

September 30, 2004

Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services, Room 4
43-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1427-P

RE: Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates; Proposed Rule



Dear Dr. McClellan:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) on the Calendar Year 2005 Hospital Outpatient Prospective Payment System (*Federal Register*, Vol. 69, No. 157, pages 50447-50994) published August 16, 2004.

While we have a few concerns, overall we would like to commend the Center for Medicare and Medicaid Services (CMS) for your diligence and thoroughness in the preparation of this proposal.

1. **Outlier Payments**

CHA supports the CMS proposal to add a fixed dollar threshold to the outlier payment methodology. However, we urge further evaluation into the implications of the new proposal on hospitals with a disproportionate high volume of low-cost cases.

For 2005, CMS proposes to add a fixed dollar threshold to the current APC multiple methodology that would have to be met in order for a service to qualify for an outlier payment. This change is designed to address the Medicare Payment Assessment Commission's (MedPAC's) concern that a significant portion of outlier payments are being made for high volume, lower cost services rather than for unusually high cost services, which is the purpose of an outlier policy.

The objective of a dollar threshold is to redirect outlier payments from lower cost, relatively simple procedures to more complex, expensive procedures. For such cases the financial risk to hospitals is potentially greater.

For CY 2005, CMS proposes that to qualify for an outlier payment, the cost of a service must exceed 1.5 times the APC payment rate and the cost must also exceed the sum of the APC rate plus a \$625 fixed dollar threshold. When the cost of a hospital outpatient service exceeds these thresholds, CMS would pay 50 percent of the amount by which the cost of furnishing the service exceeds 1.5 times the APC payment rate (the APC multiple) as an outlier payment.

While we support the proposed refinement of the outlier policy, we remain concerned about the implications of the policy on hospitals with a relatively high volume of low cost cases. It would be worthwhile if CMS could highlight such implications in future rule making efforts.

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2. Transitional Corridor Payment

CHA continues to call on Congress and CMS to extend the transitional corridor payment protections to rural hospitals with emergency facilities.

At the inception of the OPSS, hospitals were eligible to receive additional transitional payments if the payments they received under the OPSS were less than the payments they would have received for the same services under the prior payment system. Most hospitals that realized lower payments under the OPSS received transitional corridor payments equal to only a fraction or percentage of the decrease in payments. However, rural hospitals having 100 or fewer beds, as well as cancer hospitals and children's hospitals were held harmless under this provision and paid 100 percent of the decline in payments under the OPSS.

In 2005 transitional corridor payments are only available to children's hospitals, cancer hospitals, rural hospitals having 100 or fewer beds, and sole community hospitals located in rural areas.

While Congress extended pass-through payment protections to certain rural hospitals, it did not extend such protections to rural hospitals that continue to provide emergency services. We are very concerned that such rural hospitals will not be able to achieve the same level of operating efficiencies as larger rural and urban hospitals, and the decrease in payment these hospitals are experiencing now that their pass-through payments have ended will result in these hospitals having to cease providing critical services such as emergency services. Loss of access to timely emergency service could have life-threatening implications for rural Medicare beneficiaries.

We strongly urge CMS to closely monitor this situation.

3. Pass-Through Payments

CHA strongly endorses the CY 2005 proposal to increase the conversion factor by 1.17 percent—the difference between the estimated CY 2004 pass-through payment proportion and the estimated CY 2005 pass-through payment proportion.

The statute provides for an offset to the conversion factor to finance payments for pass-through drugs and devices. It also limits the total projected amount of pass-through payments for a given year to an "applicable percentage" of projected total Medicare and beneficiary payments under the hospital OPSS. For 2004, CMS set the applicable percentage at 2.0 percent. Also for 2004, CMS estimated 2004 pass-through spending to be \$303 million and determined that no pro rata reduction will be required in 2004. Significantly, estimated pass-through spending was 1.3 percent of total payments, less than the 2.3 percent estimated for 2003. Therefore, for 2004 CMS increased the OPSS conversion factor by 1.0 percent (the difference between 2.3 percent and 1.3 percent), thus effectively increasing the hospital update.

Similarly, for 2005, CMS is projecting that pass-through payments will be only 0.13 percent of total payments. Therefore, the proposed rule would increase the conversion factor by an additional 1.17 percent, the difference between 1.3 percent (estimated 2004 pass-through payments) and 0.13 percent (estimated 2005 pass-through payments).

4. APC Relative Weights

While CHA supports the proposed policy for device-dependent APCs we are concerned about the new administrative burden on hospitals and urge CMS to review this policy, if implemented within two years.

In the preamble, CMS notes that its analysis of the CY 2003 claims data used to calculate the APC weights for 2005 continues to reveal data problems with device-dependent APCs similar to the problems that plagued rate calculation in prior years. The 2003 claims data, however, do not contain any C-code data on device use because CMS had eliminated device coding requirements for hospitals in CY 2003. Thus, CMS states that it was not possible to use only the CY 2003 claims data containing device codes to calculate APC device-dependent medians as was done in 2003 and 2004. Similarly, CMS says it was not possible to calculate a percentage of the APC cost attributable to device codes, which would be needed if external data was used to adjust CY 2003 claims data.

In light of these data issues for CY 2005, CMS examined several alternatives suggested by interested parties to address the problem. In the end, however, CMS rejected all of the alternatives.

CMS decided that "the better payment approach for determining median costs for device-dependent APCs in CY 2005 would be to base such medians on the greater of (1) median costs calculated using CY 2003 claims data, or (2) 90 percent of the APC payment median for CY 2004 for such services. We believe that some variation in median costs is to be expected from year to year, and we believe that recognizing up to a 10-percent variation in our proposed payment approach would be a reasonable limit."

CMS also is proposing to require hospitals to bill selected device-dependent procedures using the appropriate device C-code. The required billing applies only to the 14 APCs to which the proposed use CY 2004 medians would apply. Improperly coded claims will be returned to the hospital.

5. E/M Services Guidelines

CHA strongly supports and endorses the coding guidelines recommendation of the independent panel convened by the American Hospital Association and the American Health Information Management Association.

Since implementation of the OPPIs, hospitals have coded clinic and emergency department (ED) visits using the same current procedural terminology (CPT) codes as physicians. CMS has recognized that existing E/M codes in CPT correspond to different levels of physician effort but do not adequately describe non-physician resources. Although hospitals were anticipating that CMS would propose a national, uniform E/M coding system in 2003, the agency chose not to do so. As a result, the AHA and the American Health Information Management Association convened an independent panel of experts to develop a set of coding guidelines for CMS. Specifically, the panel recommended that CMS should:

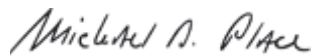
- Make payment for emergency department and clinic visits based on four levels of care.
- Create HCPCS codes to describe these levels of care as follows:

- Gxxx1—Level 1 Emergency Visit
 - Gxxx2—Level 2 Emergency Visit
 - Gxxx3—Level 3 Emergency Visit
 - Gxxx4—Critical Care provided in the Emergency Department
 - Gxxx5—Level 1 Clinic Visit
 - Gxxx6—Level 2 Clinic Visit
 - Gxxx7—Level 3 Clinic Visit
 - Gxxx8—Critical Care provided in the Clinic
- Replace all the HCPCS currently in APCs 600, 601, 602, 610, 611, 612, and 620 with GXXX1 through GXXX8.
 - Crosswalk payments from GXXX1 to APC 610, GXXX2 to APC 611, etc.

In both the proposed and final rules for 2004, CMS said it was considering the set of proposed national coding guidelines for emergency and clinic visits recommended by the independent panel.

In closing, we thank you for the opportunity to review and comment on the proposed hospital outpatient PPS rules for CY 2005.

Sincerely,



Rev. Michael D. Place, STD
President and Chief Executive Officer