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September 2, 2008

Kerry Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1404-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: File code CMS-1404-P

Dear Mr. Weems:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit comments on CMS's proposed rule entitled: *Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates* [CMS-1404-P]. We appreciate your staff's ongoing efforts to administer and improve the payment system for hospital outpatient departments and ambulatory surgical centers, particularly considering the agency's competing demands.

As you know, the outpatient prospective payment system (OPPS) classifies services provided in outpatient departments into ambulatory payment classification (APC) groups. Each APC group has a relative weight, which is an indexed measure of the resources needed to furnish a service. The OPPS determines payment rates for APC groups as the product of the relative weights and a conversion factor. This proposed rule is similar to its predecessors in the sense that it documents changes in the composition of some APC groups and proposes changes to the relative weights based on analysis of claims and cost report data. The rule also estimates the calendar year 2009 update to the conversion factor.

This rule also proposes to

- Investigate ways to address charge compression in the method for setting payment rates.
- Combine some imaging services that are performed in the same outpatient visit into composite APCs.
- Add four imaging-related quality measures to the seven quality measures for which hospitals already have to submit data to receive full updates to the OPPS conversion factor.
- Develop a method that better reimburses hospitals for the pharmacy overhead costs of drugs that are separately paid under the OPPS.
- Implement new APCs and payment rates for visits that occurred in emergency departments (EDs) that are not available 24 hours per day, 7 days per week. These services are currently

reimbursed at the rate for standard clinic visits, while visits to EDs available 24 hours per day, 7 days per week are paid at higher rates.

- Seek public comment on deferring the collection of quality data from ambulatory surgical centers (ASCs) to after 2009.
- Seek public comment on extending the provision in the inpatient prospective payment system (IPPS) regarding hospital acquired conditions to the OPPS.

We focus our comments on these seven topics.

Addressing charge compression in rate setting

CMS uses a detailed method to set payment rates for APC groups. Hospitals report charges and costs for the services they provide in cost centers on hospital cost reports. In each cost center, hospitals divide costs by charges to create a cost-to-charge ratio (CCR). Although hospitals report charges on their cost reports, these charges originate on claims, where the hospitals bill Medicare for the services they provide. Each service on a claim has a revenue center, and CMS has a method for crosswalking the charges for a revenue center to a cost center on the cost reports. CMS multiplies the charges from the claims by the CCRs from the appropriate cost centers to create a cost estimate for each service. CMS uses these estimated costs to estimate a median cost for each APC. The median costs in the APCs serve as the basis for setting payment rates in the APCs.

CMS has received complaints that its use of cost center-level CCRs from the cost reports creates payment inaccuracies because of charge compression. This phenomenon results from the fact that hospital cost centers often encompass a wide range of items, and within a cost center hospitals often have low markups for high-cost items and high markups for low-cost items. This means that costs relative to charges—cost-to-charge ratios—often are higher for high-cost items than for low-cost items. But, CMS applies the same cost center-level CCR to all charges from the same cost center. This results in cost estimates that are too low for high-cost items and too high for low-cost items. Because CMS uses these estimated costs as the basis for setting payment rates, charge compression can cause payments to inaccurately reflect the true cost of providing services.

CMS is concerned about charge compression and commissioned a report from RTI International (RTI) to study the effects of charge compression on the payment rates in the IPPS as well as the OPPS. RTI's study produced several recommendations for refining the OPPS rate setting over the short term and the long term. We believe these recommendations offer excellent opportunities for improving payment accuracy in the OPPS.

CMS has proposed to largely adopt the recommendations that are suited for the long term (beyond 2009) including:

- Support industry-led educational initiatives to improve the quality of reporting capital costs on the hospitals' cost reports.
- Create two new standard lines on the cost reports: Drugs with High Overhead Costs Charged to Patients and Drugs with Low Overhead Costs Charged to Patients.

- Clarify instructions to providers that they are required to use all the standard cost centers lines for which they offer applicable services. Currently, providers often sum together the costs and charges from services that are applicable to different cost centers, treating them as if they apply to the same cost center.

CMS also has invited public comment on creating standard cost centers for CT scanning, MRI, and cardiac catheterization. Providers can currently report costs and charges for these services on more highly aggregated standard lines or on nonstandard lines that are specifically targeted for these services. Most hospitals record charges and costs for these services on the more highly aggregated standard lines.

We encourage CMS to create the new standard cost centers for CT scanning, MRI, and cardiac catheterization. Analysis by RTI indicates that CCRs for these services are substantially different from the standard lines into which providers often place them. For example, analysis by RTI indicates that a strong majority of providers places CT scans into a standard line for all radiology services. RTI analysis also shows that CT scans have a significantly lower CCR than most other radiology services. For providers using the standard radiology line, the overall radiology CCR causes CMS to overestimate the cost of CT scans, which can cause overpayments for these services. Adding a separate standard line for CT scans would help ensure that hospitals separate charges and costs for these services, thereby correcting this problem.

We support all of CMS's long-term proposals and especially commend CMS for proposing to adopt new standard lines for drugs with high overhead costs and for those with low overhead costs. This will help pay more accurately for drugs that are paid separately from the associated independent service. We discuss this issue in more detail below (see pages 7–8).

In contrast to CMS's proposal to adopt these long-term recommendations, the agency proposes not to adopt any of RTI's short-term recommendations. CMS's rationale for proposing to ignore these short-term recommendations is the magnitude and scope of the impacts that these adjustments would have on the APC payment rates. However, we believe that these recommendations would improve the accuracy of payments over the short term. Specific short-term recommendations that we believe CMS should adopt include three that address cost report accounting issues and one that uses statistical methods to adjust CCRs:

- Correct an error that apparently is commonly made by the individuals who prepare the hospitals' cost reports. To use nonstandard lines—such as a line specifically for CT scans—providers have to furnish a description of each nonstandard line they are using. Cost report preparers are also required to supply from a set of possible 4-digit codes the code that best describes the nonstandard line. RTI discovered that the cost report preparers often record the wrong 4-digit code for these nonstandard lines, causing the cost and charges for these services to be placed in the wrong cost centers. RTI recommends using text searches of character strings from the descriptions that providers furnished for the nonstandard lines. In cases where a text search makes it is clear that a nonstandard line was assigned the wrong 4-digit code, the costs and charges can be reallocated to the

correct cost center. RTI has developed an algorithm that CMS can use for these text searches.

- To help prevent this problem of misallocation of costs and charges for nonstandard lines, implement a change in the cost report preparation software that will impose fixed descriptions on the nonstandard cost report lines that providers choose to use.
- Revise the method that CMS uses to crosswalk revenue centers indicated on claims to cost centers listed on cost reports. RTI found that CMS's method often results in charges that do not match to a cost center. In these cases, charges are adjusted to costs using a default CCR. The crosswalk recommended by RTI would substantially reduce the percentage of charges from claims that do not match to a cost center.
- Use regression-based adjustments to create disaggregated, more refined CCRs from three existing cost centers: medical supplies, drugs, and radiology services. This adjustment would create CCRs for nine new cost centers: devices, other supplies sold, additional detail coded drugs, IV solutions, other drugs sold, CT scanning, MRI, therapeutic radiology, and nuclear medicine. Because of concerns about the magnitude of the results from the regressions for the radiology services (CT scanning, MRI, therapeutic radiology, and nuclear medicine) RTI recommends using the regression results to adjust the hospitals' CCRs for these four services, but the adjustments should be limited so that the CCR for an individual hospital is not less than the average CCR for each respective service. For example, the average CCR for CT scans is .0687. If the regression-based adjustment method would result in a hospital having a CCR for CT scans that is below this level, RTI recommends that this hospital be assigned a CCR of .0687.

We agree with CMS that the short-term recommendations have the potential to produce substantial changes in the APC payment rates, which could cause large changes in revenue for individual hospitals. However, this is also an indication that charge compression is creating substantial discrepancies between the payment rate for a service and the cost of furnishing it. To the extent that the payment rate for a service is less than or greater than the cost of providing it, some services are more profitable than others. This can cause hospitals' decisions over which services to furnish to be based on financial rather than clinical criteria.

Therefore, we believe that CMS should implement the short-term recommendations—those that address accounting issues and the regression-based adjustments to CCRs. Moreover, the RTI recommendations that CMS has proposed to implement will take years to address charge compression. If CMS is concerned about instability in payment rates that may occur if it implements RTI's short-term recommendations, then perhaps the agency could phase-in their effects on payment rates over a few years.

A final issue we discuss in this section pertains to addressing charge compression for devices implanted through surgical procedures. RTI's analysis suggests that the OPSS underpays for these services because of charge compression. However, the method that CMS uses to adjust payments in the OPSS for geographic variations in hospital labor costs exacerbates this underpayment for some hospitals and counteracts it for others. CMS uses hospital wage indexes (HWIs) to adjust 60 percent of the payment rate of each service for geographic variations in labor costs. This 60

percent is based on an estimate of the labor related share of costs for the average outpatient service.

In many device-implantation services, the cost of the device is well above 40 percent of the cost of the service, so the share of labor costs is well below 60 percent. This implies that CMS overadjusts for the labor costs in these services. Moreover, CMS's labor-cost adjustment typically adjusts payments down to hospitals in low-wage areas because they typically have HWIs below 1.0, and adjusts payments up in high-wage areas because they often have HWIs above 1.0. Consequently, in these services where devices make up a large percentage of the cost of the service, the underpayments from charge compression tend to be exacerbated among hospitals in low-wage areas and counteracted among hospitals in high-wage areas. MedPAC plans to evaluate CMS's method for adjusting payments for variations in labor costs, and we encourage CMS to explore this issue as well.

Expanding the number of composite APCs

In the 2008 proposed and final rules for the OPPI, CMS expressed concern over the growth in spending and service volume. As part of an effort to slow this growth, CMS proposed and then made final the creation of four composite APCs. The concept of composite APCs combines independent services that are usually performed in conjunction with each other into a single APC if they are provided on the same date. Hospitals receive one payment for the composite APC rather than separate payments for the individual services. Bundling multiple services into a single payment rate encourages hospitals to consider methods for furnishing care more efficiently and evaluate whether the services ordered by practitioners maximize efficient use of hospital resources. The incentives created by composite APCs have the potential to slow volume growth and, consequently, spending in the OPPI.

For 2009, CMS has proposed to continue to use the four composite APCs developed for 2008 and to add five new composite APCs. The proposed new composite APCs are defined by modality of advanced imaging and include:

- APC 8004, Ultrasound
- APC 8005, CT and CTA without Contrast
- APC 8006, CT and CTA with Contrast
- APC 8007, MRI and MRA without Contrast
- APC 8008, MRI and MRA with Contrast

Each of these APCs would have a list of HCPCS codes assigned to it. Each HCPCS code within an APC defines an imaging service that falls under the imaging modality defined by the APC. Each time a hospital bills more than one service described by the HCPCS codes in the same composite APC, the hospital would receive one composite APC payment. For example, HCPCS 76604 and HCPCS 76700 represent two services that fall under APC 8004. If a hospital bills services represented by those two HCPCS on the same day for the same patient, the hospital would receive the payment rate for APC 8004 rather than separate payments for the two services.

In our June 2005 Report to the Congress, we presented the benefits of larger payment bundles in the OPSS. The proposed composite APCs are consistent with larger payment bundles, so we support the proposal to create them. They should increase hospitals' incentives to furnish care efficiently. Moreover, they can serve as a starting point for creating more comprehensive payment bundles that reflect encounters or episodes of care.

Finally, these composite APCs for imaging services address the issue of cost savings that hospitals experience when performing multiple imaging services using the same modality in the same session. In the proposed outpatient rule for 2006, CMS proposed reducing by 50 percent the OPSS payments for multiple imaging services within the same family of codes performed in the same session. We supported this policy in our comment letter to the 2006 proposed rule, based on a recommendation from our March 2005 Report to the Congress.

However, in the final outpatient rule for 2006, CMS deferred implementing a payment reduction for multiple imaging studies subject to further study. In our comment letters on the proposed outpatient rules for 2007 and 2008, we responded to CMS's decision to defer the 50 percent discount by encouraging CMS to continue its examination of ways to improve payment accuracy for imaging procedures. We believe the proposed composite APCs for imaging services addresses this issue.

Collection of quality data

For hospital outpatient services furnished on or after April 1, 2008, CMS began requiring hospitals to report data on seven quality measures. Five of these measures reflect the quality of care in emergency departments for patients who have acute myocardial infarction and who are treated and then transferred to another facility for further care. The other two measures are surgical care improvement measures related to the use of antibiotic prophylaxis for surgical patients. Hospitals that fail to meet CMS' 2008 reporting requirements for these measures will incur a 2.0 percentage point reduction in their CY 2009 OPSS payment rate update factor.

For 2009, CMS proposes to add four new measures to the current seven measures to determine a hospital's CY 2010 payment rate update factor. The proposed new measures relate to the efficiency and quality of certain types of imaging services:

- MRI lumbar spine for low back pain: Percentage of people who had an MRI of the lumbar spine with a diagnosis of low back pain without claims based on evidence of antecedent conservative therapy.
- Thorax CT—use of contrast material: The ratio of combined CT studies (with and without contrast) to total CT studies performed.
- Mammography follow-up rates: Percentage of patients with a screening mammography study followed by a diagnostic mammography study in an outpatient or office setting. Also, average number of days between mammography screening study and diagnostic study.
- Abdomen CT—use of contrast material: Percentage of abdomen CT studies performed without the use of contrast material excluding calculi of the kidneys, ureter, and/or urinary

tract. Also, percentage of abdomen CT studies performed without the use of contrast material for diagnosis of calculi in the kidney, ureter, and/or urinary tract.

All of these measures are claims-based measures that CMS can calculate using Part B claims data without requiring hospitals to perform clinical chart abstraction. The four proposed measures have been submitted to the National Quality Forum (NQF) for consideration.

The Commission prefers that CMS seek authority from the Congress to move beyond pay-for-reporting toward pay-for-performance, so that payment updates depend on empirical results from quality data, not on whether the data are submitted. In our March 2005 Report to the Congress, we recommended that the Congress grant CMS the authority to base payments on pay-for-performance, and we encourage CMS to request this authority from the Congress.

Nevertheless, we support collecting measures of hospital quality, and we commend CMS for proposing to include imaging services in quality measures for hospital outpatient services. We note that a steering committee at the NQF reviewed the four proposed imaging measures and recommended two for endorsement by the full NQF: MRI lumbar spine for low back pain and thorax CT—use of contrast material.

However, the proposed rule provides scant information about the proposed measures, making it difficult to provide fully informed comments. It would be helpful if CMS provided detailed information on all proposed imaging measures when they are submitted for public comment, so we may make informed comments on the measures' potential usefulness to policy makers in evaluating the quality and efficiency of imaging services.

Reimbursing hospitals for separately paid drugs

In the OPPI, CMS provides separate payment for drugs whose costs exceed a set threshold. For 2009, CMS has proposed to set this threshold at \$60 per day. For drugs whose costs do not exceed this threshold, CMS packages their costs into the payment rate of the applicable outpatient service.

To determine the payment rates for separately paid drugs, CMS uses drug charges from claims and estimates a cost for each drug by multiplying the drug charges by the cost-to-charge ratio (CCR) from the cost center for drugs from the hospitals' cost reports. There is only one cost center for drugs, so for all drugs furnished by a hospital, CMS estimates their costs using the same CCR. CMS compares the average of these estimated costs across all separately paid drugs to the average of the average sales price (ASP) for these drugs. CMS bases the payment rates for separately paid drugs on this comparison. In the proposed rule for 2009, for example, CMS found that the average estimated cost of the separately drugs is 104 percent of their average ASP. Therefore, CMS has proposed a payment rate for each of these drugs equal to 104 percent of its ASP. These payments are intended to cover both the hospitals' acquisition cost and pharmacy overhead cost of these drugs.

There is a problem that stems from CMS's use of the same CCR to estimate the cost of all drugs furnished by a hospital. Hospitals have stated that they tend to mark-up charges for low-cost drugs

by a greater proportion than they mark-up high-cost drugs. This implies that hospitals reallocate overhead costs from high-cost drugs to low-cost drugs. This also implies that the actual CCR for high-cost drugs is higher than that for low-cost drugs, creating a case of charge compression (see pages 2–5). Consequently, the costs of high-cost drugs are underestimated, including their overhead costs. Because separately paid drugs tend to fall in the high-cost category, CMS underestimates their costs, which results in hospitals being underpaid for these drugs.

However, CMS has made an additional proposal in the current rule that should eventually provide a first step towards paying more accurately for separately paid drugs. CMS is proposing to break the drug cost center into two new cost centers: Drugs with High Overhead Costs Charged to Patients and Drugs with Low Overhead Costs Charged to Patients. CMS would be able to use the CCRs from these two cost centers to more accurately estimate the cost of each drug. This would reduce the degree of charge compression, resulting in more accurate reimbursement for separately paid drugs.

However, a fair amount of charge compression will likely remain under these new cost centers. Therefore, we encourage CMS to create more cost centers that more finely define drugs on the basis of overhead costs.

Reporting emergency department visits

Hospitals currently use HCPCS codes to describe three types of OPPS visits on claims: clinic visits, emergency department (ED) visits, and critical care services. Current procedural terminology (CPT) guidelines indicate that EDs must be available 24 hours per day, 7 days per week in order to be able to use ED visit codes and be reimbursed for the evaluation and management services that the ED codes represent. CMS refers to EDs that meet this CPT criterion as Type A.

CMS refers to EDs that are not available 24 hours per day, 7 days per week as Type B. The OPPS currently pays for visits to Type B EDs at the rates for clinic visits, which are lower than the rates for analogous ED visits to Type A EDs. However, in 2007 CMS created five new HCPCS codes that hospitals could use to report visits to Type B EDs. These HCPCS codes categorize Type B ED visits by the severity of the patient's condition from least severe (Level 1) to most severe (Level 5). Hospitals' use of these five HCPCS for visits in Type B EDs allowed CMS to collect and analyze the hospital resource costs of visits to these types of facilities in order to determine if an alternative payment policy might be warranted.

CMS now has cost data derived from 2007 claims to use in 2009 rate setting for the Type B emergency department HCPCS codes. For 2009, CMS is proposing to pay for Type B ED visits as follows:

- Level 1, 2, 3, and 4 Type B ED visits would get separate, distinct APCs and payment rates.

- Level 5 Type B ED visits would be in APC 0616, the same APC as Level 5 ED visits for Type A EDs. CMS has proposed to put Level 5 ED visits for Type A and Type B EDs into the same APC because they have nearly identical median costs.

We applaud CMS's foresight and effort in first creating distinct HCPCS codes for Type B ED visits and then using charge data collected for those new HCPCS codes to create payment rates.

Reporting of quality data from ambulatory surgical centers

Section 109(b) of Tax Relief and Health Care Act of 2006 authorizes (but does not mandate) the Secretary to require ASCs to submit data on quality measures and to reduce the annual payment update in a year by 2.0 percentage points for ASCs that fail to do so.

In the CY 2008 OPPS/ASC final rule with comment period, CMS decided not to require ASCs to begin reporting quality data in CY 2008. In that rule, CMS stated that the transition to a revised ASC payment system in CY 2008 posed such a significant challenge to ASCs that it would be most appropriate to allow ASCs to gain some experience with the revised payment system before introducing other new requirements such as quality measure reporting. In the current proposed rule, CMS proposes to defer quality reporting for ASC services again for CY 2009.

While we are aware of the administrative challenges facing providers during transition to the new ASC payment system, we are concerned about further delay in implementing quality measurement for the rapidly-growing ASC setting. We believe that it is feasible for ASCs to begin reporting in CY 2009 on the set of five quality measures that were developed by the ASC Quality Collaboration, an industry-based coalition, and endorsed by the NQF in April 2008.

The five facility-level ASC measures endorsed by the NQF are:

- Patient being burned
- Patient fall in the ASC
- Wrong site, wrong side, wrong patient, wrong procedure, wrong implant
- Prophylactic intravenous antibiotic timing
- Hospital transfer/admission

The first three of these measures are patient safety measures, and therefore also could be considered for a broader healthcare-associated conditions non-payment policy, which we discuss below. The fourth measure, on prophylactic antibiotic timing, is similar to a measure already required to be reported for surgical patients in the hospital inpatient and outpatient settings, and it may be voluntarily reported by physicians under the Physician Quality Reporting Initiative (PQRI). Requiring the reporting of this measure by ASCs would harmonize use of this measure across four settings of care, a small but important step toward the goal of consistent use of quality measures across care settings in the future. The fifth measure, tracking ASC patients who are transferred or admitted to a hospital upon discharge from the ASC, may be a useful measure of the occurrence of adverse patient safety events during an ASC procedure.

Given that all five of these measures were developed by an industry coalition—and therefore, presumably are considered by the industry to be technically feasible to report by ASCs without undue administrative effort—and have received NQF endorsement, we believe CMS should require ASCs to submit these measures at the earliest feasible opportunity. However, we regard pay for reporting as a first step towards improving quality, and pay for performance should be the ultimate goal.

Paying for healthcare-associated conditions

CMS does not propose new Medicare policy with regard to healthcare-associated conditions (HACs) as they relate to the OPSS. Instead, the agency seeks public comments on options and considerations related to extending the current inpatient prospective payment system (IPPS) hospital-acquired conditions payment policy to the OPSS.

The Commission commends CMS for considering and requesting public input on options and considerations related to extending the current IPPS policy to other care settings and payment systems, including the OPSS. We believe that quality measures should apply to a broad range of care and providers; the greater the proportion of providers whose care is measured, the broader the impact will be on beneficiaries. Thus, we believe the current inpatient payment policy should be expanded to other care settings as supported by the clinical evidence base. For HACs in the hospital outpatient setting, it may be reasonable to start with patient safety-related conditions such as object left in during surgery, air embolism, blood incompatibility, falls and trauma fractures, dislocations, intracranial injuries, crushing injuries, and burns.

Because all of these conditions are “never events” listed on the National Quality Forum’s list of “Serious Reportable Adverse Events,” the Commission suggests that the payment penalty should be large enough to stimulate hospitals to eliminate them. In our comment letter on the IPPS proposed rule earlier this year, we suggested that CMS should bar payment for any costs incurred by a hospital in treating one of these “never events.” To apply this concept to the OPSS, CMS could make a flat case rate reduction to all services provided in the clinical encounter during which a “never event” occurred. As noted in the proposed rule, the reduction potentially could be derived empirically by comparing the costs from OPSS claims for beneficiaries with healthcare-associated conditions to those without.

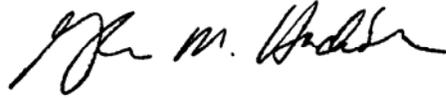
Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals from CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

Kerry Weems
Acting Administrator
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If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a large initial "G" and "H".

Glenn M. Hackbarth
Chairman

GMH/dz/wc