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Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**Attention: CMS-1414-P**

Dear Ms. Frizzera:

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 2010 Payment Rates ...*" [74 Fed. Reg. 35,232]. (July 20, 2009). AAMC is a not-for-profit association representing approximately 400 major teaching hospitals and health systems; all 130 accredited U.S. medical schools; nearly 90 professional and academic societies; and the nation's medical students and residents.

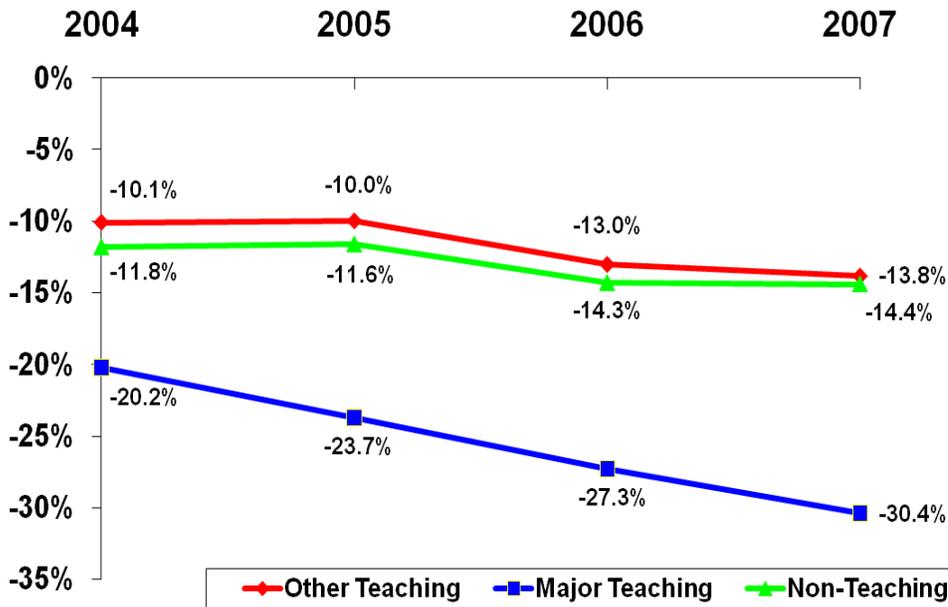
Our comments focus on the following areas: the requirements for "direct supervision" of hospital outpatient therapeutic services furnished in a hospital and in on-campus provider-based departments (PBDs) of a hospital; the proposed payment rate for separately payable drugs and biologicals; outlier payments; the partial hospitalization program (PHP); and the outpatient quality reporting program. 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 2004 - 2007 hospital Medicare cost reports conducted by Vaida Consulting shows a disturbing trend of not only negative margins but a widening gap between the outpatient margins of teaching hospitals and those of other teaching and nonteaching hospitals. As the chart below shows, while Medicare outpatient margins are negative for all hospitals, they are significantly lower for major teaching hospitals, and they are decreasing at a faster pace relative to other types of hospitals.

The AAMC urges CMS to conduct analyses to determine the 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 OPSS to ensure equitable payments for all classes of hospitals.

### Hospital Outpatient Margins by Teaching Status 2004 - 2007



Source: Margin Analysis of Centers for Medicare and Medicaid Services, HCRIS Database from June 30, 2006 Update, September 30, 2007, Update, March 31, 2008 Update, and December 31, 2008 by Vaida Health Data Consultants.

Note: Cost reports with ratios of revenue to cost outside the interval of +/- three standard deviations from the geometric mean were not included in the calculation of aggregate statistics.  
The hospitals included in this analysis are short-term hospitals subject to IPPS Medicare Outpatient Margins excluding direct medical education costs and payments for cost reporting periods beginning in fiscal years 2004, 2005, 2006 and 2007.

### PHYSICIAN SUPERVISION

The AAMC appreciates CMS's willingness to provide a second opportunity for comments on requirements for physician supervision in a hospital outpatient department (HOPD). While CMS continues to believe that the 2009 changes were a "restatement and clarification [that] made no change to longstanding hospital outpatient physician supervision policies," we disagree. The impact of the 2009 changes was not well-

understood until the 2009 proposal was finalized and hospitals received further clarification about how the requirements would be implemented. Given this situation, the AAMC is disappointed that CMS has opted “not to instruct contractors to delay enforcement actions or to discontinue pursuing pending enforcement actions regarding the physician supervision of hospital outpatient services.” The Association asks that CMS reconsider this decision as it puts hospitals at considerable risk for being out-of-compliance with a CMS policy that – prior to January 1, 2009 – was understood differently by the hospital community and CMS.

In the current proposal, the AAMC has serious concerns about the definition of “direct supervision” for hospital outpatient therapeutic services. Specifically, CMS says that “direct supervision” means that the “physician or non-physician practitioner must be present **on the same campus**, in the hospital, or the on-campus PBD of the hospital and **immediately available** to furnish assistance and direction throughout the performance of the procedure.” (emphasis added; p. 35,367). The AAMC agrees with the comments submitted by the American Hospital Association that while CMS attempted to provide additional flexibility to hospitals, the reality is that these changes are more likely to severely hamper hospitals because of the conditions and limitations that CMS wants to impose.

First, the definition of “in the hospital” is overly restrictive. CMS proposes to define this term to mean areas in the main building(s) of a hospital that are under the ownership, financial and administrative control of the hospital; that are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital’s provider number. As CMS notes in the preamble, the practical effect of this definition is to prohibit the supervising professional from being at any location that does not meet this definition, including a physician’s office, an independent diagnostic testing facility, a co-located hospital, or a hospital-operated provider or supplier, such as a skilled nursing facility, end-stage renal disease facility, or home health agency, or any other non-hospital space that may be co-located on the hospital’s campus.

CMS does not provide the reasoning behind the need for this restriction in the physical location of the supervising professional. If finalized, this policy will prohibit many arrangements that currently are in place and work well to ensure continued access to high quality outpatient services. For instance, in an academic medical center, this means that the supervising professional may not be in any on-campus area of the center that has been leased to the faculty, such as faculty academic offices, even if these academic offices are located in close proximity to the PBD where outpatient therapeutic services are being furnished.

This requirement also would mean that hospitals would have to hire and pay physicians and/or non-physician practitioners (NPPs) to do nothing other than supervise, and would have significant implications, both in terms of costs and patient access to care. In cases in which compliance is impossible due to personnel shortages or high costs, hospitals

may be forced to shut down services or severely restrict their hours of operation. The impact on patient access to care could be severe. It is unclear why it is important that the supervising professional be constrained to only areas on the hospital's campus that are under the hospital's control. The relevant issue should be whether the supervising professional is available and able to respond in a timely way, while procedures or services are being furnished, to address any patient issues that may arise.

A second major concern is that CMS has stated unequivocally that the term "immediately available" means "without interval of time." This definition is so restrictive that it is difficult to imagine how it could be met unless a physician was in the same room with the patient. This requirement also seems to be at the level of "personal supervision," rather than "direct supervision." According to 42 CFR 410.32 (b)(3)(iii), personal supervision means a physician must be in attendance in the room during the performance of the procedure.

CMS far better captures the essence of the term "immediately available" when providing an example of what is considered to be not immediately available: "performing another procedure or service that he or she could not interrupt." (emphasis added) This statement suggests that there is flexibility about what constitutes "immediately available," and provides hospitals and physicians with the ability to make decisions about what is safe and reasonable based on the particular procedure that is being done. This approach is akin to the rule for a teaching surgeon who must be present during the key or critical portion of a surgery and must be "immediately available to return to the procedure, i.e., he/she cannot be performing another procedure," during other portions of the surgery, or must arrange for another qualified surgeon to be immediately available. (see CMS Manual System, Change Request 3928, January 12, 2006, Teaching Physician Services) Just as teaching surgeons are allowed to determine what constitutes "immediately available," so too, should hospitals and physicians be allowed to determine what "immediately available" means within the context of outpatient therapeutic services. The AAMC agrees with CMS that "appropriate supervision is a key aspect of the delivery of safe and high quality hospital outpatient services," but disagrees that a single standard should apply in every instance.

The AAMC urges CMS to establish a new definition for "direct supervision" that eliminates these problems and permits appropriate flexibility. For example, CMS could define "direct supervision" to mean that the physician or NPP must be present on the same campus or in a location in close proximity to the campus and be able to respond in a timely manner, in accordance with the hospital's policies, procedures, guidelines and/or bylaws, so as to be able to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or NPP must be present in the same room where the procedure is performed.

In addition, we believe that the term "available to respond in a timely manner" should not be limited to the physical presence of the supervisor at the patient's bedside. Given the

Administration's focus on advancing the applications of technology in health care, including telemedicine and robotic technologies for health care delivery, we recommend that direct supervision should explicitly include, as appropriate, response via radio or telephone, or through other technologies, such as telemedicine, approved for use in Medicare.

**The AAMC supports the AHA's recommendations regarding a new approach for physician supervision of outpatient therapeutic services.**

### **PROPOSED PAYMENT FOR SEPARATELY PAYABLE DRUGS**

CMS proposes to pay for separately payable drugs and biologicals at the average sales price (ASP) plus four percent in 2010. This payment rate is unchanged from last year and continues to be less than the ASP plus six percent rate that was used to reimburse these products in 2007 when CMS first introduced the ASP methodology as a proxy for the acquisition and overhead cost for these products. Acknowledging problems with the current methodology, which would result in a payment for separately payable drugs and biologicals of ASP minus two percent, the Agency proposes a new methodology to determine the acquisition and overhead cost for these items, which results in the ASP plus four percent amount.

We are concerned that the proposed payment rate does not adequately reimburse separately payable drugs and biologicals thereby having deleterious effects on beneficiary access to 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 high-cost drugs as part of the clinical care mission.

We urge the Agency to pay these drugs at ASP plus six percent until CMS establishes a more precise methodology for determining the acquisition and overhead costs of these products. This rate is the same as the physician office setting payment rate and is consistent with the ASP plus six percent payment level set forth in the Medicare statute. Under the Medicare statute (Section 1833(t)(14)(A)), CMS is to use this payment rate or the rates set under the Competitive Acquisition Program (CAP) as an alternative, if average acquisition cost for the drug – as determined by the Government Accountability Office (GAO) or CMS surveys of hospital acquisition costs – is not available.<sup>1</sup> The law also authorizes (Section 1833(t)(14)(E)) CMS to adjust payments for these drugs to pay for overhead and pharmacy service and handling costs.

CMS's proposal is based on an analysis of outpatient claims data and hospital cost reports as well as a methodology that would calculate the average acquisition cost of separately

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<sup>1</sup> While GAO did a report that analyzed 2004 data there has been no subsequent update. Thus no current data are available.

payable drugs and biologicals as in the prior methodology but in addition, it would distribute between one-third and one half (approximately \$150 million) of the overhead costs (\$395 million) of packaged drugs to separately payable drugs and biologicals. Under the current methodology, CMS estimates the acquisition and pharmacy overhead costs for separately payable drugs and biologicals by comparing the estimated aggregate cost of separately payable drugs and biologicals in the claims data to the estimated aggregate ASP dollars for these products, using the ASP as a proxy for average acquisition and pharmacy overhead cost.

CMS recognizes that due to the combined effects of charge compression and the Agency's choice of a drug packaging threshold, the current allocation of pharmacy overhead costs to packaged and separately payable drugs and biologicals does not reflect an appropriate allocation of overhead costs. Charge compression is the practice of applying a lower charge markup to higher-cost services and a higher charge markup to lower-cost services. 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 an estimated cost calculation for separately payable drugs that is significantly lower than it should be. The charge compression problem is exacerbated as the packaging threshold increases because 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.

The AAMC believes that the proposed methodology still continues to underestimate the acquisition and overhead costs of separately payable drugs and biologicals for several reasons. First, the proposed payment rate 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 four percent value.

Second, the Agency continues to include claims data for hospitals that participate in the 340B program in the calculation of payment for drugs and biologicals. The 340B program allows certain hospitals that serve poor and uninsured patients to purchase drugs at discounted prices not available to other types of hospitals. Thus, incorporating claims data from these hospitals results in an underestimation of aggregate costs of drugs and biologicals. In addition, 340B hospital data are excluded from the ASP calculation. When CMS compares aggregate costs to ASP, the result is an ASP-based rate that is too low.

Third, because the cost of packaged drugs that do not have HCPCS codes or ASP data are excluded from the estimation of packaged drug costs, CMS underestimates the total cost of packaged drugs. This in turn results in an underestimation of the amount of overhead costs the Agency assumes would need to be distributed to the separately payable drugs and biologicals.

The cost of packaged drugs for which CMS does not receive the HCPCS code level information is potentially quite significant. Because packaged drugs are not reimbursed separately and there is no specific requirement that providers report HCPCS codes for packaged drugs, some hospitals have been reporting HCPCS codes for packaged drugs with revenue code 0250 (General Classification of Pharmacy), while others have been reporting HCPCS codes for packaged drugs with revenue code 0636 (Drugs Requiring Detail Code). According to the guidelines published by the National Uniform Billing Committee (NUBC), revenue code 0250 does not utilize HCPCS reporting. In other words, when hospitals report HCPCS codes under revenue 0250, the HCPCS codes do not print on the bill and CMS does not receive the HCPCS code level information. Instead, revenue code 0636 is the appropriate revenue code where HCPCS codes should be reported.

Although most of our members already report HCPCS codes for packaged drugs with revenue code 0636, other hospitals report them with revenue code 0250. Even if the provider has made changes to the billing system, so that the HCPCS codes reported in revenue code 0250 do print on the bill, the Medicare Administrative Contractor (MAC) may return the claim to the hospital. Thus, when hospitals report HCPC codes with revenue code 0250, CMS does NOT receive the HCPCS code level information for packaged drugs to use in establishing the pharmacy handling/overhead cost pool.

To investigate the effect of excluding these data on the proposed payment rate, a group of organizations (referred to in the proposed rule as the “stakeholder group”) hired consultants to do additional analyses. An analysis presented by the stakeholders group at the August 2009 APC Panel meeting estimates that the cost of drugs and biologicals that do not have HCPCS codes and ASP data and are therefore not included in the estimation of overhead cost to be distributed to the separately payable drugs is around \$800 million. In contrast, CMS’s estimation of the acquisition and overhead costs for these drugs based solely on claims data that contain HCPCS codes and ASP information is \$555 million.

We appreciate CMS’ willingness to revise the methodology to better account for the overhead costs of drugs and biologicals. However, the proposed methodology still leaves significant room for improvement. As the Agency acknowledges in the proposed rule “the amount of overhead cost redistribution that would be appropriate between the packaged and separately payable drugs and biologicals in a payment system that is fundamentally based on averages is not fully evident.” Given CMS’s uncertainty with regard to the appropriate allocation of overhead cost from packaged to separately payable drugs and biologicals, as well as the insights regarding the proposed methodology, it is clear that the proposed methodology is likely to result in a payment rate for these items that is too low and should not be implemented.

We urge CMS to reconsider its proposal and reimburse separately payable drugs and biologicals at ASP plus six percent. We also recommend that CMS describe the NUBC guidelines and encourage hospitals to report HCPCS codes for both packaged and

separately payable drugs and biologicals under the revenue code 0636. Furthermore, the Agency could increase the correct reporting of packaged drug codes if it includes an explanation of how a policy of correctly following the guidelines and using revenue code 0636 for detailed HCPCS reporting could affect the amount of money distributed to the separately payable drugs.

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. Given that neither the GAO nor CMS has conducted surveys of hospital acquisition costs since 2004, this action is consistent with the default rate set forth in the Medicare statute. We also believe that this rate will stop the unwarranted payment reductions for these items, is comparable with the rate payment for these drugs in physicians' offices and is appropriate given the surrounding context, which must take into account payments for other items, as well as the system as a whole.

### **REPORTING QUALITY DATA FOR ANNUAL PAYMENT RATE UPDATES**

The Tax Relief and Health Care Act of 2006 (the Act) modified the payment update for OPSS services provided by hospitals in outpatient settings starting January 1, 2009. The Act required the establishment of a quality reporting program for the hospital outpatient setting and mandates hospitals to submit data on quality performance measures. The penalty for not submitting the data is a reduction in the annual payment update factor by 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 now requires data submission for eleven quality measures in the areas of imaging, perioperative care and care for acute myocardial infections (AMI) in the emergency department.

#### *Proposed Measures for CY 2011*

CMS has proposed not to add any additional measures to the outpatient reporting program for this year. The AAMC supports this decision. As CMS looks at future measures to be implemented the AAMC believes that measures selected for the outpatient reporting program should be supported by scientific evidence, sufficiently tested for reliability and validity and ultimately be endorsed by the National Quality Forum (NQF) and approved by the Hospital Quality Alliance (HQA).

#### *Validation*

CMS is proposing to implement a new validation program similar to what was proposed for the inpatient program. The new program would be fully implemented for CY 2012, with CY 2011 as a test year. For the proposed validation process for CY 2012, CMS would randomly select 800 hospitals for validation. For each hospital that is selected, a

total of 12 cases per quarter, or a total of 48 cases for the year, would be validated on their measure rate rather than the individual data elements. Hospitals would need to pass a reliability score of 90 percent in order to receive their full update.

The AAMC is supportive of the proposed validation process; however the data from the CY 2011 test year should be reviewed to ensure the process is functioning as it was intended and ultimately make modifications if necessary. We also support the matching process for overall measure rates as opposed to individual data elements in the validation process. We do not agree with CMS's proposal to utilize a 90 percent validation rate for the initial year of the validation process. Data and experience from the CY 2011 test year should be utilized to determine what an appropriate rate should be, and until that is determined, the rate should be the same for what is required in the inpatient setting, which is 75 percent. We urge the Agency to make this change.

#### *Reconsideration and Appeals*

In the CY 2009 OPPI Final Rule, CMS adopted a mandatory reconsideration and appeals process similar to one in the inpatient program that would apply for the CY 2010 payment determination. CMS has now proposed to continue the process for the CY 2011 payment update. The AAMC supports the mandatory reconsideration and appeals process and believes it should be a permanent component to the quality reporting program and therefore not be proposed or renewed each calendar year.

#### *Public Reporting*

The Tax Relief and Health Care Act requires the data collected through the hospital outpatient reporting program be publicly reported. CMS had stated in the CY 2008 final rule that non-validated data, including data from the initial reporting period, would not be publicly reported. In the proposed rule, CMS has stated the Act does not require the data being publicly reported to be validated and therefore is proposing to report the hospital outpatient quality data on the Hospital Compare website beginning with third quarter of CY 2008 (July – September 2008) whether or not the data has been validated.

The AAMC continues to support the public reporting of the outpatient data; however we strongly believe that only validated data should be reported as is the case for the inpatient program. Making non-validated data available on the Compare website may lead to inaccurate portrayals of hospital performance. In addition, the data reported on Hospital Compare is made available in a public use file which is downloaded by a multitude of entities (consumer groups, researchers, purchasers, health plans and others) for various purposes. Making these data available on Hospital Compare and in the public use file may lead to inappropriate use of these data in research, policy deliberations and in accurate portrayals of the data on various other websites that currently utilize Hospital Compare data.

In order to publicly report the outpatient data within the timeframe CMS is interested in, we suggest that CMS look at the possibility of reporting the validated data from the “test validation program” and begin reporting in June 2010 with 2<sup>nd</sup> and 3<sup>rd</sup> quarter 2009 validated data rather than the third quarter 2008 data proposed.

#### *Reporting ASC Quality Data for Annual Payment Update*

The Tax Relief and Healthcare Act authorized the Secretary to establish a similar quality reporting program for Ambulatory Surgery Centers (ASC). The implementation of this program has been delayed and we believe that CMS should move forward as quickly as possible to implement the reporting program. 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.

#### **Health Care Associated Conditions**

CMS has proposed not to expand the inpatient hospital acquired conditions (HAC) program to the hospital outpatient setting in this rulemaking. CMS will be conducting a study on the impact of the HAC program and present on admission (POA) reporting for the inpatient setting and will utilize the results of the report to inform future decisions regarding the expansion of the HAC program. The AAMC strongly supports CMS’s decision and we believe that a thorough program evaluation is warranted prior to any policy decision to expand the current inpatient program.

#### **OUTLIER PAYMENTS**

Outlier payments are an important component of the OPSS, 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 2010, CMS is proposing to continue to maintain the total outlier payments at one percent of aggregate total OPSS payments.

Currently, 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 \$1,800. CMS proposes to increase the fixed-dollar threshold by \$425 (from \$1,800 to \$2,225), while keeping the multiplier threshold at its current level of 1.75. The Agency estimates that setting the fixed-dollar threshold at \$2,225 would result in outlier payments of one percent of aggregate total payments.

In CY 2009, CMS implemented a policy to reconcile hospital outlier payments at cost report settlement for services furnished during cost reporting periods beginning in CY 2009. According to CMS, this policy is intended to ensure accurate outlier payments for

facilities with cost-to-charge ratio (CCR) that fluctuate significantly relative to the CCRs of other facilities. The Agency applies provider-specific overall CCRs to the charges on the claims to determine the cost of services and therefore whether the cost exceeds the outlier threshold to qualify for outlier payments.

CMS notes that, as in the inpatient PPS, the Agency does not adjust the fixed-dollar threshold or amount of total OPSS payment set aside for outlier payments for reconciliation activity. CMS believes that the predictability of the fixed-dollar threshold is an important component of a prospective payment system and making retrospective adjustments would be contrary to the prospective nature of the system. However, since the reconciliation process itself constitutes a retrospective review of payments, it may be necessary for CMS to reconsider its policy on retrospective adjustments to the fixed-dollar threshold or the outlier pool.

The AAMC agrees with the recommendation made by the American Hospital Association that CMS should use its annual rulemaking process and begin reporting aggregate amounts recovered by provider type and region. If the recovered outlier amounts are significant, it may be necessary to adjust the fixed-dollar threshold or the outlier pool to account for the recovered amount. Otherwise, the total outlier payment pool that ultimately gets distributed to hospitals whose outlier payments do not need to be reconciled is less than the one percent of total payments CMS prospectively sets aside for outlier payments. Also, given that CMS is increasing the outlier threshold at a fast pace to meet its one percent outlier payment target – an almost 24 percent increase in the outlier threshold for CY 2010 – this is a major concern for major teaching hospitals, whose patient population tends to include a larger proportion of complex and costly cases, thereby relying more heavily on outlier payments.

## **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. To distinguish between the costs associated with partial hospitalization services provided during days with four or more services and those with three services, beginning in CY 2009, CMS began using two separate APC payment rates for PHP – one for days with three services (APC 0172) and one for days with four or more services (APC 0173).

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. For CY 2009, CMS calculates median costs for the PHP APC payment rate based on

hospital-based PHP claims data only. Prior to CY 2009, the Agency calculated the PHP APC payment rate by combining hospital-based and CMHC median per-diem costs derived from both hospital and CMHCs claims data.

For CY 2010, CMS proposes to continue to pay for PHP services based on two separate APC payment rates (APC 0172 paid at \$149, and APC 0173, paid at \$213). The proposed payment rate is based on CY 2008 hospital-based PHP claims only. However, the Agency requests comments on the possibility of returning to its pre-CY 2009 policy of using hospital-based and CMHC data to derive the median per-diem cost and set payment rates for CY 2010. The only rationale the Agency is offering for reverting to the pre-CY 2009 policy of setting payment rates using both hospital-based and CMHC data is that both CMHCs and hospital-based PHPs are paid the same two APC per diem payment rates. CMS concluded that both provider types should have their data utilized in the development of the payment rates.

The AAMC would like to echo the AHA's recommendation that CMS continue to use only hospital-based data to set payment rates for PHP services. CMS states in the proposed rule that it decided to base the payment rate on hospital-based PHP data only for CY 2009, because of the Agency's concern that using CMHC data would have significantly reduced the CY 2009 PHP rates and negatively impacted hospital-based PHP programs. CMS further states that hospital-based PHPs are geographically diverse, whereas CMHCs are located in only a few States, and a significant drop in payments could result in hospital-based PHPs closing, which could lead to beneficiary access to care problems.

Given that there have been no changes to any of the reasons that led to CMS's decision to base payment rates for PHP services in CY 2009 on hospital-based data only, we urge the Agency to continue using hospital-based data to set payment rates for PHP services. If CMS were to use CMHC data and base payment rates on the combined hospital-based and CMHC data, payment for APC 0173 would decline by more 12 percent while payment for APC 172 would decline by more than 16 percent. In addition, the geographic distribution of CMHCs remains highly concentrated in a few states – 78 percent are located in six southern states. At the same time, most states have only hospital-based PHPs. Closure of these programs could lead to access problems for beneficiaries and potentially a transfer of care from the outpatient to the inpatient setting resulting in higher costs for the Medicare program.

Furthermore, CMS considers partial hospitalization to be provided in lieu of inpatient care and expects that the services last most of the day. Hospital-based PHPs meet this expectation as evidenced by the fact that 70 percent of hospital-based PHP days consist of four or more units of services. In contrast, only 33 percent of CMHC PHP days consist of four or more units of services.

Finally, CMS made significant changes to the PHP program in CY 2009, but due to the two-year lag between data collection and rulemaking, the changes made in 2009 would not be reflected in the claims data until the CY 2011 rulemaking process. Without an understanding of how these changes have affected the PHP program, reverting to the use of both hospital-based and CMHC data to base payment rates for hospital-based PHPs would be premature.

Thus, we strongly urge CMS to continue 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 hospitals' 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 physician supervision requirements please contact Ivy Baer at [ibaer@aamc.org](mailto:ibaer@aamc.org) or 202-828-0499. For quality-related questions, please contact Jennifer Faerberg at [jfaerberg@aamc.org](mailto:jfaerberg@aamc.org) or 202-862-6221. For all other issues, please contact Diana Mayes, at [dmayes@aamc.org](mailto:dmayes@aamc.org), 202-828-0498.

Sincerely,



Karen Fisher, JD  
Senior Director

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