ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N Street, NW, Washington, DC 20037-1127
Phone 202-828-0400 Fax 202-828-1125
www.aamc.org

October 6, 2003

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

Attention: **CMS-1471-P**

Dear Administrator Scully:

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 *"Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates; Proposed Rule",* 68 Fed. Reg. 47966 (August 12, 2003). The AAMC represents approximately 400 major teaching hospitals and health systems; all 126 accredited U.S. medical schools; 96 professional and academic societies; and the nation's medical students and residents.

OPPS PAYMENT EQUITY FOR TEACHING HOSPITALS

In our comment letter submitted on the 2003 outpatient proposed rule, we shared our concerns about the financial impact of the Medicare outpatient prospective payment system (OPPS) on teaching hospitals (AAMC Comment letter, dated October 7, 2002). In that letter we noted that the 2003 proposed rule impact table showed a financial impact of the OPPS for major teaching hospitals that lags behind that of non-teaching hospitals. This year's proposed rule impact table indicates that this trend is continuing, with major teaching hospitals estimated to receive OPPS payment increases that are less than other hospital groups (Table 23, 68 Fed. Reg. 48017).

The negative financial impact of the OPPS on major teaching hospitals also is apparent by examining these hospitals' disproportionate reliance on outlier and transitional corridor payments:

> *Transitional Corridor Payments*--Since the inception of the OPPS three years ago, hospitals have been eligible to receive transitional corridor payments if their OPPS payments were less than the payments they would have received under the prior payment system. These payments reduce the gap between OPPS and prior payments, but do not eliminate it. With the exception of children's and designated cancer hospitals, transitional corridor payments are legislatively mandated to end on December 31, 2003.

The transitional corridor payments have been a critical source of financial support for many major teaching hospitals. According to an AAMC analysis of transitional corridor payments as reported in Medicare's FY 2001 Medicare cost report database,[1] while major teaching hospitals represented only 9 percent of the total number of hospitals receiving these payments, they received nearly 39 percent of total transitional corridor payments. The typical teaching hospital received $677,026 in corridor payments compared to $146,828 and $82,916 for other teaching and non teaching hospitals, respectively. A quarter of teaching hospitals received more than $1.6 million in these payments (see Table 1).

1. Medicare Outpatient PPS Transitional Corridor Payments, FY 2001

	All	**Major Teaching****	**Other Teaching**	**Non Teaching**
No. Hospitals*	1203	110	202	891
% of Total Hospitals	34.5%	44.0%	23.1%	37.7%
Median Payment	$107,524	$677,026	$146,828	$82,916
75th Percentile	$255,900	$1,637,470	$413,789	$176,707

Source: AAMC Analysis of 2001 Medicare Cost Report Data.
* Reflects those hospitals receiving transitional corridor payments
** Defined as teaching hospitals with intern/resident-to-bed ratios of 0.25 or higher.

It is important to recognize the relationship between the corridor payments and the financial impact of the OPPS generally. As previously mentioned, in order to even qualify for corridor payments, a hospital's OPPS payments need to be significantly below their prior payments. Under the prior system, Medicare outpatient payments for all hospitals were significantly below their corresponding outpatient costs; consequently hospitals receiving corridor payments have OPPS payments that represent an even smaller share of their corresponding costs. Moreover, major teaching hospitals, as a group, had Medicare outpatient margins that were lower than other hospital groups during the period prior to the OPPS implementation.[2] Consequently, the receipt of significant amounts of transitional corridor payments by major teaching hospitals not only highlights the disparity in the impact of the OPPS on major teaching hospitals compared to other hospitals, but also highlights the reductions in payments, and the associated gap between payments and costs, that is occurring for these hospitals under the OPPS. In the proposed rule, CMS indicated a concern about the impact on small rural hospitals when the transitional corridor payments cease. As our data indicate, we think that major teaching hospitals are another group meriting concern.

---

[1] Worksheet E, Pt B, Line 1.06, columns 1 and 1.01.
[2] According to the Medicare Payment Advisory Commission (MedPAC), major teaching hospitals had an aggregate outpatient margin of -17.8 percent in 2000, the outpatient margin for other teaching hospitals was –12.0 percent and nonteaching hospitals had an aggregate margin of –13.2 percent. (Table D-6 of MedPAC's 2003 Report to the Congress: Medicare Payment Policy (March, 2003).

> *Outlier Payments*—Major teaching hospitals receive substantial amounts of outlier payments. These payments occur because for many outpatient services, major teaching hospitals receive payments that are substantially below their corresponding costs.
>
> According to Table 24 in the proposed rule (68 Fed. Reg. 48019), outlier payments for major teaching hospitals represent 3.1 percent of their total OPPS payments, compared to 1.7 percent for minor teaching hospitals and 1.8 percent for nonteaching hospitals. Data from the proposed rule OPPS impact file show that while major teaching hospitals comprise only 5.5 percent of all hospitals, they receive nearly a 25.7 percent of all outlier payments distributed.

The disproportionate reliance on transitional corridor payments by major teaching hospitals demonstrates that the ambulatory payment classification (APC) payment methodology does not address the higher outpatient patient care costs associated with the unique characteristics of teaching hospitals. The disproportionate receipt of outlier payments also demonstrates this phenomenon to the extent that a portion of outlier payments is compensating for inadequate APC payment rates, rather than random cases that have unusually high costs.

In the Association's comment letter on the original OPPS proposed rule, we presented a number of reasons why teaching hospitals would fare more poorly than other hospitals under the OPPS (see AAMC Letter to Nancy-Ann Min DeParle, dated July 30, 1999). For example, an analysis of 1996 outpatient claims data revealed that the costs incurred by major teaching hospitals for a disproportionate number of individual outpatient services were consistently higher than the average cost. In such cases, the APC rate would result in a systematic underpayment for these services. Our July 30, 1999 letter also pointed out that regression analyses conducted by *both* CMS and the Lewin Group showed a significant effect related to cost differentials and teaching intensity, indicating that teaching hospitals would perform more poorly than other hospitals under the OPPS. The experience to date under the outpatient PPS indicates that, unfortunately, this prediction of poor performance is a reality for many teaching hospitals.

In the initial OPPS Final Rule, published April 7, 2000 CMS stated that it would "conduct analyses and studies of cost and payment differential among different classes of hospitals, including teaching facilities, when sufficient data under the PPS have been submitted. We will carefully consider whether permanent adjustments should be made in the system once the BBRA 1999 transition provisions expire." (65 Fed. Reg. at 18500). In addition, the Balanced Budget Act of 1997 requires the Secretary to establish adjustments "as determined to be necessary to ensure equitable payments . . . for certain classes of hospitals." (Section 4523 of the BBA).

We urge CMS to begin conducting these analyses as soon possible. We believe one of the analyses should involve examining the reliance of teaching hospitals on pass-through, outlier, and transitional corridor payments. If the results suggest that teaching hospitals have depended upon these payments to achieve payment equity relative to other hospital types, we believe a teaching hospital adjustment should be developed and implemented as soon as possible.

OPPS OUTLIER PAYMENT POLICY

As with the inpatient PPS, the OPPS makes additional payments for outpatient services that are extremely costly ("outliers"). Services for which a hospital's costs exceed the applicable OPPS payment by a certain "threshold" are eligible for the additional payments. The payment "pool" for outlier services is obtained by reducing the conversion factor for all outpatient services; i.e., the policy is budget neutral. Current law mandated that the outlier pool not exceed 2.5 percent through 2003; CMS, however, chose to set a target of 2.0 percent for outlier payments. In 2003, if an outpatient service costs exceeds 2.75 times the applicable OPPS payment, the hospital receives 45 percent ("payment percentage") of its costs in excess of that threshold.

Under the proposed rule, CMS would establish separate outlier pools and thresholds for hospitals and community mental health centers (CMHCs). For hospitals, the outlier threshold would remain at 2.75 times the OPPS payment amount but the payment percentage would be increased from 45 to 50 percent. CMHCs, which receive OPPS payments for partial hospitalizations, would have the same payment percentage but the outlier threshold would be substantially higher, 11.75 times the APC payment amount. According to the proposed rule, this higher threshold is needed because of an "excessive" amount of outlier payments being made to CMHCs (68 Fed. Reg. 48012). While the proposed rule would retain an overall outlier pool of 2.0 percent, 0.36 percent of that amount (or .0072 percent of total OPPS payments) would be designated for CMHC outlier claims.

As discussed above, outlier payments are an important source of reimbursement for the high cost outpatient services provided by teaching hospitals. While outlier payments are critical to teaching hospitals, it also is important to remember that these payments only partially offset the costs of high-cost cases; the remainder is absorbed by the teaching hospital.

As we have written in the past, we continue to believe that outpatient services that qualify for outlier payments should receive 80 percent of their costs above the threshold, rather than the current level of 50 percent. While teaching hospitals would still incur significant unreimbursed costs, increasing the payment level would help ameliorate the level of these losses for hospitals, such as teaching hospitals, that provide complex outpatient services. Increasing the payment level also would make the OPPS consistent with the policy under the inpatient PPS.

While we believe the payment level should be increased for all services qualifying for outlier payments, we recognize that certain outpatient services are much costlier than other services. Given that the outlier threshold is a multiple (2.75 times) of the APC payment, rather than a fixed dollar amount, hospitals providing these services must absorb significantly more in costs before even qualifying for outlier payments. For these services, increasing the threshold from 50 to 80 percent payment is particularly important.

The imperative to increase the outlier payment percentage leads us to recommend that CMS give serious consideration to increasing the outlier payment pool from its current 2.0 percent level. Current law increases the maximum allowed outlier pool for 2004 and beyond to 3.0 percent. Rather than following the legislative approach of increasing outlier payments, CMS chose to propose maintaining the outlier payment target at 2.0 percent. We recognize that increasing the payment level to 80 percent will require additional funds, unless the other changes are made. Moreover, there continues to be significant instability in the payment-cost relationship for a number of outpatient services. Given these factors, we believe a higher pool level is necessary and urge CMS to consider this action.

In terms of a separate outlier pool for community mental health centers, we concur with the comments of the American Hospital Association (AHA) and urge CMS to rescind this proposal.

NEW DRUG TRANSITIONAL PASS-THROUGH PAYMENTS

Currently, transitional pass-through payments for qualifying new drugs are based on 95 percent of their average wholesale price (AWP), which is the method use to pay for drugs generally under Medicare Part B. On August 20, 2003, CMS published a proposed rule that would revise the payment methodology for Medicare-covered drugs (68 Fed. Reg. 50428). Comments on the proposal are due October 14.

In the outpatient proposed rule, CMS states that when the AWP changes are made final, the Agency intends to adopt and apply those changes to the OPPS, even if it necessitates mid-year changes.

We question CMS' authority to implement these changes without first proposing them in an OPPS rulemaking process. The impact of these changes could have a significant impact on OPPS payments and policies. For example, changing the payment methodology for pass-through drugs could impact the payment pool for these items, which has repercussions for possible pro-rata reductions and conversion factor reductions.

We urge CMS to evaluate the AWP final rule when it is released to determine if the changes are appropriate for the OPPS. If so, these changes should be proposed as part of the 2005 rulemaking process.

OPPS DRUG CODING

In the 2003 final rule, CMS implemented a policy by which drugs and radiopharmaceuticals costing less than $150 would be packaged with their associated outpatient service and receive a single APC payment rate. Drugs and radiopharmaceuticals that cost more than $150 would receive a separate APC payment. Because the packaged drugs are not paid for separately, they do not have to be coded separately on the outpatient claim.

CMS is concerned about the calculation of APC payment weights for services involving packaged drugs because of the lack of coding information. To address this concern, CMS proposes to require the separate coding of all drugs, both packaged and separately paid. The Agency believes that this requirement may also be in the best interest of hospitals because it will result in more accurate APC payments.

We appreciate CMS' concern about ensuring that the Agency has accurate cost data for drugs. Calculating stable and accurate payments for drugs and services involving drug administration has proven difficult since the inception of the OPPS, as indicated by the proposed rule preamble discussion. We also recognize, however, that coding of drugs for many hospitals can be burdensome, particularly when there is no specific payment associated with the code—as is the case with packaged drugs.

We believe that, at least in the short term, more drugs should be separately payable. This would increase drug coding information, which could help to stabilize these payment rates. We suggest that the threshold for determining whether a drug should be separately payable be reduced from $150 to $50 or $100. In addition, or alternatively, we believe that as drugs are removed from transitional pass-through status, they should be assigned to separate APCs, rather than being packaged. Hospitals had been coding these latter drugs when they were had pass-through status so that it would be no additional burden to continuing coding these drugs.

We do not believe that CMS should require coding of packaged drugs. Given that there is no distinct payment associated with these drugs, we believe hospital compliance in coding these drugs would be difficult. We also are confused about CMS' concern that coding of these drugs would ensure more accurate payments. Our understanding is that the charges for packaged drugs are, or should be, contained on the claim regardless of whether the drug is coded. Given that the APC payment weights are based on total charges, we are unclear as to the need for separate coding for these items.

DRUG ADMINISTRATION

Currently, Medicare pays separately for the administration of certain drugs through one of four "Q" codes. Each code is to be reported once per visit no matter how many drugs are administered. Data have shown that costs appear to vary widely based on whether the drug is packaged or in a separately payable APC.

Because CMS believes both over and underpayments are possible under the current methodology, the proposed rule discusses four coding and drug administration payment options that the Agency is considering:

1. To continue the current coding structure and payment policy;
2. To eliminate the four existing codes and create eight new codes to differentiate administration of packaged versus separately payable drugs;
3. To eliminate the four existing codes and create six new codes to differentiate administration of packaged versus separately payable drugs; and
4. To continue use of the current codes but create new payment policy by modifying the outpatient code editor (OCE) to allow it to pay differently for the administration of packaged versus separately payable drugs.

The AAMC appreciates CMS efforts to ensure accurate payment for drugs and drug administration. However, the proposed options that would change the status quo would be extremely difficult to implement and pose significant administrative burdens. We believe our suggestion (see above) to increase the number of separately payable drugs would ameliorate some of the payment issues observed by CMS.

We urge CMS to continue the current policy, at least for 2004. We would be happy to work with the Agency to identify additional options that would both ensure adequate payments and be administratively reasonable.

EVALUATION AND MANAGEMENT CODING GUIDELINES

Since the implementation of OPPS, hospitals have coded clinic and emergency department visits using the same codes as physicians use to receive Medicare physician payments. CMS has recognized that these "E/M codes" may not adequately describe the hospital resources need to provide clinic and emergency department services and in last year's final outpatient rule solicited suggestions on coding guidelines that would be appropriate for hospitals to code under the OPPS.

The AHA and the American Health Information Management Association (AHIMA) convened a panel of experts to develop a set of coding guidelines that were presented to CMS. While these guidelines were discussed in the proposed rule, CMS did not officially "propose" them. Rather, the Agency currently is considering the national coding guidelines recommended by the panel, and, upon completion of its review, plans to make any proposed guidelines available on the OPPS web site for public comment.

We applaud the AHA and AHIMA for their efforts to develop these guidelines. We believe that for many hospitals and clinic and emergency room services, the guidelines will help ensure that hospital resources for a particular service are aptly reflected by the suggested coding scheme. However, several of our members that have large volumes of clinic and emergency department visits have discovered that for some services, there is a strong correlation between physician resource use and facility resource use. Consequently, it may be desirable for CMS to give hospitals the discretion to use either national facility guidelines or to use the national criteria established for E & M services under CPT-4, with the stipulation that the guidelines be used consistently based on the type of visit provided. We urge CMS to closely review all comments received on the E/M guidelines to better understand whether this suggestion merits serious consideration.

CONCLUSION

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President, Health Care Affairs, or Karen Fisher, Associate Vice President. These individuals may be reached at (202) 828-0490.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC