

applicable to the OPD (for example, excluding room and board). We acknowledge that this system for determining relative values is imperfect, but we believe that it continues to be preferable to total reliance for particular items on external data which could inappropriately inflate Medicare payments for those items to the detriment of general hospital services. As indicated above, we hope to explore use of mean costs, and mean and median charges in preparation for the 2005 OPPS to determine if such a change would result in better relative weights and less instability in OPPS payments for particular services from year to year. However for 2004, we based relative weights on median costs derived through the application of a cost-to-charge ratio to the charges for the services.

#### *General Concerns About Decreases*

*Comment:* We received many comments objecting to proposed decreases in the proposed payment rates for specific services. These commenters indicated that the service has become more expensive rather than less expensive over the year, or indicated that the payment for the service declined for 2003 and should not decline for 2004. In some cases, the comments indicated that the payment should remain at the 2003 rate so that hospitals will not consider discontinuing the service.

*Response:* The OPPS is a relative payment system based upon the relative median costs of services. We calculate the costs of services by applying a cost to charge ratio to the charges for the services and then packaging the costs together for major HCPCS codes. We then calculate the median of the array of costs across all claims for HCPCS codes in an APC. There are many factors that can affect whether the cost of services rises or falls from one year to the next. In general, for the 2004 OPPS, about half the APC median costs increased and about half decreased compared to the 2003 median costs. In most cases, the changes were modest and such changes from year to year are to be expected as hospitals find ways to reduce costs for some services and incur higher costs for others. Because we do not expect the mix of services furnished in hospitals to vary hugely from year to year across the universe of hospitals, we do not expect that the changes in relative costs to create enormous impacts either.

#### *Disparity in Payments for Overhead Costs for the Same Service*

*Comment:* A commenter indicated that OPPS provides disparate payment for the overhead costs associated with services that are furnished both in physician offices and in hospital outpatient departments. As an example, the commenter indicated that CMS attributes \$25.36 in physician practice expense to CPT code 99213 (office or outpatient mid level evaluation and management service for an established patient) but pays a hospital \$54.46 (the amount set forth in the proposed rule) for the overhead for the same service and indicated that for other services the OPPS payment is as much as 4 times the amount paid to physicians for practice expense for the same service. The commenter asked that CMS establish payment equity for the same service furnished in these respective settings.

*Response:* The method for calculating payment for physicians' practice expenses under the Medicare physician fee schedule is established by law, as is the method we use for the outpatient setting. The application of the different methodologies results in different payment amounts in the two settings.

Comments and responses on payment amounts for specific APCs are included in section II.B.

#### *Source of Data for Weight Setting*

*Comment:* One commenter stated that we should conduct a study to establish a source for cost data other than claims data on which to base APC weights. Another commenter strongly objected to use of survey data because the commenter did not believe that it could ever fully capture all hospital costs for services and that therefore, the survey data would be used only for items and would have to be integrated with claims data for services. The commenter did not believe that the two could be integrated in a way that would properly reflect the relative costs.

*Response:* We believe that relative weights should generally be based on claims data because, notwithstanding the weaknesses, claims data are the most complete and accurate source of information about all services furnished by all providers paid under OPPS. We believe that it would be unreasonably expensive to acquire survey data that would be representative of the entire population of Medicare hospitals and all OPPS services furnished in them. We do not support the idea of using only selected hospitals and/or selected services because we think data from a limited survey would not be representative of the whole population

of Medicare hospitals and services and would not be accurate to reflect relative costs of all services.

#### *Incomplete Hospital Bills*

*Comment:* Commenters indicated that when OPPS was implemented, hospitals no longer had a payment incentive to ensure that all charges were shown on the claim because there was no longer a direct relationship between the amount of charges on the claim and the interim payment they would receive for services. Therefore they ceased to complete the claim as fully as when the charges were directly related to the Medicare interim payment. Several commenters indicated that in some cases, hospitals went as far as to remove items from the chargemaster so that a charge was no longer created when an item or service was used, particularly if the item or service were from a department other than the department billing the CPT code. A commenter said that in many cases, hospitals ceased to bill all charges for services if the completion of the claim with all charges would delay the submission of the claim to Medicare and therefore delay the Medicare payment to the hospital. Commenters indicated that hospitals did this particularly for services like brachytherapy in which the services were furnished from multiple departments of the hospital and the claim could be delayed significantly to accumulate all charges. Commenters indicated that the absence of all charges for services could result in poor data and instability in median costs from year to year, particularly when we use only single procedure claims.

*Response:* We encourage hospitals to report all charges for all services on claims for Medicare payment so that the data on which relative weights are set will fully reflect the relative costs of all services. However, where all charges are not included on the claim but the costs exist in the cost centers, the cost-to-charge ratios would increase and, to some extent, offset the effect of the absence of charges. Hence, while we would prefer that hospitals bill all charges for the services they furnish, where they do not do so, it does not necessarily mean that the costs derived from applying the hospital's cost-to-charge ratio to charges would result in improper relative weights for the services.

#### *C. Discussion of Relative Weights for Specific Procedural APCs*

##### *New APC for Antepartum Care*

We proposed rule to split APC 0199, Obstetrical Care Service, into two APCs.