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# Congress of the United States

## House of Representatives

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July 27, 2001

The Honorable Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services  
Hubert Humphrey Building, Room 314-G  
200 Independence Avenue S.W.  
Washington, D.C. 20201

Dear Mr. Scully,

We are writing to you to express our concerns about pass-through payments for drugs, biologicals and devices under the Medicare outpatient prospective payment system (OPD PPS). As you know, the Balanced Budget Refinement Act (BBRA) of 1999 created these payments as a transitional mechanism to ensure beneficiary access to new technologies. Congress also included a provision for outlier payments in the OPD PPS because it was unclear and uncertain the 1996 data used for the development of the PPS was adequately reflected in the payment rates for the costs for drugs and technology. Although the overall amount of payments for all hospital outpatient services was not affected, Congress was concerned that hospitals providing cancer, imaging or other essential patient care services incorporating technology might have experienced inadequate payments for these critical programs and services without the pass-through payments.

The pass-through payments were to be constrained to no more than 2.5 percent of total payments for OPD services, and 2.5 percent was taken out of the OPD PPS rates to fund these pass-through payments. In addition, if the payment cap of 2.5 percent was exceeded, a pro-rata reduction would have been imposed on future pass-through payments. Similarly, 2.5 percent was removed from the rates and used for outlier payments. At the time, due to the poor quality of the data, Congress did not know if the 5 percent total for the pass-through payments and outliers was sufficient, or if a 2.5 percent set-aside was adequate or inadequate for pass-through or for outlier payments.

In August 2000, the Centers for Medicare and Medicaid Services (CMS) implemented

the new prospective payment system for hospital outpatient services (OPD PPS), including the pass-through payments for drugs, biologicals and devices. Last fall, the agency estimated that pass-through payments would exceed the 2.5 percent cap, and that a 50 percent reduction would need to be applied to bring the payments within the cap. However, in response to a letter from Chairman Thomas, CMS delayed the reduction until actual data became available this summer. CMS now has informally indicated that the pro-rata reduction proposed for 2002 will be significant (between 60 and 80 percent.)

Under the BBRA, after a two or three year period, the costs of technologies and drugs and biologics eligible for pass-through payments are to be incorporated into the base OPD PPS payment rates so that the payment for a service reflects all of the costs – clinical staff, capital, and overhead, as well as the pharmaceutical and device costs. We recommend that CMS accelerate the process of including these costs within the base payment rates, which would create more accurate payment rates and reduce the need for a pro-rata reduction. Including these costs within the base rates would also aid CMS in meeting the statutory requirement that the pass-through payments for new technology represent only the incremental costs above the old technology.

However, these changes would affect only part of the pro-rata reduction – perhaps a third – so additional policy changes need to be examined to preserve the appropriate payment rates for the affected services. An examination of the following issues also points to a need for potential legislative changes:

- **The time frame is too short.** The first data that included the pass through payments – October through December 2000 – were not available until late Spring 2001. However, the proposed rule must be published by no later than August 1 to ensure that the payment update for 2002 is effective January 1. Compounding the problem concerning the short time frame is that CMS is also responsible for updating and revising all of the payment groups, as required by BBRA. Thus, the amount of time required to analyze the data and adjust the fee schedule is too short given the magnitude of the analysis required.
- **Pricing is inaccurate.** Device payments are based on hospital “charges” reduced to costs, using hospital-specific cost to charge ratios. Given that hospitals know what cost-to-charge ratio is used for payment, it is very easy for them to increase their “charges” above and beyond the appropriate level of payment. Moreover, 95 percent of average wholesale price (AWP) that is used to pay for drugs exceeds the acquisition price, and since overhead was included in the base rate, this payment methodology result in excessively high payments for drugs. In addition, CMS has noted that some AWP’s increased rapidly after the drugs were added to the pass-through list.
- **Outliers are unworkable.** The BBRA established outpatient outlier payments that were initially based on the number of services provided in a day, which poorly targets

expensive cases. However, the outliers were to be on a service-specific basis beginning in 2002. Because hospitals have one consolidated charge for multiple surgeries, the outlier payments cannot be service-specific as Congress required. So the outlier is not technically feasible unless hospitals change their accounting and billing systems. Moreover, given the use of updated 1999 data in this year's rates, the need for an outlier payment is diminished.

In sum, we recommend that, to the extent possible, CMS take the following administrative actions:

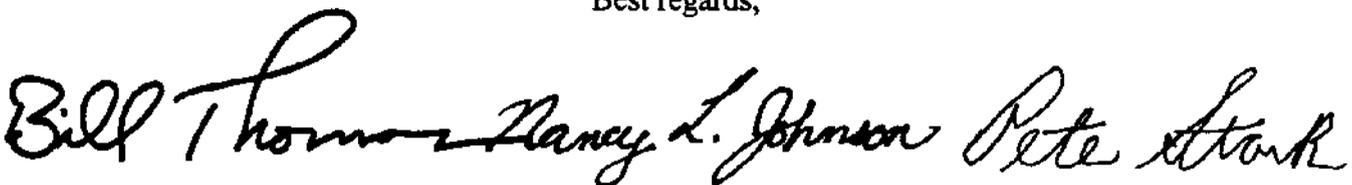
- Move the costs for the pass-through items into the base payment rates.
- Reassess eligibility criteria for purposes of pass-through payments (see March 1, 2001 MedPAC report).
- Move the update of the payment rates from January 1 to April 1, and adjust the update to account for the delay so that hospitals and beneficiaries are held harmless from this change. This change would provide the critical time needed to improve the rates.

In addition, we would like to work together with you on the following legislative proposals to ensure that the rates are updated and the underlying methodology is improved:

- Change the payment methods for the pass-through items to better reflect acquisition costs.
- The outlier payments should be eliminated and added to the 2.5 percent used for the pass-through payments. In future years, the amount set aside might be less than 5 percent, which would increase the base rates.
- Pass-through payments should be made on a budget-neutral basis, in keeping with the intent of the Congress.

We must ensure that seniors have access to efficacious health care treatments and innovative technologies. To meet that goal, the payments must be accurate and the policies sound. We are committed to working with you on these policies so that we can prevent any "train-wreck" in hospital outpatient payments for services using drugs or devices.

Best regards,



Bill Thomas  
Chairman

Nancy L. Johnson  
Chairman, Health Subcommittee

Pete Stark  
Ranking Member, Health  
Subcommittee