



**Minnesota Hospital Association**

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October 10, 2006

Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Ave., S.W., Room 445-G  
Washington, DC 20201

**Ref: [CMS-1506-P and CMS-4125-P] Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates:**

Dear Dr. McClellan:

On behalf of the Minnesota Hospital Association's (MHA) 132 member hospitals and health care organizations, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule related to the policies and payment rates for the hospital outpatient prospective payment system (OPPS) for calendar year (CY) 2007.

The proposed rule indicates that many ambulatory payment classification (APC) rates continue to fluctuate dramatically, with payments much lower or higher in 2007 than in 2006. These changes make it extremely difficult for hospitals to plan and budget from year to year. We would expect that four years after the start of the OPPS, the payment rates and associated payment-to-cost ratios would be much more stable.

The proposed rule contains several significant policy changes in the OPPS and in other areas of Medicare policy. In addition to this instability, the entire OPPS is under-funded, paying only 87 cents for every dollar of hospital outpatient care provided to Medicare beneficiaries. Hospitals must have adequate funds to address critical issues such as severe workforce shortages, increasing liability premiums, the rising cost of drugs and technologies, aging facilities, expensive regulatory mandates and more. MHA will continue to work with Congress to address inadequate payment rates and updates in order to ensure access to hospital-based outpatient services for Medicare beneficiaries.

#### **LINKING INPATIENT QUALITY DATA REPORTING TO OUTPATIENT PPS UPDATE**

MHA and its member hospitals are committed to public transparency of hospital quality information. Indeed, MHA has worked toward increasing the amount of publicly available, reliable and useful quality data, including the activation of "Price-Check," our new Web-based hospital price information on Oct. 1.

For CY 2007, CMS has proposed to use its authority under §1833(t)(2)(E) of the *Social Security Act* to reduce the OPPS update for those hospitals that are required to report quality data under the hospital inpatient PPS, but failed to do so. Specifically, CMS proposes that hospitals that failed to submit the required quality data for a full marketbasket update for inpatient PPS for FY 2007 would have their outpatient update also reduced by two percentage points.

We are concerned by CMS' proposal for linking outpatient payments to inpatient measures of quality, linking a reduction in the conversion factor to the submission of inpatient PPS data that have already been reported, linking payment to data submission that predates the OPPTS rule, and in linking outpatient payments to the reporting of quality data.

MHA urges CMS to rescind the proposal to link inpatient quality reporting to the outpatient payment update and rely on efforts of the Hospital Quality Alliance and the Ambulatory Quality Alliance to develop outpatient quality measures.

#### **HOSPITAL CLINIC AND ED VISIT CODING**

MHA is concerned that in 2007 CMS proposes to establish new G codes to describe hospital clinic visits, ED visits and critical care services in the absence of national guidelines. Creating temporary G codes without a fully developed set of national guidelines will increase confusion and add a new administrative burden requiring hospitals to manage two sets of codes — G codes for Medicare and current procedural terminology (CPT) codes for non-Medicare payers — without the benefit of a standardized methodology or better claims data. MHA recommends that CMS support the continued use of the current five level CPT codes, which would be assigned to the three existing APCs for hospital clinic and ED services until national coding definitions and guidelines are formally proposed, subjected to stakeholder review and finalized. This would provide for stability for hospitals in terms of coding and payment policy and allow CMS and stakeholders to focus on developing comprehensive national hospital visit guidelines that could be applied to a new set of hospital visit codes in the future.

#### **APC RELATIVE WEIGHTS**

Current law requires CMS to review and revise the relative payment weights for APCs at least annually. MHA continues to support the agency's use of hospital data, rather than data from other sources, to set the payment rates, as this information more accurately reflects the costs hospitals incur to provide outpatient services. However, since the August 2000 implementation of the OPPTS, payment rates for specific APCs have fluctuated dramatically. For 2007, the proposed rates continue to show significant volatility.

In the proposed rule, CMS uses the most recent claims data for outpatient services to set the 2007 weights and rates. MHA continues to support the use of the most recent claims and cost report data to set the 2007 payment weights and rates. We also continue to support the use of multi-procedure claims, as we believe these data improve hospital cost estimates. MHA also supports the expanded list of codes for bypass, as it appears unlikely that these codes would have charges that would be packaged into other services or procedures.

#### **PROPOSED REVISION TO THE OVERALL COST-TO-CHARGE RATIO (CCR) CALCULATION**

The proposed rule includes a significant change in the way the overall hospital-specific CCR is calculated. CMS uses the overall hospital CCR to set outlier thresholds and to estimate outlier and pass-through payments and in other services paid based on charges reduced to costs. The fiscal intermediaries (FIs) use overall CCRs to determine outlier payments and payments for certain other services. CMS recently discovered that it calculates the overall hospital CCR differently than the FIs. Compared with the CMS "traditional" overall CCR calculation, the FIs' method includes allied health education costs and adds weighting by Medicare Part B

charges. In the rule, CMS proposes to use features of both methods by excluding allied health education costs and adopting weighting by Medicare Part B charges.

It is important to have a consistent methodology for setting policy, modeling impacts and making outpatient PPS payments. In addition, the decisions to exclude allied health education costs and to adopt weighting by Medicare Part B charges are appropriate policy decisions.

#### **PARTIAL HOSPITALIZATION**

MHA is concerned that an additional proposed 15 percent reduction in the per-diem payment rate for partial hospitalization services could harm the financial viability of partial hospitalization services and could endanger Medicare beneficiary access to them. This will be the second consecutive year that the per-diem rate was reduced by 15 percent. Hospitals cannot sustain further reductions in the per-diem rates. These services are quite vulnerable, with many programs in recent years closing or limiting the number of patients they accept.

We share CMS' concern about the volatility of the community mental health center (CMHC) data and support the agency's intent to monitor and work with CMHCs to improve their reporting.

#### **OPPS: RURAL HOSPITAL HOLD-HARMLESS TRANSITIONAL PAYMENTS**

MHA is concerned about the impact that the phase-out of the transitional corridor hold-harmless payments will have on small rural hospitals. These are vulnerable facilities that provide important access to care in their communities. MHA supports S. 3606, *Save Our Safety (SOS) Net Act of 2006*, which would permanently extend hold-harmless payments to small rural hospitals and sole community hospitals, as is currently the case for cancer hospitals and children's hospitals.

#### **OUTLIER PAYMENTS**

Outlier payments are added to the APC amount to mitigate hospital losses when treating high-cost cases. For 2007, CMS proposes to retain the outlier pool at 1 percent of total outpatient PPS payments. Further, CMS proposes to raise the fixed-dollar threshold to \$1,875 — \$625 more than in 2006 — to ensure that outlier spending does not exceed the reduced outlier target. This increase in the fixed-dollar threshold is largely due to the projected overpayment of outliers resulting from the change in the CCR methodology. To qualify for an outlier payment, the cost of a service would have to be more than 1.75 times the APC payment amount and at least \$1,875 more than the APC payment amount.

MHA is concerned that CMS has set the threshold for outliers too high. With the significant changes to outlier policies, including the methodology for calculating the hospital-specific CCR proposed for 2007, MHA is concerned that Medicare may not spend the targeted outlier pool.

#### **NEW TECHNOLOGY APCs**

CMS proposes to assign 23 services from new technology APCs to clinically appropriate APCs. CMS generally retains a service within a new technology APC group for at least two years, unless the agency believes it has collected sufficient claims data before that time. In the proposed rule, CMS proposes to assign some services that have been paid under the new technology APCs for less than two years to clinically appropriate APCs. For example, positron

emission tomography/computed tomography scans, which had been assigned to new technology APC 1514 in 2005, is scheduled to move to a clinical APC in 2007. Some hospitals that adopt these new technologies may be unable to quickly change their charge masters, including changing codes and setting charges that reflect actual costs of the new service. Additionally, the data that CMS obtains in the first year or two of adoption of these technologies may not appropriately reflect the use and cost of these services because diffusion of new technologies can be slow, and waiting additional years for more hospitals to adopt and use new technology is important.

MHA recommends that when CMS assigns a new service to a new technology APC, the service should remain a new technology APC for at least two years until sufficient claims data are collected.

MHA member hospitals are committed to working with CMS to develop and examine all the potential alternatives for the proposed OPSS payment system. MHA understands the importance of collaboration to ensure any changes to payment system methodology are fair, workable, compliant, and meets the needs for all member hospitals.

MHA appreciates the opportunity to comment on the proposed OPSS rule. If you have any questions about our comments, please feel free to contact me or Ann Gibson, federal relations director, at (651) 603-3527 or [anngibson@mnhospitals.org](mailto:anngibson@mnhospitals.org).

Sincerely,

A handwritten signature in purple ink, appearing to read "Gregg Redfield".

Gregg Redfield, CMA  
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