

understand how they could be harmed by publicly disclosing prices that were applicable in 2002 but have now been obsolete for a year. Moreover, since upward adjustment of any median cost results in reduction of payments for all other items and services, we believe that, in a governmental payment program, the parties whose payments are reduced by the use of external data should be able to examine all elements of the payment system.

We do not believe that widespread use of external data to set median costs for selected APCs is appropriate in a system that relies on relativity to establish payment amounts. We are sympathetic with the concerns of some commenters that widespread use of external data will result in payment inequities rather than appropriate payments to hospitals based on the relative weights of the services they furnish. However, we are also concerned about circumstances in which we are convinced that the payment amounts that would result from the medians from our data will discourage hospitals to provide access to needed care. Therefore, in the case of several APCs as discussed elsewhere, we used external data to adjust the medians. In general, however, we continue to have confidence in the integrity of our claims data with respect to the procedural APCs. For the future, we prefer to seek ways to refine the methodologies that we apply to our own data, such as the use of a greater percentage of claims to set the weights for certain APCs.

*Comment:* Several commenters stated that we should work with them to set the methodology for the 2005 medians in view of the absence of device codes in the 2003 data and should pursue a study of the acquisition costs of devices in particular, so that there will be valid device related data for setting the 2005 OPPS.

*Response:* We are always interested in hearing the proposals of outside parties with regard to our methodology for setting OPPS weights. We recognize the concern that the absence of device codes for 2003 claims may lead to median costs that fail to fully incorporate the costs of the devices used in the applicable APCs and we are interested in all ideas for preventing this problem. Our proposed methodology will be presented in the proposed rule for the 2005 OPPS and will be open to public comment.

#### *General Comments About Payment*

*Comment:* A commenter asked that we base the relative weights on the geometric mean that we use for

trimming the data. The commenter indicated that the use of the geometric mean is the industry standard for both trimming aberrant data, as we use it, and also for calculating relative weights when costs are not distributed symmetrically. The commenter stated that the use of the geometric mean is particularly useful in circumstances that mirror those of OPPS: the first years of a new system and with low-volume high-cost services. The commenter noted that we agreed to move forward with analyses to look at the use of a mean versus median cost for weight setting in the November 1, 2002 final rule published in the **Federal Register**, but believes that not much analysis is needed since the use of the geometric mean is an industry standard for setting relative weights.

*Response:* We appreciate the thoughtful comments on this issue and other suggestions on how we might improve our rate setting methodology. We will continue to explore these options in 2004. Our efforts in 2003 were limited to creating unscaled weights from the means used for the 2003 OPPS and comparing them to the unscaled weights for medians for 2003 OPPS. Our preliminary comparison revealed that there would be many swings in payments. Hence, for the 2004 OPPS, we continued our use of the median cost.

In preparation for 2005 OPPS, we hope to calculate OPPS amounts using the mean costs, and also mean and median charges (to circumvent the effects of cost-to-charge ratios), and the 2004 OPPS conversion factor. This should give us a more complete view of the impact of revising our methodology in this way.

#### *Charge Compression and Cost Finding*

*Comment:* A commenter indicated that the use of cost to charge ratios is consistent with the concept of averaging that underpins a prospective payment system and that the system should not seek to micro-cost individual items or services but rather should rely upon the hospital charging patterns irrespective of Medicare policy to base relativity. The commenter indicated that while some items have different markups than others, the use of a standardized methodology to establish relative weights for all services should result in appropriate relative payments. The commenter strongly objected to any additional burdens that would be imposed in order to fine tune the pass-through payment system or weights at the expense of all other APC payments. The commenter specifically objected to CMS overriding the claims data to alter

the ratio for new technology devices because the commenter believes that such adjustments will make the OPPS unduly administratively complex and create unfair imbalances in payment.

Other commenters opposed the use of cost-to-charge ratios applied to charges to acquire cost data. They indicated that in many cases, we had to use overall hospital cost-to-charge ratios that had no relevance to the costs of the services being determined and therefore resulted in invalid representations of median costs. They also indicated that both the departmental and the hospital specific cost-to-charge ratios were derived in part from costs that are commingled between inpatient and outpatient services and therefore are not necessarily representative of a ratio that could be applied to outpatient services alone, as we do. Some commenters indicated that we ignore studies that demonstrate that charges are compressed, with low-cost services being marked up more than high-cost services, thus resulting in systematic underpayment of high-cost items and diminishing beneficiary access to high-cost services. A commenter suggested that, for drugs, biologicals and radiopharmaceuticals, we set a minimum payment based on the Federal Supply Schedule price plus a percentage markup to ensure that payment for drugs, biologicals, and radiopharmaceuticals was sufficient to make them available to Medicare beneficiaries who need them.

Several commenters indicated that the application of hospital specific cost-to-charge ratios at the department level where available, otherwise at the hospital level will always result in incorrect costs because hospitals do not have a consistent markup for all items and services within a department. They indicated that hospitals markup low-cost items more than high-cost items and that therefore, the application of a cost-to-charge ratio, even at the department level, will never result in the hospital acquisition cost for an item. They indicated that there is no easy adjustment to correct for charge compression and they urge us to explore using external data, developing surveys or doing studies to acquire hospital cost data that can be used in place of the median costs acquired from claims data.

*Response:* We recognize that the application of cost-to-charge ratios to charges for individual items as needed to develop median costs for APCs is imperfect. However, the only means at our disposal for determining costs from the charges on the claims was to calculate a cost-to-charge ratio using the cost report data that we believe is