

Lead

CY 2014 OPPS Proposed Rule Data & Member Feedback Discussion

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OPPS Proposed Rule

- Published in Federal Register on July 19, 2013, at page 43534.
- Available at: http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16555.pdf
- Comments due Friday, Sept. 6 at 5pm



Comment Letter Themes

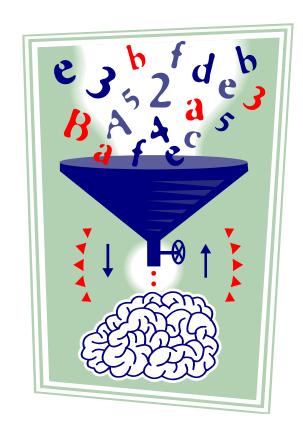
- Data Errors
- Impossibility of teasing apart impacts of various proposals
- Recommend waiting and re-proposing in future years
- Administrative Procedure Act concerns



Data Discussion



Attempt at Comic Relief



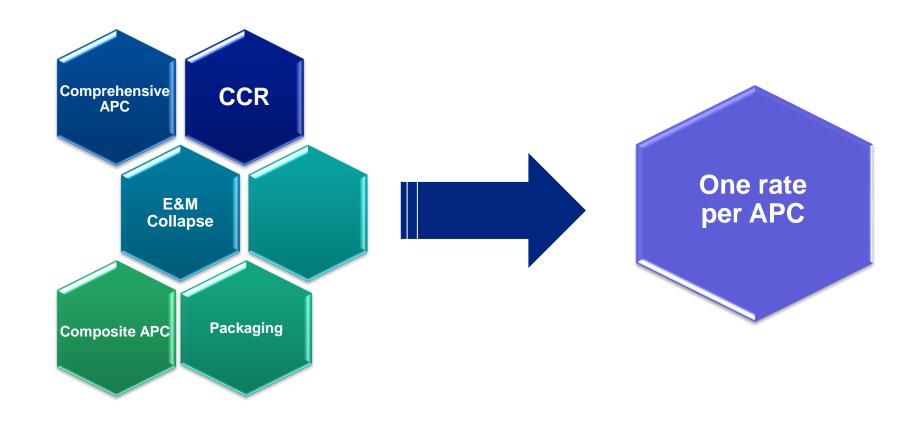
Brain before release of OPPS regulations



What's left after trying to understand it all



Many Interacting Proposals with Planned Simultaneous Implementation





Steps in Rate Setting: How Proposals & Identified Errors Impact Rate Setting*

CCR

- Using UB-04 claims from the most recent year (2012), revenue codes are mapped to cost centers for cost calculation.
- CCR for MRI & CT dramatically reduced.

Wage Index

• For the first time in memory, 0.5% of claims have no wage index.

Create Singles

- Claims are divided into single and multiple procedure categories.
 Where possible, multiples are further divided into "pseudo singles".
- Due to complexity of multiples, many (more than 40%) of claims are not eligible to be included in rate setting.
- Complex, multi-procedure services are more likely to be excluded.



^{*}Not all steps are presented in the order in which they occur as order is not always discernable from proposed rule.

Steps in Rate Setting: How Proposals & Identified Errors Impact Rate Setting

Packaging

- For single majors, "pseudo singles", and bypass claims, packaged services are attached.
- A large number of ancillary services and lab services that were not previously packaged now are; multiple packaging proposals.

Collapse E&M

- All E&M clinic visits would be collapsed into APC 0634. All Type A ED visits would be collapsed into APC 0635 and Type B into APC 0636.
- All now would include visit and packaging, including clinical labs.
- Not all E&M codes make the bypass list.

Assign Costs

- Costs are assigned by summing charges for procedures and associated packaged items and multiplying by the CCR.
- Within each APC, costs are distributed, outliers are trimmed, and the geometric mean is calculated.



Steps in Rate Setting: How Proposals & Identified Errors Impact Rate Setting

Determine Weight

- The geometric mean cost for each APC is then divided by the geometric mean cost for APC 0634 (collapsed E&M).
- We are unable to replicate the cost for APC 0634 and differ from CMS by more than 10%.

Price

- The weights by APC are then calibrated to the budget neutral spending target.
- The finalized weight is multiplied by the proposed conversion factor (\$72.728) to arrive at payment.



Steps in Rate Setting: How Proposals & Identified Errors Impact Rate Setting

Comprehensive APC

- Proposal to create 29 comprehensive APCs to replace 29 existing device-dependent APCs. Includes primary service and all adjunctive services (entire claim).
- Proposal will increase volume of claims used to estimate costs.

Composite APC

- Since 2008, CMS has used composite APCs to make a single payment for groups of services performed together.
- Cardiac resynchronization therapy services moving to a new, comprehensive APC.



Practical Examples

Type A ED Visit Codes with Packaging & Costs (APC 0635: Weight = 2.9274, Payment Rate = \$212.90)

HCPCS	Single Claims* (n)	Claims w/Packaging (n)	% with Packaging	Average Packaging Cost
99281	269,444	69,612	25.8%	\$15.22
99282	849,892	373,368	43.9%	\$30.17
99283	2,601,017	1,892,004	72.7%	\$74.34
99284	1,863,203	1,631,595	87.6%	\$151.48
99285	1,039,350	976,417	96.9%	\$342.18

^{*}ED singles and "pseudo singles" from Moran replication to identify whether these codes have packaging codes.



Practical Examples

Type A ED Visit Codes "Singles vs. Totals" Used in Rate Setting by HCPCS

HCPCS	Single Frequency	% of All Singles	Total Frequency	% of All Total	% Used in Rate Setting
99281	267,680	4.0%	310,887	2.4%	86.1%
99282	848,900	12.5%	1,144,129	8.7%	74.2%
99283	2,615,562	38.6%	4,145,332	31.4%	63.1%
99284	1,949,746	28.8%	4,639,087	35.2%	42.0%
99285	1,091,688	16.1%	2,951,145	22.4%	37.0%
TOTAL	6,773,576	100.0%	13,190,580	100.0%	51.4%

Data Source: CMS Rate Setting tables provided with proposed rule.



Practical Examples

Type A ED Visit Codes: Proportion of Claims with ED Visit as Only Major Procedure on Claim

HCPCS	Claims* (n)	Claims w/ED as Only Major Procedure (n)	% with ED as Only Major Procedure
99281	310,433	236,649	76.2%
99282	1,142,881	630,007	55.1%
99283	4,140,210	1,177,833	28.4%
99284	4,633,873	336,063	7.3%
99285	1,947,243	113,519	4.0%

^{*}Moran used claims before rate setting to identify whether there are no other major procedures in the same claim.



Summary

- Very difficult to peel out the impact of each new proposed policy; too much interaction.
- Attempts to recreate CMS methodology further confounded by likely errors in support materials provided by CMS.
- OPPS has always been biased by dropped claims, but new collapsing policy adversely effects institutions with a preponderance of high intensity services.



And Now Think Zen Thoughts



Follow Up from Member Survey



Questions Posed to Members Through Reimbursement List

- Information collection on off-campus providerbased departments
 - Members split on preferring claims-based vs. cost report-based data collection
- Policy premise of collapsing E/M codes
 - Members split, but majority opposed concept
- Reporting of no cost / full credit and partial credit devices
 - Members expressed various concerns with overall policy







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