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**United States General Accounting Office**
**Washington, DC 20548**

October 6, 2003

The Honorable Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

Subject: *Medicare: Discrepancy in Hospital Outpatient Prospective Payment System Methodology Leads to Inaccurate Beneficiary Copayments and Medicare Payments*

Dear Mr. Scully:

Under the Medicare hospital outpatient prospective payment system (OPPS), beneficiaries can be responsible for paying 50 percent or more of the total payment for outpatient services they receive in hospitals. The Balanced Budget Act of 1997 (BBA)[1] introduced a mechanism to gradually decrease beneficiary cost sharing to 20 percent of the payment rate for each hospital outpatient service.[2] The Centers for Medicare & Medicaid Services (CMS) published a final rule that implemented, effective with the 2002 payment rates, a methodology for calculating copayment amounts that was designed to ensure that even as certain changes affect the payment rates for hospital outpatient services over time, beneficiary coinsurance[3] for services would eventually be 20 percent of the total payment rate for each service.[4] Under this 2002 methodology, the copayment amount for each outpatient payment group of services, called an ambulatory payment classification (APC) group, could not increase from year to year, and the beneficiary coinsurance percentage would remain the same or decrease, eventually reaching 20 percent for each APC.[5]

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[1] Pub. L. No 105-33, § 4523(a), 111 Stat. 251, 445.

[2] Beneficiary cost sharing will decline to 20 percent at a different time for each outpatient service depending on the service's initial cost-sharing percentage. In 2000, the Medicare Payment Advisory Commission estimated that achieving a 20 percent cost-sharing rate for services will take an average of 30 to 40 years.

[3] We use the term "coinsurance" to refer to the percentage of the Medicare payment amount that beneficiaries are responsible for paying for a service under the OPPS. We use the term "copayment" to refer to the dollar amount that beneficiaries are responsible for paying for a service under the OPPS.

[4] 66 *Fed. Reg*. 59,856, 59,888 (2001).

[5] Under the OPPS, outpatient services with clinical and resource use similarities are grouped into APCs for payment purposes. Each service within an APC is paid at the same rate. The total payment rate for an APC is composed of two parts: an amount that the beneficiary is responsible for paying and an amount that Medicare is responsible for paying. As the beneficiary coinsurance proportion declines to 20 percent, the proportion that

When CMS published the final rule updating the OPPS payment rates for 2003, the agency stated that it used the methodology implemented in 2002 for determining 2003 copayments.[6] However, in the course of other ongoing work, we found several APCs for which copayment amounts increased from 2002 to 2003, contrary to the methodology implemented in 2002.[7] For a federal agency to adopt a new position or payment methodology that is inconsistent with existing rules and regulations, it must follow Administrative Procedure Act rulemaking requirements, which generally include publishing its intentions and allowing for public comment.[8] Because of our concerns about this methodological discrepancy, we discussed the issue with CMS staff in May 2003. Thereafter, in its August 2003 proposed rule setting forth the 2004 OPPS payment rates, CMS stated that it would revise and clarify the copayment methodology implemented in 2002, and that this revised methodology would be used to calculate copayment amounts beginning in 2004.[9]

In this report, we present our complete analysis of the 2003 copayment methodology and the implications its use holds for copayment amounts in 2003 and future years. We also present the estimated financial impact this methodology has had on both beneficiary cost sharing and Medicare payments in 2003.

To estimate the impact of the 2003 copayment methodology on beneficiary cost-sharing obligations, we used 2001 Medicare outpatient claims data[10] together with the 569 APC groups in 2003 and the 2003 payment rates. We calculated the 2003 copayment amount for each of the APCs according to the 2002 methodology and calculated the difference between that amount and the amount published in the 2003 OPPS final rule. We compiled a list of the differences, multiplied the difference by the respective service volume for each APC from the 2001 claims, and then summed them across all affected APCs to estimate the total amount of inaccurate copayments. See Enclosure I for more details on our methodology. We performed our work in accordance with generally accepted government auditing standards from May through October 2003.

In summary, we found that use of a copayment methodology in 2003 that differed from the copayment methodology in 2002 has resulted in inaccurate 2003 copayment

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Medicare is responsible for will increase. Once the coinsurance percentage is 20 percent of the payment rate, the copayment amount will increase to maintain the 20 percent coinsurance rate if the payment rate increases.

[6] 67 *Fed. Reg*. 66,718, 66,788 (2002).

[7] In this report we will refer to the methodology CMS implemented for 2002 as the 2002 copayment methodology. We will refer to the methodology used for 2003, but not implemented through the rulemaking process, as the 2003 copayment methodology.

[8] See, e.g., *Shalala v. Guernsey Memorial Hosp*., 514 U.S. 87, 100 (1995).

[9] 68 *Fed. Reg*. 47,966, 48,006-07 (2003).

[10] The 2001 Medicare outpatient claims contain all outpatient claims for services furnished on or after April 1, 2001 and on or before March 31, 2002.

amounts for 75 APCs.[11] For 28 APCs, this methodology has resulted in beneficiaries being responsible for higher copayments than they would have been under the 2002 methodology. For 47 APCs, beneficiaries are responsible for lower copayments, and, therefore, Medicare is making higher payments than it would have under the 2002 methodology. Moreover, under this methodology, copayment amounts for some APCs may never decline to 20 percent of the APC payment rate. Although CMS is proposing to revise the copayment methodology for 2004, the agency did not recalculate the 2003 copayment amounts using the 2002 methodology before using them as the basis for calculating the 2004 copayment amounts. Thus, certain proposed 2004 copayment amounts are higher and others are lower than they would have been if CMS had used the 2002 methodology in 2003. In addition, the time it will take for the copayment amounts for some of these APCs to reach 20 percent of the APC payment rate will increase. We estimate that in 2003 the methodology used by CMS will result in about $414 million in inaccurate copayments, with a net of $192 million in Medicare program overpayments. Specifically, we estimate beneficiaries will be overcharged by approximately $111 million for certain services, and Medicare will overpay by approximately $303 million for other services.

We recommend that, for the purpose of calculating the 2004 OPPS beneficiary copayment amounts, the Administrator of CMS first apply the 2002 copayment methodology to the 2003 APCs for which beneficiaries were inaccurately charged. The 2004 copayment amounts should then be based on these revised 2003 copayment amounts. In written comments on a draft of this report, CMS stated that it would take the information we provided into consideration as part of issuing its 2004 final rule.

## Background

The initial OPPS payment rates that went into effect August 1, 2000 were based on hospitals' median costs in 1996. The initial copayment amounts were based on hospitals' median charges for the same year, but were to be no lower than 20 percent of the payment rate for each APC. Because hospitals' median charges usually exceeded hospitals' median costs, the copayments for most APCs were set at levels well above 20 percent of the payment rate.

BBA provides the methodology by which copayment amounts were to be initially determined and specifies that a copayment amount for an APC would be held constant as the payment rate increases for that APC with the annual inflation adjustment until the copayment amount declines to 20 percent of the payment rate. However, BBA does not specify how copayments are to be determined when CMS reviews and revises the APCs, as it is required to do at least annually in accordance with section 1833(t)(9)(A) of the Social Security Act.[12] CMS takes into account changes in medical practice and technology and the addition of new services, cost

[11] Enclosure II contains a list of these APCs.

[12] 42 U.S.C. § 1395l(t)(9) (2000).

data, and other relevant information and makes revisions in the services assigned to a particular APC, known as reclassification, and in the relative payment weight for an APC, known as recalibration. Thus, although the payment rates are annually adjusted upward for inflation, an APC's payment rate could either increase or decrease from one year to the next because of reclassification and recalibration or recalibration alone.

In the final rule that established the 2002 OPPS rates, CMS set forth a methodology for calculating copayments that was designed to take reclassification and recalibration changes into account and ensure that the copayment amount for a particular APC would not increase from one year to the next due to these changes, until it represented 20 percent of the total payment rate. CMS stated that if an APC's payment rate increased, the copayment dollar amount would remain the same, causing the coinsurance percentage to decrease. If an APC's payment rate decreased, the coinsurance percentage for the APC would remain the same, causing the copayment amount to decrease. If two or more APCs were combined to make a new APC, the lowest of the contributing APCs' coinsurance percentages would apply to the new APC.[13] According to the 2002 copayment methodology, the transfer of a service from one APC to another is not considered the creation of a new APC. The proposed 2004 copayment methodology confirms this position.[14]

**Change in 2003 Copayment Methodology Affects Beneficiary Copayment Amounts in 2003 and Future Years**

In the final rule that established the 2003 payment rates, CMS stated that it calculated the copayment amounts using the 2002 methodology.[15] However, when the 2003 copayment amounts were calculated in that final rule, CMS made unexplained modifications that were inconsistent with its rules. As a result, the 2003 copayment amounts for 28 APCs increased compared to the 2002 amounts, and the copayment amounts for 47 other APCs decreased more than they would have using the 2002 methodology. In addition, under the 2003 methodology, copayment amounts for some APCs may not have eventually declined to 20 percent of the APC payment rate. Finally, certain proposed 2004 copayment amounts are higher and others are lower than they would have been if CMS had consistently applied the 2002 methodology in 2003.

The fundamental difference between the 2002 and 2003 methodologies was that, according to CMS documentation, for 2003, CMS deemed any APC that had one or more services added to it to be a "new" APC. In 2002, an APC was not considered to

[13] 66 *Fed. Reg.* 59,856, 59,888 (2001).

[14] 68 *Fed. Reg.* 47,966, 48,006 (2003).

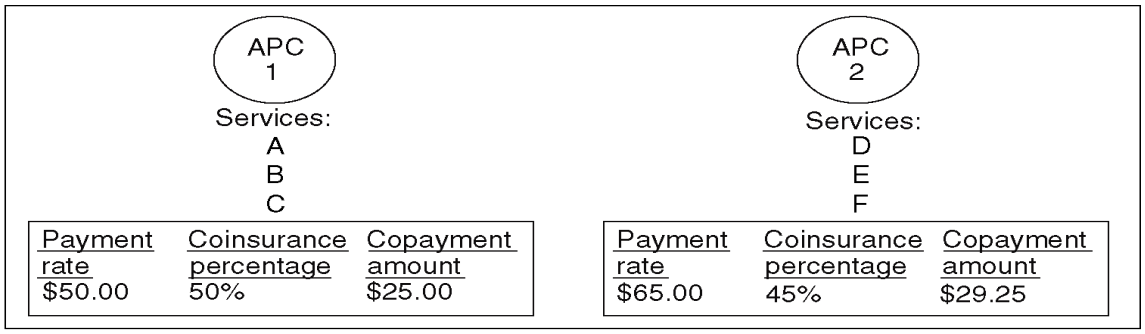
[15] 67 *Fed. Reg.* 66,718, 66,788 (2002).

be new if it had services added to it.[16] Under the 2002 methodology, CMS calculated the copayment amount of an APC containing reclassified services, referred to as a "revised" APC, from its own copayment amount or coinsurance percentage from the previous year depending on whether the payment rate increased or decreased. Under the 2003 methodology, CMS calculated the copayment amount of an APC containing reclassified services by adopting the lowest coinsurance percentage from the previous year of any APC that contributed a service to that APC. This change, when coupled with payment changes, led the copayment amounts for some APCs to inaccurately increase or decrease between 2002 and 2003. In order to illustrate how the methodology used in 2003 affected copayment amounts, we present two simplified hypothetical examples below.

Example 1: Demonstration of How the 2003 CMS Copayment Methodology Led to Inaccurately High 2003 Beneficiary Copayment Amounts

In 2002, hypothetical APC 1 had a payment rate of $50.00, a coinsurance percentage of 50 percent, a copayment amount of $25.00, and included services A, B, and C (see fig. 1). Hypothetical APC 2 had a payment rate of $65.00, a coinsurance percentage of 45 percent, a copayment amount of $29.25, and included services D, E, and F.

**Figure 1: Hypothetical APCs in 2002**

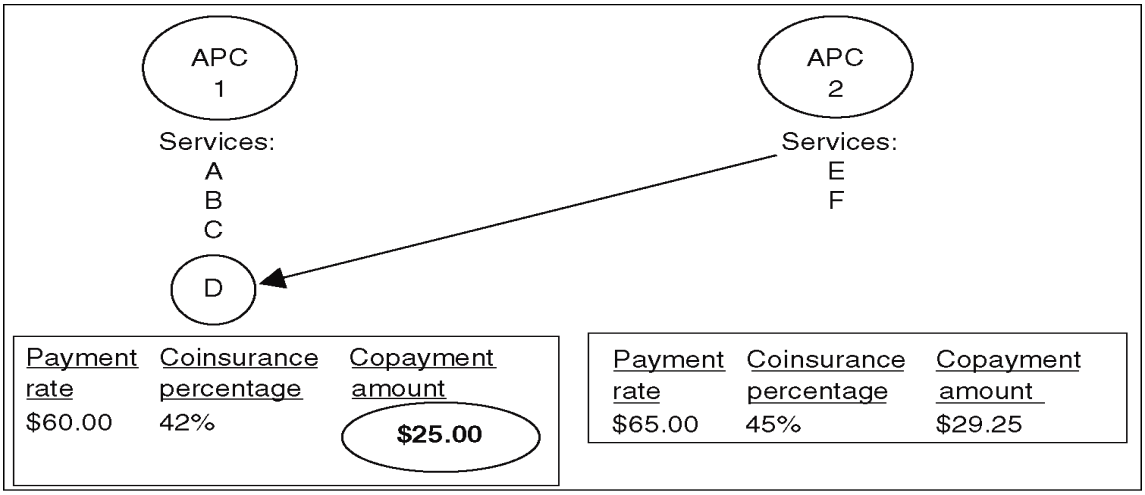



Source: GAO.

For 2003, service D was reclassified to APC 1, and the payment rate of APC 1 increased to $60.00 through recalibration and application of the annual inflation adjustment (see fig. 2). Applying the 2002 methodology, the 2003 copayment amount should have remained $25.00 because this APC was not considered new, and the 2003 coinsurance percentage should have decreased to 42 percent.

[16] According to the 2002 methodology, a new APC would be one that is either composed of new outpatient services or is created from some or all of the services from two or more existing APCs. (66 *Fed. Reg.* 59,856, 59,888 (2001).)

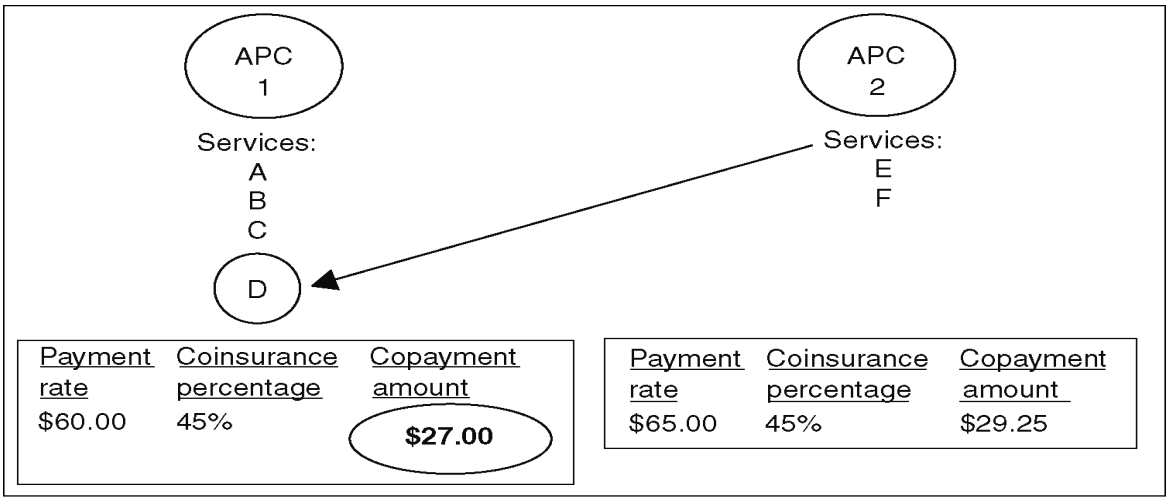
**Figure 2: Update to the Copayment Amount for a Hypothetical APC with a Payment Rate Increase for 2003 If the 2002 Methodology Had Been Used**




Source: GAO.

However, because service D was reclassified to APC 1, CMS would have considered it a new APC under the 2003 methodology. Therefore, the 2003 coinsurance percentage for APC 1 would have been 45 percent, the lowest 2002 coinsurance percentage of all APCs contributing services to it, in this case, APC 1 and APC 2 (see fig. 3). However, the payment rate for APC 1 increased enough so that 45 percent of $60.00 ($27.00) is higher than the $25.00 the copayment should have been.

**Figure 3: Update to the Copayment Amount for a Hypothetical APC with a Payment Rate Increase for 2003 Using the 2003 Methodology**

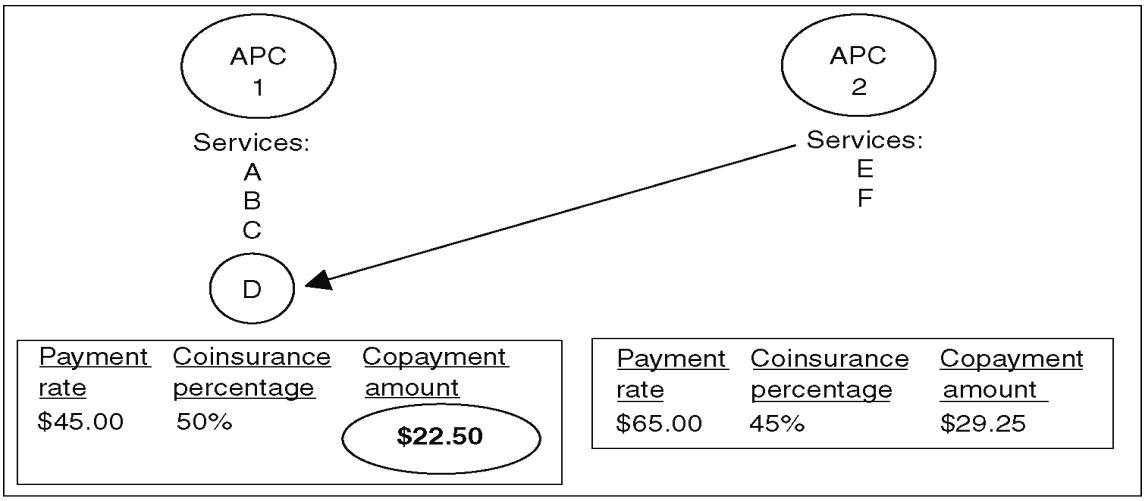



Source: GAO.

Example 2: Demonstration of How the 2003 CMS Copayment Methodology Led to Inaccurately Low 2003 Beneficiary Copayment Amounts

This example uses the same hypothetical APC 1 and APC 2 as presented in figure 1. For 2003, service D was again reclassified to APC 1; however, in this example, the payment rate of APC 1 decreased to $45.00 in 2003 (see fig. 4). Applying the 2002 methodology, the 2003 coinsurance percentage of APC 1 should have remained 50 percent, because this APC was not considered new, and the 2003 copayment amount should have decreased to $22.50.

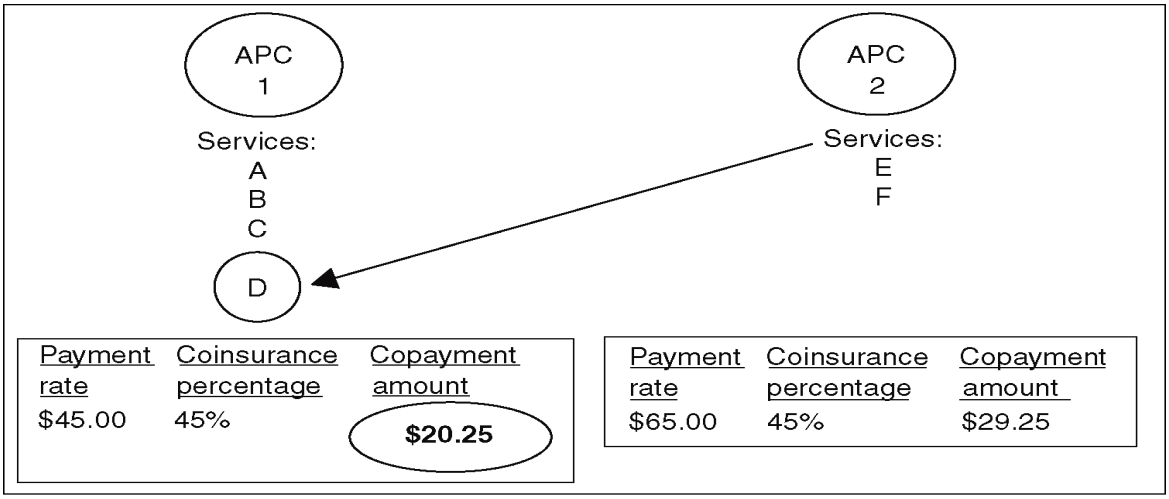
**Figure 4: Update to the Copayment Amount for a Hypothetical APC with a Payment Rate Decrease for 2003 If the 2002 Methodology Had Been Used**




Source: GAO.

However, under the 2003 methodology, CMS would have considered APC 1 a new APC. Because the 2002 coinsurance percentage of APC 2 (45 percent) was lower than the 2002 coinsurance percentage of APC 1 (50 percent), CMS would have used 45 percent to calculate the copayment amount for APC 1 (see fig. 5). In this example, because the payment rate for APC 1 decreased, the lower coinsurance percentage in conjunction with a lower payment rate would have resulted in a copayment amount of $20.25, instead of the $22.50 calculated using the 2002 methodology.

**Figure 5: Update to the Copayment Amount for a Hypothetical APC with a Payment Rate Decrease for 2003 Using the 2003 Methodology**




Source: GAO.

In the proposed rule updating the OPPS payment rates for 2004, CMS stated that, effective with the 2004 payment rates, it would revise and clarify the copayment methodology. Our review of the proposed methodology indicates that it would be consistent with the statute because it would not allow copayment amounts to increase from year to year, and they would eventually decline to 20 percent of the APC payment rate. However, CMS did not recalculate the 2003 copayment amounts using the 2002 methodology before using them as the basis for calculating the 2004 copayment amounts. Thus, certain 2004 copayment amounts are higher, and others are lower, than they would have been if CMS had consistently applied the 2002 methodology, and the time it will take for the copayment amounts for some of these APCs to reach 20 percent of the APC payment rate will increase.

## 2003 Copayment Methodology Results in Inaccurate Beneficiary Copayments and Medicare Payments

We estimate that in 2003, the copayment methodology used by CMS will result in about $414 million in inaccurate copayments, with a net of $192 million in Medicare program overpayments. More specifically, we estimate that beneficiaries will be overcharged by approximately $111 million for certain services. Beneficiaries will be undercharged for other services, and therefore we estimate that Medicare will overpay by approximately $303 million for these other services. The exact amounts will depend on the actual number of services provided in the affected APCs in 2003.

For some APCs, the beneficiary is being overcharged. APC 0291, Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans, is an example of an APC for which the beneficiary is responsible for paying a higher copayment as a result of the 2003 copayment methodology. We determined that the 2003 copayment for this APC is more than $14 higher than it would have been had the 2002 methodology been used. Multiplying that amount by the total number of 2001 claims for this APC results in an

estimated $1.7 million in beneficiary overcharges for 2003. For the APCs for which beneficiaries were overcharged, we estimate that the sum of those overcharges is approximately $111 million.

For the majority of the miscalculated APCs, however, Medicare is overpaying. For example, for APC 0110, Transfusion, we determined that the 2003 copayment amount for this APC was $46 lower than it would have been had the 2002 methodology been used and, therefore, the Medicare payment portion was that much higher. Multiplying that amount by the total number of 2001 claims for this APC results in an estimated $15.2 million in Medicare overpayments for 2003. Summing the Medicare overpayments of all APCs for which beneficiaries were undercharged results in an estimated total of approximately $303 million.

## Conclusions

The methodology that CMS used to calculate beneficiary copayment amounts in 2003 is inconsistent with (1) the methodology published by CMS in its final rule setting forth the 2002 OPPS payment rates and (2) the statutory objective of steadily decreasing all copayment amounts until they are 20 percent of the total payment rate for each service.

Though CMS has proposed clarifications to its methodology for 2004, there are reasons for concern. First, some beneficiaries continue to be inaccurately charged and Medicare continues to overpay for certain outpatient hospital services delivered in 2003. In addition, although CMS has proposed a methodology for 2004 and later years that would not increase copayment amounts for an APC from one year to the next and that would eventually decrease copayment amounts to 20 percent of the payment rate, CMS would be using the miscalculated 2003 copayment amounts as the basis for these and future copayment amounts. Finally, the time it will take for the copayment amounts for certain APCs to reach 20 percent of the APC payment rate will increase.

## Recommendations for Executive Action

For the purpose of calculating the 2004 OPPS beneficiary copayment amounts, we recommend that the Administrator of CMS first apply the 2002 copayment methodology to the 2003 APCs for which beneficiaries were inaccurately charged. The 2004 copayment amounts should then be based on these revised 2003 copayment amounts.

## Agency Comments

In written comments on a draft of this report, CMS stated that in 2003 it treated reconfigured APCs as if they were new APCs. CMS also stated that in the 2004 OPPS proposed rule, it proposed to change the method of copayment calculation to treat reconfigured APCs in the same manner as recalibrated APCs, consistent with the methodology that we stated should have been used in 2003. However, CMS noted

that it did not propose to recalculate the 2003 copayments, which must be used in part as the basis for the calculation of the 2004 OPPS copayments. In its comments, CMS stated that it would carefully consider the information we provided to it as part of issuing its final rule.

CMS's comments about its methodology are generally consistent with the information in our draft report. We believe that CMS should apply the 2002 copayment methodology to the 2003 copayment amounts before calculating the 2004 copayment amounts to ensure that they are accurate. CMS's comments appear in Enclosure III.

We are sending copies of this report to interested congressional committees. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have questions, please contact me at (202) 512-7119. Another contact and key contributors to this report appear in Enclosure IV.

Sincerely yours,

A. Bruce Steinwald
Director, Heath Care—Economic
and Payment Issues

Enclosures—4

## Scope and Methodology

We obtained the 2001 Medicare outpatient prospective payment system (OPPS) claims data, the latest data available, directly from the Centers for Medicare & Medicaid Services (CMS).[17] We used these claims data together with the 569 ambulatory payment classification (APC) groups in 2003 and the published 2003 OPPS copayment amounts to estimate the impact of the 2003 copayment methodology on copayment amounts. We calculated the 2003 copayment amount for each of the APCs using the 2002 methodology and calculated the difference between that amount and the published 2003 copayment amount. The copayment amounts we analyzed were those published in the final rules setting both the 2002 and 2003 payment rates. We did not take wage index adjustments into account, and thus our estimates are based on national APC payment rates.

We determined that 75 APCs had inaccurate copayment amounts in 2003; however, 6 of these 75 APCs are not included in our financial impact estimate because, while they existed in 2002, they did not exist in 2001 and were not in the 2001 Medicare claims data. We multiplied the difference between the two 2003 copayment amounts by the frequency of each APC in the 2001 Medicare hospital outpatient claims data and summed the beneficiary overcharges for the affected APCs. We then summed the beneficiary undercharges (Medicare overpayments) for the other affected APCs. We applied the CMS rule that payment rates and copayment amounts for certain APCs are discounted by a factor of 50 percent when these services are performed more than once or with certain other procedures during a single operative session by using the discounted rates as appropriate in our analysis when these APCs appeared in the claims data.

[17] The 2001 outpatient claims data file contains all final action outpatient claims for services furnished on or after April 1, 2001 and on or before March 31, 2002. As it is the file that CMS used to set the 2003 OPPS payment rates, we consider it reliable for the purpose of our estimate, which is to count the frequency with which outpatient services were performed.

## List of APCs for Which Beneficiaries Are Overcharged or Medicare Overpays for 2003 Services

**Table 1: List of APCs for Which Beneficiaries Are Overcharged for 2003 Services**

| APC | Title |
|---|---|
| 0010 | Level I Destruction of Lesion |
| 0012 | Level I Debridement & Destruction |
| 0022 | Level IV Excision/Biopsy |
| 0025 | Level II Skin Repair |
| 0035 | Placement of Arterial or Central Venous Catheter |
| 0148 | Level I Anal/Rectal Procedure |
| 0155 | Level II Anal/Rectal Procedure |
| 0156 | Level II Urinary and Anal Procedures |
| 0164 | Level I Urinary and Anal Procedures |
| 0192 | Level IV Female Reproductive Procedures |
| 0214 | Electroencephalogram |
| 0216 | Level III Nerve and Muscle Tests |
| 0230 | Level I Eye Tests & Treatments |
| 0231 | Level III Eye Tests & Treatments |
| 0232 | Level I Anterior Segment Eye Procedures |
| 0234 | Level III Anterior Segment Eye Procedures |
| 0247 | Laser Eye Procedures Except Retinal |
| 0248 | Laser Retinal Procedures |
| 0254 | Level IV ENT Procedures |
| 0260 | Level I Plain Film Except Teeth |
| 0265 | Level I Diagnostic Ultrasound Except Vascular |
| 0266 | Level II Diagnostic Ultrasound Except Vascular |
| 0286 | Myocardial Scans |
| 0290 | Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans |
| 0291 | Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans |
| 0343 | Level II Pathology |
| 0344 | Level III Pathology |
| 0360 | Level I Alimentary Tests |

Source: CMS.

Note: GAO analysis of 2003 OPPS copayment rates and 2002 OPPS final rule.

**Table 2: List of APCs for Which Medicare Overpays for 2003 Services**

| APC | Title |
|---|---|
| 0002 | Fine Needle Biopsy/Aspiration |
| 0003 | Bone Marrow Biopsy/Aspiration |
| 0006 | Level I Incision & Drainage |
| 0015 | Level III Debridement & Destruction |
| 0021 | Level III Excision/Biopsy |
| 0041 | Level I Arthroscopy |
| 0045 | Bone/Joint Manipulation Under Anesthesia |
| 0049 | Level I Musculoskeletal Procedures Except Hand and Foot |
| 0050 | Level II Musculoskeletal Procedures Except Hand and Foot |
| 0051 | Level III Musculoskeletal Procedures Except Hand and Foot |
| 0052 | Level IV Musculoskeletal Procedures Except Hand and Foot |
| 0054 | Level II Hand Musculoskeletal Procedures |
| 0058 | Level I Strapping and Cast Application |
| 0070 | Thoracentesis/Lavage Procedures |
| 0072 | Level II Endoscopy Upper Airway |
| 0081 | Non-coronary Angioplasty or Atherectomy |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty |
| 0084 | Level I Electrophysiologic Evaluation |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator |
| 0099 | Electrocardiograms |
| 0110 | Transfusion |
| 0113 | Excision Lymphatic System |
| 0114 | Thyroid/Lymphadenectomy Procedures |
| 0115 | Cannula/Access Device Procedures |
| 0141 | Upper GI Procedures |
| 0147 | Level II Sigmoidoscopy |
| 0153 | Peritoneal and Abdominal Procedures |
| 0162 | Level III Cystourethroscopy and other Genitourinary Procedures |
| 0163 | Level IV Cystourethroscopy and other Genitourinary Procedures |
| 0182 | Insertion of Penile Prosthesis |
| 0183 | Testes/Epididymis Procedures |
| 0218 | Level II Nerve and Muscle Tests |
| 0220 | Level I Nerve Procedures |
| 0251 | Level I ENT Procedures |
| 0253 | Level III ENT Procedures |
| 0256 | Level V ENT Procedures |
| 0261 | Level II Plain Film Except Teeth Including Bone Density Measurement |
| 0263 | Level I Miscellaneous Radiology Procedures |
| 0264 | Level II Miscellaneous Radiology Procedures |
| 0288 | Bone Density: Axial Skeleton |
| 0292 | Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans |
| 0300 | Level I Radiation Therapy |
| 0340 | Minor Ancillary Procedures |
| 0345 | Level I Transfusion Laboratory Procedures |
| 0346 | Level II Transfusion Laboratory Procedures |
| 0368 | Level II Pulmonary Tests |
| 0689 | Electronic Analysis of Cardioverter-defibrillators |

Source: CMS.

Note: GAO analysis of 2003 OPPS copayment rates and 2002 OPPS final rule.

Enclosure III

## Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Service

*Administrator*
Washington, DC 20201

**DATE:** OCT - 3 2003

**TO:** A. Bruce Steinwald
Director, Health Care—Economic
and Payment Issues

**FROM:** Thomas A. Scully
Administrator

**SUBJECT:** GAO Draft Correspondence, *MEDICARE: Discrepancy in Hospital Outpatient Prospective Payment System Methodology Leads to Inaccurate Beneficiary Copayments and Medicare Payments*, (GAO-04-103R)

We appreciate the opportunity to review and comment on the above-referenced draft correspondence and its findings.

Your letter raises the issue of how the Centers for Medicare & Medicaid Services (CMS) should calculate the beneficiary copayment under the hospital outpatient prospective payment system (OPPS) for groups of services called ambulatory payment classification (APCs) that contain new Healthcare Common Procedure Coding System (HCPCS) not previously assigned to that APC. While you approve of the methodology we are proposing to use in the 2004 OPPS, you believe that we should revisit the copayments in the 2003 OPPS, before using them as the basis for the 2004 copayment calculation.

In enacting the OPPS, Congress sought, among other things, to change how beneficiary copayments had been calculated under the prior cost-based methodology. Because copayments were tied to 20 percent of the hospital's charges, and because hospital charges rose faster than Medicare payments, beneficiaries were paying as much as 50 percent or more of the total payments to the hospital for outpatient services.

Under the OPPS, Congress established a statutory formula to cap beneficiary copayments and gradually lower beneficiary coinsurance to 20 percent of the payment for the APC.

On August 12, 2003, CMS issued a proposed rule that proposed payment rates and beneficiary copayment amounts for hospital outpatient services under the OPPS for 2004. These changes would be applicable to services furnished on or after January 1, 2004. The proposed rule went on display on August 9, 2003 and the public comment period ends on Monday October 6, 2003. (See August 12, 2003 Federal Register 42 CFR Parts 410 and 419).

Enclosure III

Page 2 – A. Bruce Steinwald

The specific issue raised by the General Accounting Office (GAO) deals with how to determine the copayment for an APC that contains HCPCS codes not previously assigned to that APC.

In a November 30, 2001 final rule, we adopted a methodology that applied five rules for calculating APC copayment amounts when payments for APC groups change because the APCs' relative weights are recalibrated or when individual services are reclassified from one APC group to another. In calculating the unadjusted copayment amounts for 2004, we encountered circumstances that the methodology in the November 30, 2001, final rule either did not address or whose applicability was ambiguous. For example, two rules refer to payment rate changes resulting from the recalibration of relative payment weights but do not clearly apply to payment rate changes resulting from the reclassification of HCPCS codes from one APC group to another APC group. Therefore, we proposed to revise and clarify the methodology we would follow to calculate unadjusted copayment amounts.

For the 2003 OPPS, we treated reconfigured APCs as if they were new APCs, while GAO contends that we should have treated them as if they were recalibrated APCs. In the 2004 OPPS proposed rule, we proposed to change the method of copayment calculation to treat reconfigured APCs in the same manner as recalibrated APCs, consistent with the methodology GAO indicates should have been used in 2003. However in the proposed rule, we did not propose to recalculate the 2003 copayments, which must be used in part as the base for the calculation of the 2004 OPPS copayments. The GAO is suggesting that we both revise our methodology as we proposed and also set the 2004 OPPS copayments as if we had determined the 2003 copayments under the 2004 proposal.

Under the Administrative Procedure Act, we are required to carefully consider the information GAO and all interested parties provided to CMS during the open comment period and will take them into consideration as part of issuing a final rule. At this time, it would be inappropriate to prejudge the issue while the comment period is still open and in the absence of careful review of all public comments that may be submitted in response to the NPRM.

## GAO Contact and Staff Acknowledgments

### GAO Contact

Nancy A. Edwards, (202) 512-3340

### Acknowledgments

Beth Cameron Feldpush, Joanna L. Hiatt, Maria Martino, and Jonathan Sclarsic made major contributions to this report.

(290326)

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