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Via Electronic Submission (www.regulations.gov)

September 6, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS–1601-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Ms. Tavenner:

Re: CY 2014 Outpatient Prospective Payment System Proposed Rule, File Code CMS–1601–P.

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) proposed rule entitled *Medicare and Medicaid Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*, 78 *Fed. Reg.* 403534 (July 19, 2013). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems. The AAMC also represents all 141 accredited U.S. medical schools and 94 professional and academic societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 82,000 medical students, and 110,000 resident physicians who collectively deliver over one-fifth of all clinical care in the nation.

CMS seeks to implement significant changes to the OPPS payment methodology, including proposals to collapse evaluation and management (E/M) codes for clinic and emergency department visits, expand the current packaging policy to new items and services, and establish a new concept called "comprehensive ambulatory payment classifications" (comprehensive APCs) to replace device-dependent APCs. These policy proposals represent major changes to the way hospitals are currently reimbursed for their outpatient services. The AAMC does not support these proposed changes, because CMS has not provided the public with a meaningful opportunity to comment on these proposals. The Agency calculated payment rates using faulty data and does not provide enough information to assess the impact of each proposal.

CMS issued a correction notice and limited extension of the comment period on September 5, 2013, the day before the original comment deadline. This extension provides ten days to

evaluate and comment on CMS' technical data corrections released on August 28, 2013, which correct some of the data errors in the proposed rule. The AAMC may modify our comments by the September 16, 2013, limited extension deadline based on the new data release.

CMS also seeks to begin collecting data on the frequency, type, and payment for services furnished in off-campus provider-based departments and seeks advice on the best method of collecting these data. While teaching hospitals have not reached a consensus on the data collection method CMS should use, the AAMC encourages CMS to engage the hospital stakeholder community in identifying the most accurate and least burdensome way of collecting the data and in putting the data into context.

Our comments focus on the following areas:

- Data Concerns and Impact Analysis Difficulties
- Collapsing Evaluation and Management (E/M) Codes for Clinic Visits
- Collapsing E/M Codes for Emergency Department Visits
- Expanding Packaging to Seven Categories of Items and Services
- Establishment of Comprehensive Ambulatory Payment Classifications (APCs)
- Collecting Data on Off-Campus Provider-Based Facilities
- Creation of New Cost to Charge Ratios
- No Cost/Full Credit and Partial Credit Device Policy
- Separately Payable Drugs and Biologicals
- Payments to Certain Cancer Hospitals
- Proton Beam Radiation Therapy
- Supervision Requirements for Observation Services
- Hospital Outpatient Quality Reporting Program
- Hospital Value Based Purchasing Program
- Ambulatory Surgical Center Quality Reporting Program

DATA CONCERNS AND IMPACT ANALYSIS DIFFICULTIES

In the CY 2014 OPPS proposed rule, CMS proposes several significant policy changes, including collapsing Evaluation and Management (E/M) codes, substantially expanding packaging of services, and creating comprehensive APCs, that would fundamentally alter the way many payments are made under the outpatient prospective payment system. CMS envisions a world where OPPS payments are more streamlined and more services are packaged together for payment, and the AAMC shares this vision. The Association would like to be supportive of several of CMS' proposed policy changes. Data errors and a lack of meaningful impact analyses

in the proposed rule, however, leave the Association unable to assess the impact of these proposals and with no choice but to oppose them.

There is no statutory directive or deadline driving CMS' proposed policy changes. Rather than prematurely finalizing major proposals that may in fact be based on incorrect and incomplete data, CMS should take the time to work from accurate data and explain the impacts of each of the Agency's proposals in a meaningful way. CMS could, for example, re-propose some or all of these policy changes next year or in subsequent years, giving stakeholders the ability to understand the proposals and provide the Agency with informed comments.

The AAMC engaged a data consultant, the Moran Company, to help assess the impact of the proposed rule on teaching hospitals. The Moran Company was not able to replicate CMS' rate-setting methodology. Among other problems they identified, their calculation of the geometric mean cost for APC 0634, the newly proposed E/M APC, differs from the cost CMS listed in the proposed rule by more than 10 percent. This was particularly problematic, as CMS proposes to make APC 0634 the base APC in calculating the weights of all other APCs. CMS ultimately released a data file correcting the calculation of APC 0634 but did so on August 28, 2013, only nine days prior to the end of the original comment period, leaving insufficient time to fully assess the impact of the correction. The Moran Company identified additional data errors (*e.g.*, status indicator inconsistencies), some of which were corrected in the August 28 data file and some of which were not. Please see the attached memorandum for further details on these data errors.

The Association appreciates CMS' effort to correct some of the incorrect data, but the AAMC believes that there are still problems with the data that make it impossible to determine how each distinct proposal will impact individual stakeholders. Each data issue the Moran Company identified as problematic has interactions with the others and also interacts with unrelated proposals in the rule. This interaction across the entire OPPS system still makes it impossible for the AAMC to fully understand the impact of the analyses CMS used to support the proposed policies. The Association and our teaching hospital members, therefore, are not able to make informed, meaningful comments on these proposals. In the future, if the Agency decides to propose more than one policy that has a significant impact on OPPS payment, CMS should provide the public with sufficient information to tease apart the impacts of the various proposals independently as well as be able to assess the overall impact.

COLLAPSING EVALUATION AND MANAGEMENT (E/M) CODES FOR CLINIC VISITS

Under the current outpatient payment system, CMS recognizes five levels of clinic visits through five codes that are intended to recognize the variation in severity from low complexity cases to high complexity cases. There is no national standard that defines each code level, and hospitals have been required to develop their own internal guidelines to distinguish among levels of resource use. CMS now proposes to eliminate the five levels of E/M codes and replace them with a single outpatient hospital visit code that would be paid under newly created APC 0634. CMS would establish a payment rate for APC 0634 based on the total mean cost of all five levels of claims billed in CY 2012 and would no longer code distinctions between new and established patients. The payment rate would also include services that would be packaged under the proposed new packaging policy discussed below.

The AAMC is unable to assess the implications of this policy proposal on teaching hospitals, because of data errors and a lack of explanation in the proposed rule about how this proposal interacts with other proposed policy changes. As discussed above, CMS did not correct data used to establish the cost of APC 0634 until 9 days before the end of the original comment period and has not provided any encounter data that would enable a comparison of current rates to proposed rates. The AAMC appreciates CMS' efforts to reduce administrative burden for hospitals and is not opposed to the concept of reducing the number of E/M clinic visit codes to fewer than five. Nevertheless, data errors in the proposed rule and an inability to understand the interaction between this policy and the proposed packaging policies leave the AAMC without a meaningful opportunity to comment and lead the AAMC to oppose this proposal.

If CMS re-introduces a similar proposal next year, the AAMC urges the Agency to correct all data errors, offer detailed explanations and impact analyses of how this proposal interacts with other proposals (*e.g.*, packaging of laboratory and other ancillary services), and design a system that still recognizes cases that require high levels of hospital resource use.

COLLAPSING EVALUATION AND MANAGEMENT (E/M) CODES FOR EMERGENCY DEPARTMENT (ED) VISITS

Similar to the proposals to collapse clinic visit codes, CMS also proposes to collapse all five levels of Type A Emergency Department (ED) visit codes into a single code and all five levels of Type B ED visit codes into a single code. As with the new clinic codes, CMS also proposes to package various services into these codes. Type A visits would be assigned to newly created APC 0635, and Type B visits would be assigned to newly created APC 0636. Because the

weights for all OPPS services, including ED visits, would be based on an incorrectly calculated APC 0634, and because packaging and other proposals would also interact with these ED visit codes, the AAMC has been denied an opportunity to meaningfully comment on this proposal and urges CMS not to finalize it.

The AAMC has several serious concerns with a broad policy of collapsing ED visit codes and urges CMS to study carefully the effects of such a proposed policy on hospitals that have trauma facilities and/or are academic tertiary referral centers, as these facilities tend to treat higher acuity ED patients. Based on the data the Moran Company was able to analyze by isolating this proposal as best they could from other proposed policy changes, collapsing the ED E/M visit codes into a single code would have a disproportionately negative effect on major teaching hospitals.

Eighty percent of the nation's level I trauma centers are located at COTH hospitals.[1] The high standards required for designation as a trauma center are designed to ensure that patients with severe conditions receive proper and timely care. In many areas of the country, trauma centers are the only providers equipped and trusted to offer the type of emergency services required for patients with severe and complex conditions. As a result, hospitals with level I trauma centers tend to provide twenty percent more Level 4 and Level 5 ED visits (60 percent, on average), than hospitals without trauma centers (50 percent, on average).[2] Collapsing the five ED E/M visit codes into a single rate would, therefore, have a disproportionately negative effect on hospitals with trauma centers and harm their ability to continue to provide these critical services. The data interactions and erroneous data in the proposed rule make it impossible, however, to quantify the amount of the disproportionate impact on hospitals with trauma centers.

Additionally, the AAMC is concerned about an inherent bias in the way the proposed Type A ED E/M rate was calculated. CMS' rate-setting process has the effect of reducing payment rates, because the simpler, less-costly services generally are included in rate-setting, while the more complex, more-costly services on claims are dropped. With respect to Type A ED visits in particular (though also with clinic and Type B ED visits), collapsing the five codes may over-weight the low intensity codes and under-weight the high intensity codes, leading to a lower geometric mean and payment. While this bias may not be an inherent problem for services that are provided at all facilities, it adversely affects hospitals – such as those that have trauma centers and that are academic tertiary referral centers – that provide a disproportionate amount of high intensity services.

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[1] Level I trauma centers identified by American College of Surgeons at http://www.facs.org/trauma/verified.html.
[2] Moran Company's analysis of rate-setting file for CY 2014 OPPS proposed rule (2012 data).

In conclusion, the AAMC strongly urges CMS not to finalize the Agency's proposal to collapse Type A ED E/M visit codes into a single code for the following reasons: the proposed payment is based on data errors and is biased toward lower level services; the public is not able to understand the impact of the interaction of this proposal with other proposals in the rule leaving the AAMC without a meaningful opportunity to comment; and the teaching hospitals that provide the most intense level of critical ED services would be disproportionately harmed by its implementation.

EXPANDING PACKAGING TO SEVEN CATEGORIES OF ITEMS AND SERVICES

CMS proposes substantial packaging of services in the CY 2014 OPPS proposed rule. As stated in the preamble, "the OPPS is currently a prospective payment system that packages some items and services but not others. . .our overarching goal is to make OPPS payments for all services paid under the OPPS more consistent with those of a prospective payment system and less like those of a per service fee schedule…" 78 *Fed. Reg.* at 43569. CMS conducted a review of items and services in the CY 2008 OPPS and adopted packaging for seven categories. For CY 2014, CMS proposes seven additional categories of items and services to expand packaging in the OPPS.[3]

The AAMC is generally supportive of CMS' attempt to improve payment accuracy through increased bundling of services. However, the Association has significant concerns with CMS' methodology in determining payment rates for the CY 2014 OPPS overall, and particular concerns with the interactive effect of the numerous proposed policy changes.

One specific concern relates to the inclusion of packaged services in rate setting. During rate setting, claims are divided into single and multiple procedure categories; where possible, multiples are further divided into "pseudo singles." Because of the complexity of multiples, many are not eligible to be included in rate setting, so many complex, multi-procedure services, which frequently include packaging, are more likely to be excluded. Given this year's E/M code collapse proposal, the impact of the exclusion of many complex, packaged claims is significant.

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[3] Four categories of items and services are proposed for unconditional packaging, meaning these services are integral to the performance of the primary service, and are proposed to be assigned status indicator "N." CMS is proposing to discontinue the use of status indicator "X" for ancillary services; under the proposal these services would be assigned status indicator "Q1" and be conditionally packaged when provided with a service assigned status indicator "S," "T," or "V." CMS is also proposing to assign status indicator "Q1" to diagnostic tests on the bypass list. The Agency proposes to assign status indicator Q2 to device removal procedures. A complete list of codes impacted by this proposal can be found in Addendum P of the proposed rule.

The AAMC is extremely concerned that it is impossible to meaningfully assess the packaging proposals that are layered onto the E/M proposal.

Going forward, as emphasized above, the AAMC requests that CMS provide individual impacts when proposing policies that have an interactive effect. Given the data challenges and lack of legislative mandate, the AAMC strongly urges CMS to not finalize this proposal for CY 2014 and to revisit this proposal in future rulemaking.

ESTABLISHMENT OF COMPREHENSIVE APCS

For CY 2014, CMS proposes to create 29 comprehensive APCs to replace 29 existing device-dependent APCs. CMS proposes to define a comprehensive APC as "a classification for the provision of a primary service and all adjunctive services provided to support the delivery of a primary service." 78 *Fed. Reg*. at 43558. Under the proposal, CMS would make a single prospective payment based on the cost of all individually reported codes representing a primary service and all adjunctive services; all other services would be conditionally packaged. CMS states this proposal furthers the Agency's "ongoing efforts to move the OPPS towards a more comprehensive payment system in support of our objectives to increase flexibility and efficiencies." 78 *Fed. Reg*. at 43558. Furthermore, CMS believes this proposal will improve the accuracy in setting payment rates, while also enhancing beneficiary understanding and transparency. Under the proposal, six categories of services would be included in the newly created comprehensive APCs.[4]

As with a number of other proposals in the CY 2014 OPPS proposed rule, the AAMC and its analytic contractor were unable to replicate CMS' methodology for creating the 29 comprehensive APCs, and the AAMC and its contractors have significant concerns regarding the impact data accuracy. One specific issue arises from the identification of codes associated with device-dependent services. In the rule, CMS states there are 136 HCPCS codes that define the device-dependent services to be included in comprehensive APCs. 78 *Fed. Reg*. at 43559. However, in Addendum B, there are 148 HCPCS codes listed with the proposed new J1 status indicator.

[4] Items to be included in the comprehensive APCs include: 1) otherwise packaged services and supplies, 2) adjunctive services, 3) devices, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), 4) outpatient department services reported by therapy codes, 5) additional hospital room and board revenue centers in the calculation of covered costs, and 6) hospital administered drugs. These categories of items and services include services not typically paid for under the OPPS. For example, the costs of the bed and room occupied by the patient, nursing services, and any necessary fluids and nutrition would be considered covered services even when reported in revenue cost centers not usually used for OPPS.

The AAMC is generally supportive of CMS' attempt to improve payment accuracy through increased bundling of services. However, given the large number of significant payment policy changes proposed in the rule and the inability to replicate CMS' methodology, the AAMC cannot meaningfully comment on the proposals as set forth. It is particularly challenging to comment on this specific proposal given the interaction between this comprehensive APC proposal and the various other changes being proposed to E/M codes, CCRs, and packaging more broadly. Going forward, the AAMC requests that CMS provide individual impacts of each proposed policy when proposing several policies that have an interactive effect. Given the data challenges and lack of legislative mandate, the AAMC strongly urges CMS to not finalize this proposal for CY 2014 and to revisit it in future rulemaking.

COLLECTING DATA ON SERVICES PROVIDED IN OFF-CAMPUS PROVIDER-BASED FACILITIES

CMS is interested in better understanding hospital acquisition of physician practices and the integration of those practices as departments of the hospital, particularly given the co-payment implications for Medicare beneficiaries and the cost to the Medicare program of paying hospital facility fees. To collect data on the frequency, type, and payment for services furnished in off-campus provider-based departments, CMS suggests the possibility of collecting data through a claims-based approach (adding a HCPCS modifier for services furnished in these provider-based departments) or a cost-report based approach (breaking out costs and charges for provider-based departments as outpatient service cost centers on the hospital cost report). In the physician fee schedule proposed rule, CMS also suggests the option of adding a site of service code to physician claims forms.

The AAMC appreciates and concurs with CMS' assessment that the Agency "expect[s] hospitals to have overall higher resource requirements than physician offices because hospitals are required to meet the conditions of participation, to maintain standby capacity for emergency situations, and to be available to address a wide variety of complex medical needs in a community." 78 *Fed. Reg.* at 43627. These costs for HOPDs are real and are documented annually through an audited cost report. HOPD costs also stem from the unique role the hospital has in the health system. An AAMC analysis of office visits confirmed that HOPDs see more complex patients, and a higher proportion of dual-eligible, disabled and non-white patients compared to physician offices. HOPDs provide comprehensive and coordinated care settings for patients with chronic or complex conditions, such as pain centers or cancer clinics. Many centers of excellence provide services in HOPDs; provide outstanding team-based, patient-centered care, the gold standard of care; and include wrap around services, such as translators.

The Association recognizes the importance of beginning to collect this type of data, given how little is currently known in the aggregate about provider-based facilities and how important having accurate information is to the broader conversation around the site in which healthcare services are delivered. There is currently no consensus within the teaching hospital community, however, as to which of CMS' options would be preferable. Some AAMC member hospitals already collect this information on a claim level and believe it would not add considerable additional burden, while others find that adding a place of service code or HCPCS modifier would be difficult and burdensome because of the manual nature of this task. Some teaching hospitals already report sites separately on the cost report, while others who have multiple on-campus and off-campus based clinics in a single accounting unit would find a cost report approach extremely difficult.

Given the differing opinions and the complexities surrounding this data collection, the AAMC encourages CMS to convene a group of CMS staff and hospital stakeholders to identify the most accurate and least burdensome way of collecting meaningful data. In discussing CMS' proposed options, AAMC members raised granular issues that are best identified by providers themselves and must be resolved by CMS if the Agency moves forward with this proposal. For example, CMS should consider how to address cases in which a patient is treated on the same day in both on-campus and off-campus provider-based settings. Additionally, given the inaccuracies that often persist in codes on claims that are not tied to payment, CMS should work with a stakeholder group to determine the best way of collecting the most accurate data.

The AAMC also urges CMS to work with stakeholders to review results of the survey the Department of Health and Human Services Office of Inspector General (OIG) is conducting on some of these issues. CMS and the provider community should have the advantage of understanding what the OIG has learned from this effort and should target future data collection at questions that remain unanswered.

Finally, the AAMC strongly encourages CMS to engage the hospital and physician stakeholder community in putting any data the Agency collects on off-campus provider-based departments into context. CMS says the Agency wants to better understand trends around hospital acquisition of physician offices, but the type of data CMS proposes to collect will not answer the questions the Agency is asking. This data will provide only a snapshot in time and will not immediately identify shifts in hospital ownership of physician practices or the types of patients who are treated in these off-campus provider-based locations. Beginning to collect data on these locations may be an important first step, but it should only be an introduction to a much broader dialog with providers about the what services are being provided and the characteristics of patients who are treated in provider-based facilities.

CREATION OF NEW COST TO CHARGE RATIOS

In recent years, CMS has added to the hospital cost report cost centers for cardiac catheterization, CT scan, MRI and implantable medical devices. CMS first used the implantable medical device cost-to-charge ratio (CCR) in calculating OPPS payment weights in 2013, and the Agency proposes to continue using this CCR again for 2014. CMS also proposes to use the new CCRs for cardiac catheterization, CT scan, and MRI for the first time in CY 2014 to calculate relative payment weights.

The AAMC urges CMS not to finalize the proposal to use the two new radiology CCRs. Although a large number of hospitals are reporting the new cost centers, AAMC members have noted that the capital costs for CT and MRI are not applied consistently. For example, some hospitals do not directly allocate capital expense, but rather allocate by the square foot, which undercounts the relatively high capital costs for CT and MRI machines. Other hospitals have difficulty separating out the CT and MRI costs from the general radiology costs. These variations in applying costs could distort the relative value of advanced imaging services, thus distorting the payment system more broadly. The AAMC also is unable to calculate the impact of these proposed changes on its members, given the interaction of this proposal with the proposals to create comprehensive APCs and to make policy changes to composite APCs.

Given that proposed payments for these imaging services would be significantly lower than those of their parent cost centers, the AAMC is also concerned that finalizing this proposal will have a negative impact on patient access to these services. The Association encourages CMS to study patient access issues before using these new CCRs to set payment weights.

NO COST / FULL CREDIT AND PARTIAL CREDIT DEVICES

In CY 2007, CMS implemented a policy that reduces the payment for specified device-dependent APCs by the estimated portion of the APC payment attributed to device costs when a hospital receives the specified device at no cost or with full credit. Hospitals are instructed to report no cost/full credit cases using the modifier "FB" on the line of the procedure code in which the no cost/full credit device was used. Hospitals are instructed to use the modifier "FC" on the line of the procedure code when they receive a partial credit of 50 percent or more of the cost of the new device.

For CY 2014, CMS proposes that the OPPS payment would be reduced by the full or partial credit a provider receives for the replaced device (for the applicable APCs listed in Table 17 of the proposed rule). The Agency is proposing that hospitals would be required to report the amount of the device credit received for the replacement device in the amount portion for value

code "FD" (Credit Received from the Manufacturer for a Replaced Device) when the credit is 50 percent of greater than the cost of the device. Hospitals would no longer be required to use the existing "FB" and "FC" modifiers.

The AAMC does not support CMS' proposal to revise the no cost/full credit and partial credit device policy. The existing no cost/full credit and partial credit device policy is administratively complex for providers to comply with and slows billing as providers verify and match credits with given procedures. The proposal put forth in the rule would add an unnecessary level of administrative burden. Under current policy, it is already a challenge to identify that a credit exists without delaying the normal billing cycle. Should CMS finalize this proposal, hospitals would frequently find themselves in the position of awaiting an invoice copy with an actual dollar credit amount at the time billing should occur. The actual dollar amount can take months to obtain, leading to the need for the hospital to hold the claim. This challenge is magnified by the fact that many teaching hospitals replace devices that were originally implanted at another facility; as such, there is no record in the accounting system related to the original purchase. Last, gathering this information through the use of the value code would be an entirely manual process, which raises data integrity issues. Finalizing this proposal would add significant burden to providers without necessarily improving accuracy of payment. The AAMC urges CMS to not finalize the current proposal, but rather to find a more effective way of reconciling the no cost/full credit and partial credits with OPPS payments.

PROPOSED PAYMENT FOR SEPARATELY PAYABLE DRUGS AND BIOLOGICALS

In the CY 2013, CMS finalized a proposal to pay for separately payable drugs and biologicals at the average sales price (ASP) plus six percent. The AAMC previously supported this rate, which is the same as the physician office setting payment rate and is consistent with the ASP plus six percent payment level set forth in the Medicare statute.

The AAMC commends CMS for once again proposing to pay these separately payable drugs at ASP plus six percent. The Association agrees with CMS that this rate is appropriate, because it increases predictability in payments for separately payable drugs and biologics under the OPPS. Accordingly, the AAMC urges the Agency to finalize the proposal.

PROPOSED ADJUSTMENT FOR CANCER HOSPITALS

After a 2011 Affordable Care Act (ACA) study determined that outpatient costs incurred by the eleven specified cancer hospitals were greater than costs incurred by other OPPS hospitals, CMS finalized a payment adjustment reflecting these higher costs in the CY 2012 OPPS final rule.

CMS proposes to continue the policy of providing additional payments to each of the eleven cancer hospitals so that each hospital's final payment-to-cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (or "target PCR") for other hospitals paid under the OPPS. For CY 2014, CMS estimates a weighted average or target PCR of 0.90. Therefore, the cancer hospital payment adjustment would be the additional payment needed to result in a proposed 0.90 target PCR for each cancer hospital. The actual amount of the CY 2014 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital's CY 2014 payments and costs.

The AAMC continues to believe that CMS' policy to provide additional payments to cancer hospitals to reflect their higher costs addresses many provider and beneficiary concerns. The Association therefore supports CMS' proposal to continue the same policies for payment adjustments to cancer hospitals in CY 2014.

For similar policy reasons, the AAMC encourages CMS to examine the adequacy of OPPS payments to teaching hospitals, and particularly to determine whether major teaching hospitals' PCRs are consistently lower than those of other hospitals.[5] If CMS determines that, like cancer hospitals, the costs incurred by major teaching hospitals are consistently greater than costs incurred by other OPPS hospitals, the Agency should also ascertain the reasons for any systematic differences. If CMS analysis determines that the disparity is due to the unique missions of teaching hospitals or other characteristics typical of such hospitals and the patients they treat, the AAMC believes it only equitable for CMS to adopt a teaching adjustment reflecting these higher costs to ensure that all classes of hospitals receive adequate payments.

PROTON BEAM RADIATION THERAPY (APCs 0664 and 0667)

CMS proposes to reassign all proton therapy CPT codes to one APC, despite substantial differences in resources and clinical homogeneity of the codes. CMS' stated reason for this proposal is that the Agency believes there is a violation of the Two Times Rule in APC 0664 based on updated data for CY 2014. Under the Two Times Rule, the cost of the highest cost item or service within an APC group may not be more than two times greater than the cost of the lowest cost item or service within that same group. However, the Two Times Rule does not apply for codes that do not meet a claims volume threshold.

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[5] The AAMC's most recent analyses of HCRIS data, for example, indicate that in fiscal year (FY) 2011major teaching hospitals (defined as hospitals with an intern and resident to bed (IRB) ratio of greater than 0.25) had a Medicare outpatient PCR of approximately 84 percent, compared to 90 percent of all hospitals and 92 percent of non-teaching hospitals.

The AAMC strongly opposes assigning all proton therapy CPT codes to APC 0667. Contrary to CMS' data, the cost statistics files show that claims for CPT Code 77520 did not increase to the extent that the code would meet the claims volume threshold. Finalizing this proposal could result in inappropriate groupings of clinical services and inadequate payments for certain services, which could deter to access to care. The AAMC urges CMS to maintain the current APC configuration, which is more reflective of the significant differences in clinical nature and resource intensity between the CPT codes in APC 0664 and APC 0667.

SUPERVISION REQUIREMENTS FOR OBSERVATION SERVICES

The AAMC commends CMS for clarifying supervision requirements for outpatient observation services in the CY 2014 OPPS proposed rule. According to the Agency, once the supervising physician determines a patient is stable, documents it, and transitions the patient to general supervision, general supervision may be furnished throughout the duration of the observation service. This clarification answers many questions regarding whether Medicare requires hourly evaluations of the patient during the provision of observation services. The AAMC supports the inclusion of this language in the CY 2014 OPPS final rule.

OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

In the proposed rule, CMS outlines changes to the OQR program starting in CY 2016. CMS proposes the addition of five new measures relating to healthcare personnel influenza vaccination status, cataract surgery, and endoscopy surveillance. AAMC's comments on these measures and on proposed changes to the OQR, VBP, and ASCQR programs are provided in more detail below.

The Association supports the concepts and goals of the proposed OQR measures, but has concerns with the selection of the two endoscopy and two cataract surgery measures because none of them were designed or tested for hospital outpatient departments (HOPDs). These four measures are part of the Physician Quality Reporting System (PQRS) program and are specified for the clinician office. Measures designed for the physician office setting are typically geared towards tracking patients over time, as patients continue to see their same physicians for care; whereas, measures for the outpatient setting are geared towards tracking patients at a point in time. Patients who receive care in the HOPD are not having the majority of their care in this setting. Therefore, it is generally not practical to have the HOPD track long-term follow-up care of their patients. Despite CMS' desire to eventually align the hospital and physician quality programs, the Agency must design measures that recognize that there are differences in how facilities and physicians collect information, report quality measures, and interact with patients.

The AAMC requests that CMS adopt the following principles to guide the selection of a measure for use in a Federal quality reporting program:

- **Every measure must be specified for the healthcare setting in which it will be implemented.** All measures proposed for the OQR program should be specified, tested, and validated for the outpatient facility setting. Measures that were previously part of PQRS cannot simply be added to a hospital quality program, and vice-versa. If the measure concept is important, then the measure should be redesigned and tested for the new unit of measurement. The redesign should include a reconsideration of how the entity can act upon the information.

- **Every measure, at a minimum, should be fully endorsed by the National Quality Forum (NQF) and supported by the Measure Applications Partnership (MAP) before it is implemented in a quality reporting program.** Full NQF-endorsement ensures that a measure has gone through a rigorous evaluation of the supporting evidence base and has been adequately tested at the correct setting. MAP's support for a measure ensures that the measure is appropriate for implementation in a quality reporting program.

Quality Measures Proposed for CY 2016

CMS has proposed the following five new outpatient measures to be publicly reported starting CY 2016:

Identifier/NQF #	**Measure name**
OP-27, NQF #0431	Influenza Vaccination Coverage Among Healthcare Personnel
OP-28, NQF #0564 (time-limited endorsed)	Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
OP-29, NQF #0658 (time-limited endorsed)	Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
OP-30, NQF #0659 (time-limited endorsed)	Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps Avoidance of Inappropriate Use

OP-31, NQF #1536 (time-limited endorsed)	Cataracts- Improvement in Patients Visual Function within 90 Days Following Cataract Surgery

OP-27 Influenza Vaccination Coverage among Healthcare Personnel

The proposed influenza vaccination coverage among healthcare personnel (HCP) measure assesses the percentage of HCP who receive a vaccination for influenza between October 1 (or when the vaccination is available) and March 31. CMS finalized the HCP vaccination measure for the inpatient quality reporting (IQR) program for FY 2015, and previously proposed this measure for the OQR program in the CY 2012 rule, but decided not to finalize in order to incorporate refinements to the measure. The measure proposed in this year's rule is the same measure finalized in the IQR program (NQF #0431).

The AAMC supports efforts to increase influenza vaccination rates among all health care personnel. However, the AAMC continues to be concerned about the logistics of collecting this information. We are also confused how this measure differs from the IQR measure reporting. We ask that CMS address the following questions before this measure is finalized:

- How will the reporting requirements for this measure be aligned with the IQR HCP vaccination measure, especially as several outpatient staff are already covered under the IQR measure?
- If this measure is finalized, will hospitals need to submit this data twice?

Because the proposed measure is the same as the IQR measure, if it is finalized, the AAMC asks that hospitals only be required to submit the HCP influenza data once to receive reporting credit for both the IQR and OQR programs.

Cataract Surgery Measures

Starting CY 2016, CMS proposes the following two cataract surgery measures to the OQR program:

- OP-28: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
- OP-31: Cataracts- Improvement in Patients Visual Function within 90 Days Following Cataract Surgery

CMS proposes to add two cataract surgery measures to the OQR program starting CY 2016: OP-28 assesses complications that occur within 30 days of the initial surgery requiring additional surgery and OP-31 assesses whether the patient experienced improvements in vision following surgery. While the AAMC supports the concept of these two measures, the Association believes that they must be specified and tested for the facility setting before being proposed in a hospital outpatient quality program. As stated above, these two measures were designed for physician measurement in the PQRS program and have not been re-specified for outpatient departments, which leads to data collection complications. For example, it is unclear how the patient survey for OP-31 would be distributed and collected, and how the facility could respond to these survey results in a manner that leads to improved care. Moreover, the MAP's support for this measure was contingent on NQF's full endorsement, which has not yet occurred. Until these measures are specified and tested for the outpatient department, the AAMC does not support their inclusion in the OQR program.

Endoscopy Surveillance Measures

Starting CY 2016, CMS proposes adding the following two endoscopy surveillance measures to the OQR program:

- OP-29: Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
- OP-30: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps Avoidance of Inappropriate Use

OP-29 assesses the percentage of patients who are 50 or older who received a colonoscopy, and had a recommendation for a follow-up colonoscopy in no less than 10 years documented in the colonoscopy report, with specified exemptions. OP-30 assesses the percentage of patients receiving a colonoscopy who have a history of prior colonic polyp, and have a documented follow-up colonoscopy of three or more years since their last colonoscopy. Both of these measures aim to reduce the overuse of this procedure. While the AAMC supports efforts to limit overuse of colonoscopies, we believe that these measures must be specified and tested for the outpatient department before being used in a quality program.

As with the cataract surgery measures, the endoscopy surveillance measures were originally specified for clinician offices and have not undergone appropriate testing at the facility setting. Both measures are NQF time-limited endorsed, and the MAP "supported the direction" of these measures, noting serious concerns with the feasibility of data collection and the lack of testing at the correct setting. For example, in these measures, the patient interfaces with the hospital outpatient department (HOPD) for the endoscopy procedure, but may receive follow-up services

elsewhere. Similarly, a hospital may not have a prior record of the patient endoscopy. These measures also rely on CPT codes, which are not consistently coded in the HOPD setting.

Proposed Removal of Measures for CY 2016

Starting in CY 2016, CMS proposes to remove two measures from the OQR program:

- OP-19: Transition Record with Specified Elements Received by Discharged Patients
- OP-24: Cardiac Rehabilitation Measures: Patient Referral from an Outpatient Setting

CMS originally proposed OP-19 for inclusion in the OQR program for CY 2013 payment determination with data collection for this measure starting on January 1, 2012. After receiving concerns regarding potential patient privacy issues and following an internal Agency review, CMS decided to suspend data collection of this measure in January 2012. CMS finalized a delay in data collection for OP-24 in the CY 2013 final rule due to limitations in defining the appropriate care setting. The AAMC thanks CMS for responding to stakeholder concerns on this measure, and asks that these measures be removed starting CY 2014 instead of CY 2016.

MAP Recommendations for the Removal of Measures

In 2012, the MAP recommended seven measures for removal from OQR and in 2013 an additional measure was recommended for removal. CMS has not recommended the removal of any of these measures in the OPPS proposed rule. The AAMC asks CMS to address all of the MAP's recommendations in proposed rules and to specifically discuss when the Agency chooses to disagree with a MAP recommendation for removal.

2013 MAP Recommendations for Removal:[6]

Identifier	Measure Title
OP–22	ED–Patient Left Without Being Seen

[6] http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

2012 MAP Recommendations for Removal:[7]

Identifier	Measure Title
OP-9	Mammography Follow-Up Rates
OP-10	Abdomen CT-Use of Contrast Material: For Diagnosis Of Calculi In The Kidneys, Ureter, And/Or Urinary Tract—Excluding Calculi Of The Kidneys, Ureter, And/Or Urinary Tract
OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
OP-15	Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache
OP–20	Door to Diagnostic Evaluation by a Qualified Medical Professional
OP–22	ED–Patient Left Without Being Seen
OP-25	Safe Surgery Checklist

With the exception of OP-22, the 2012 measures were not reviewed again in 2013. Therefore, the recommendations of the MAP from 2012 remain relevant. The AAMC requests that these measures be removed from the OQR.

Proposed Quality Data Submission Procedures

CMS proposes to require data submission for one measure, influenza vaccination for HCP, through the Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN) reporting system. As the AAMC stated earlier, if this measure is finalized, CMS should take steps to ensure that the data reporting requirements align with those for the IQR influenza vaccination measure.

For the other four proposed measures (OP-28, OP-29, OP-30, and OP-31), CMS intends to use a web-based submission process. Hospitals would submit aggregate data (numerators, denominators, and exclusions) through QualityNet similar to how OP-22, Patient Left Without Being Seen, is currently reported. The submission process requires a considerable amount of

[7] http://www.qualityforum.org/Publications/2012/02/MAP_Pre-Rulemaking_Report__Input_on_Measures_Under_Consideration_by_HHS_for_2012_Rulemaking.aspx

resources to create the necessary data collection tool, and additional support may be necessary to aid the submission of this data. Therefore, CMS should provide additional abstraction resources or guidance for submitting these web-based measures.

Extraordinary Circumstances Extension or Waiver

For hospitals facing extraordinary circumstances beyond their control, CMS proposes that it may grant a waiver or extension if there is a systemic problem with the data collection systems that affects a hospital's ability to submit data. The AAMC commends CMS for including this proposal in the proposed rule.

HOSPITAL VALUE BASED PURCHASING (VBP) PROGRAM

Proposed Baseline and Performance Periods for CLABSI, CAUTI, and SSI Measures for FY 2016

In the FY 2014 IPPS proposed rule, CMS mistakenly left out the baseline and performance periods for central line associated blood stream infections (CLABSI), catheter associated urinary tract infections (CAUTI) and surgical site infections (SSI). For all three measures, CMS proposes the baseline period to be CY 2012 and the performance period to by CY 2014, which aligns with the process of care, patient experience, and efficiency measure for FY 2016. The AAMC supports the identified time periods.

As stated in our comments on the IPPS proposed rule,[8] the AAMC continues to believe measures should not be included in more than one hospital performance program. In the FY 2014 IPPS final rule, CMS finalized the CLABSI, CAUTI, and AHRQ PSI-90 composite measures for both the VBP and Hospital Acquired Condition (HAC) Reduction programs starting FY 2015. The AAMC disagrees with CMS' decision and requests that these measures be removed from the VBP program because they are finalized in the HAC program.

Proposed Independent CMS Review Process

CMS also proposes an additional independent CMS review process for hospitals that are dissatisfied with the initial appeal of their VBP score. Hospitals would only be allowed to request this secondary review process if they have completed the first appeals process. CMS intends to provide hospitals with an independent review decision within 90 calendar days of the hospital's request. The AAMC appreciates that CMS recognizes the need for an independent review process and supports the proposal as outlined.

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[8] https://www.aamc.org/download/346874/data/aamccommentsonippsfy2014proposedrule.pdf

AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM

ASC Quality Measures for CY 2016

CMS proposed four measures for the ASCQR in CY 2016:

- Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
- Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
- Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps Avoidance of Inappropriate Use
- Improvement in Patients Visual Function within 90 Days Following Cataract Surgery

These four measures are the same as those proposed for the OQR program. The MAP cited concerns with the feasibility of data collection and lack of testing for the endoscopy and cataract surgery measures. The AAMC believes that until these measures are specified and properly tested for the facility level of analysis, they should not be included in the ASCQR program.

Concerns with a Lack of Data Validation

CMS has yet to propose a data validation process for the ASC measures. If the trend is to have HOPDs and ASCs reporting the same or similar measures, then it is important the data be accurate and reliable. Otherwise, inappropriate comparisons may occur if the rates were publicly reported. The AAMC asks that CMS develop such as process as soon as possible to ensure that the data submitted to CMS is accurate.

CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. We will submit any modifications to our comments based on CMS' September 5, 2013 technical corrections by the September 16, 2013 limited extension deadline. If you have questions regarding our comments, please feel free to contact Lori Mihalich-Levin, J.D. at 202-828-0599 or at lmlevin@aamc.org regarding payment related issues and Mary Wheatley at 202-862-6297 or at mwheatley@aamc.org regarding quality related issues.

Sincerely,

Darrell G. Kirch

Darrell G. Kirch, M.D.
President and CEO

cc: Ivy Baer, J.D., AAMC
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Issues in the CY2014 Proposed Outpatient Prospective Payment System (OPPS) Rate-setting Process

Updated on: September 6, 2013

In The Moran Company's review of the Centers for Medicare & Medicaid Services' (CMS) Proposed Outpatient Prospective Payment System (OPPS) Rule for Calendar Year (CY) 2014 and our attempts to replicate the agency's rate-setting methodology, we found numerous issues and inconsistencies which call into question the accuracy and completeness of the CMS published analysis. At a minimum, we believe that additional information, clarifications, and potentially corrections are necessary in order to more appropriately document CMS' methodology and allow the public to understand the CMS analysis.

In the evening of August 28, less than six business days before the end of the OPPS comment period, CMS released new data files that correct some of the issues we had identified. Then, on September 5, one day before the comment period ended, CMS released a correction notice that provided a brief description of the issues addressed in the August 28 data files, and extended the comment period for issues relating to the new data to September 16. This document is an updated version of our previous report dated August 22. In this update, we provide an accounting of the issues that CMS has corrected, and the data concerns still outstanding. We note that given the late release date of the new files, we have only been able to perform preliminary analyses of the updated files. The complexity of the OPPS requires significant time to run the replication and alternatives. The release of the files so close to the end of the comment period has limited the analyses possible prior to the end of the comment period—even with the comment period extension due to the length of time required for running simulations. In addition, changes can have unintended consequences which there is not time to explore and understand.

Introduction

In order to help our clients evaluate proposed policies in the OPPS proposed rule each year, The Moran Company attempts to match the OPPS published rates by replicating the OPPS rate-setting methodology. We use those results as a baseline, against which we compare the effects of the proposed policies.

The payment weights and then payment amounts are based on historical OPPS claims that have been split apart to represent a major procedure and accompanying costs (a combination used in rate-setting is known generally as a "single bill" or "single." Although there are several types of "singles," we will use the term to refer to any part of a claim used in rate-setting). These singles are then combined into different Ambulatory Payment Classification (APCs) groups by HCPCS code. The geometric mean cost of an APC is compared against a reference APC to assign a weight and then a payment amount.

This system is complex, and subject to sensitivity in both what is determined to be a single and the cost characteristics of each single.

Historically, we have been able to match the CMS published statistics with a great deal of accuracy. We generally start by comparing our counts of the number of singles used in rate setting and the geometric mean cost (median cost in previous years). We do this at the HCPCS and APC levels. For example, with the CY 2013 Final Rule, for the count of singles, we had more than 66% of the HCPCS codes within 0.5% of the CMS published figures and over 90% of the HCPCS codes within 5% of these counts. When comparing geometric means on a case weighted basis, we had over 80% within 0.5% of the CMS published figures, and over 99% within 5.0%. Our APC results were similar.

In contrast, even after multiple and significant attempts to incorporate the CMS policy proposals for CY2014, our comparisons with the agency's figures are further apart than previous years—even after incorporating the most recent updated files.. There is enough of a discrepancy that we engaged in significant efforts to identify elements that could lead to differences between our analyses and the agency's.

Based on our research using the data, comparisons and examinations of the published statistics in the rule, we have found several issues which call into question the accuracy of some of the estimates CMS published with the rule.

This brief report lays out some of the major issues that we have identified to date. These range from issues of numbers that CMS reported that appear to conflict with the data released and other calculations, to internal inconsistencies between tables and appendices that CMS has released, to theoretical issues. These issues, both individual and jointly, could have dramatically affected the CMS released results and the potential expected impact of proposed policies.

The issues to be discussed are:

- Calculation of the geometric mean cost for APC 0634;
- Inconsistent status indicators in CMS published appendices; and
- Treatment of E&M codes and the bypass list.

Update: As detailed below, CMS has corrected the issue related to the geometric mean cost for APC 0634, and partially corrected the inconsistent status indicators of the published appendices. The treatment of E&M codes on the bypass list is not addressed. In addition, our replication is still not comparable to what we have achieved in previous years and we have concerns that other issues in the data and documentation remain.

It should be noted that each issue raised here can have interactions with the other issues. These issues may make it problematic for the public to understand the analyses CMS used to support the policies of the proposed rule, thereby making it difficult for the public to comment on the proposals in an informed way. Finally, we would note that these issues affect other proposals, such as packaging, not directly discussed in this document.

We do not believe that this is an exhaustive list of issues, but merely those we have been able to identify in the relatively short time available during the comment period to date. We have

learned that other analysts attempting to replicate CMS' rate-setting methodology have run into some of the same problems we have, and have discovered other potential issues with the CMS data and documentation. In this document, we have focused on the issues that will have the most effect on the ability of stakeholders to analyze and comment on CMS' proposals. We recognize that there may be other issues present or questions that could also have a material impact on the results of various analyses.

Calculation of the geometric mean cost for APC 0634

Please note that this analysis was conducted prior to the updated results released by CMS at the end of August. We are continuing to include this analysis because it highlights the complexity of the system, and the challenges that CMS left to researchers attempting to understand the CMS proposals for CY2104.

While we were able to come close to matching CMS' published geometric mean costs for most APCs, we were more than 10% off in our calculation of the geometric mean cost for one particular APC—APC 0634, which is the new proposed APC for Evaluation & Management (E&M).[1] This is a major concern because CMS has proposed to make APC 0634 the base APC in calculating the weights of all other APCs. The general formula for an APC's weight is: geometric mean cost for the APC divided by geometric mean cost for APC 0634. Thus, any problems with the geometric mean cost for APC 0634 leads to improperly calculated weights for all other APCs.

A table showing the CMS calculation and ours is immediately below. The CMS numbers are from the APC cost statistics file, released as a part of the rule.

APC Level Comparison

		Moran Computed			CMS Reported			Ratio: (Moran/CMS) -1		
APC Code	SI	Single Count	Median Cost	Geomean cost	Single Count	Median Cost	Geomean cost	Single Count	Median Cost	Geomean cost
0634	V	20,408,966	$ 95.85	$ 99.69	20,396,735	$ 86.07	$ 89.20	0.06%	11.36%	11.76%

As can be seen in the table, we found very similar numbers of singles as CMS. Generally, when we are far off on geometric mean costs, we are also relatively far off on counts of singles. However, that is not the case here. We also observed that the comparison of our results to CMS' was much more similar at the HCPCS level than at the APC level, and the single largest point of difference at the APC level was APC 0634.

To examine why our findings differed so dramatically from the agency's, we approached this by performing a:

1) Close examination of our data results compared to CMS'; and
2) Close examination of the consistency of the results that CMS reported.

[1] For comparison in our replication, we have only 11 APCs where we are 10+% away on geometric mean, and we have more than 50% of the APCs within 0.5% of the CMS published figures.

Data results compared to CMS

In order to troubleshoot our calculation for APC 0634, we looked at the values CMS reports for the component HCPCS codes. We match closely CMS' values for the underlying HCPCS codes. We are generally within 0.5% for the count of singles, and generally within 1% on the median and geometric mean for the HCPCS codes. We match on the component parts for APC 0634, but do not match on the aggregation, which suggests that CMS' APC calculation may be incorrect. The CMS numbers we used as a point of comparison that appear in the table below are from the HCPCS cost statistics file released as a part of the rule.

HCPCS Level Comparison

			Moran Computed			CMS Reported			Ratio: (Moran/CMS) -1		
HCPCS Codes	SI	APC	Single Count	Median Cost	Geomean cost	Single Count	Median Cost	Geomean cost	Single Count	Median Cost	Geomean cost
99201	V	0634	160,390	$ 74.33	$ 84.62	162,472	$ 73.24	$ 83.40	-1.28%	1.49%	1.46%
99202	V	0634	159,837	$ 101.26	$ 104.60	160,204	$ 100.78	$ 103.57	-0.23%	0.47%	0.99%
99203	V	0634	267,824	$ 132.17	$ 136.98	267,189	$ 131.26	$ 136.42	0.24%	0.70%	0.41%
99204	V	0634	202,916	$ 174.96	$ 171.51	203,004	$ 173.51	$ 170.65	-0.04%	0.84%	0.50%
99205	V	0634	94,737	$ 211.69	$ 214.54	94,640	$ 211.69	$ 213.49	0.10%	0.00%	0.49%
99211	V	0634	4,494,680	$ 76.67	$ 81.38	4,514,357	$ 76.42	$ 80.58	-0.44%	0.33%	0.99%
99212	V	0634	4,440,942	$ 88.06	$ 90.99	4,438,154	$ 88.06	$ 90.76	0.06%	0.00%	0.25%
99213	V	0634	5,851,135	$ 94.44	$ 97.72	5,843,094	$ 94.24	$ 97.61	0.14%	0.21%	0.11%
99214	V	0634	4,065,873	$ 119.56	$ 121.40	4,078,881	$ 119.57	$ 121.27	-0.32%	-0.01%	0.11%
99215	V	0634	670,632	$ 174.62	$ 176.99	671,221	$ 173.28	$ 176.07	-0.09%	0.77%	0.52%

Thus, from a data analysis perspective, we found inconsistencies. We also note that the sum of singles from the HCPCS cost statistics file for APC 0634 does not match the number of singles reported in the APC cost statistics file.

CMS internal comparison

We then explored the issue from a purely theoretical perspective, using only the data that CMS published. We attempted to roll-up the geometric mean costs of the HCPCS codes that make up APC 0634 to calculate the APC's geometric mean cost. In theory, we should be able to compute the geometric mean cost for an APC by taking a weighted average of the geometric mean cost for all of the component codes.

To calculate the weighted average geometric mean, we took the natural log of the geometric mean values for the HCPCS codes and computed a weighted average of the logged values. Finally, we took the exponential to convert back to the overall geometric mean cost. Using this method, and using CMS' own reported data, we calculated a weighted geometric mean cost value of $99.31, which is 11.3% higher than what is published in the APC table of the rule (but only 0.65% lower than our calculated geometric mean cost for the APC of $99.69).

We also examined the proposed rule—both the preamble text and accompanying files—to see if there were any steps or changes that were different for this year compared to previous years. We were not able to find any differences in methodology documented in the rule.

Summary: This potential error has major implications for the entire OPPS rule-making process. The error also makes it difficult to assess if CMS appropriately measured the impact of the proposed E&M coding changes, in addition to every other proposal in the rule.

Update: The new files released by CMS on August 28 provide updated weights for APC 0634. With the updated files, CMS is now reporting a result within $0.40 of our result. However, this update also forced a recalculation of all of the other weights and payment amounts. In a correction notice that CMS issued on September 5th, CMS gave an explanation of how this error occurred.

Inconsistent status indicators in CMS published appendices

Please note: This analysis was conducted prior to the update at the end of August. Based on a preliminary review, we believe that CMS corrected the inconsistencies with the codes with the J1 status indicators, however, some of the others are still present.

In order to determine the appropriate payment weights for particular procedures, CMS pulls lines from the claims to create single claims. The creation of these singles depends on the categorization of HCPCS procedure codes listed on each line. The HCPCS codes (and certain revenue centers) are categorized using a "status indicator" that CMS assigns to each HCPCS code. CMS reports the status indicator for HCPCS codes in two files accompanying the rule: Addendum B and the Cost Statistics file.

We have found multiple instances where the status indicator for a code is inconsistent across the different files that CMS has released. We are unable to determine which status indicator CMS used in its rate-setting (or whether different status indicators were used for different parts of the methodology). An error in the status indicator assignment will affect the creation of singles and geometric mean costs across multiple procedure codes.

The following table provides details on inconsistencies we were not able to reconcile.

		From Addendum B			From Cost Statistics File		
HCPCS	Short Description	SI	APC	Payment Rate	SI	APC	Payment Rate
22526	Idet single level	E			T	0050	2598.32
27216	Treat pelvic ring fracture	E			T	0050	2598.32
33233	Removal of pm generator	Q2	0088	3294.15	J1	0106O	5873.24
75635	Ct angio abdominal arteries	Q2	0662	283.78	Q3	0662	283.78
75962	Repair arterial blockage	N			J1	0083O	4541.84
75966	Repair arterial blockage	N			J1	0083O	4541.84
93619	Electrophysiology evaluation	Q3	0085	11517.62	J1	0085O	11517.62
93620	Electrophysiology evaluation	Q3	0085	11517.62	J1	0085O	11517.62
93650	Ablate heart dysrhythm focus	Q3	0085	11517.62	J1	0085O	11517.62
96110	Developmental screen	E			S	0373	116.42

In particular, we note HCPCS code 33233 for "Removal of PM generator." Depending on the data source, this code is assigned to two distinctly different APCs, complete with different

payment rates. This should not be possible given CMS' described methodology. This leads us to believe that either CMS made a mistake or has not fully documented its methodology.

The inconsistency in the assignments of the other codes will have an effect primarily on the codes and APCs listed, but will also have secondary effects on all other statistics in the system. Also, the J1 codes are a new proposed code for Comprehensive APCs—a significant change proposed for the first time in the current rule.

Summary: The problems found with consistency of Status Indicators could affect weights and payment amounts throughout the entire system. In addition, the inconsistency on a select group of HCPCS codes with J1 status indicators poses problems for those seeking to appropriately comment on the CMS Comprehensive APC proposal.

Update: The newly released files correct the status indicator inconsistencies for some, but not all codes. The J1status indicators appear to be corrected. In the correction notice of September 5th, CMS describes adjusting these status indicators, but not how the errors occurred. In addition, inconsistencies remain.

Evaluation & Management Codes and the Bypass list

Please note: This issue does not appear to be addressed at all from the CMS updated files, and so is still an unresolved issue.

In the proposed rule, CMS proposed collapsing 10 different E&M HCPCS codes into a single new HCPCS code, and assigning the codes to a new APC. Table 29 in the rule illustrated this proposal, with HCPCS code ranges 99201-99205 and 99211-99215 assigned to a single new HCPCS (placeholder of "GXXXC") code and APC 0634.

To be analytically consistent, all of these codes should be treated the same way for determination of single bills. However, Addendum N of the rule lists which codes are considered "bypass" codes. Bypass codes are treated in a certain way for identification of singles, and are believed to include only minor amounts of packaging.

However, as can be seen from Addendum N, only 8 of the 10 codes proposed for APC 0634 are on the bypass list. 99211 and 99215 are not included on the bypass list.

Our understanding of the current methodology based on our review of the current and previous years' rules have no circumstances where it is possible to have a non-imaging code only be considered a "bypass" code some of the time.

This inconsistency then raises issues as to the appropriate calculation of the new E&M APC, and all associated weights. It is not possible to tell if:

1) Addendum N is wrong, and all codes in this range should be on the bypass list;
2) Addendum N is wrong, and none of the codes should be on the bypass list;
3) There is a new policy that has not been sufficiently documented; or

4) There was a mistake in CMS calculations.

Since this is the "reference APC" which all weights are assigned off of, this inconsistency is problematic.

Summary: This inconsistency raises questions as to the creation of APC 0634, which leads to issues both in other weights, and also for the ability to appropriately comment on the E&M proposals in particular.

Update: The newly released files do not address the inconsistencies in the bypass list. This issue is also not addressed in the correction notice update of September 5th.