



601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov
Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

October 6, 2003

Thomas Scully, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: File code CMS-1471-P

Dear Mr. Scully:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the notice of proposed rulemaking (NPRM) entitled Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates (August 12, 2003). We appreciate the ongoing efforts of the CMS staff to administer and improve the outpatient prospective payment system (PPS), particularly considering competing demands on the agency.

As you know, services provided in the hospital outpatient department are classified into ambulatory payment classification (APC) groups for payment. Each APC group is given a relative weight. Payment is determined by multiplying the relative weight by a conversion factor. The proposed rule documents changes in the definition of APC groups and proposes changes to the relative weights based on analysis of claims and cost report data. The NPRM also discusses payment for drugs, possible revisions to payments for drug administration, parameters for outlier payments, and the end of transitional corridor payments (including hold-harmless payments for small rural hospitals). Finally, the rule estimates the calendar year 2004 update to the conversion factor.

Our comments on the proposed rule center on six issues: the payment classification system, the methodology for setting payment rates, payments for drugs, outlier payments, the end of hold-harmless payments for small rural hospitals, and your responses to our recommendations.

Payment classification system

The proposed rule includes about 660 APC groups, approximately 90 more than last year. As a result, the outpatient PPS has more payment groups than the inpatient hospital, skilled nursing facility, or home health payment systems. While the increasing number of APCs may speak to the variety of services provided in outpatient departments, it also suggests that the amount of bundling that is occurring under the system may be decreasing. As you know, greater bundling provides hospitals with stronger incentives to improve efficiency. The number and extent of the changes to the APCs also raises questions about the stability and sufficiency of the classification system. While we appreciate the constraints imposed on the agency by the two-times rule,¹ we are concerned that less bundling in the classification system takes away some of the efficiency incentives meant to be provided by prospective payment. In addition, it is more challenging for CMS to set accurate and precise payment rates for many smaller units given the data available. MedPAC plans to look at refinements to the classification system in the future; we encourage CMS to do so as well.

Methodology for setting payment rates

The rule indicates that there were fewer swings in payment rates compared to last year's experience. The rule describes refinements to the methodology that result in more claims being used to set payment rates. These are positive steps. MedPAC continues to believe that hospital data are the appropriate basis on which to set payment rates. However, we recognize some of the difficulties inherent in the process of setting payment rates. These include dealing with claims with multiple services and understanding the potential impact of charge compression, where the charges for services in the same department may have distinctly different mark-ups over costs. We encourage CMS to continue to refine the methodology for establishing payment rates and we plan to conduct analyses of hospitals' cost allocation and charge-setting practices that may provide additional insights into how it can be refined.

Although the payment rates are more stable, a number of APCs still have large decreases, particularly separately-paid drugs and procedures using items coming off the pass-through list. Declines for these services are not unexpected, given that the payment rates for these items were based on manufacturers' prices in 2002, and declines from 2002 to 2003 were limited by a dampening policy.² The NPRM also proposes to limit payment declines from 2003 to 2004 for separately paid drugs.

Payments for drugs

The proposed rule continues the policy of paying separately for drugs that cost \$150 or more per administration or day. Less expensive drugs would continue to be

¹The two-times rule requires that the median cost of distinct services classified into the same APC (as denoted by HCPCS codes) cannot vary by more than a factor of two.

²The dampening process in 2003 allowed payment rates to fall by 15 percent. Any decrease greater than 15 percent was cut in half. For example, a drop of 25 percent was dampened to be a drop of 20 percent $(-15 + 0.5 \times -10)$.

packaged into the payment rate for related procedures. As we noted in our comment letter on the proposed rule for calendar year 2003, paying separately for high-cost drugs poses significant problems. When some items are bundled and others are not, the payment system provides an incentive to use those paid separately, if these items are more profitable than the bundled items. By setting an arbitrary cut-off to determine when separate payment will be made, hospitals have an incentive to increase their costs or doses of drugs administered to meet the threshold. Similarly, manufacturers have an incentive to price their products so that they will exceed the \$150 cut-off. MedPAC has encouraged more bundling of drugs in the past, and would urge you to pursue that goal.

The proposed rule indicates that the threshold will not be applied uniformly. Although the data available to CMS suggest that some drugs previously paid separately no longer meet the threshold, the agency proposes to continue to pay separately for them. Those that were not previously eligible but now meet the threshold will also be paid separately. In addition, the NPRM proposes to pay separately for all drugs coming off the pass-through list, whether or not they meet the threshold. As long as the \$150 threshold is in place, it should be applied uniformly.

The rule solicits comments on a number of options for refining the way in which hospitals bill and get paid for drug administration. All of the options would result in higher payments when hospitals administer packaged drugs and lower payments when they administer separately paid drugs. We agree with the agency's intention, which is to pay more accurately for drug administration, but have no comment on the specific coding options.

Finally, we are concerned about differences in payment rates for drugs, as well as services, across settings. For many drugs, reimbursement will be higher in settings such as physicians' offices, where CMS will continue to pay 95 percent of average wholesale prices. These payment differences may influence decisions regarding the setting of care. Addressing this issue requires a new approach for paying for Part B drugs, which is clearly on the agency's agenda, as outlined in the NPRM of August 20, 2003 entitled Payment Reform for Part B Drugs. Setting payments for pass-through drugs based on a reformed payment system for Part B drugs, as proposed, will help achieve some consistency across settings. However, CMS has not given clear indications of which approach it wishes to take, so it is difficult to understand how this would work. The issue would also be informed by analyses that look across payment systems. We encourage CMS to look across payment systems.

Outlier payments

The NPRM proposes an outlier cost threshold (2.75 times the APC payment amount) and a marginal payment factor (50 percent of costs above the threshold) for hospitals similar to those applied in 2003. For community mental health centers, however, the rule describes a pattern of charge escalation for partial hospitalization services, leading to large outlier payments. We are concerned about the susceptibility of the outlier provision to gaming through charge escalation. Consequently, we plan to review the outlier policy in the coming year, including analyzing payments in 2001 and 2002.

Hold-harmless payments

By law, the hold-harmless payments for small rural hospitals with 100 or fewer beds, and all transitional corridor payments, will cease at the end of 2003. In the case of small rural hospitals, the hold-harmless payments made up the difference between what a hospital would have been paid under previous payment policies and what it actually received under the PPS, when PPS payments were lower. In enacting this payment provision, the Congress recognized that rural hospitals may be more financially vulnerable than others to prospective payment and additional payments may be needed to ensure beneficiary access to care in rural areas. One reason for this could be that these facilities generally have a lower volume of services, and consequently, a higher unit cost than larger hospitals.

The NPRM recognizes that small rural hospitals may continue to need assistance after the end of the hold-harmless payments and seeks comments on a proposal to increase payments for clinic and emergency visits for these facilities. The rule does not, however, provide a rationale for this approach to supporting small rural hospitals. Possible rationales might include that small rural hospitals provide more of these services, or that these increases are needed for Medicare to ensure access. Unfortunately, only limited cost report data are available to assess the performance of small rural hospitals under the outpatient PPS. CMS has not centrally collected data on the distribution of the hold-harmless payments among hospitals.

The agency should consider other options to ensure access to care for rural beneficiaries. In addition to increased payments for clinic and emergency services, CMS could consider other regulatory approaches, such as a low-volume adjustment. Legislative remedies could include extending the hold harmless policy and/or providing a transition from the hold-harmless. Any payment adjustment should be accompanied by an analysis of how small rural hospitals have fared under the outpatient PPS and the impact of the payment adjustment. That analysis should also take into account other policies that impact rural hospitals, such as the conversion of many rural hospitals to critical access hospital status.

Responses to MedPAC recommendations

We appreciate the time and effort the agency took in considering our recommendations and responding to them in the proposed rule. MedPAC recommended that the Congress increase the conversion factor by the market basket less 0.9 percent for 2004. We understand that the agency does not have the authority to make an update other than that provided for in legislation. Nevertheless, it is our judgement that a full market basket update is excessive.

MedPAC also recommended that the Secretary introduce clinical criteria for eligibility of drugs and biologicals to receive pass-through payments. We are pleased that the agency states that limiting extra payment to those items most likely to improve the treatment of beneficiaries appears useful. We understand that the multiple conditions for

which a drug might be used could pose technical challenges in establishing criteria that you are not prepared to address at this time. However, we hope that the idea can be pursued and the technical challenges resolved.

MedPAC appreciates your consideration of our comments. If you have any questions, feel free to contact me or Mark Miller, Executive Director.

Sincerely,

Glenn M. Hackbarth
Chairman

GH/cwm