

associated with services for specific patients that are extraordinarily expensive. Through a comparison of the median per diem costs, we have determined that CMHCs dramatically increased their charges between CY 2001 and CY 2002. During this period, the median per diem cost for CMHCs increased by 58 percent. We believe that in most cases, these increases in charges were not related to a corresponding increase in costs. Since the CMHC cost-to-charge ratios used to calculate outlier payments remained constant during this period, we believe that the 58 percent increase in computed cost is attributable to artificial increases in charges designed to enhance outlier payments. Approximately two-thirds of outlier payments made to PHP providers were paid to 20 of the 125 CMHCs. The charges reported by these providers, on average, were over 10 times more than hospital per diem charges.

Given the difference in PHP charges between hospitals and CMHCs, we no longer believe it is appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Therefore, we are proposing to designate a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPSS in CY 2004, excluding outlier payments. CMHCs are projected to receive 0.36 percent of total OPSS payments in CY 2004, excluding outlier payments. Therefore, we are proposing to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we are proposing to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We believe that this approach would neutralize the impact of inflated CMHC charges on outlier payments. We are proposing to apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we are proposing to pay 50 percent of CMHC per diem costs over the threshold. To the extent charges remain relatively constant, CMHCs would qualify for outlier payments in CY 2004 only for truly high cost patients.

As noted previously, we expect to receive updated cost-to-charge ratios from the FIs this summer. Many of the cost-to-charge ratios are expected to be considerably lower than those currently used to determine a provider's cost for the purpose of outlier and transitional pass-through or corridor payments. For

example, we are aware of a number of situations where the updated cost-to-charge ratios have declined by more than 50 percent.

We specifically request public comments on this proposed outlier policy. We intend to monitor the extent to which the current pattern of escalating charges continues. CMS and the Office of the Inspector General will be further examining the excessive outlier payments to CMHCs.

XII. Summary of and Responses to MedPAC Recommendations

The Medicare Payment Advisory Commission (MedPAC) in its March 2002 Report to the Congress: "Medicare Payment Policy," makes a number of recommendations relating to the OPSS. This section provides responses to those recommendations.

Recommendation: The Congress should increase payment rates for the OPSS by the rate of increase in the hospital market basket, less 0.9 percent, for CY 2004.

Response: Section 1833(t)(3)(C)(ii) of the Act requires the Secretary to update the conversion factor annually. Under section 1833(t)(3)(C)(iv) of the Act, the update must be equal to the hospital market basket percentage increase applicable under the hospital inpatient PPS. For years 2000 and 2002 only, the statute required the update to be determined by reducing the increase by one percentage point, but current law specifies such a reduction only for those 2 years. For 2004, we propose to increase the conversion factor by the rate of increase in the hospital market basket.

Recommendation: The Secretary should introduce clinical criteria for eligibility of drugs and biologicals to receive pass-through payments under the outpatient PPS.

Response: In accordance with section 402 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), pass-through payments for medical devices is made on the basis of categories of devices. On November 2, 2001, we published in the **Federal Register** (66 FR 55850) a rule that specified the criteria for establishment of a new category of devices for purposes of pass-through payments. Among these is the requirement that the devices to be included in a possible category must demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to benefits obtained by devices in previously established categories or other available treatments. We elaborated further about this criterion in the final rule updating

the OPSS for CY 2003, published in the **Federal Register** on November 1, 2002. As we stated at that time, "We established this criterion because it is important for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in the treatment of Medicare beneficiaries to facilitate access by beneficiaries to the advantages of the new technology. Conversely, the need for additional payments for devices that offer little or no clinical improvement over a previously existing device is less apparent." (67 FR 66782)

At present, pass-through payment for drugs and biologicals is not made on the basis of categories, and no comparable criterion applies to them. Whether we should apply such a requirement to drugs and biologicals is an important question. On the one hand, as noted above, limiting extra payment to those items that have the potential to make a significant difference in treatment of Medicare beneficiaries appears useful. On the other hand, developing an appropriate mechanism for identifying which drugs or biologicals might qualify is difficult. Because the clinical characteristics of particular cases that are relevant for drug use may vary substantially, we believe that this challenge is more difficult than in the case of devices. Consequently, we have not developed a proposal in this area, and we are not prepared to advance one at this time.

XIII. Summary of Proposed Changes for 2004

A. Changes Required By Statute

We are proposing the following changes to implement statutory requirements:

- Add APCs, delete APCs, and modify the composition of some existing APCs.
- Recalibrate the relative payment weights of the APCs.
- Update the conversion factor and the wage index.
- Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.
- Cease transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.
- Cease transitional outpatient payments (TOPS payments) for all hospitals paid under OPSS except for cancer hospitals and children's hospitals.