MEDPAC Medicare Payment Advisory Commission

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

September 14, 2007

Kerry Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1392-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: File code CMS-1392-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 2008 Payment Rates; Proposed Changes to the ASC Payment System and CY 2008 Payment Rates* [CMS-1392-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. Also, the rule estimates the calendar year 2008 update to the conversion factor.

This rule also proposes to

- increase the extent of packaging ancillary services with independent services,
- combine some services that are frequently performed in the same encounter into composite APCs,
- investigate ways to address charge compression in the method for setting payment rates,
- begin a program for collecting hospital quality data that would affect OPPS payment updates for individual hospitals, and
- request that hospitals record pharmacy overhead charges on uncoded revenue code lines, with the purpose of packaging these charges with the associated independent services.

We focus our comments on these five topics.

OPPS: Packaged services

CMS expressed concern over the growth in spending in the OPPS, which has increased by about 10 percent per year since 2001. This rapid growth is fueled mainly by increases in the intensity and use of services per outpatient visit rather than by general price or enrollment changes. CMS believes that it is important to encourage efficiency in outpatient departments to help control future growth in the volume of OPPS services. This proposed rule cites two alternatives for controlling growth:

- A spending control mechanism such as the sustainable growth rate system that has been used in the physician fee schedule.
- Increased packaging of supportive ancillary services and perhaps (later) bundling of multiple independent services into a single payment rate.

CMS views increased packaging and bundling as preferable to a spending control mechanism. Expanded packaging and bundling 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 packaging have the potential to slow volume growth and, consequently, spending in the OPPS.

CMS proposed two methods for expanding the breadth of packaging and bundling in the OPPS in 2008:

- Package more ancillary services that are currently paid separately. Packaging is the process of combining a primary, independent service with associated secondary, ancillary services into a single payment unit rather than paying each service separately. Under packaging, hospitals receive a single payment rate for furnishing an independent service and all the ancillaries they furnish with it. The payment rate is the same no matter which ancillaries are furnished. Consequently, payments may be more or less than the costs hospitals incur in furnishing an independent service and associated ancillaries, but payments fully reflect costs on average.
- Combine independent services that are usually performed in conjunction with each other into composite APCs. Like packaging, this policy would pay hospitals a single rate when these services are provided together. CMS views creation of these composite APCs as a first step towards greater bundling, which is the process of combining multiple independent services so that payments are on an encounter or episode-of-care basis.

Package more ancillary services

As an initial step to expand packaging, CMS has proposed to package ancillary services from seven categories into the payment rates for the independent services with which they are furnished. These categories include: guidance services, image processing services, intraoperative services, imaging supervision and interpretation, diagnostic radiopharmaceuticals, contrast agents, and observation services.

We generally support CMS's proposed method for packaging these ancillary services. Packaging these services is logical because—as CMS stresses—they are always or usually provided on the same date and in the same facility as an independent service with which they are used. Therefore, hospitals would have

little opportunity to unpackage by referring patients to other facilities in order to receive separate payment for the ancillaries. For example, contrast agents are typically provided immediately prior to an imaging service and there is little or no opportunity for a contrast agent and an associated imaging service to be provided in separate facilities.

Current policy is fairly restrictive in regard to the circumstances in which observation care can be separately paid. Consequently, most observation services—about 70 percent—are already packaged under the OPPS. Therefore, we do not view the proposal to package all observation services as much of a change from current policy. Moreover, CMS notes rapid growth in the volume of separately paid observation care, and packaging all observation services can help slow that growth.

One concern we have over the proposal to package observation services is that it may have an unintended consequence of increasing inpatient admissions. In some instances the observation care would be packaged with services that have relatively high payment rates, in other instances they will be packaged with services that have relatively low payment rates. In situations where the cost of observation care is high in relation to the payment rate of the service with which it would be packaged, such as emergency department (ED) visits, hospitals' costs could be higher than payments when they provide observation and ED services in the same outpatient encounter.

Hospitals could avoid losses from providing an ED visit with observation care by simply forgoing observation care and admitting the patient for inpatient care instead. Therefore, we encourage CMS to be diligent in monitoring whether hospitals change their behavior in regard to admitting patients.

Composite APCs

Using data analysis and comments from external sources, CMS has found that providers typically perform some services in conjunction with each other. In this rule, CMS identified two situations where multiple services could be combined into composite APCs where hospitals receive a single payment rate if practitioners provide more than one of these services in a single hospital outpatient encounter:

- APC 8001, Low Dose Rate Prostate Brachytherapy, which would provide hospitals with a single bundled payment when they furnish CPT codes 55875 and 77778 on the same date of service.
- APC 8000, Cardiac Electrophysiologic Evaluation and Ablation Composite, which would provide hospitals with a single bundled payment when they furnish one or both of CPT codes 93619 or 93620 on the same date of service as one or more of CPT codes 93650, 93651, or 93652.

We support the proposal to create these composite APCs. It should increase hospitals' incentives to furnish care efficiently and should increase the number of "single-procedure" claims that CMS can use for setting payment rates, which will result in payment rates that more accurately reflect hospitals' costs. Moreover, it can serve as a starting point for creating more comprehensive payment bundles that reflect encounters or episodes of care.

Next steps for packaging and bundling

We support CMS's initial steps for expanding packaging and bundling in the OPPS. We encourage CMS to continue to seek ways to increase the amount of packaging and the extent to which services can be bundled based on encounters or episodes of care. MedPAC plans to explore methods to advance the level of packaging and bundling. In contrast to packaging—which combines a primary, independent service and associated ancillary services into a single payment unit—bundling collects multiple independent services that occur in an outpatient encounter or episode of care into a single payment unit. Creating payment bundles can become quite complex because an episode of care can involve services provided over several days.

The central premise of our method for expanding the packaging in the OPPS is to identify ancillaries that are frequently provided or inexpensive in relation to the associated independent service. Packaging relatively expensive ancillaries that are infrequently performed with the associated independent service may result in hospitals facing excessive financial risk. For example, if the cost of an independent service is $200, the cost of an ancillary is $200, and providers use the ancillary half the time they perform the service, packaging the ancillary would result in a payment rate for the independent service of perhaps $300 ($200+0.5*200). Because the ancillary is high cost in relation to the independent service, whether a provider uses this ancillary with this independent service will have a strong effect on the profit the hospital earns on furnishing it. The profit margin is -33 percent in the situations where providers use the ancillary with the independent service and +33 percent when they do not use the ancillary.

Another issue we intend to explore in regard to packaging is the use of relative cost, rather than absolute cost, to identify which drugs could be packaged with independent services. CMS currently uses an absolute cost threshold—proposed to be $60 per day in 2008—to identify which drugs should be paid separately and which should be packaged. However, absolute thresholds can result in separate payments for drugs that are low cost in relation to the associated independent services. For example, if a drug that costs $100 per day is used with a procedure that costs $5,000, the cost of the drug is only 2 percent of the cost of the procedure but it would be paid separately in the OPPS because it costs more than $60. We believe the OPPS should use a measure of relative cost—such as the cost of a drug as a percentage of the associated procedure with which it is used—to determine whether a drug should be separately paid. Packaging drugs that cost more than $60 per day but are low in relative cost and are frequently used with the associated services would probably not place hospitals at great financial risk.

Finally, our work that will explore the expansion of bundling in the OPPS will focus on options for creating payment bundles that more fully reflect episodes of care. We plan to focus on bundles for outpatient surgical procedures that could include the procedure, related physician services, and other clinically-related services such as tests and follow-up visits, furnished over a period of time. This policy could encourage providers to use resources more efficiently and better coordinate care across settings.

APC payment rates: Addressing charge compression

CMS uses a detailed method to set payment rates for APC groups. Part of this method uses charges for individual services and inputs that CMS adjusts to costs using cost-to-charge ratios (CCRs) from hospital departments.

CMS has received complaints that its use of these department-level CCRs creates payment inaccuracies

because of charge compression. This phenomenon results from the fact that hospital departments often encompass a wide range of items, and within a department 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 department-level CCR to all charges from the same department. 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 RTI International (RTI) to study the effects of charge compression on the payment rates in the inpatient prospective payment system (IPPS). RTI's study produced several recommendations for reducing the effects of charge compression in the IPPS. In this proposed rule, CMS discussed these recommendations within the context of the OPPS.

One of the key recommendations from RTI for the IPPS is to use regression-based adjustments to create disaggregated, more refined CCRs in three departments: medical supplies, drugs, and radiology services. However, CMS is reluctant to implement this recommendation in the OPPS because:

- The disaggregated CCRs that RTI developed for the three departments and recommended for use in the IPPS would not always be appropriate for the OPPS. RTI's method for creating disaggregated CCRs is derived from a regression model that RTI calibrated using inpatient charge data, but the CCRs that CMS uses to set payment rates in the OPPS are based on both inpatient and outpatient data. CMS argues that disaggregated CCRs should be derived from an "all-charges" regression model calibrated with both inpatient and outpatient charges. CMS has proposed to develop an all-charges model and will consider whether it would be appropriate to adopt its use for disaggregating CCRs and using those CCRs in setting 2009 payment rates in the OPPS.
- The OPPS already uses, in some instances, CCRs disaggregated to RTI's recommended level. For example, RTI's method disaggregated CCRs for radiology services, creating specific CCRs for MRI, CT, and all other radiology services. However, some hospitals report CCRs for CT and MRI services on their cost reports and CMS uses these CCRs to set OPPS payment rates.
- CMS is concerned that using the disaggregated CCRs from RTI's model to set payment rates in 2008 and disaggregated CCRs from an all-charges model to set payment rates in 2009 could result in substantial instability in payment rates over the 2007 through 2009 period.

We believe that charge compression is a serious issue and should be addressed within the context of the OPPS. In our comment letter on the IPPS proposed rule, we recommended that CMS use the disaggregated CCRs from RTI's model in the 2008 rate setting for the IPPS. Despite CMS's concerns, we also believe that it would be reasonable to use the disaggregated CCRs from RTI's model as part of the OPPS rate setting in 2008. We acknowledge that the disaggregated CCRs from RTI are not a perfect solution to charge compression in the OPPS. However, the issue of charge compression is serious enough that CMS should move forward with this imperfect solution. But, if CMS believes it is better to use disaggregated CCRs based on an all-charges model and chooses not to correct for the effects of charge compression on the 2008 rate setting, we believe the agency must correct for charge compression in the 2009 rate setting.

Collection of quality data

CMS proposes to link updates in OPPS payments to the collection of hospital quality data. CMS will begin collecting these data in calendar year 2008, and hospitals' submission of these data will affect whether they receive the full update to the OPPS conversion factor in 2009. CMS has identified 10 measures for the initial implementation of this program, all of which are applicable to care provided in hospital outpatient departments. Five of these measures reflect the quality of care in emergency departments for patients who have acute myocardial infarction and are treated and then transferred to another facility for further care. The other five measures are directly related to conditions treated or interventions provided in outpatient departments.

In addition to the 10 measures that CMS has proposed for 2008, the agency is considering 30 additional measures for assessing quality in later years. All measures are intended to specifically measure quality of hospital outpatient services.

MedPAC is a strong supporter of collecting measures of hospital quality, and we commend CMS for expanding the collection of quality measures. However, we prefer that CMS seek the authority to move beyond pay-for-reporting toward pay-for-performance so that payment updates depend on empirical results from the 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.

In addition to the quality measures proposed by CMS, we believe that the hospital component of the Consumer Assessment of Health Providers and Systems (HCAHPS) has several questions that are applicable to hospital outpatient care. We believe the HCAHPS can provide useful quality information because its questions are directed to patients. Measures from the HCAHPS that could provide useful information about outpatient quality are:

- For nurse care
    - How often did nurses treat you with courtesy and respect?
    - How often did nurses listen carefully to you?
    - How often did nurses explain things in a way you could understand?
- For doctor care
    - How often did doctors treat you with courtesy and respect?
    - How often did doctors listen carefully to you?
    - How often did doctors explain things in a way you could understand?
- For hospital experience
    - Were you given any medicine that you had not taken before?
    - How often did hospital staff tell you what the medicine was for?
    - Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
- When you left the hospital
    - Did you go directly to your own home, to someone else's home, or to another health facility?

    - Did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
    - Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
- Overall rating
    - Rate this hospital during your stay, from 1 to 10.
    - Would you recommend this hospital to your friends and family?
- About you
    - How would you rate your health?
    - What is the highest grade you have completed?
    - Are you Spanish, Hispanic, or Latino origin or descent?
    - What is your race?
    - What language do you mainly speak at home?

Reimbursing hospitals for pharmacy overhead costs

In the proposed outpatient rule for 2006 (*Federal Register*, July 25, 2005), CMS proposed a method of paying for pharmacy overhead costs that largely reflected a method that we recommended in our June 2005 Report to the Congress. CMS decided not to make its proposed method final, in response to concerns over collecting the data necessary to set payment rates in the APCs. In our comment letter on the proposed outpatient rule for 2007 (*Federal Register*, August 23, 2006), we encouraged CMS to revisit this issue and develop a method that recognizes large differences in pharmacy overhead costs between different classes of drugs and reimburses hospitals accordingly.

In this proposed rule, CMS is revisiting this issue by proposing to instruct hospitals to separate pharmacy overhead charges from overall charges for drugs and report the overhead charges on uncoded lines on claims beginning in 2008. This will allow CMS to use these charges in the rate setting process by packaging overhead costs into the costs of associated independent services. We support this proposal because it allows hospitals to be reimbursed more accurately for the variation in pharmacy overhead costs.

Other outpatient issues

Under the OPPS, hospitals receive full APC rates for each diagnostic imaging service on a claim, even though hospitals may save costs when they perform multiple services using the same imaging modality on contiguous body parts in the same session. In the proposed outpatient rule for 2006 (*Federal Register*, July 25, 2005), CMS cited an analysis that showed that many costs incurred for an initial imaging service are not incurred in subsequent services. The agency proposed reducing by 50 percent the OPPS payments for multiple imaging services within the same family of codes performed in the same session. Full payment would be made for the service with the highest APC rate, and the 50 percent discount would be applied to the APC rate for each additional service in the same family performed in the same session. We supported this policy in our comment letter on the proposed rule (submitted on September 16, 2005), based on a recommendation from our March 2005 Report to the Congress.
In the final outpatient rule for 2006, CMS deferred implementing a payment reduction for multiple imaging studies subject to further study (*Federal Register*, November 10, 2005). Some commenters on

the proposed policy argued that any efficiency related to providing multiple imaging services in the same session are already reflected in hospitals' costs, which are the basis for the APC rates. Based upon initial analyses that failed to disprove this contention, CMS decided to defer the policy while it further examined ways to improve the accuracy of imaging payments, such as changing the median cost calculation for imaging services or discounting payments for multiple imaging studies. CMS has yet to indicate that it has revisited this issue. We encourage CMS to continue its examination of ways to improve payment accuracy for imaging services, including a multiple procedure reduction.

Proposed update of the revised ambulatory surgical center payment system

In the discussion of the proposed payment for covered ancillary services provided by ambulatory surgical centers (ASCs), the proposed rule notes CMS's decision in the 2007 ASC final rule to align the payment bundles in the ASC and outpatient payment systems. Beginning in 2008, Medicare will pay ASCs separately for certain ancillary services that are integrally related to the provision of surgical procedures, as long as those services are paid separately under the OPPS. Separately-payable services include certain radiology studies, drugs and biologicals, and brachytherapy sources. Under the current ASC payment system, these ancillary services are packaged into the payment for the surgical procedure.

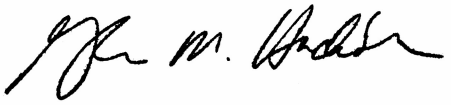
Although we understand that consistent packaging policies in the ASC and outpatient payment systems make it easier to align the two payment systems, we are concerned that paying separately for services in ASCs that are currently packaged may lead to growth of the separately-payable services. Thus, we encourage CMS to pursue broader packaging policies for both the revised ASC payment system and OPPS. Expanding the payment bundle would promote efficient resource use in both settings.

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.

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

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/dz/wc