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October 7, 2002

Thomas A. Scully, Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Ave, SW, Room 445-G  
Washington, DC 20201

Attention: **CMS-1206-P**

Dear Administrator Scully:

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 "*Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports*" 67 Fed. Reg. 52092 (August 9, 2002). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. medical schools; 98 professional and academic societies; and the nation's medical students and residents.

The Medicare Outpatient Prospective Payment System (OPPS) is one of the most challenging payment systems implemented by CMS. We appreciate the level of effort and diligence CMS staff have expended to develop and make modifications to the system. It is obvious from the proposed rule that staff have spent immense effort on this important payment system.

Despite the laudable efforts of CMS staff, we believe the OPPS policies for calendar year (CY) 2003 require modifications. This is not unusual given the system's complexity and its relative infancy; yet these modifications are important to teaching hospitals for which OPPS payments help to ensure that high quality outpatient care is available to Medicare patients.

This letter addresses issues involving payment equity for teaching hospitals, ambulatory payment classification (APC) groups and payment rates, outlier and pass-through payments, the inpatient-only list, multiple procedure discounting, evaluation and management coding, and cost-to-charge ratio calculations.

## **I. OPSS Payment Equity For Teaching Hospitals**

We continue to be concerned about the financial impact of the OPSS on teaching hospitals. The proposed rule's financial impact table demonstrates that the financial impact of the OPSS for major teaching hospitals lags significantly behind that of non-teaching hospitals. Analysis of 2001 OPSS data indicates that APC payment-to-cost ratios for major teaching hospitals are less than those of other hospitals, with OPSS payments significantly below corresponding costs.

Examination of the OPSS data also indicates that teaching hospitals are more dependent on outlier, pass-through, and transitional corridor payments. These payments, however, are not stable, predictable funding sources. In particular, under current law, the transitional corridor payments expire at the end of 2003.

In the Association's comment letter on the original OPSS proposed rule, we presented a number of reasons why teaching hospitals would fare more poorly than other hospitals under the OPSS (see AAMC Letter to Nancy-Ann Min DeParle, dated July 30, 1999). For example, an analysis of 1996 outpatient claims data revealed that the costs incurred by major teaching hospitals for a disproportionate number of individual outpatient services were consistently higher than the average cost. In such cases, the APC rate would result in a systematic underpayment for these services. Our July 30, 1999 letter also pointed out that regression analyses conducted by *both* CMS and the Lewin Group showed a significant effect related to cost differentials and teaching intensity, indicating that teaching hospitals would perform more poorly than other hospitals under the OPSS.

In the initial OPSS Final Rule, published April 7, 2000 CMS stated that it would "conduct analyses and studies of cost and payment differential among different classes of hospitals, including teaching facilities, when sufficient data under the PPS have been submitted. We will carefully consider whether permanent adjustments should be made in the system once the BBRA 1999 transition provisions expire." (65 Fed. Reg. at 18500). In addition, the Balanced Budget Act of 1997 requires the Secretary to establish adjustments "as determined to be necessary to ensure equitable payments . . . for certain classes of hospitals." (Section 4523 of the BBA)

We urge CMS to begin conducting these analyses as soon possible. We believe one of the analyses should involve examining the reliance of teaching hospitals on pass-through, outlier, and transitional corridor payments. If the results suggest that teaching hospitals depend on these payments to achieve payment equity relative to other hospital types, we believe a teaching hospital adjustment should be developed prior to the expiration of the transitional corridor payments to ensure that it can be implemented as soon as it is needed.

## **II. APC Groupings and Payment Rates**

Like CMS (67 Fed. Reg. at 52093), we are concerned about the dramatic decrease in payments for a number of APCs that involve high cost drugs and devices.

The impact of the payment rate reductions for services involving high cost drugs and devices is going to fall disproportionately on major teaching hospitals where the majority of these services are performed. According to our members, proposed APC payments for a number of drugs and devices are significantly below their acquisition costs. High cost cardiac and neurological devices are particular problems. Chemotherapy treatments also will be seeing large payment reductions unless modified. Payment reductions like these strain the abilities of teaching hospitals to continue as sites for these services—services that Medicare beneficiaries look to teaching hospitals to provide.

Under the Medicare inpatient PPS, an indirect medical education (IME) adjustment is provided, in part, because of the difficulty in precisely calibrating payment weights for high cost, complex diagnosis-related groups, significant numbers of which are treated in teaching hospitals. In the absence of a similar adjustment in the OPSS, it is imperative that the relationship between costs and payment rates for the high cost, complex APC groups be comparable to that of other APCs.

There are a number of potential reasons for the imprecision of the APC payment rates, including coding difficulties by hospitals. Cost-to-charge ratios also have been pointed out by our members as a potential significant source responsible for payment discrepancies. This is because high cost drugs and devices generally have higher cost-to-charge ratios (CCRs) than other items within the same department. Consequently, applying a department level CCR to the charges for a particular device (the methodology used by CMS) will result in costs that are lower than if the CCRs of both the device and the department as a whole were the same. For certain APCs, the “CCR-driven” costs are significantly below hospitals’ acquisition costs. Because these artificially-low costs are then used to compute the APC relative weights, the result is weights that are lower than they should be if the “true” costs were known.

We appreciate the difficulty of obtaining accurate cost data. However, cost-to-charge ratios are only a means of reaching the goal of accurate costs. If that means fails to achieve the intended goal, it should be re-thought. We believe CMS should re-examine its methodology and data for determining costs for those APCs that contain services involving high cost drugs and devices. We would be happy to assist the Agency in gathering data from our members if this would be useful.

## **III. Outlier Payment Policies**

As with the inpatient PPS, the OPSS makes additional payments for outpatient services that are extremely costly (“outliers”). Under CY 2002 policy, if an outpatient service

costs were 3.5 times more (“cost threshold”) than the sum of the corresponding APC payments plus any transitional pass-through payments, the hospital would receive an outlier payment equal to 50 percent of the costs that exceeded the 3.5 times threshold.

Under the proposed rule, the cost threshold for 2003 would be reduced to 2.75 times, rather than 3.5 times, the applicable APC payments. The payment percentage for outlier cases would remain the same—50 percent of the service’s costs above the cost threshold.

As Table 11 in the proposed rule (67 Fed. Reg. at 52148) indicates, outlier payments are an important source of reimbursement for the high cost outpatient services provided by teaching hospitals. According to the table, major teaching hospitals comprise only 6 percent of all hospitals, yet CMS estimates they will receive 32 percent of all outlier payments. While outlier payments are critical to teaching hospitals, it also is important to remember that these payments only partially offset the costs of high-cost cases; the remainder is absorbed by the teaching hospital.

Over the last several years, CMS has made important changes to OPPS outlier policies. The AAMC is troubled by the swings in key determinants of outlier payments. This is particularly troubling given that, unlike the inpatient PPS, CMS has provided little or no substantive information on levels of outlier payments that would support the Agency’s policy changes. In addition, CMS has provided no analytical basis for its 2003 proposed change, other than to say the decision was based on “simulations.”

We urge CMS to provide more information on outlier payments and analyses in the final rule. In particular, we would like clarification regarding CMS’ rationale to decrease the cost threshold, which permits more items to qualify for outlier payments, rather than to increase the payment percentage from its current level of 50 percent, which would provide more payments for high cost cases.

We also are concerned that without correcting for the significant reductions proposed for a number of high cost APCs, a number of them will unnecessarily qualify for outlier payments. This may occur because the cost levels that go into the outlier payment calculations are based on hospitals’ overall cost-to-charge ratios (see VIII, below) which may be higher than the department level CCRs that are used to determine costs for APC payment rate calculations. If this occurs, it will result in outlier payments that are higher than anticipated, which could unduly raise thresholds in the future and affect the overall integrity of the outlier policy.

#### **IV. Pro Rata Reduction to Transitional Pass-Through Payments for New Drugs/Devices**

The OPPS provides for temporary pass-through payments for new drugs and devices that meet specified criteria. These payments were provided for because the current APC rates do not reflect the additional costs of these items. Under current law, the amount of monies available for these payments is limited to an “applicable percentage” of total

OPPS payments. For 2003, this percentage is 2.5 percent. If CMS determines that pass-through payments will exceed that level, it will implement a “pro rata reduction” to the pass-through payments to ensure that no more than 2.5 percent of OPPS total payments will be spent on pass-through payments.

CMS estimates that 2.5 percent of total OPPS spending in 2003 will be approximately \$457 million (67 Fed. Reg. at 52118). Thus, CMS will apply a pro rata reduction to the pass through payments if the Agency estimates that transitional pass-through payments will exceed \$457 million in 2003.

CMS has not yet made an estimate for 2003 pass-through spending. The proposed rule states that the Agency is still examining the device/drug/biologicals data. In addition, CMS states that there may be new drugs and/or device categories that receive pass-through status for 2003 that were not reflected in the proposed rule but that will be factored into the 2003 payment estimate.

While CMS did not provide an estimate of transitional pass-through payments in the proposed rule, a spreadsheet on the CMS outpatient PPS web site sheds some light on this figure. According to the spreadsheet, 2003 pass-through payment estimates are still “to be determined” for a number of pass-through items. But the aggregate estimate for the remaining items is approximately \$450 million. Given that this estimate is only slightly below the \$457 million threshold that would trigger a pro rata reduction, and that additional payments will be added to the estimate, we are very concerned that CMS may decide to implement a pro rata reduction.

We understand that OPPS analyses of 2001 data indicate that the estimate of 2002 pass-through spending may have been overstated and, therefore, the 64 percent pro rata reduction that was applied to pass-through payments may have been unnecessary. Developing assumptions regarding spending for new medical items are extremely complex, and subject to inherent potential for inaccuracy. As demonstrated by the fluctuations in the proposed APC rates, we do not believe the OPPS has reached a level of stability that would provide a sufficient level of confidence on pass-through payment assumptions. Moreover, unlike last year, there are far fewer items on the CY 2003 pass-through list. Consequently, the risk of exceeding the 2.5 percent threshold is less than last year.

The items that are on the pass-through list were chosen because they represent important medical treatments. Reducing payments for these items has important negative financial consequences for the teaching hospitals that utilize them. We urge CMS not to impose a pro rata reduction for CY 2003.

## **V. Inpatient-Only List**

Under current OPPS policy, CMS deems certain procedures as “inpatient-only” for which hospitals will not receive an OPPS payment if these procedures are performed in the

hospital outpatient department. Under the proposed rule, 41 procedures would be taken off the inpatient-only list and paid under the OPPTS in 2003. CMS relied on recommendations from its APC Advisory Panel to develop this list. Agency staff also looked at physician outpatient claims and the list of procedures that are paid by Medicare when performed in ambulatory surgical centers to help identify procedures that should be taken off the inpatient-only list.

While we appreciate that CMS has removed a significant number of procedures, we urge CMS to accept the recommendation of its own APC Advisory Panel and eliminate the inpatient-only list altogether. The determination of whether a patient should be admitted as an inpatient or treated as an outpatient should be based on the professional judgement of the physician, as overseen by the Medicare Quality Improvement Organizations. CMS' current policy penalizes beneficiaries because they must be admitted as inpatients for these procedures rather than receiving services in an outpatient setting and then returning to their homes.

If the Agency decides to retain an inpatient-only list, we urge CMS to revisit the criteria to determine when a procedure is removed from that list (67 Fed. Reg. 52114). Two of these criteria require that the procedure is being performed in "most outpatient departments" or that "most outpatient departments" are equipped to provide the service. Major teaching hospital outpatient departments often are the first places to perform services that heretofore had been performed only in an inpatient setting. Thus, there likely will be a time gap between when these services are performed safely in teaching hospital outpatient departments and "most" hospitals' outpatient departments. The issue should be whether a procedure can be performed safely in an outpatient department, *not* the number of outpatient departments in which the procedure is occurring. We urge CMS to reconsider its current policy on this issue.

## **VI. Multiple Procedure Discounting and Device Payments**

Under the OPPTS, when two or more surgical procedures are performed together, the highest paying procedure is paid 100 percent of its APC rate, and the additional procedures are paid 50 percent of their corresponding APC rates.

Under current policy, when a device is involved in the additional procedure(s), the methodology is modified such that the payment rate discount is actually less than 50 percent. This modification is in recognition that there are no savings associated with the device costs when multiple devices are used during a multiple-procedure operative session.

The proposed rule would essentially rescind current policy by applying a 50 percent reduction uniformly when multiple procedures are performed in the same operative session, regardless of whether multiple devices are involved.

The rationale for a discounting policy is that the costs of performing multiple significant procedures are less when they are performed in the same operative session because of efficiencies achieved through readying one operating room, one anesthesia session and other comparable items. Such efficiencies do not extend to device costs when a device is needed for each procedure performed. The proposed policy of applying the 50 percent discount when multiple devices are involved runs counter to the discounting principle and should be rescinded.

## **VII. Coding of Evaluation and Management (E/M) Services**

Currently, hospitals code clinic and emergency room visits using the same CPT codes used by physicians for Medicare payments. CMS has expressed concern that these codes do not aptly describe the range and mix of services provided by hospitals to clinic and emergency patients because they are defined based on physician, not hospital, activity. Consequently, CMS has permitted hospitals to develop their own guidelines for determining which code applies to a particular clinic or emergency room visit. At the same time, CMS has been seeking to achieve national, uniform standards related to emergency room and clinic visit coding for hospitals. While CMS has examined several approaches, the proposed rule states that the drawbacks of guidelines that have been suggested to date outweigh the benefits.

In the proposed rule, the Agency appears to be proposing an interim approach to E/M coding while continuing to examine uniform guidelines. Depending upon comments received, CMS expects to finalize an incremental approach in the CY 2003 final rule, but would not implement that approach until CY 2004. (67 Fed. Reg at 52134). At the same time, the proposed rule indicates that CMS will continue to pursue more uniform guidelines over the next year and, if possible, propose that those guidelines be implemented in CY 2004. If our understanding is correct, this parallel strategy could result in hospitals preparing throughout 2003 for implementation of the interim guidelines when those guidelines could be obsolete if CMS decides to propose a uniform system in next year's rulemaking. We believe that CMS should maintain its current policy and not propose changes until it determines a uniform approach that the Agency would like to implement on a permanent basis.

## **VIII. Cost-to-Charge Ratios Used for Pass-Through, Outlier and Transitional Corridor Payments**

The cost-to-charge ratio (CCR) calculation is an important determinant for a number of OPSS payments beyond its role in the calculation of APC rates. Consequently, it is critical that this calculation be as accurate as possible.

Currently, CMS is using an *overall* hospital CCR (that reflects costs and charges for both inpatient and outpatient settings) for calculations determining outlier, pass-through, and

Thomas A. Scully

October 7, 2002

Page 8

transitional corridor payments.<sup>1</sup> A CCR that is based solely on outpatient costs and charges is more appropriate for purposes of determining Medicare *outpatient* payments.

In the Medicare inpatient PPS, for example, the outlier calculation is based on inpatient costs and charges only. This philosophy should also apply in the OPSS outlier calculation—that is, OPSS outlier payments should be based on an outpatient-only CCR. We have spoken to CMS staff about this issue and understand that a program memorandum that would make this correction is in the final clearance process. We urge CMS to release this program memorandum immediately so that this calculation inaccuracy can be corrected.

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Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President, or Karen Fisher, Associate Vice President, in our Division of Health Care Affairs. They may be reached at (202) 828-0490.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler  
Karen Fisher

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<sup>1</sup> As discussed above, *department*-level CCRs are used in the calculation of the APC rates.