

*Response:* We recognize that the allocation of capital and equipment costs to revenue centers that do not use the equipment could distort cost to charge ratios for the revenue centers that use the equipment (and presumably whose charges reflect those costs). It is not clear how cost to charge ratios could be adjusted for such allocations. However, for the 2005 OPPS, we hope to explore the effect and impact of basing relative weights on relative hospital charges, rather than costs. If weights are based on relative charges, then presumably, the charges for services with high cost equipment and capital expenses would reflect those costs relative to other services without such costs.

#### *Dates of Service on Revenue Code Lines*

*Comment:* Commenters supported requiring dates of service on lines with revenue code charges but asked that the requirement not be enforced until June 2004 to enable hospitals to have sufficient time to adjust their systems to provide this information.

*Response:* Subsequent to the proposed rule, we learned that the X 12N 837 standard transaction with which covered entities had to be in compliance on October 16, 2003, requires a date of service on each line item containing a charge.

#### *Single Revenue Code List for Packaging*

*Comment:* One commenter supported the use of a single revenue code list for packaging costs into separately paid HCPCS codes. The commenter indicated that this change would result in more accurately attributing costs to services. Another commenter objected to our proposed changes for packaging revenue centers. This commenter is concerned that the use of a single set of revenue codes for packaging into the major procedure on a claim may inappropriately allocate charges not associated with the major service on the claim. For example, the commenter stated that revenue code 254 and revenue code 255 should continue to map to a radiological APC, and charges in these revenue centers should not be assigned to a major non-radiological procedure.

*Response:* We proposed to combine the multiple lists of revenue codes into one because there was significant overlap in them and our physicians believed that the risk of not picking up appropriate charges was greater than the risk of picking up charges that were not appropriate. In the case cited by the commenter, we are depending on hospital billing and our reliance on single procedure claims to preclude us

from packaging a charge for a radiological service into a HCPCS code for a non-radiological service. We have never had a complaint that we have packaged more costs than were appropriate into a HCPCS code, although we frequently are told that we neglected to pick up all related charges. For the final rule, we retained the single set of revenue codes for packaging into separately payable major HCPCS codes.

#### *Need for Stability in Relative Weights*

*Comment:* Commenters stated that significant changes in weights for services from year to year are difficult for hospitals because not all hospitals provide all services and if the APC rates fall for the particular service mix the hospital furnishes, this can mean significant shifts in total payment for outpatient services from Medicare from year to year. Commenters indicated that we should adjust medians derived from claims data to limit the amount of change that occurs from year to year. Commenters indicated that hospitals are limiting availability of services based on declining Medicare OPPS revenues and that once a service is curtailed or eliminated, it is not likely to be reintroduced again because the hospital will cease monitoring the costs of the device and equipment needed to offer the service once it is no longer provided in the hospital and, therefore, even if it would be cost effective to reintroduce the service, it is not likely to occur. Commenters indicated that the pattern of revenue changes is a factor in hospital decisions regarding whether to acquire state-of-the-art equipment. Therefore, reductions in payments for equipment-intensive services discourage hospitals from acquiring the equipment necessary to provide state-of-the-art services to Medicare beneficiaries. Commenters also indicated that the cumulative effects of the reductions from 2002 payment rates, particularly for procedures to implant medical devices, have resulted in significant payment cuts for many of these procedures and will discourage acquisition of the items necessary to provide the highest quality care.

A commenter stated that we should stabilize the APC rate when a device comes off of pass-through status. Several commenters stated that the proposed rates reverse the progress that was made in 2002 by using the manufacturer prices in the setting of medians for 2002. Commenters indicated that we should adjust the medians from claims data to ensure that no APC's median falls more than 5 percent compared to the medians used for payment in 2003. A commenter suggested that we adjust

the medians whenever there is more than a 20 percent reduction from one year to the next. Another commenter indicated that all APCs that decline more than 10 percent compared to 2003 adjusted medians should be adjusted in the same way that we proposed to adjust medians for drugs, biologicals and radiopharmaceuticals and that these adjustments also should apply to brachytherapy sources.

Another commenter asked that we let no median cost used in weight setting fall more than half the difference between the loss and 15 percent because this methodology offers a buffer for hospitals to minimize annual changes. Another commenter indicated that we should freeze the 2003 payment rates, particularly for brachytherapy services and should educate providers to show all of the charges for all of the ancillary services on the claim so that they will be included in the development of relative weights for future years.

*Response:* We are sympathetic with the concerns of hospitals that the OPPS should be sufficiently stable that hospitals would have the capacity to plan and budget for future years. We recognize that the early years of a payment system may result in shifts in payment across services. However, a prospective payment system is a system of averaging in which the payment to the hospital becomes an overall amount that the hospital has at its disposal to use in the way it finds to be most efficient and effective. The payments for individual services are the means by which the amount of money to be spent on OPPS is distributed among hospitals but the hospitals have the right to use that payment as they choose across all services they choose to furnish. The OPPS is a system that attempts to calibrate payments for a service or procedure to best approximate the costs that an efficient provider would incur in providing the service or procedure in order to give providers incentives for efficient procurement and service delivery.

As we indicated in the proposed rule, for 2004, some of the same services had significant declines in median costs compared to the 2003 adjusted median but not compared to the 2003 median before adjustment. We did not propose to adjust the 2004 medians for procedural APCs compared to the 2003 adjusted median. Instead, we indicated that we would consider using external data that could be made publicly available if we were convinced that the medians for 2004 would result in payment rates that were grossly aberrant in the context of the service.