



American Hospital
Association

Regulatory Advisory

AHA's Regulatory Advisory, a service to AHA members, will be produced whenever there is a significant regulatory development that affects the job you do in your community.

Medicare Outpatient PPS: The Proposed Rule for CY 2005

A Message to AHA Members:

The Centers for Medicare & Medicaid Services (CMS) published in the August 16 *Federal Register* a proposed rule with changes to the calendar year (CY) 2005 outpatient prospective payment system (OPPS). This proposed rule includes statutory changes mandated by the Medicare Modernization Act (MMA) as well as policy changes, such as revisions to the Ambulatory Payment Classifications (APC) weights and rates; payments for drugs, devices and biologicals; and payments for outliers. A final rule, expected around November 1, will take effect January 1, 2005.

Go to <http://www.cms.hhs.gov/providers/hopps/2005p/1427p.asp> to view the proposed rule.

The proposed rule provides a full 3.3 percent market basket update in payment rates for hospital outpatient services. The rule also implements a 1.001 wage index budget neutrality adjustment factor and a 1.17 percent increase to the conversion factor due to a reduction in new technology pass-through spending (primarily for drugs that are now paid in a different way). The resulting impact of these adjustments is a 4.6 percent increase in the conversion factor, increasing it to \$57.098 in 2005 – up from \$54.561 in CY 2004.

The rule also proposes a change in the OPPS outlier policy to better target outlier payments to unusually high cost services. **While the AHA continues to analyze the impact of CMS' revised outlier methodology, we support the continued need for an outlier policy in all prospective payment systems and support revisions that target outlier payments to unusually high cost services.**

In a disappointing move for hospitals, CMS fails to appropriately implement a new evaluation and management (E/M) coding system for hospital billing of emergency department and clinic services. Hospitals need codes that adequately describe non-physician resources used for E/M services. It has been over a year since the AHA provided CMS with recommendations from an expert panel co-chaired by the AHA and the American Health Information Management Association (AHIMA). Because we believe that these E/M coding recommendations will meet hospitals' needs and we are concerned about the absence of a standard system or guidelines, the AHA will continue to urge CMS to issue guidance to address this concern.

After reviewing this advisory, check off the following items from your to-do list:

- ✓ Share this advisory with your chief financial officer and outpatient department directors.
- ✓ Model the impact of the proposed APC changes on your 2005 Medicare revenue. A spreadsheet comparing the changes in APC payment rates from CY 2001–2005 is available for AHA members at http://www.aha.org/aha/members_only/member/040914APCweights01_05.html. Please note that you must first login to view the spreadsheet.
- ✓ Submit your comments on the rule to CMS before the October 8th deadline. Feel free to use the AHA's comment letter as a guide; it will be available at the end of September at www.aha.org.

While the AHA is pleased with many aspects of the rule, the outpatient PPS continues to be underfunded, paying hospitals about 92 cents for every dollar providing outpatient care to Medicare beneficiaries. Together, we must convince CMS and Congress that inadequate payment rates and updates must be addressed to ensure continued access to outpatient services for Medicare beneficiaries.

Sincerely,

Rick Pollack
Executive Vice President

September 16, 2004



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Background

The Centers for Medicare & Medicaid Services (CMS) published in the August 16 *Federal Register* a proposed rule with changes to the calendar year (CY) 2005 outpatient prospective payment system (OPPS). This proposed rule includes statutory changes for 2005 that result from the Medicare Modernization Act (MMA) as well as policy changes, such as revisions to the Ambulatory Payment Classifications (APC) weights and rates; payments for drugs, devices and biologicals; and payments for outliers. A final rule, expected around November 1, will take effect January 1, 2005.

Go to <http://www.cms.hhs.gov/providers/hopps/2005p/1427p.asp> to view the proposed rule. Comments on the proposed changes are due to CMS by **October 8th**.

PPS Update to the Conversion Factor

The outpatient PPS rate update for 2005 is equal to the full rate of change in the hospital market basket – a measure of inflation in goods and services used by acute care hospitals. The hospital market basket increase forecast for fiscal year 2005 is 3.3 percent, as published in the inpatient PPS final rule.

In CY 2005, CMS estimates that pass-through spending on new drugs and devices will be only 0.13 percent (or \$30.8 million) of total projected OPPS payments for 2005 and so proposes to return the difference between 2004 and 2005 pass-through spending, 1.17 percent, to the conversion factor to fund all other APCs.

The proposed conversion factor for 2005, after accounting for the 3.3 percent hospital market basket increase, the 1.17 percent pass-through spending adjustment and a 1.001 budget neutrality adjustment due to wage index changes, is \$57.098 in 2005, up from \$54.561 in 2004.¹

Recalibration of the APC Weights

By law CMS is required to review and revise the relative payment weights for APCs at least annually. Since the August 2000 implementation of the OPPS, payment rates for specific APCs have fluctuated dramatically. For 2005, the proposed rates continue to show significant volatility. For 45 APCs, the 2005 weights would decrease by 10 percent or more; for 14 of these, the reduction is greater than 20 percent. In total, weights would be lower for 125 APCs. On the other hand, weights increase for 258 APCs, going up 10 percent or more for 59 of them.

¹ $\$54.561 \times 1.033$ [2005 market basket update] = $\$56.362 / (1 - 0.132)$ [2004 pass-through adjustment] = $\$57.115 \times (1 - 1.0013)$ [2005 pass-through adjustment] = 57.041×1.001 [budget neutrality adjustment] = $\$57.098$

The increase for 22 APCs is 30 percent or more.

There are several reasons for changes in payment rates, including:

Use of more recent cost reports and claims data. CMS proposes to use the most recent claims data for outpatient services, tapping into approximately 119 million final action claims for hospital outpatient department services furnished from January 1, 2003 through December 31, 2003. In addition, CMS uses more recent cost reports, from 2001 and 2002, and employs new procedures in calculating cost-to-charge ratios (CCRs), including trimming CCRs at the departmental level for the first time.

Use of more multiple procedure claims. Consistent with past AHA recommendations, CMS continues to include more claims data in calculating the APC payment rates, especially those that contain charges for more than one service or procedure. Increasing the number of multiple procedure claims used will help improve data quality in APC recalibration. CMS is proposing to use 93 percent of total claims to calculate the weights (up from the 82 percent of claims used for the 2004 OPSS).

Elimination of the “dampening rule.” In the past, CMS has used a “dampening” policy to minimize the impact of large reductions in the median costs that are used to calculate APC weights. For 2005, CMS does not propose a dampening policy for any service, but the proposed rule does include a provision to limit the reduction in median cost for device-dependent APCs (discussed below).

The AHA is concerned that the description of the methodology employed to calculate the APC weights does not provide adequate information for hospitals to use to evaluate the impact of each of the proposed policy changes independently or in combination. We will request that CMS provide additional data upon which hospitals can assess the impact of these important changes in methodology.

A spreadsheet comparing the changes in APC payment rates and weights from CY 2001–2005 is available for AHA members at http://www.aha.org/aha/members_only/member/040914APCweights01_05.html. Please note that you must first login to view the spreadsheet.

Transitional Pass-Through Payments

In 1999, Congress created temporary additional or “transitional pass-through payments” for certain innovative medical devices, drugs and biologicals to ensure that Medicare beneficiaries had access to new technologies in patient care. As described above, for 2005, CMS is projecting that pass-through payments will be 0.13 percent of total payments, or \$30.8 million. Because outpatient payments must be budget neutral, CMS proposes to return 1.17 percent – the difference between the 1.3 percent pass-through payments in 2004 and the 0.13 percent estimated for 2005 – to the conversion factor to fund all other APCs.

Payment for Medical Devices

Pass-Through Devices. By law, categories of devices are eligible for pass-through payments for between two and three years. Effective January 1, 2005, six device categories approved for new technology pass-through payments expire because they first received pass-through payment under OPSS between January 2002 and January 2003. The costs of these pass-through devices will be packaged into the APCs in which the devices are used.

In 2005, three device categories will continue to receive pass-through payments. Pass-through payments will be calculated based on hospital charges, converted to costs (according to a hospital-specific cost-to-charge ratio) less that portion of the APC rate already associated with the device. In some cases, the APCs may not contain any identifiable costs associated with the device. Thus, for 2005, CMS has set the offset for each of the three remaining device categories to \$0 since none of them is replacing a device whose costs have been packaged into the APCs.

Proposed Policies for Device-Dependent APCs in 2005. Since the inception of the OPSS, CMS has claimed that problems in the hospital billing data used to calculate the APC weights have complicated setting payments for device-dependent APCs. CMS used several policies in setting the payment rates for 2003 and 2004 to address these concerns including using only those claims that contained the C codes for devices, making limited use of external data, and applying a “dampening” policy to moderate payment reductions.

The 2003 claims data, used for 2005 rates, do not contain any C-code data on device use because CMS had eliminated device coding requirements for hospitals in 2003. For CY 2005, CMS examined and rejected, several alternatives to address the problem. Instead, CMS states that it is transitioning to the use of pure claims data for these services to ensure the appropriate relativity of the median costs for all payable OPSS services. Therefore, CMS is proposing to determine the median costs for device-dependent APCs in CY 2005 based on the greater of:

- median costs calculated using CY 2003 claims data; or
- 90 percent of the APC payment median in CY 2004 for such services.

Required Use of C Codes for Device-Dependent APCs. CMS also is proposing to *require* hospitals to bill selected device-dependent procedures using the appropriate device C codes. This differs from CMS’ policy in 2004, which provided for *voluntary* use of C codes. The required use of C codes will apply to 16 APCs for which CMS used 2004 payment medians to calculate median costs for 2005. Improperly coded claims will be returned to the hospital. While CMS believes that this approach will improve the quality of claims data for the purpose of setting future payment rates for device-dependent APCs, the agency recognizes that mandating the use of C codes imposes a burden on hospitals. It is considering gradually expanding the device coding requirements in the future so as to minimize the marginal annual coding burden on hospital, while at the same time begin to improve data for these “problematic” device-dependent APCs. CMS is soliciting comments on their proposed C-code requirement.

While the AHA agrees that setting appropriate payment rates for device-dependent APCs in the future will require improved claims data to accurately reflects device costs, we are concerned that the 60 days between publication of the final rule for the January 1, 2005 effective date, is not enough time for hospitals to change their systems and train coders on the new policy. In addition, we are concerned that the Medicare fiscal intermediaries (FIs) will not be able to incorporate the changes into their Outpatient Code Editor (OCE) and other systems within this timeframe. **Therefore, we will urge CMS to provide a grace period of 90 days from January 1, 2005 during which the use of C codes for these 16 device-dependent APCs will be voluntary for providers.**

A larger concern is CMS’ piecemeal expansion in device coding requirements – a confusing approach for providers and coders. **Therefore, the AHA will recommend that CMS begin to require the use of C codes for all APCs that utilize devices by CY 2006, with the proviso**

that adequate lead time be provided for hospitals and the FIs to train and change their systems. Further, because of compliance concerns related to the confusion around which C codes apply to which devices, **we will recommend that CMS work with the Food & Drug Administration (FDA) and device manufacturers to strongly encourage the placement of C codes on device packaging.**

Payment for Drugs, Biologicals, Radiopharmaceuticals and Blood

The MMA mandates a number of complex changes in the payment methodology for drugs, biologicals, radiopharmaceuticals and blood. These and other proposed policy changes for 2005 are described below.

Drugs and Biologicals Eligible for Transitional Pass-Through Payments. In the rule, CMS identifies 13 drugs whose pass-through status will expire on December 31, 2004. CMS proposes to package two of these 13 products into their appropriate APC because the drug's median cost per day falls below the \$50 packaging threshold. The remaining 11 drugs and biologicals were determined to be sole source items and will be paid separately according to the payment methodology for sole source products (described below).

CMS proposes to continue pass-through status in 2005 for 19 drugs and biologicals. According to the MMA, these pass-through drugs and biologicals will be paid at a rate equivalent to what they would receive in a physician office setting, as set out in the 2005 Physician Fee Schedule proposed rule. This rate is based on the average sales price (ASP) plus 6 percent.

Drugs, Biologicals and Radiopharmaceuticals Without Pass-Through Status. CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs).

- **Packaged Payment for Drugs, Biologicals and Radiopharmaceuticals.** For 2005, CMS proposes to continue its policy of paying separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds \$50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per day is less than \$50 into the procedures with which they are billed. This proposal is required by the MMA.
- **Separately Payable Drugs, Biologicals and Radiopharmaceuticals**
 - ◆ **Payment for “Specified Covered Outpatient Drugs”:** MMA provisions require special classification and payment of certain separately paid drugs, biologicals and radiopharmaceuticals which had previously (commencing on or before December 31, 2002) received pass-through payments. With certain limited exceptions (e.g. drugs without HCPCS codes and orphan drugs), the MMA sets payment limits for three categories of specified covered outpatient drugs – sole source drugs, innovator multiple source drugs, and noninnovator multiple source drugs.

Payment limits for these specified covered outpatient drugs are to be based on the reference average wholesale price (AWP) for the drug, biological or radiopharmaceutical as of May 1, 2003. CMS interprets this to mean the AWP set under the CMS single drug pricer (SDP) based on prices published in the Red Book on May 1, 2003. CMS proposes to determine the payment rates for specified covered outpatient drugs by comparing the payment amount calculated under the median cost methodology to the reference AWP.

- For *sole source* drugs, the payment rate may be no lower than 83 percent

- of the reference AWP, but no more than 95 percent of the reference AWP.
 - For *innovator multiple source* drugs, the payment rates may be no more than 68 percent of the reference AWP.
 - For *non-innovator multiple source* items, the payment rates may be no more than 46 percent of the reference AWP.
- ◆ Payment for New Drugs and Biologicals with HCPCS Codes and without Pass-Through Application and Reference AWP: The MMA does not address OPSS payment in 2005 for new drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. CMS proposes to pay for these new drugs and biologicals at a rate that is equivalent to the payment they would receive in the physician office setting, which will be established in accordance with the ASP plus 6 percent methodology described in the 2005 Physician Fee Schedule proposed rule. This is the same methodology that would be used to calculate payments for pass-through drugs and biologicals for 2005. CMS also proposes to assign status indicator “K” to HCPCS codes for new drugs and biologicals that have not received a pass-through application.
- ◆ Proposed Payment for Certain Other Separately Payable Non-Pass-Through Drugs and Biologicals: The MMA did not specify a payment methodology for separately payable drugs and biologicals that either: have been paid separately since implementation of the OPSS on August 1, 2000, but were not eligible for pass-through status; or, have historically been packaged with the procedure with which they are billed but, based on the CY 2003 claims data, their median cost per day is above the legislated \$50 packaging threshold. For 2005, CMS proposes to set payment based on median costs derived from the CY 2003 claims data. The proposed rule lists the 41 drugs and biologicals to which this proposed payment policy would apply.

Payment for New Drugs, Biologicals and Radiopharmaceuticals Prior to HCPCS Code Assignment. Effective January 1, 2004, a provision in the MMA required CMS to pay 95 percent of AWP for an outpatient drug or biological for which a HCPCS code has not been assigned. It was not until May 28, that CMS instructed hospitals to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code, C9399, Unclassified drug or biological. When C9399 appears on a claim, the OCE suspends the claim for manual pricing by the FI. The FI prices the claim at 95 percent of its AWP using Red Book and processes the claim for payment. In the rule, CMS is proposing to formalize this methodology for CY 2005 and to expand it to include payment for new radiopharmaceuticals to which a HCPCS code is not assigned.

While the AHA is pleased that this MMA provision now allows these new drugs to receive separate payment, we continue to be concerned about the ability of hospitals to correctly code using NDC codes. Many hospital billing systems are unable to report NDC codes. Currently only pharmacy systems designed to handle purchasing of drugs can properly handle the assignment of a drug’s NDC. Today NDCs are not typically used in hospital billing systems and

it is difficult and burdensome for hospitals to correctly link the drug given to a particular patient to the exact NDC code that the pharmacy obtained when it purchased the drug.

Payment for Orphan Drugs. For CY 2005, CMS is not proposing any changes to its list of

single indication orphan drugs. CMS proposes to pay for all 12 single indication orphan drugs at the rate of 88 percent of AWP or 106 percent of the ASP, whichever is higher. However, payments for these drugs would be capped at 95 percent of AWP, which is the upper limit allowed for other sole source specific covered outpatient drugs.

Payment Policy for Radiopharmaceuticals. Since January 1, 2003, CMS has not classified diagnostic or therapeutic radiopharmaceuticals as drugs or biologicals. Because the MMA specifically included radiopharmaceuticals as specified covered outpatient drugs, CMS has revisited this issue and now proposes to include radiopharmaceuticals in the general category of drugs. Therefore, in CY 2005, CMS proposes to apply to radiopharmaceuticals all the same payment policies that are applied to other drugs.

Coding and Payment for Drug Administration. Since implementation of the OPPS, Medicare OPSS payment for administration of cancer chemotherapy drugs and infusion of other drugs has been made using a series of HCPCS Q codes. For CY 2005, CMS proposes to instead use the CPT codes for drug administration but to crosswalk the CPT codes into APCs that reflect how the services would have been paid under the Q codes. Although hospitals would bill the CPT codes and include the charges for each CPT code on the claim, payment would be made on a per visit basis. CMS would use the cost data from the per visit Q codes (Q0081, Q0083 and Q0084) to set the payment rate for CY 2005. CMS notes that if it adopts the CPT codes for drug administration to ensure accurate payment in the future, it would be critical for hospitals to bill the charges for the packaged CPT codes for drug administration for CY 2005 (that is, the CPT codes with status indicator = N), even though there would be no separate payment for them in CY 2005. **The AHA is generally pleased with this proposal because it will simplify the reporting of drug administration, and hospitals already use these CPT codes to report drug administration to non-Medicare payers.**

Vaccines. CMS proposes to continue payment for influenza and pneumococcal pneumonia vaccines under a reasonable cost methodology for 2005.

Blood and Blood Products. CMS proposes several changes to its payment methodology for blood and blood products. First, the agency proposes to establish new APCs that would allow each blood product to be in its own separate APC as well as to reassign some of the HCPCS codes already contained in certain APCs to new APCs. Second, CMS proposes to set payment rates for all blood and blood products based on their CY 2003 claims data, utilizing an actual or simulated hospital blood-specific CCR to convert charges to costs for blood and blood products. For certain low-volume products, CMS would combine claims data for CYs 2002 and 2003. While this approach results in modest payment increases for many blood and blood product related APCs, payment rates for certain low-volume APCs will decline significantly under this methodology. **Therefore, the AHA will recommend that CMS freeze the reimbursement rates for low volume blood products at the 2004 levels. In addition, we agree with CMS regarding the need to clarify confusing billing and coding policies for blood-related services and strongly support the agency's intent to issue further billing guidelines soon.**

New Technology APCs

CMS proposes to reassign 25 procedures currently assigned to new technology APCs into clinically appropriate APCs, using CY 2003 claims data to determine median costs. Eighteen out of 25 procedures will migrate to APCs with lower payment, with about half receiving reductions of 20 percent or more.

Wage Index Changes for CY 2005

CMS proposes to use the final FY 2005 hospital inpatient wage index to calculate the payment rates and coinsurance amounts that they will publish in the final rule. The wage index in this proposed rule is based on the FY 2005 hospital inpatient PPS proposed rule wage index. These indices reflect proposed major changes for CY 2005 relating to hospital labor market areas as a result of Office of Management and Budget revised definitions of geographical statistical areas; implementation of an occupational mix adjustment as part of the wage index; hospital reclassifications and redesignations, including the one-time reclassifications under section 508 of the MMA and the wage index adjustment based on commuting patterns of hospital employees under section 505 of MMA. CMS proposes to adjust 60 percent of the APC payment by the wage index, as is currently done today.

Outlier Payment Pool and Policy Change

Outlier payments are additional payments to the APC amount to mitigate some of hospitals' losses when treating high-cost cases. The rule proposes to maintain the outlier pool at 2 percent of total OPSS payments (the same level as in 2004). Consistent with a change made last year, in 2005 CMS is proposing to continue to establish separate thresholds for community mental health centers (CMHC) and hospitals, thus of the 2 percent, 0.6 percent would be allocated to CMHCs for partial hospitalization program services.

Further, to address concerns from the Medicare Payment Advisory Committee (MedPAC) that a significant portion of outlier payments are made for high volume, lower cost services rather than for unusually high cost services, CMS proposes to add a new fixed dollar threshold that would have to be met in order for a service to qualify for an outlier payment. **In order to qualify for an outlier payment, CMS proposes that the cost of a service would have to be both more than 1.5 times the APC payment rate (down from the 2004 threshold of 2.6 times APC rate) and would have to be at least \$625 more than the APC rate.** When the cost of a hospital outpatient service exceeds these thresholds, the outlier payment would be 50 percent of the amount by which the cost of the service exceeds 1.5 times the APC payment rate.

While the AHA continues to evaluate the impact of CMS's revised outlier methodology, we support the continued need for an outlier policy in all prospective payment systems and support revisions that better target outlier payments to unusually high cost services.

Transitional Corridor "Hold Harmless" Payments

Consistent with the requirements of the MMA, transitional corridor "hold harmless" payments are extended, through December 31, 2005, for rural hospitals with 100 or fewer beds and to sole community hospitals located in rural areas. Cancer hospitals and children's hospitals are held harmless permanently under the transitional corridor provisions of the statute. Thus, in 2005, "hold harmless" payments are only available to children's hospitals, cancer hospitals, rural hospitals having 100 or fewer beds, and sole community hospitals located in rural areas. **The AHA remains concerned about the harm that will result from the December 31, 2005 sunset of the transitional corridor "hold harmless" payments for small rural hospitals and sole community hospitals located in rural areas. We believe that these protections are important for the continued viability of these vulnerable facilities and will work to extend these protections in the future.**

Evaluation and Management (E/M) Services

Since the implementation of OPSS, hospitals have coded clinic and ED visits using the same current procedural terminology code as physicians. CMS has recognized that existing E/M codes correspond to different levels of physician effort but fail to adequately describe non-physician resources. Although hospitals were anticipating that CMS would propose a national, uniform E/M coding system in 2003, the agency chose not to do so. As a result, the AHA and the American Health Information Management Association (AHIMA) convened an independent panel of experts to develop a set of coding guidelines that were submitted to CMS more than a year ago.

The AHA believes that the E/M coding recommendations from the AHA-AHIMA expert panel will meet hospitals' needs and should be adopted by CMS. And, while we support CMS' proposal to give providers the time necessary to review and implement new provisions, we are concerned about the continued absence of a standard system or guidelines for application to hospital outpatient E/M services. The AHA will continue to urge CMS to issue guidance to address this concern.

Observation Services

Currently, Medicare provides a separate observation care payment for patients with congestive heart failure, chest pain and asthma. Consistent with recommendations from the Advisory Panel on APC Groups, CMS has proposed to simplify how it pays for observation services. **The AHA supports these proposed changes as they will result in a simpler and more reasonable process for providing necessary outpatient observation services.**

CMS proposed changes include eliminating current requirements to provide specific diagnostic tests and instead rely on clinical judgment in combination with internal and external quality review processes to ensure appropriate diagnostic testing is provided for patients in observation.

CMS also proposes modifying instructions to indicate that observation time ends when the patient is discharged from the hospital or admitted as an inpatient (Current policy is that observation time ends when physician writes order for discharge.)

CMS is predicting increased volume of services for APC 339 Observation in CY 2005 as a result of the proposed simplification and reduction in requirements.

Inpatient-Only Procedures

In the rule, CMS dismisses recommendations from the AHA and the Advisory Panel on APC Groups to eliminate its inpatient-only procedure list, a list that identifies services that are unable to receive payment if they are performed in an outpatient setting. Instead, CMS proposes to remove 22 codes from the "inpatient only" list and assign them to clinically appropriate APCs. **The AHA continues to believe this list should be eliminated, as physicians, not hospitals, determine what procedures should be performed, as well as whether a patient's condition warrants an inpatient admission.**

Preventive Services

The MMA authorized Medicare to pay for a "Welcome to Medicare Physical" for new beneficiaries. CMS proposes to establish a new HCPCS code, GXXXX that will be used by hospitals and physicians to bill for this service. When this service is performed in a hospital outpatient department, this code will be assigned to the new technology APC 1539 that has

payment level of \$75.

In addition to the new physical, the proposed rule would increase payment rates to hospitals for other screening examinations that are already covered by Medicare. The proposed rule also includes a significant increase in the payment rate for mammograms. It would implement a provision of the MMA that requires diagnostic mammograms to be removed from payment under the OPSS and paid, like screening mammograms, under the physician fee schedule.

Beneficiary Coinsurance

The proposed rule would decrease beneficiary liability for coinsurance for outpatient services. As required by law, the rule proposes to reduce the maximum coinsurance rate in 2005 for any service to 45 percent of the total payment to the hospital for that service, down from 50 percent in 2004. Overall, the average coinsurance rate would drop from 34 percent in 2004 to 32 percent in 2005. Under Medicare law, the cap on coinsurance rates is to be reduced gradually until all services have a coinsurance rate of 20 percent of the total payment.

Financial Impact on Hospitals

CMS estimates that implementing the rule's changes will result in the following per-case change in payment from 2004 to 2005 – excluding the impact of changes to outlier and transitional pass-through payments:

All Hospitals	4.6%
Urban Hospitals	4.5 %
Large Urban	4.5 %
Other Urban	4.5 %
Rural	5.3 %

Comments

The AHA will submit a comment letter to CMS on the proposed changes in the 2005 outpatient PPS rule and urge you to do the same. A sample letter will be posted soon at www.aha.org that may help as you prepare your comments. All comments are due to CMS by **October 8, 2004**. Mail written comments (an original and two copies) to the following address:

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