirements for specific diagnostic tests. In addition, CMS is proposing to modify the rules so that time in observation care would end when the outpatient is actually discharged from the hospital or admitted as an inpatient. **WHA supports these changes, which will result in more accurate billing and provide payment for more clinically appropriate care.**

CMS also proposes to exclude from the rate calculation any claims that report more than 48 hours of observation care. **WHA believes that CMS should reevaluate the final payment rate for APC 0339, including those claims exceeding 48 hours of observation care.** These observation service claims have been paid by Medicare and reflect services that were reviewed and determined to be medically necessary. The costs for such covered services should be included in calculating the payment rates.

Inpatient Procedures (*Federal Register page 50536*)

CMS identifies certain procedures that are typically provided only in an inpatient setting. These procedures are assigned a status of "C: inpatient procedure, not payable under the OPSS." Hospitals were advised to admit these patients to receive payment. CMS rejected an APC Advisory Panel recommendation to eliminate the list of inpatient-only procedures.

WHA joins AHA in recommending that the inpatient-only list be eliminated, as recommended by the APC Advisory Panel. Hospitals are unable to receive any payment for services on this list that are performed in the outpatient setting. Yet, physicians, not hospitals, determine what procedures should be performed and whether

a patient's condition warrants an inpatient admission. We believe it is appropriate to leave this clinical decision making process in the hands of physicians.

Device-Dependent APCs (*Federal Register page 50491*)

CMS is proposing to modify payments for 43 "device-dependent" APCs. These are APCs for services that CMS has determined cannot be provided without an associated medical device. CMS has consistently experienced problems in determining payment rates for the procedures that include packaged devices. When APC rates were calculated for these procedures using claims data, the resulting rates were often substantially less than the cost of the device. In CY 2005, CMS proposes to determine rates for device-dependent APCs based on the greater of:

- median costs calculated using CY 2003 claims data, or
- 90% of the APC payment median for CY 2004 for such services.

CMS states that the proposal to limit decreases to 90% of the CY 2005 rate allows for cost variations from year to year. However, the 10% decrease assumes that costs may have gone down compared to CY 2004. There is no evidence to support this assumption. **WHA recommends that median cost for the device-dependent APCs be based upon the greater of CY 2003 median costs or 100% of the APC payment median in CY 2004.**

Devices (*Federal Register page 50500*)

CMS proposes to retire six devices from pass-through status after December 31, 2004. In 2005, these items will be treated as packaged items with no separate payment provided. Instead, the cost for these devices will be incorporated into the rates of associated procedure APCs.

The "retirement" of pass-through devices and drugs highlights a basic problem of underfunding for the OPSS. Total funds do not increase as new devices and drugs are removed from pass-through status and are incorporated into the APC rates. As a result, payments for other services are decreased to ensure overall budget neutrality. WHA will continue to advocate for new funding that will ensure adequate payment for new technologies while protecting payments for basic outpatient services.

WHA appreciates having the opportunity to comment on the proposed rule.

Sincerely,

Brian Potter
Vice President, Finance and Operations