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September 2, 2008

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: CMS–1404–P

Dear Mr. Weems:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates ..."* 73 Fed. Reg. 41416 (July 18, 2008). The AAMC represents approximately 400 major teaching hospitals and health systems; all 126 accredited U.S. allopathic medical schools; 89 professional and academic societies; and the nation's medical students and residents.

Our comments focus on the following areas: the outpatient quality reporting program, proposed composite ambulatory payment classification (APC) groups for multiple imaging services, proposed payment rate for separately payable drugs and biologicals and charge compression, proposed changes to the cost report, outlier payments and the partial hospitalization program (PHP). But first, we would like to address whether a teaching adjustment should be included in the outpatient prospective payment system (OPPS).

AN OPPS TEACHING ADJUSTMENT

An analysis of the 2006 hospital Medicare cost reports conducted by Vaida Consulting shows that while Medicare outpatient margins are negative for all hospitals, they are significantly lower for major teaching hospitals. For example, in 2006, the average outpatient margin was -27.3 percent for major teaching hospitals, -13.0 percent for other teaching hospitals and -15.2 percent for nonteaching hospitals.

We have been conducting preliminary analyses to determine the causes of such low outpatient margins. So far, these analyses seem to suggest that major teaching hospitals may have significantly lower outpatient margins because of their unique education,

research and patient care missions. The AAMC will continue to study this issue but urges CMS to conduct its own analyses to determine reasons for the consistent and systematic differences in outpatient margins for major teaching versus other hospitals. If such analyses reveal that the differences are due to the unique missions of teaching hospitals we believe a teaching adjustment should be included in the OPPS to ensure equitable payments for all classes of hospitals.

QUALITY REPORTING UNDER THE OPPS

Reporting Quality Data for Annual Payment Rate Updates

The Tax Relief and Health Care Act of 2006 (the Act), modified the payment update for OPPS payments. The Act required the establishment of a quality reporting program for the hospital outpatient setting and mandates that hospitals submit quality data on outpatient performance measures or receive a reduction in their annual payment update of 2.0 percentage points. The Act states that the Secretary shall develop measures that are appropriate for measuring quality of care in the hospital outpatient setting and that reflect consensus among affected parties.

The outpatient reporting program was implemented in CY 2008 and required the submission of quality data for seven outpatient measures, including five emergency room measures and two perioperative care measures. Data collection on these measures began in April 2008. CMS is now looking to expand the program and is proposing four claims-based imaging efficiency measures to be required for the CY 2010 payment update; data collection would begin in CY 2009.

The AAMC, and its members, are very dismayed that CMS proposes measures for implementation when no background or supporting information, such as measure specifications and/or results of field testing, was available for review. The purpose of the rulemaking process is to allow for public comment and it is impossible to make informed comments regarding measure selection without the proper supporting materials. As stated by the Act, the measures selected for implementation in the reporting program must reflect consensus among the affected parties and this can only be achieved with full disclosure and appropriate timeframes. We do not consider having the draft report from the National Quality Forum being made available two weeks prior to the public comment deadline to be ample time nor notice for review, particularly when only the limited population that is regularly monitoring the NQF materials would know about the report.

Consistent with our previous comments, we continue to believe strongly that all measures that are reported on Hospital Compare must be NQF-endorsed and approved by the Hospital Quality Alliance. Due to the late release of the proposed measures and lack of supporting documentation, the HQA has not approved these measures and the NQF is proposing adoption of only two of the five measures. We think these measures may need

further work and their implementation should be delayed. However, we are providing comments on the MRI Lumbar Spine for Low Back Pain measure, one of the two measures recommended for endorsement by the NQF, since we have serious concerns regarding its implementation.

Specific Comments on the Proposed Measures for CY 2010

Our comments focus only on the two measures that were recommended by the NQF steering committee for endorsement.

MRI Lumbar Spine for Low Back Pain - This measure assesses the percentage of patients who had an MRI of the lumbar spine for a diagnosis of low back pain without evidence from their medical claims that they received more conservative therapy before receiving the MRI. We are concerned that the measure assesses the utilization of imaging services by the rendering facility and not by the ordering practitioner. The measure is more applicable to physicians who order the imaging tests than to the hospital outpatient departments that implement the physicians' orders. It is not known to what extent hospitals have control over the ordering practices of physicians and/or may be unaware of the appropriate indication for imaging that led to the referral.

This measure also does not allow for the consideration of over-the-counter (OTC) medications as an indicator of antecedent therapy. The NQF steering committee recommended that OTC medications be considered as an indicator of antecedent therapy, however that is not feasible because this measure is based on claims data and that information is not captured. As an aside, this is another limitation of using administrative claims data.

It is also unclear what steps hospitals should take to improve their performance on this measure. We are uncertain if CMS believes hospitals should refuse access to MRIs for those patients who did not receive prior therapy. If this is CMS's intent, implementation of this measure could have unintended consequences for patients' access to needed services.

It will be important to clearly communicate what the measure portrays and whether better quality is indicated by a higher or lower efficiency score and whether there is an appropriate rate or benchmark.

Process for Updating Measures

CMS has proposed to establish a sub-regulatory process to update the technical specifications used to calculate the measures when scientific or consensus standards change. We appreciate that measure modification is difficult when tied to the regulatory rulemaking process because the process does not offer much in the way of flexibility and timeliness. However, any change to a measure must allow for a public comment period.

We need to ensure that the stakeholders are aware of what is being proposed and have an opportunity to comment on, and provide input about, the proposed change.

Data Validation Requirements and Appeals for CY 2010

There are no validation requirements for payment determinations for CY 2009 since it is the initial year of the reporting program. CMS has proposed new validation requirements for services, as of January 2009, to be implemented for CY 2010 payment determinations. The proposal moves away from the current validation requirements in the inpatient setting where all hospitals are subject to validation. Rather, CMS proposes to randomly select 800 hospitals per year for data validation. All hospitals would be eligible for validation but only those 800 selected would actually submit cases for review. Once a hospital is selected, 50 cases would be identified for re-abstraction and data review. Each selected hospital will need to pass the 80 percent reliability rate for the overall measure rather than at the data element level (which is the case for the inpatient measures). CMS is also looking at applying the same validation system to the inpatient program in the future.

We appreciate CMS' work in developing a more appropriate and accurate validation system than what is currently in place. Our main concern is to ensure that no particular hospital would be at risk for being selected for multiple years. Hospitals should not be subjected to undue data validation burden due to over-selection. While we are supportive of the proposed method, we recommend a phased-in approach. In order to give hospitals the opportunity to familiarize themselves with the new method, the first year of validation should be considered a "test run." The selected hospitals would have the opportunity to identify any issues with the process without it affecting their payment update. The program would then be fully tied to the payment determination in CY 2011.

Reconsideration and Appeals

Currently there is no appeals and reconsideration process in the outpatient reporting program. CMS has proposed to develop a mandatory reconsideration and appeals process that would be in place for the CY 2010 payment decisions. We strongly support the creation of a reconsideration and appeals process that would be simple and occur in a timely manner.

Public Reporting

We encourage CMS to move forward with its plan to post the hospital outpatient measures on Hospital Compare in CY 2010. We would expect that the process would be the same as the inpatient program in which all hospitals have the opportunity to review their data prior to being posted on the website. Any additions to the website, including display, language, and navigation, need to be thoroughly tested with consumers to ensure the most useful way to integrate the information on Hospital Compare.

The imaging measures mark the first foray into including provider efficiency measures for public reporting. Since this is a new area of quality measurement for Hospital Compare, it is critically important that CMS communicate this information in a manner that clearly interprets the differences between providers; for example, whether higher quality is associated with a higher or lower efficiency score, whether there is an appropriate rate or benchmark, and how consumers should integrate this information into their decision-making.

Reporting of ASC Quality Data

The Tax Relief and Healthcare Act authorized the Secretary to establish a quality reporting program for Ambulatory Surgery Centers (ASC) that is similar to what is being implemented in the hospital outpatient setting, however, the implementation of this program has been delayed.

We believe that CMS should move forward as quickly as possible to implement the reporting program in the ASC setting. All providers that perform the same services should be held to the same accountability standards with respect to the quality of the care they deliver. Likewise, patients deserve the same transparency about the quality of care from all facilities where they may seek a particular service. It is inappropriate that patients have access to surgical quality information from hospital outpatient departments, yet that same level of transparency is unavailable from ASCs.

Healthcare Association Conditions

Through the Deficit Reduction Act, CMS was given the authority to implement a non-payment policy for selected hospital acquired conditions (HAC program) in the hospital inpatient setting. In this proposed rule, CMS has expressed its interest in applying the HAC program to other settings including the hospital outpatient setting, nursing homes, home health agencies and physician offices. As stated in the proposed rule, however, CMS currently does not have the statutory authority to implement the HAC program beyond the inpatient setting. We strongly suggest that CMS fully evaluate the effects of the current program in the inpatient setting prior to considering implementation in alternate settings or urging Congress to give the Agency that authority.

The AAMC and its membership have had serious concerns about the way the HAC program was designed and implemented in the inpatient setting. By law, the selected conditions for non-payment need to be “reasonably preventable” and supported by evidence based guidelines. However, there is a lack of agreement on whether all of the selected conditions already implemented are reasonably preventable. We believe that many of the conditions are not supported by evidence based-guidelines, and thus the inclusion of these measures has the potential to inappropriately penalize hospitals. There also is no provision to account for the severity of the patients being treated, many of

whom may be naturally prone to, or at risk of, contracting several of the selected conditions. There also is no mechanism to properly attribute where the condition was contracted. This is more problematic within teaching hospitals since many of their patients are admitted by transfer and those patients are typically more severely ill.

As with any program, there is the potential for unintended consequences. These need to be studied and evaluated prior to any planned expansion. A cost/benefit analysis would be appropriate to ensure that the benefit of implementing the program outweighs the additional costs incurred to support the program, including the possible increase in diagnostic testing and additional staff resources to accommodate the more complicated coding demands.

We strongly suggest that CMS fully evaluate the effects of the current program in the inpatient setting prior to considering any future implementation in alternate settings.

PROPOSED COMPOSITE APCs FOR MULTIPLE IMAGING PROCEDURES

Beginning with the CY 2006 proposed rule, CMS has been trying to identify a payment methodology that would reflect what CMS considers "efficiencies" resulting from performing multiple imaging procedures during the same operative session. Currently hospitals receive a full APC payment for each imaging procedure on a claim, regardless of how many procedures of the same modality are performed during a single session.

As a result of a recommendation to reduce the technical component of the physician payment for multiple imaging services included in MedPAC's March 2005 Report to the Congress, for CY 2006 CMS included proposals to discount payment for multiple imaging procedures in both the OPPS and the physician fee schedule proposed rules. MedPAC's rationale for its recommendation was that multiple imaging procedures using the same imaging modality that are performed in a *physician's office* in the same session are less resource intensive than those that are performed during separate sessions. While the policy was finalized in the physician fee schedule for 2006, in response to comments, including those by the AAMC, CMS rescinded the multiple imaging proposed policy in the CY 2006 OPPS final rule. The Agency acknowledged that hospitals' cost structures may already account for some of these efficiencies, as the commenters indicated, but stated that it would continue to look for ways to improve the payment methodology so that it would reflect the efficiencies resulting from performing multiple imaging procedures performed during the same session.

For CY 2009, CMS proposes a new payment methodology for imaging procedures that the Agency believes would account for the efficiencies resulting from performing multiple procedures during a single session. CMS is proposing to package multiple imaging procedures into a newly implemented type of APC called a "composite APC." Composite APCs, first introduced in CY 2008, pay a single rate for several major

services that are commonly performed in the same hospital outpatient encounter and that were previously reimbursed separately.

For CY 2009, CMS proposes to create the following five imaging composite APCs:

1. APC 8004 (Ultrasound Composite);
2. APC 8005 (CT and CTA without Contrast Composite);
3. APC 8006 (CT and CTA with Contrast Composite);
4. APC 8007 (MRI and MRA without Contrast Composite);
5. APC 8008 (MRI and MRA with Contrast Composite).

CMS would pay for the composite APCs based on the median cost for multiple imaging services provided in a single session. This amount would also include payment for packaged services furnished on the same date of service as the imaging services included in the composite APC.

We appreciate CMS's efforts to improve payment accuracy and encourage efficiency in care delivery by increasing the number of services whose costs are packaged into a single APC. An analysis of the payment rates for the proposed composite APCs indicates that the rates closely approximate the sum of the individual rates for two or three imaging procedures, depending upon the specific composite APC. While these payment rates may be appropriate for most operative sessions, there are a number of sessions that consist of three or more imaging procedures. For example, one of our members conducted preliminary studies to determine to what extent and under which circumstances three or more imaging procedures were performed during a single session. This hospital determined that approximately 7.5 percent of their total imaging procedures involved three or more imaging procedures performed during a single session. When breaking down the imaging procedure by modality, 19 percent of the Computed Tomography (CT) Scans, three percent of the Magnetic Resonance Imaging (MRI) and less than one percent of ultrasound services involve three or more procedures performed during the same session. While the hospital did not have specific data, it indicated that many of these multiple imaging procedures occurred in the trauma unit. This sentiment was echoed by other AAMC member teaching hospitals. Under the proposed policy, imaging services would be underpaid when three or more occur in the same session. To the extent that these services primarily occur in trauma units, we are particularly concerned about how the proposed changes could disproportionally affect the ability of hospitals to maintain their trauma capabilities.

We urge CMS to analyze claims that contain multiple imaging services and, depending on the results, modify the final policy to ensure that the payment policy does not penalize hospitals that perform the appropriate number of imaging services, particularly in trauma units. The purpose of a prospective payment system is to increase the efficiency in care delivery and avoid negatively affecting access to care.

PROPOSED PAYMENT FOR SEPARATELY PAYABLE DRUGS AND BIOLOGICALS AND CHARGE COMPRESSION

CMS proposes to pay for separately payable drugs and biologicals at the average sales price (ASP) plus four percent in 2009. This proposal would continue a disturbing downward trend in payments for these important outpatient items—the payment was ASP plus 6 percent in 2007 and ASP plus 5 percent in 2008. We are very concerned that these continued payment reductions could have deleterious effects on beneficiary access to these necessary but more expensive drugs that are provided in the hospital outpatient department. We also think it unfairly penalizes those hospitals, many of which are major teaching hospitals that provide a disproportionate amount of these drugs as part of the clinical care mission. We urge the Agency to pay these drugs at ASP plus 6 percent. This rate is the same as that paid in the physician office setting payment rate and is consistent with the ASP plus 6 percent payment level set forth in the Medicare statute.

CMS's proposal is based on an analysis of outpatient claims data and hospital cost reports that indicates that a payment of ASP plus 4 percent reflects hospital costs for both acquisition and pharmacy overhead. However, this result does not comport with the perspectives of our members or with research conducted by the Medicare Payment Advisory Commission (MedPAC) indicating that overhead costs are significantly more than what is reflected in the ASP plus 4 percent value.

To investigate this issue, a group of organizations (referred to in the proposed rule as the "stakeholder group") hired consultants to do additional analyses. These analyses provide important insights, particularly with regard to the methodology used to calculate the costs of separately payable drugs. CMS calculates the estimated costs for these drugs solely from claims data that contain separately payable drugs. Claims containing drugs that cost less than $60 (the current threshold level) are not included in the analysis because they are "packaged" with the outpatient service in which they are billed and reimbursed as part of the APC payment.

When examining only claims containing separately payable drugs, the outside data analysis obtained the same ASP plus 4 percent results that CMS calculated. However, when the analysis was expanded to include claims with both packaged and separately payable drugs, the results were significantly higher, in the range of ASP plus 13 percent.[1]

The reason this occurs is because of "charge compression," in which lower cost drugs have a higher mark up than higher cost drugs. As a result, some of the pharmacy costs that should be associated with the separately payable drugs are being included with the packaged drugs, thus resulting in estimated cost calculation for separately payable drugs that is significantly lower than it should be. The charge compression problem is

[1] Note that this amount reflects only those drugs that could be identified by HCPCS codes and have ASPs. Assuming that those drugs without HCPCS codes had similar overhead costs as the HCPCS-identified drugs, the total cost could be as high as ASP + 27 percent. Source: The Moran Company.

exacerbated as the packaging threshold increases—the outside data analyses show that as the packaging threshold increases, the cost value for the remaining high cost separately payable drugs decreases, even though there is no change in the overhead costs for these items.

Given the new insights regarding the current cost methodology, it is clear that the proposed payment for separately payable drugs is too low and should not be implemented. While ASP plus 6 percent may not represent the full costs of these drugs, we believe it is an acceptable rate, at least for now. This action will stop the unwarranted payment reductions for these items, is comparable with the rate payment for these drugs in physician offices, and is consistent with the default rate set forth in the Medicare statute (Section 1833(t)(14)(A)). We also believe that the rate is appropriate given the surrounding context, which must take into account payments for other items, as well as the system as a whole. We know that charge compression exists for items beyond drugs. It also is well documented that the entire OPPS system is underfunded (for all hospitals, OPPS payments represent only about 90 percent of total outpatient costs[2]). Finally, it is important to recognize that the OPPS is a budget neutral system, and thus any payment increases for an item or items is offset by payment decreases for other items.

CMS recognizes the existence of charge compression. However, the Agency's response, as enunciated in the proposed rule, is to separate cost center 5600 into two new cost centers on the Medicare hospital cost report that would segregate drugs that have high and low overhead costs; the proposal would affect both the hospital inpatient and outpatient settings. While we appreciate CMS's efforts to address charge compression, we strongly oppose this proposal. Creating these additional cost centers would create significant administrative and operational burdens for our members that we do not believe are offset by the potential that in several years the cost centers will improve the payment rates for separately payable drugs. In addition, as CMS notes, hospitals would also be required to implement this policy for inpatient claims even though the change would have not impact on the accuracy of the MS-DRG weights (73 Fed. Reg. at 41490).

In addition to opposing this specific proposal, we also must express our deep concern about CMS's seemingly growing appetite to address payment issues through expanding an already overly-burdensome cost report. The inpatient final rule added a cost center for devices. In addition, the outpatient proposed rule noted "the need for a judicious number of additional cost centers" (73 Fed. Reg. at 41491). While we appreciate the Agency's use of the word "judicious" we believe that there still is not a full understanding of the operational issues and burdens of adding even just one cost center, particularly for large teaching hospitals that deal with multiple payers, have complex structural arrangements, and provide millions of items and services each year.

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[2] INSERT MEDPAC CITE

We recognize that as Medicare payments move from a methodology based on charges to one based on costs, it is important to rethink the Medicare cost report. However, we also believe it is time that the Medicare cost report be reviewed in its entirety with the goal of comprehensive reform. In the inpatient final rule, CMS stated that the Agency has begun a comprehensive review of the cost report and will make those changes available to the public for comment (73 Fed. Reg. at 48461).

We appreciate CMS' willingness to receive public input on cost report changes. However, we believe a more productive process would be for CMS to meet with hospital cost report experts who could explain and describe the myriad intricacies involved with completing a cost report and help identify changes that would meet the goal of having a cost report that would improve the accuracy of the cost-based methodology without being unduly burdensome. There is much expertise within hospitals that could help facilitate such an effort. The Medicare cost report experts in our member teaching hospitals would be happy to participate in such an important effort and we would be pleased to facilitate any meetings.

OTHER COST REPORT PROPOSED CHANGES

In an effort to increase the accuracy of cost-based weights, CMS is proposing several additional technical changes to the cost report. If finalized, these changes would affect both the inpatient and outpatient payment systems and would take effect on October 1, 2008 and January 1, 2009 respectively.

The proposed rule would:

1. Add fixed descriptions for nonstandard cost center lines to the cost report software.

The AAMC supports the addition of fixed description on nonstandard cost center lines of the cost report software because it would improve clarification to the types of cost centers that are reported. This would lead to more uniform reporting, which in turn would lead to improved data collection. Furthermore, this change would not increase the reporting burden on hospitals.

2. Clarify the instructions which require hospitals to report all standard cost centers for which they provide a service. This proposal would also create standardized cost centers for CT scanning, MRI, and Cardiac Catherization.

We are concerned with adding these three standard cost centers and requiring hospitals to report all standard cost centers for which they provide a service. Even for hospitals that have more sophisticated accounting systems that can increase the likelihood of better matching of costs and revenues, the allocation of costs may still be based on estimation of

which costs should be allocated to a cost center. That is because certain services such as cardiac catherization, may be provided in more than one department, which makes it difficult to allocate the costs associated with this service to a specific cost center.

Thus, this proposal may result in fewer and fewer hospitals being able to comply with this requirement as fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) expect a level of precision in cost allocation that is unlikely to be achieved. This would likely result in more errors and therefore less accurate data.

In addition, even if CMS would make this proposal voluntary, and only a handful of hospitals (200 or 300 hospitals) would be able to implement it, the actual impact on the accuracy of the data may be minimal, while the administrative burden for these hospitals would increase.

Improving the cost information for these three cost-centers is a worthwhile endeavor, but this approach will not lead to the desired results.

3. Use text searches of provider's line descriptions to more appropriately classify nonstandard cost centers in the current hospital cost reporting data.

The AAMC supports this proposal as it would likely result in more accurate data from already submitted cost reports.

4. Revise CMS's cost center aggregation table to eliminate duplicative or misplaced nonstandard cost centers. This proposal would also add nonstandard cost centers for common services that don't have a nonstandard cost center.

We support the revision of the cost center aggregation table to eliminate duplicative and misplaced nonstandard cost centers, but would urge caution with regard to the proposal to add nonstandard cost centers for common services that do not have one. As in the second proposal listed above, this proposal also should not be mandatory, as many hospitals do not have the accounting systems to allow them to separate the costs and charges related to these nonstandard cost centers.

5. Create new nonstandard cost centers for services that are well represented in line descriptions associated with "other ancillary services" cost centers including cardiac rehabilitation, hyperbaric oxygen therapy, and patient education.

This proposal is also likely to result in more precise mapping of revenue code-to-cost center crosswalk. However, we caution against making this proposal mandatory due to the fact that some hospitals may not have the ability to separate the costs and charges related to these new nonstandard cost centers. Furthermore, since patient education is provided throughout all hospital outpatient departments, allocating the costs of patient education to a cost center may prove difficult.

As mentioned previously, we urge caution in implementing incremental changes to the cost report that simply add new layers of complexity to an already complex process and increase the administrative burden on hospitals. Furthermore, many of these proposed changes may not be feasible for hospitals that do not have sophisticated accounting systems or the necessary funds to be able to change their accounting systems. Thus we believe that an overhaul of the entire cost report that would include input from hospital cost report experts is more likely to lead to accurate data without imposing an undue administrative burden on hospitals.

OUTLIER PAYMENTS

Outlier payments are an important component of the OPPS, because they provide some financial cushion when hospitals provide high cost outpatient services. Currently the outlier pool is financed by a one percent reduction in the APC conversion factor. For 2009, CMS is proposing to continue to maintain the total outlier payments at one percent of aggregate total OPPS payments.

A hospital receives an outlier payment for a service if the hospital's cost for that service exceeds 1.75 times the APC payment rate and the cost exceeds the APC payment rate plus a fixed dollar threshold of $1,575. CMS proposes to increase the fixed-dollar threshold by $225 (from $1,575 to $1,800), while keeping the multiplier threshold at its current level of 1.75. The Agency estimates that setting the fixed-dollar threshold at $1,800 would result in outlier payments of one percent of aggregate total payments.

Currently, CMS determines the cost of services (and therefore whether it exceeds the outlier threshold to qualify for outlier payments) by applying a provider-specific overall cost-to-charge ratio (CCR) derived from the most recently settled or tentatively settled cost report for each facility to the charges on claims. To accurately determine whether a service qualifies for outlier payments, the CCR should be representative of the current hospital cost structure. However, CMS has learned that the time lag between the latest settled cost report and the current charges could leave room for an inappropriate determination of CCRs. For example, some providers have increased their current charges so that when CMS applies the CCRs from the latest settled cost report, it results in an overestimation of costs. This in turn results in a provider inappropriately receiving outlier payments or receiving inappropriately high outlier payments.

To address this issue, CMS is proposing a number of changes to the methodology for determining the CCR that would be used in determining whether a service qualifies for outlier payments. Specifically, the Agency proposes to clarify when a Medicare contractor may substitute the statewide average CCR for a provider's CCR; to allow a provider to request, or a contractor to use, a different CCR under certain circumstances; and to include an outlier reconciliation process.

According to CMS the proposal to implement a reconciliation process would ensure accurate outlier payments for facilities with CCRs that fluctuate significantly relative to the CCRs of other facilities. CMS proposes to allow Medicare contractors to subject certain outlier payments to reconciliation when a provider's cost report is settled. When the cost report is settled, the overall CCR would be calculated based on the cost report at the time that the cost report coinciding with the service date is settled. The final outlier payments determined during reconciliation would be adjusted by "the time value of funds for that time period." CMS does not propose a method to determine how the adjustment would be calculated, but it notes that it would be based on a widely available index that would be established in advance by the Secretary and would be applied from the midpoint of the cost reporting period to the date of reconciliation.

The "trigger" for a reconciliation process would be determined by a reconciliation threshold that CMS would establish annually. The thresholds would be based on a measure of an acceptable percentage change in a provider's CCR and outlier payments involved.

We appreciate CMS's effort to ensure that more accurate data are used to calculate providers' CCRs and consequently more accurate outlier payments. However, we encourage CMS to provide clarification as to how it would determine the reconciliation threshold. CMS states that the Agency would set the reconciliation thresholds in the manual, reevaluate them annually, and modify them as necessary. However, CMS does not provide information as to what criteria would be used to determine the reconciliation threshold. We believe this information is necessary for hospitals to be able to provide CMS with input with regard to the impact of the proposal.

CMS is also proposing to apply the reconciliation process to services provided starting on January 1, 2009, but seeks comments on whether this or another date might be less administratively burdensome for hospitals. As a result of the feedback we have received from our members, we encourage CMS to use the beginning of each hospital's fiscal year as the effective date for the application of the reconciliation process.

PARTIAL HOSPITALIZATION SERVICES

The partial hospitalization program (PHP) is an outpatient program for psychiatric services provided to patients in lieu of inpatient care. According to CMS, the PHP is a highly structured and clinically-intensive program, usually lasting most of the day.

Currently, CMS pays for partial hospitalization services provided by both hospital outpatient departments and community mental health centers (CMHCs), based on the same PHP APC rate. Because the Agency considers a day of care as the unit that defines partial hospitalization services, payment for the PHP APC is determined based on a per

diem methodology. Specifically, CMS calculates median costs for the PHP APC payment rate by combining hospital-based and CMHC median per-diem costs derived from both hospital and CMHCs claims data.

Since CY 2006, CMS's analyses of hospital and CMHC data have shown a much lower combined hospital-based and CMHC median per diem cost than what CMS was expecting. Because CMS was concerned that these rates did not accurately reflect the costs of partial hospitalization services, and to ensure access to this needed service to vulnerable populations, the Agency reduced the PHP rates by less than the decline in the hospital-based and CMHC median per diem cost. CMS however, continued to study the causes for the low per diem median cost for PHP.

In the CY 2008 proposed rule, CMS began exploring the possibility that the number of units of service provided in a day of care may be a reason for the low median cost for PHP. According to the CY 2009 proposed rule, the Agency's analyses, presented in the CY 2008 final rule and based on CY 2006 hospital and CMHC data, showed that both hospitals and CMHCs were providing fewer than four units of service per day for a significant number of days. Specifically, 64 percent of CMHC days and 31 percent of the hospital-based PHP days were days in which fewer than four units of service were provided.

In the CY 2009 proposed rule, CMS continues to look at the number of services being provided in a day of care as a possible explanation for the lower than expected per diem median cost for PHP. Based on analyses of CY 2007 data, CMS concludes that the trend continued, in that, days with fewer than four units of services have actually increased for CMHCs (73 percent), while for hospitals they have decreased slightly (28 percent).

CMS notes that it expects the PHP to be a clinically-intensive program consisting of days with five or six services and that days with three services would be provided only in limited circumstances, such as when a patient is transitioning towards discharge or would be required to leave the PHP early for the day due to an unexpected medical appointment. CMS believes that the lower than expected per diem median cost for PHP is due to the relatively high proportion of days with fewer than four units of services.

Thus, for CY 2009, CMS is proposing to create two separate APC payment rates for PHP – one for days with three services (APC 0172, paid at $140) and one for days with four or more services (APC 0173, paid at $174).

We appreciate CMS's efforts to establish more accurate payments for PHP APCs and we support the proposal to create two separate APCs that distinguish between the costs associated with services provided during days with four or more services and those with three services. This policy provides a more tailored approach to the reimbursement of PHP services.

However, we strongly urge CMS to rescind the proposed payment rates and instead calculate hospital-based PHP payment rates based on the hospital-based claims data only, in order to ensure that vulnerable populations continue to have access to this service.

The proposed payment rate for the APC used for PHP days with four or more services would drop from $203 in CY 2008 to $174 in CY 2009. This represents a 14 percent drop in payments for these services. We are concerned that this continued decrease in the reimbursement of these needed services will force many hospitals to provide these services on an inpatient basis. As CMS noted, CMHCs data have been less reliable and more volatile from year to year than hospital data. Although CMS now believes that its analyses and refinements to the methodology used to calculate the PHP APC payment rates have led to more accurate payments for these services, we have great concern about CMS's continued use of both types of data. Furthermore, as the proposed rule notes, while the number of CMHC PHPs days in which three or fewer units of service are provided have been increasing (from 64 in CY 2006 to 73 percent in CY 2007), hospital-based PHP days have decreasing (from 31 to 28 percent during the same period).

Thus, we strongly urge CMS to use hospital-based only data to set payment rates for hospital PHPs. This approach would more accurately reflect differences in resource intensity between hospitals and CMHCs and ensure adequate payments for partial hospitalization services provided by hospitals outpatient departments.

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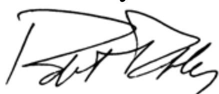
Teaching hospital's outpatient departments are critical to providing needed services to beneficiaries as well as fulfilling the mission of teaching hospitals. Medicare outpatient payments are essential for teaching hospitals to continue their missions in the outpatient setting, including serving important access roles for outpatient services that range from clinic and emergency room visits to technically-advanced innovations. We would be pleased to work with CMS as it continues to refine and improve this important Medicare payment system.

If you have questions concerning comments on the charge compression and payment for separately payable drugs and biologicals, please contact Karen Fisher at kfisher@aamc.org or 202-862-6140. For quality-related questions, please contact Jennifer Faerberg at jfaerberg@aamc.org or 202-862-6221. You may also contact Diana Mayes, at dmayes@aamc.org, 202-828-0498 for comments related to other sections of the letter.

Sincerely,



Robert Dickler

cc: Karen Fisher, AAMC
Jennifer Faerberg, AAMC
Diana Mayes, AAMC