The premier education and advocacy organization for the oncology team

ACCC
Association of Community Cancer Centers

September 6, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201

RE: CMS-1601-P: (Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs)

Dear Administrator Tavenner:

On behalf of the Association of Community Cancer Centers (ACCC), we appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding revisions to the hospital outpatient prospective payment system (OPPS), published in the Federal Register on July 19, 2013 (the "Proposed Rule").[1]

ACCC represents more than 18,000 cancer care professionals from approximately 1,100 hospitals and more than 1,000 private practices nationwide. These include Cancer Program Members, Individual Members, and members from 28 state oncology societies. It is estimated that 60 percent of cancer patients nationwide are treated by a member of ACCC.

ACCC is committed to ensuring that cancer patients have access to the entire continuum of quality cancer care, including access to the most appropriate cancer therapies in the most appropriate settings. Hospital outpatient departments

[1] 78 Fed. Reg. 43534 (July 19, 2013).

(HOPDs) are a crucial part of the cancer care delivery system, providing a significant portion of this country's cancer care. In fact, according to ACCC's annual report on Trends in Community Cancer Centers, the amount of care delivered in the HOPD department has grown in recent years, compared to care delivered in the physician office setting.[2] Because advanced cancer treatments often are associated with considerable risk, several are available only through hospital-based oncologists, nurses, and pharmacists. Patients receiving these treatments must have substantial on-site clinical support in case of adverse reactions. ACCC members often serve patients who have numerous complications or histories of infusion reactions. In addition, some treatments, such as those involving radiopharmaceuticals, are available only in hospitals because they require specialized equipment and handling that is only available in that setting. Finally, HOPDs play an important role in the early adoption of new technologies and frequently serve patients who recently have completed participation in clinical trials.

Our members also play an important role in the health care safety net. In some cases, HOPDs are the only sites available for Medicare and uninsured patients who need cancer care. HOPDs also are becoming the only option for Medicare beneficiaries who lack supplemental insurance. In addition, sequestration cuts to Medicare providers have led to an increase in beneficiaries seeking care in HOPDs, according to an ACCC survey from June 2013.[3] As hospitals face growing numbers of patients who need care for cancer and other serious illnesses but have nowhere else to turn, their ability to continue to provide care will depend on Medicare's payment rates.

Adequate OPPS payment rates for cancer drugs[4] and the services required to prepare and administer them are critical to ensuring patient access to care. We are once again encouraged that CMS proposes a payment rate of Average Sales Price (ASP) plus six percent to cover the cost of drug acquisition and related pharmacy overhead services costs.

We are deeply concerned, however, about the breadth of CMS's proposals to package payment for many items and services, including for many drug administration codes, and the significant problems that analysts have found in CMS's rate-setting calculations. None of the three analysts who traditionally have replicated CMS's OPPS methodology could replicate it this year. Instead, they have found serious errors that call into question the accuracy and completeness of CMS's analysis and have been unable to provide clients with the data analyses they require to form thoughtful, data-driven arguments to support their comments. We have attached four memoranda to this comment letter that describe these data issues in depth. Overall, we believe these data errors have prevented the public from commenting meaningfully on the Proposed Rule. We agree with the Advisory Panel on Hospital Outpatient Payment ("HOP Panel") recommendation that "CMS delay implementation of the CY 2014 proposals regarding

[2] Trends in Community Cancer Centers: A Survey of ACCC Membership, 2013, http://www.accc-cancer.org/surveys/CancerCareTrends-2013-introduction-openaccess.asp.
[3] ACCC Survey Shows Impact of Sequester Across All Sites of Service, June 12, 2013, http://www.accc-cancer.org/mediaroom/press_releases/2013/ACCCPR-06-12-13.asp.
[4] We refer to drugs, biologicals, and radiopharmaceuticals collectively as "drugs" throughout our comments.

comprehensive APCs, expanded packaging, visit reconfiguration, and cost-center-based reimbursement changes for computed tomography (CT) and magnetic resonance imaging (MRI) until data can be reviewed by the Panel at its spring 2014 meeting regarding interactions between the proposals and their potential cumulative impact."[5] As described in depth below, ACCC urges CMS to not implement the proposed changes in packaging and other policies until it clarifies its proposals, corrects the proposed payment rates, and provides an opportunity for stakeholders to comment meaningfully on the revised rates.

It is imperative to continued patient access in this crucial setting that the OPPS rates in 2014 and beyond adequately reimburse hospitals for the costs of providing advanced cancer therapies. Toward this end, ACCC recommends that CMS:

- Implement the proposal to reimburse hospitals for the acquisition cost of separately payable drugs at ASP plus six percent;
- Make separate payment for all drugs with Healthcare Common Procedure Coding System (HCPCS) codes, or, at a minimum, not increase the packaging threshold for drugs;
- Reinstate separate payment for diagnostic radiopharmaceuticals and contrast agents;
- Not implement the proposal to change the calculation for payment rates of computed tomography (CT) scans and magnetic resonance imaging (MRI);
- Not implement the proposal to consolidate clinic and emergency department evaluation and management (E&M) codes from five levels to one level;
- Not implement the proposal to expand packaging for additional items and services until the agency corrects the significant errors and inconsistencies in the proposed rates, provides opportunity to comment on the corrections and clarifications, and reviews those comments;
- Implement the proposed payment rates for low dose rate prostate brachytherapy;
- Not implement the proposed changes to ambulatory payment classifications (APCs) for Proton Beam Therapy (0664 and 0667);
- Work with ACCC to study the issue of payment to services rendered in an off-campus hospital-based department; and
- Implement the proposal for prospective payment system (PPS)-exempt cancer hospitals payments in the same manner as 2013.

Our comments on these issues and others are presented below.

[5] CMS, Advisory Panel on Hospital Outpatient Payment, August 26-27, 2013, Final Recommendations, available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.

I. Proposed Payment for Drugs and Biologicals Without Pass-Through Status That Are Not Packaged

A. CMs should reimburse all separately payable drugs and biologicals without pass-through status at ASP plus six percent.

We are encouraged that CMS proposes to continue to reimburse all separately paid drugs without pass-through status at ASP plus six percent.[6] ACCC is very pleased that CMS has retained this payment rate from 2013.

In our comments on prior years' proposed rules, we have explained the importance of appropriate payment for pharmacy overhead and service costs to hospitals' continued ability to provide cancer drugs to patients. The advanced drugs we use to help our patients fight cancer require careful handling by specially trained personnel to ensure that each patient receives the correct dosage of each drug, in the correct sequence, and through the safest administration method. Hospitals employ complex medication use processes in which physicians, nurses, and pharmacists review drug choices at each step of their prescribing, dispensing, and administration. Pharmacists make essential contributions to these processes by using a sequence of activities commonly referred to as "safety through redundancy." Registered pharmacists consult with physicians to determine drug interactions and contraindications, toxicity management and verification of therapy appropriateness, and dosing before and during administration of chemotherapy to a patient. Pharmacists also perform critical quality assurance tasks during the preparation of a drug, such as labelling, recording, and tracking mixed drugs for safety purposes, sampling drugs at random to verify quality, and developing and reviewing protocols to flag potential interactions. The costs of these services, plus necessary supplies, equipment, and facilities used in preparing drugs, are significant. It is critical that Medicare's reimbursement amounts reflect the current costs of providing care, and with the proposed change in methodology and payment rate, we feel CMS has recognized this need.

Payment for the acquisition and overhead costs of drugs at ASP plus six percent will help to continue to protect patients' access to care in the most clinically appropriate setting. It also would maintain parity with the physician office setting. To provide for stable, appropriate payment, CMS should continue to reimburse drugs provided under the OPPS at ASP plus six percent.

B. CMS should make separate payment for all drugs with HCPCS codes, or, at a minimum, not increase the packaging threshold for drugs.

For 2014, CMS proposes to increase the packaging threshold to $90 and to continue to package payment for all diagnostic radiopharmaceuticals and contrast agents.[7] We are concerned that continued use of any threshold and the implementation of expanded packaging could harm hospitals' ability to provide essential cancer care. Even if CMS implements our

[6] 78 Fed. Reg. at 43608-09.
[7] Id. at 43604-05.

other recommendations to maintain appropriate payment for acquisition and pharmacy overhead costs for separately payable drugs, we remain concerned that packaging may discourage hospitals from providing appropriate care.

As in previous years, we continue to be troubled by CMS's policy of packaging payment for contrast agents and diagnostic radiopharmaceuticals. CMS explains that it believes these drugs function as supplies and are not subject to the statutory payment requirements for specified covered outpatient drugs (SCODs). This interpretation disregards both the plain language of the statute and Congressional intent behind the detailed statutory payment requirements for SCODs. Congress enacted these provisions after CMS set a high packaging threshold in 2003, and we believe that Congress intended for CMS to continue to protect access to care by keeping the packaging threshold low. For these reasons, we recommend that CMS make separate payment for all 5-HT3 anti-emetics, contrast agents, diagnostic radiopharmaceuticals, and all other drugs with HCPCS codes. At a minimum, CMS should maintain the packaging threshold at no more than the current level of $80.

C. CMS should reinstate separate payment for diagnostic radiopharmaceuticals and contrast agents.

CMS proposes to continue to package payment for diagnostic radiopharmaceuticals and contrast agents, regardless of their cost per day.[8] Radiopharmaceuticals are extremely complex therapies to prepare and administer. Preparation and administration of each drug requires a unique bundle of services, such as compounding, infusions, and scanning of the patient to assess bio-distribution of the therapy. The costs of these services vary for each drug, and many of these costs are not reimbursed adequately under the OPPS. Contrast agents also vary in cost and may not be compensated adequately through the OPPS rates for imaging services. We urge the agency to reinstate separate payment for diagnostic radiopharmaceuticals and contrast agents.

II. CMS should not implement the proposal to change the calculation for payment rates for CT scans and MRI.

CMS proposes that, beginning in CY 2014, the agency will calculate the OPPS relative payment weights using distinct cost-to-charge ratios (CCRs) for CT scans and MRI. As ACCC stated in its comments on the CMS Inpatient Prospective Payment System (IPPS), submitted on June 25, 2013, the proposed CCRs do not adequately capture the full costs of providing these services. According to the Proposed Rule, this change will result in reductions of 15 to nearly 40 percent in reimbursement for MRI and CT APCs. For many services, the proposed payment rates for a CT scan are almost equal to an X-ray of the same anatomy, even though the CT scan clearly requires more resources to perform. For example, the proposed payment rate for a CT of the abdomen is $113.21,[9] only $6 more than the proposed rate for an abdominal X-ray. ACCC is concerned that these payment reductions could harm access to imaging services that are critical

[8] Id. at 43601.
[9] NPRM Corrected Files, http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/NPRM-2014-vG-082213.zip/.

to providing effective cancer care. ACCC requests that CMS not implement the proposed changes in order to protect access to these important technologies in the HOPD.

III. CMS should not implement the proposal to consolidate clinic and emergency department E&M codes from five levels to one level.

CMS proposes to replace the current five-levels of codes and APCs for clinic and emergency department visits to a single code for all clinic visits and one code for each type of emergency department visit.[10] The proposed payment rate for the new APCs are less than the current payment rates for mid-level visits, despite CMS's proposals to expand packaging that should increase the costs included in calculation of these rates. Overall, we are extremely concerned that the proposed rates will not be adequate to reimburse hospitals for the advanced level of services cancer patients often require.

As discussed in detail below, ACCC is concerned that data issues may have caused significant errors in the proposed rates, particularly because of the interaction between the expanded packaging together with the consolidation of the levels. These concerns were echoed by the HOP Panel at the August meeting, and in addition to its general recommendation that implementation of multiple proposals be delayed until data can be reviewed by the Panel at its spring 2014 meeting regarding interactions between the proposals and their potential cumulative impact, the Panel made a specific recommendation that "CMS postpone moving forward with the calendar year (CY) 2014 proposal to collapse the existing visit evaluation and management Current Procedural Terminology (CPT) codes into three G codes."[11] We completely agree with the HOP Panel and urge CMS to not implement this proposal.

IV. CMS should not implement the proposal to expand packaging for additional items and services until the agency corrects the significant errors and inconsistencies in the proposed rates, provides an opportunity to comment on the corrections and clarifications, and reviews those comments.

ACCC recognizes CMS's desire to continue to expand bundling and packaging in the OPPS. We remain concerned, however, that CMS's continued expansion of packaging, including packaging of guidance services, may negatively affect patients and hospitals. In the proposed rule for 2011, CMS presented the results of its analysis of billing for radiation oncology guidance services in 2007, before expanded packaging, and in 2009, after expanded packaging. CMS reported increases in the number of intensity modulated radiation therapy (IMRT), stereotactic radiosurgery (SRS), and brachytherapy services billed and total payments for those procedures, but found a 20 percent reduction in the frequency of billing for

[10] 78 Fed. Reg. at 43615.
[11] CMS, Advisory Panel on Hospital Outpatient Payment, August 26-27, 2013, Final Recommendations, available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.

conventional radiation therapy services and a 10 percent reduction in total payment for those services.[12]

This year CMS has expanded its proposed packaging policies even further than in years past. For 2014, CMS proposes several significant changes to the OPPS, including expanded packaging for seven categories of items and services, new codes for clinic and emergency department visits that do not differentiate among visits based on the level of care provided, and conversion of 29 device-dependent APCs into new comprehensive APCs that package payment for numerous items and services into a single payment. These proposals produce dramatic changes in payment for the services that would remain separately payable. It is difficult to assess whether these payment rates have been calculated accurately to reflect the broad array of items and services that could be packaged into payment during a single episode of care.

We are deeply troubled by the fact that none of the three analysts who traditionally have replicated CMS's OPPS methodology could replicate it this year. Instead, they have found serious errors that call into question the accuracy and completeness of CMS's analysis and have been unable to provide clients with the data analyses they require to form thoughtful, data-driven arguments to support their comments. Attached to this comment letter are the following four memoranda that describe these issues in depth:

- Reproducibility of the 2014 NPRM OPPS Rule; Susan E. White, Ph.D., CHDA, President, Health Data Analytics, LLC
- Issues in the CY2014 Proposed Outpatient Prospective Payment System (OPPS) Rate-setting Process; The Moran Company
- Issues in the Reproducibility of OPPS Payment Policies in the FY 2014 Rule; Christopher Hogan, Ph.D., Direct Research, LLC
- Why Is It So Hard to Model the OPPS Rates; Christopher Hogan, Ph.D., Direct Research, LLC

Although we appreciate that CMS issued a correction notice to the Proposed Rule yesterday[13] and made corresponding changes to the addenda and supporting files on the agency's website, we are concerned that these changes are too little, too late. The revisions do not address all of the issues raised in the attached memoranda, and adding only ten more days to the comment period does not give the analysts and the public sufficient time to analyze them completely. Even with the new files, the analysts still have not been able to replicate CMS's methodology.

For example, The Moran Company was not able to replicate CMS's calculation of the payment rate for APC 0634, the proposed new APC for clinic visits. In addition, CMS appears

[12] 75 Fed. Reg. 46170, 46222 (Aug. 3, 2010).
[13] CMS, Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals; Correction and Limited Extension of Comment Period, 78 Fed. Reg. 54842 (Sept. 6, 2013).

to have treated the evaluation and management codes assigned to new APC 0634 inconsistently, raising questions about the accuracy of the proposed payment rate. These errors affect payments across the OPPS because APC 0634 is the proposed base APC used to establish weights for all other APCs. The Moran Company also found inconsistencies in the published status indicators and payment rates in the Proposed Rule's appendices. These errors are complex and interconnected, and correct payment rates cannot be calculated until CMS clarifies its data and methodology. Stakeholders are not able to provide meaningful comments on the Proposed Rule until CMS clarifies its methodology, corrects the errors, and publishes the revised rates for review. Susan White of Health Data Analytics, LLC identified similar issues with replicating CMS's calculations, and noted that she was unable to determine CMS's logic for packaging costs into codes with status indicator Q1. In addition to issues similar to those identified by The Moran Company, Chris Hogan of Direct Research LLC found challenges in understanding the description of the comprehensive APCs. Mr. Hogan explains that the OPPS is inherently difficult to model with logical, consistent results due to unpredictable interactions between the large body of ad hoc rules that govern the system and the mix of unrelated services on each of the underlying claims. As the system has grown more complex, it is increasingly difficult to verify that it operates in a consistent manner.

We urge CMS to not implement any of the proposed changes in packaging for 2014, and proceed carefully in revising its calculations, presenting a clear explanation of the data and methodology to the public, and considering comments on corrected rates and data. We strongly support the HOP Panel's recommendation that "CMS delay implementation of the CY 2014 proposals regarding comprehensive APCs, expanded packaging, visit reconfiguration, and cost-center-based reimbursement changes for computed tomography (CT) and magnetic resonance imaging (MRI) until data can be reviewed by the Panel at its spring 2014 meeting regarding interactions between the proposals and their potential cumulative impact."[14]

Even if we could be assured that the proposed rates are correct, ACCC is very concerned about the effect of these proposals on cancer care. The proposal to bundle additional hours of chemotherapy administration with the initial administration APC code appears to increase the reimbursement for most of the chemotherapy administration APCs for CY 2014, but it will ultimately result in reduced reimbursement for cancer centers if hospitals are not required to continue to report codes and charges for the packaged services. We share the same concerns about the proposal to increase packaging in radiation oncology services. CMS also proposes to package payment for all clinical diagnostic laboratory tests. It is difficult to assess whether the proposed rates for separately payable services are adequate to support continued use of these important services due to the variety of tests used in cancer care and the number of procedures into which payment might be packaged. These tests are essential to quality cancer care and we urge CMS to not implement any packaging policies that would impede hospitals' ability to furnish these tests to beneficiaries fighting cancer.

[14] CMS, Advisory Panel on Hospital Outpatient Payment, August 26-27, 2013, Final Recommendations, available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.

ACCC urges CMS to continue to make separate payment for radiation oncology procedures and for all additional hours of chemotherapy infusion and administration. These services are vital to the practice of oncology, and unconditionally packaging payment for them may discourage hospitals from providing them.

V. CMS should implement the proposed payment rates for low dose rate (LDR) prostate brachytherapy.

For CY 2014, CMS proposes to continue paying for LDR prostate brachytherapy services using the composite APC methodology proposed and implemented for CY 2008 through CY 2013. The proposed cost for composite APC 8001 is approximately $4,340.[15] This proposed payment rate is an increase compared to the CY 2013 payment for this composite APC of approximately $3,348.[16] Brachytherapy is an important treatment option for prostate cancer, and ACCC appreciates CMS's work to ensure that payment for this composite APC reflects hospitals' costs. We ask CMS to implement the proposed payment increase for this composite APC.

VI. CMS should not implement the proposed changes to APCs for Proton Beam Therapy (0664 and 0667).

In 2014, CMS is proposing to reassign CPT codes 77520 and 77522 from APC 0664 to APC 0667 and to revise the title of APC 0667 to "Proton Beam Radiation Therapy" that now would include all proton beam radiation therapy services with a proposed payment rate of $973.40.[17] CMS proposes to delete APC 0664.[18]

ACCC is concerned that these changes will result in a decrease in reimbursement for 77520 and 77522 of roughly 13%. Combined with changes from 2013, these are significant reimbursement reductions, especially given the high cost of equipment in proton beam therapy. ACCC requests that CMS not implement the proposed changes and instead continue to work closely with the limited number of hospitals that offer proton beam therapy to establish more appropriate payment rates.

VII. CMS should work with ACCC to study the issue of payment to services rendered in an off-campus hospital-based department.

In the Proposed Rule, CMS recognizes the issue that, as a result of consolidation of practices and hospitals, many more claims are being submitted under the Hospital OPPS, as opposed to the PFS. This change results in higher total Medicare payments, due to differences in

[15] 78 Fed. Reg. at 43563.
[16] 77 Fed. Reg. 68210, 68244 (Nov. 15, 2012).
[17] NPRM Corrected Files, http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/NPRM-2014-vG-082213.zip.
[18] 78 Fed. Reg. at 43593.

reimbursement levels between physicians' offices and hospital outpatient departments, and also higher patient financial responsibilities. CMS would like to know how best to capture the data from these off-campus hospital-based facilities to determine if the higher payments are justified.[19]

ACCC appreciates the opportunity to work with CMS on this issue, and we also commend CMS for reaching out to the community to determine the best method to collect data. ACCC encourages CMS to proceed carefully, however, to ensure that the data collection efforts do not create an extra administrative burden on these facilities and providers. If CMS were to require the reporting of a payment modifier for all services offered in an off-campus department, ACCC would ask that it be administratively simple to implement through electronic health records. We also ask that CMS limit the data collection requirements to physician offices that recently became provider-based. For example, CMS could limit the reporting to off-campus facilities that had been, until sometime in the past five years, a facility billing under the physician fee schedule.

VIII. CMS should implement the proposal for PPS-exempt cancer hospital payments in the same manner as 2013.

Section 3138 of the Patient Protection and Affordable Care Act (ACA) required the Secretary of Health and Human Services to study whether the 11 PPS-exempt cancer hospitals incur greater outpatient costs than other hospitals. If the cancer hospitals' costs were determined to be greater than the costs of other hospitals paid under the OPPS, as CMS found in 2010, then the Secretary shall provide an appropriate adjustment to reflect these higher costs. Section 3138 also requires that this adjustment be budget neutral, and it was to have been effective for outpatient services provided at cancer hospitals on or after January 1, 2011. After CMS's original proposal received numerous comments, CMS tabled the change in payment, and then suggested a revised proposal in the 2012 rule. The proposal was further refined after the comment period and finalized by providing additional payments to cancer hospitals so that the hospital's payment-to-cost ratio (PCR) with the payment adjustment is equal to the weighted average PCR for the other OPPS hospitals using the most recent submitted or settled cost report data.

For 2014, CMS is proposing to continue the adjustment to these hospitals in a manner similar to that in 2013.[20] ACCC agrees with this proposal and asks CMS to implement it. ACCC supports increasing the payments to these hospitals, but at the same time, we believe that the impact to all other hospitals should be as minimal as possible.

[19] Id. at 43626-27.
[20] Id. at 43582-83.

IX. Conclusion

ACCC encourages CMS to protect cancer patients' access to quality care in the most appropriate setting by providing appropriate reimbursement for cancer treatments under the OPPS. Toward this end, we urge CMS to implement its proposal to pay ASP plus six percent for the acquisition cost of separately payable drugs. We also highly recommend that CMS not move forward with its proposals to bundle more items and services, including drug administration add-on codes and consolidating all E&M levels into a single level of service. We are deeply concerned by the problems that analysts have found in CMS's rate-setting calculations. It is imperative that CMS not implement the proposed changes in packaging and other policies until it clarifies its proposals, corrects the proposed payment rates, and provides an opportunity for stakeholders to comment meaningfully on the revised rates.

ACCC appreciates the opportunity to offer these comments. We look forward to continuing to work with CMS to address these critical issues in the future. Please feel free to contact Matthew Farber at (301) 984-9496, if you have any questions or if ACCC can be of further assistance. Thank you for your attention to these very important matters.

Respectfully submitted,

Virginia Vaitones

Virginia T. Vaitones, MSW, OSW-C
President
Association of Community Cancer Centers (ACCC)

Attachments

Issues in the reproducibility of OPPS payment policies in the FY 2014 rule

By Christopher Hogan, Ph.D., Direct Research, LLC

This paper summarizes difficulties I had replicating the OPPS 2014 proposed rule APC-level geometric mean costs. It focuses on issues that first arose in the 2014 rule. Throughout, I reference the OPPS 2014 proposed rule and associated data files as originally posted by CMS. The corrected files, posted by CMS on 8/28/2013, are referenced only where noted.

I place the problems in six categories. In some cases, I can show where CMS clearly appears to have made an error. In others, I can only show that my calculated rates differ from the CMS rates or that CMS may or may not have shown significant relevant information.

Theses areas are:

1) Some inputs to the rate-setting (the bypass list, the rates use to find highest-cost codes on claims) reflect prior-year rules. Making them consistent with proposed rules would create large changes in some APC rates.
2) The description of the comprehensive APCs required clarification. APC 0085 cost is much too high due to duplication of composite APC 8000 claims.
3) The visit APC costs appear wrong and are inconsistent between APC and CPT cost file.
4) Radiosurgery excluded certain obsolete codes.
5) Other miscellaneous surprises (e.g., missing wage index data).
6) Residual unexplained discrepancies between published and calculated rates.

A separate document describes why modeling the OPPS rates is so difficult.

1 Updating the inputs to the rate-setting process to reflect the new rules

CMS uses 2013 and earlier rules for some inputs to the rate calibration. When CMS says it selects the highest-paid service on a claim, it always means highest-paid based on *last year's rates*. (This is typically left unsaid, and is only stated in passing for Q2 services.) And, while CMS provides rules for inclusion of services on the bypass list, CMS typically (though not always) keeps services on the bypass list that it identified in prior year rules, without testing whether they continue to meet the criteria.

In years when changes in the rules are small, feeding obsolete (prior year) information into the rate-setting process is an understandable shortcut. As CMS makes the first pass through the data, it does not yet have the proposed-rule payment rates. Using current-year data would require passing through the data at least twice. In a typical year, the use of the obsolete data has only minimal impact on the rates. It scarcely matters that the way the payment rates are calibrated is not the way the claims will actually be paid.[1]

However, this year when packaging rules and payment rates shift dramatically, the CMS methods may show only part of the full transition to the new rates. The way services are *sorted to generate* the 2014 rates differs from the way they are *sorted to be paid under* the 2014 rates. For the bypass list, analysis by Dr. Susan White shows that the majority of codes on the list no longer meet CMS' criteria, largely as a consequence of the enhanced packaging rules. CMS can either ignore the inconsistency or review the bypass list in light of the change in packaging. If the latter, a revised bypass list will change the set of claims counted as "single-procedure" claims, resulting in changes in the APC rates.

The upshot is that applying the new rules consistently – using the 2014 prices to determine highest-paying codes, and using 2014 packaging to determine the bypass list -- will generate materially different rates than those shown in the proposed rule.

Table 1 shows high-volume APCs that will undergo the largest gains and losses if the rate calibration were made completely consistent. This table was derived by using 2014 prices to find highest-paying codes on claims, and constructing the bypass list using CMS's criteria along with the 2014 packaging rules.[2] The first two columns of numbers are CMS published data. The third column shows that we can replicate the CMS geometric means reasonably well. The fourth column shows what will happen (in 2015, say), when CMS uses 2014 prices as input to the rate calibration, and makes the bypass list consistent with the new packaging rules.

Whether or not CMS erred in failing to note this is debatable. Most of the change is due to making the bypass list consistent with CMS's criteria and new packaging rules. The original intent of the bypass list was to find codes that seldom involved significant packaged costs. But with the proposed packaging policy, most of those codes now include such costs. CMS could just ignore that inconsistency. But if it does not, the rates will eventually change as shown.

[1] When CMS actually pays the claims, it will use the current-year (i.e., 2014) rates to determine which APC is paid, for both the comprehensive APCs and for the conditionally-packaged services.

[2] Thanks to Dr. Susan White for supplying the revised bypass list.

OPPS 2014 Proposed Rule, Effect of Using Prior-Year Data as Inputs to Rate Calibration						
Services with at least 5000 single procedures, largest gains and losses if prices and bypass list were made consistent with 2014 proposed rule.						
		CMS as published		Calculated from file		
APC	group title	Single Frequency	Geo metric mean	Use 2013 prices to sort codes, use historical bypass list	Use 2014 prices to sort codes, make bypass consistent with packaging rules	% change
Largest losses, 2015 versus 2014						
0368	Level II Pulmonary Tests	107,935	$ 145	$ 147	$ 93	-37%
0635	Type A Emergency Visits	6,760,593	$ 215	$ 252	$ 196	-22%
0274	Myelography	9,565	$ 616	$ 609	$ 506	-17%
0099	Electrocardiograms/Cardiography	1,302,504	$ 74	$ 78	$ 66	-16%
0433	Level II Pathology	658,726	$ 59	$ 60	$ 54	-10%
0189	Level III Female Reproductive Proc	8,866	$ 216	$ 218	$ 197	-10%
Largest gains, 2015 versus 2014						
0059	Level I Strapping	33,054	$ 59	$ 60	$ 66	11%
0332	Computed Tomography w/o Contrast	3,612,764	$ 116	$ 117	$ 132	13%
0191	Level I Female Reproductive Proc	28,772	$ 11	$ 11	$ 12	13%
0344	Level IV Pathology	38,951	$ 280	$ 295	$ 336	14%
0367	Level I Pulmonary Test	23,202	$ 170	$ 175	$ 211	21%
0432	Level II Health and Behavior Svcs	21,989	$ 46	$ 46	$ 60	31%
0260	Level I Plain Film Except Teeth	9,468,810	$ 62	$ 63	$ 85	37%

2 Comprehensive APCs

The majority of my time spent modeling the OPPS rates this year was spent on the new comprehensive APCs. In theory, these should have been simple. With few exceptions, add up the costs on the claim, and then summarize by APC. In practice, I ran into several issues, and never did successfully model all of the comprehensive APCs.

2.1 Ambiguous language in the Rule, logically inconsistent method chosen by CMS

Most of the difficulty arose from one simple question: When two or more comprehensive-APC codes appear on a claim, which one is paid? The proposed rule (78 Fed Reg 43560) says this: "Any claims that contained more than one of these procedures were identified but were included in calculating the cost of the procedure that had the greatest cost when traditional HCPCS level accounting was applied."

Because the rates change so radically between 2013 and 2014, I originally assumed CMS meant a two-step process. Calculate average cost, under the 2014 rules, for the claims with just one procedure (traditional HCPCS level accounting). Then assign multi-procedure claims using the 2014-rules cost of the single-procedure claims. That would come as close as possible to an internally-consistent process (where the ordering used to calibrate the claims matches the one used to pay the claims).

In fact, based on conversations with Dan Duvall at CMS, claims were assigned based on highest 2013 payment on any line, with full accounting for units of service billed. The description in the text "that had the greatest cost when traditional HCPCS level accounting was applied" actually meant APC (not HCPCS), and payment (not cost). Traditional apparently meant 2013. This is inconsistent with the way these claims will be paid both due to use of prior-year rates, and due to inclusion of units in the calculation (CMS will only pay for one unit of a code).

The 'units' clause particularly shuffles discharges among claims where multiple device leads can be implanted with a device. This is illogical in the sense that there is a difference between the claims as calibrated and the claims as paid, i.e., some claims that contribute to the cost of one APC will actually be paid under a different APC.[3] This makes a difference of a few hundred dollars in the rates of a few comprehensive APCs.

2.2 Incorrect geometric mean cost for APC 0085

I spent considerable time puzzling out what CMS did with APC 0085 and composite APC 8000. In 2012 (file-year) CPT coding, APC 8000 requires codes in APC 0085. Summing the claim counts on the cost files, CMS clearly duplicated some claims, because the total grossly exceeds the APC 0085 claims on the file.

The answer is that the APC 0085 cost is grossly too high. It includes all of the expensive composite 8000 claims, and it should not. In 2014 CPT, those composites will (largely or entirely) be coded with new CPT codes that automatically place them into 8000. Excluding the APC 8000 composite claims, the geometric mean cost of 0085 falls from the listed value of $11,633 to $4,943. Unsurprisingly, that's just modestly higher than last year's value of $4,035.

2.3 Illogical data in the APC and CPT cost files, Addendum A and Addendum B file

For many of the new comprehensive APCs, CMS shows more single procedures than total procedures on the cost statistics file. That should be impossible. Mostly that is due to too low a total count on the cost file, but for three procedures CMS literally shows more comprehensive claims than there are claims on the file (APCs 0108, 0293, and 0318).

Another complication in calculation of comprehensive APC rates is the conflicting information on the payment status for HCPCS codes assigned to comprehensive APCs (status indicator J1). You can't use the payment status on Addendum B to flag the J1 codes. You have to take the

[3] While this may not immediately strike the reader as odd, consider the comment it would raise if under the IPPS, CMS randomly shuffled claims among MS-DRGs, purely as a side-effect of the rate calibration process. That's analogous to what the OPPS does for the composite APCs.

payment status for the APC, then flag all codes in that APC. For example, for APC 0085, to get CMS's 0085 claims count, one must ignore the status on Addendum B and treat all the codes as J1 codes. (Possibly, this related to the 0085 error discussed above – that CMS intended to treat those codes differently but did not.)

I don't know the extent to which CMS has or has not corrected this on the 8/28/2013 files.

3 Visit APCs

CMS's APC-level cost file values for the visit APCs do not match the (correctly-calculated) sum of the CPT-level data. My estimated match the CPT-level data. If you roll up the CPTs in APCs 634, 635, and 636, you end up with about the right singles count, but with a geometric mean that is 11%, 17%, 8% over the geometric mean showing on the APC file.

This error appears to have been corrected in the revised files that CMS related on 8/28/2013.

4 SRS/SBRT, omission of obsolete codes

For Stereotactic Radio Surgery (SRS) and Stereotactic Body Radio Therapy (SBRT), CMS, inconsistent with past and current practice, did not use the data for predecessor codes (G0173, G0251, G0339,and G0340) that are deleted in this rule to calculate the payment rate for the replacement codes (77371, 77372, and 77373). There were a few other codes that this applies to but the SRS/SBRT codes were the only ones with significant claim volume. This appears to be an error.

This error appears to have been corrected in the files released on August 28th.

5 Other new issues with the 2014 OPPS proposed rule

5.1 Missing wage index data

This year, for the first time ever, about 0.5% of claims have no wage index. This is for about 40 hospitals. Because this has never occurred before, I only found it by accident. It's not clear what CMS did with them. In all prior years, analysts either had to put the wage index on each claim (earlier years) or CMS put the wage index on each claim (later years). Either way, it has never been missing before.

5.2 Ambiguity of use of procedure-to-device edits

CMS says they propose to abandon the procedure-to-device edits, but the cost file is still "after screens". Not that it matters much in this file, as the claims wouldn't have been paid without satisfying the edits. But it would be nice to know what CMS actually did.

5.3 Inconsistencies between CMS CPT and APC cost files

In theory, the APC cost file is supposed to be a summary of the CPT cost file, ignoring certain not-elsewhere-classified and miscellaneous services codes. It is not. The table on the next page shows all the APCs where there was a discrepancy of greater than 1% in either the count or the geometric mean or both.

Inconsistencies between CMS published CPT and APC cost files, 2014 proposed rule						
Unlisted services omitted using CMS published 2013 list						
Note: Some of these probably were corrected in the 8/28/2013 corrected files.						
	APC cost file		**Summary of CPT cost file (excluding unspecified, miscellaneous, N.E.C. codes)**		**Discrepancy**	
APC	**single frequency APC**	**geometric mean APC**	**single frequency cpt**	**geometric mean cpt**	**single frequency error**	**geometric mean error**
0635	6,760,593	$ 215	6,773,576	$ 252	0%	17%
0634	20,396,735	$ 89	20,433,216	$ 99	0%	11%
0061	2,357	$ 8,906	2,140	$ 7,985	-9%	-10%
0318	708	$ 27,226	644	$ 26,981	-9%	-1%
0636	175,374	$ 86	175,375	$ 92	0%	8%
0108	20,110	$ 31,911	18,583	$ 32,251	-8%	1%
0432	21,989	$ 46	21,989	$ 49	0%	7%
0040	9,605	$ 5,539	9,109	$ 5,303	-5%	-4%
0137	14,665	$ 1,628	14,665	$ 1,711	0%	5%
0207	609,426	$ 687	609,426	$ 668	0%	-3%
0106	2,741	$ 5,932	2,669	$ 5,818	-3%	-2%
0241	1,630	$ 2,001	1,630	$ 2,049	0%	2%
0075	5,094	$ 2,378	5,094	$ 2,338	0%	-2%
0382	30,176	$ 202	30,176	$ 199	0%	-2%
0039	20,271	$ 21,370	19,962	$ 21,426	-2%	0%
0315	1,615	$ 23,447	1,591	$ 23,392	-1%	0%
0279	51,881	$ 2,700	51,881	$ 2,662	0%	-1%
0648	3,540	$ 7,140	3,491	$ 7,131	-1%	0%
0074	15,530	$ 1,547	15,530	$ 1,568	0%	1%
0293	152	$ 8,604	150	$ 8,624	-1%	0%
0319	4,669	$ 17,333	4,613	$ 17,326	-1%	0%
0030	6,876	$ 4,126	6,876	$ 4,083	0%	-1%
0083	229,696	$ 4,587	227,391	$ 4,592	-1%	0%
0229	81,318	$ 10,576	80,598	$ 10,570	-1%	0%
0227	4,574	$ 15,528	4,538	$ 15,527	-1%	0%
0425	3,815	$ 10,191	3,785	$ 10,174	-1%	0%
0206	45,810	$ 364	45,810	$ 367	0%	1%
0082	12,304	$ 10,446	12,208	$ 10,449	-1%	0%
0259	2,072	$ 30,240	2,056	$ 30,226	-1%	0%
0104	19,557	$ 8,888	19,415	$ 8,881	-1%	0%
0253	9,771	$ 1,292	9,771	$ 1,301	0%	1%
0202	24,378	$ 4,842	24,222	$ 4,843	-1%	0%

Inconsistencies between CMS published CPT and APC cost files, 2014 proposed rule						
Unlisted services omitted using CMS published 2013 list						
Note: Some of these probably were corrected in the 8/28/2013 corrected files.						
	APC cost file		Summary of CPT cost file (excluding unspecified, miscellaneous, N.E.C. codes)		Discrepancy	
APC	single frequency APC	geometric mean APC	single frequency cpt	geometric mean cpt	single frequency error	geometric mean error
0091	9,183	$ 2,956	9,183	$ 2,974	0%	1%
0252	4,853	$ 568	4,853	$ 571	0%	1%
0237	1,058	$ 1,556	1,058	$ 1,565	0%	1%
0674	1,914	$ 8,030	1,903	$ 8,040	-1%	0%
0231	6,227	$ 263	6,227	$ 261	0%	-1%
0656	73,880	$ 10,526	73,469	$ 10,517	-1%	0%
0131	88,950	$ 3,803	88,950	$ 3,783	0%	-1%
0051	8,091	$ 3,880	8,091	$ 3,860	0%	-1%

5.4 Bypass list

As noted earlier, the bypass list is now grossly inconsistent with CMS's criteria, and the new packaging rules. The bypass list has repercussions throughout the APCs, because it plays a role in determining what claims are counted as "single procedure" claims.

6 Residual unexplained discrepancies and summary of discrepancies.

The table below shows where my estimated APC geometric means differ from the published values by more than 5 percent. I have divided these discrepancies into those newly arising in the 2014 proposed rule, versus discrepancies that existed to some degree in prior rules (and so reflect unknown but long-standing differences between what CMS does and my calculation).

2014 Proposed Rule, APCs With Discrepancy Between CMS Published and Calculated Values								
All APCs where published and calculated mean cost disagreed by 5% or more.								
For single-procedure claims and geometric mean cost								
			CMS published		Calculated		Memo: CMS CPT and APC cost files disagree?	
APC	group title		Count	Mean	Count	Mean	Count	Mean
New issues with 2014 rule								
0040	Level I Neuro. Electrodes	J1	9,605	$ 5,539	9,044	$ 5,269	Yes	Yes
0061	Level II Neuro. Electrodes	J1	2,357	$ 8,906	2,257	$ 8,491	Yes	Yes
0099	Electrocardiograms	S	1,302,504	$ 74	1,238,246	$ 78		
0106	Pacemaker	J1	2,741	$ 5,932	2,530	$ 5,262	Yes	Yes

0137	Level VI Skin Repair	T	14,665	$ 1,628	14,677	$ 1,717		Yes
0634	Hospital Clinic Visits	V	20,396,735	$ 89	20,410,510	$ 100		Yes
New issue or exacerbation of pre-existing discrepancy								
0633	Level 3 Examinations	V	3,925	$ 359	21,400	$ 768		
0635	Type A Emergency Visits	V	6,760,593	$ 215	6,640,083	$ 252		Yes
0636	Type B Emergency Visits	V	175,374	$ 86	171,615	$ 93		Yes
Exacerbation of pre-existing discrepancy								
0344	Level IV Pathology	S	38,951	$ 280	39,071	$ 295		
0345	Level I Transfusion	S	277,709	$ 85	253,331	$ 92		
0346	Level II Transfusion	S	15,020	$ 144	9,514	$ 221		
0370	Multiple Allergy Tests	S	1,392	$ 822	1,057	$ 556		
0381	Single Allergy Tests	S	295	$ 118	198	$ 77		

Why is it so hard to model the OPPS rates?

By Christopher Hogan, Ph.D., Direct Research, LLC

This paper summarizes difficulties that we have in replicating the OPPS rules historically. It is impossible to fully understand the difficulties in reproducing the payment policies in the FY 2014 proposed rule without an understanding of the ambiguous and haphazard nature of replicating the OPPS rule in past years. The difficulties in replicating the policies this year compared with past years were compounded by the number of and ambitious nature of the new payment policies proposed this year.

Modeling CMS' OPPS rates is a complex task. By way of illustration, the computer program that CMS uses to *price* outpatient claims runs 960 single-spaced 8.5x11 pages.[1] And pricing the claims (attaching the correct payment rates to the services) is substantially simpler than determining those OPPS rates in the first place.

This task is *inherently* complex, for several reasons. First, over time, CMS has developed a large body of ad-hoc rules governing the determination of the rates. A partial list of rules includes:

- What claims constitute "single procedure" claims, and the various steps allowed for breaking up larger claims into fragments to be counted as single procedure claims.
- What procedures can be ignored for that process (the bypass list).
- Which combinations of codes count as if they were a single procedure (composite APCs).
- Which combinations of codes *sometimes* count as if they were a single procedure (imaging composites).
- What costs are packaged.
- What services are sometimes packaged, depending on circumstances.
- Special rules and edits applying to specific services (allergy tests, hyperbaric oxygen, and others).
- Statistical trims for cost, cost-to-charge ratio edits, crosswalks from revenue center codes to cost report lines, device-to-procedure edits, edits for partial-credit devices … and so on.

Each of these ad-hoc rules has the potential to interact strongly with the others in unpredictable ways. For example, in the 2014 rule, CMS packaged ancillary services (payment status X). This decision greatly *reduced* the number of single-procedure claims in several unrelated APCs. Why? Where the status X code was formerly on the bypass list, this created packaged costs on claims that formerly had none. In turn, that blocked creation of single-procedure claims where multiple payable codes occurred on a claim without packaged costs. This unanticipated drop in single-procedure claims was due to the interaction of bypass list, the single-procedure claim algorithm, and packaging policy.

Second, each of the underlying claims contains a mix of unrelated services, creating additional unpredictable interactions. For example, imaging, tests, and surgery will typically be found on the same claim. Changes in the treatment of one type of code (e.g., ancillary tests) can

[1] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/Outpatient-PPS-Pricer-Code.html

profoundly affect the set of single-procedure claims used to estimate costs for a completely unrelated code (e.g., surgical services that happen to involve that test routinely.)

These interactions – among the rules and among services on the same claim -- mean that modest changes in implementation of one rule may have large and unexpected effects on seemingly unrelated APCs. Looking at that the other way around, interactions among rules and the spillovers across claims often make it impossible to determine why a particular modeled APC rate differs from the published CMS value.

The result is a system that is ludicrously difficult to "debug". When modeled and published APC rates differ, it is often impossible to determine why the discrepancies occur. Discrepancy between modeled APC rates and the rates published by CMS may result from a) a mistake directly related to that APC, b) a mistake on some completely unrelated APC, or c) a seemingly trivial difference of opinion on the exact meaning of some portion of some rule, that one would not even call a mistake. And the mistakes can be either by CMS, by the modeler, or both.

Modeling each year's OPPS then becomes an iterative guessing game. That is, guess what the error might be, then test that guess -- over and over. And because the rules interact with each other, and the services are commingled on claims, the only way to test each guess is to modify the underlying programming *and re-run the rate-setting model in its entirety.*

This is labor-intensive and consumes substantial calendar time. In a good year, this process proceeds until there is a reasonably good fit between modeled and published APC rates. In a bad year, the work proceeds until the available time runs out. The 2014 proposed rule was a particularly bad year.

CMS complicates this already difficult process in two ways.

- First, written descriptions of the rate-setting process are typically unclear and sometimes contradictory.
- Second, CMS often makes small and large technical mistakes, both in its published cost and rate files, and in its underlying programming.

1. Written descriptions of the rate-setting process are typically unclear and sometimes contradictory

There is a fundamental and long-standing problem with the documentation of the programming logic for the payment system. The description of how CMS goes about generating the single-procedure claims, in the proposed rule text and in the claims accounting document are supposed to be describing the same process, but they are different in terms of the order in which steps occur in the processing. Doing steps in a different order can have very different results on payment rates. Further, the logic often refers to CMS assigned properties of HCPCS codes to determine the logic branch that that that claim should take, for example the status indicator of a code or whether it appears on the bypass list. I will call these look-up tables. The status indicators and the codes on the by-pass list change from year to year and the documentation does not describe which year of the look-up tables is to be used, the year the claim was paid, the

current year, or the new proposed status. When there are numerous changes in the policies, the year chosen can also have a significant effect on the results. In past years through trial and error I have been able to determine which was used. The look-up tables used have often been from past years and thus not internally consistent with the policies proposed in the rule in question.

Another longstanding issue involves the payment status indicator, while CMS assigns ONE payment status, you need three or four to show what the actual payment status of a code is, for purposes of rate calibration. You often have to hunt out what the actual payment status is, in any one situation. For some codes, CMS lists different payment statuses on different supporting files, e.g. Addendum B and Addendum M, which further complicates the situation.

A particularly problematic example is: 75635 Ct angio abdominal arteries. This year, I noticed in the rule a discussion about forming the imaging composites (Q3) except when the code is a conditionally packaged (Q2) code, in which case, we conditionally package first, and then form the imaging composite. How can a code be both Q2 and Q3? Well, that's the code. You have to start it in the processing as Q2, do the conditional packaging, then if it survives, flip it to Q3, and carry on with forming the imaging composites. The only way to tell that is to take Addendum M, map on the Addendum B status, and see that for that one code, it's Q3 on M and Q2 on B.

In fact, there are all kinds of cases where you have to change the payment status of a code mid-way through processing in order to get the cost numbers that CMS publishes. In my processing, I count four separate, distinct payment statuses, depending on the situation. I believe I now process those as CMS does, but CMS does not adequately document the process and I could only replicate the published cost numbers by trial and error.

An example of the complexity of the programming logic follows. You have a bunch of status Q3 imaging HCPCS on a claim. You resolve those and determine which ones are and are not part of an imaging composite. You then need to resolve the Q1s on the claim. In order to do that (I think) you must flip the Q2s to their ultimate payment status (typically S), and if Q1s appear on the same claim, they are then packaged. So a Q1 code, on same claim and date as a Q3 code, will get packaged, one way or the other. But, nominally, Q1s only package under STV codes. You have to flip the Q3 to S to get that right. (But for imaging composites, do that for only one code in the composite.)

The programming logic is extraordinarily complicated. It started out complicated at the beginning of the payment system and has only gotten more layers of complication added to it.

2. **Small and large technical mistakes, both in its published cost and rate files, and in its underlying programming**

Each year has brought its own errors that are not documented in the rule text or claims accounting and can only be surmised by the trial and error process of trying to replicate CMS's published cost numbers. Below is a sample of transient problems from past years:

- When CMS first put the "MJMC" indicator on the claims file to show the payment status of each code and claim, it turned out that these were the obsolete payment status from the year in which the claim was paid and not status for the proposed rule year. They now reflect service and claim status under the proposed rule, not as they existed in the claims payment year.

- There have been services grossly mispriced and over-paid, due to errors in the crosswalk between cost report line and claims revenue center. One service was paid about 80% too much for a year before we brought that to CMS's attention.

Sometimes the inconsistencies or mistakes resolve themselves in the next rule cycle and sometimes they persist over time. CMS never publically documents them.

Issues in the CY2014 Proposed Outpatient Prospective Payment System (OPPS) Rate-setting Process

Updated on: September 4, 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. 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. In addition, we note that CMS did not release a narrative description or any other documentation of the methodology used to update the data.

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.

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.

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.

HEALTH POLICY ANALYTICS, LLC

RE: Reproducibility of the 2014 NPRM OPPS Rule

Date: August 28, 2013

From: Susan E. White, Ph.D., CHDA
President, Health Data Analytics, LLC

Health Policy Analytics, LLC models the OPPS proposed rule for a number of clients based on information released by CMS. We have been doing this for the past decade using CMS' OPPS claims accounting document, titled, "CMS-1601-P-2014-OPPS-Claims-Accounting-narrative,"and the text released by CMS in its annual proposed rule(s). For the OPPS proposed rules released from 2004 to 2013, we were able replicate CMS' calculation of geometric mean costs (and, previously, median costs) at both the HCPCS and APC level, along with counts of the single/pseudo-single claims within 0.5% or less of CMS' published figures. Unfortunately, this year, for the first time ever, we were unable to replicate the 2014 OPPS proposed rule. We believe this inability stems from a number of significant data-related issues that we discovered during six weeks of analyses conducted since we received the claims data file from CMS. These issues are described below.

1. Inconsistency in the status indicator codes assigned to HCPCS/CPT codes
   In order to properly identify single and pseudo-single procedure claims to calculate the geometric mean cost of each HCPCS and APC group, the status for each HCPCS code must be identified. We have always relied on the information CMS releases in Addendum B to identify the status indicators for every HCPCS/CPT code, including status indicator changes. This year, we observed that the status indicators for certain HCPCS/CPT codes did not match between Addendum B and CMS' cost statistics file released in support of the CY 2014 OPPS Proposed Rule. For example, CPT codes 75962, 75966, 93619, 93620 and 93650 are assigned to status indicator J1 in the CPT Cost Statistics file, but to status indicator N or Q3 in Addendum B. Since CMS is newly proposing status indicator J1 to designate comprehensive APCs, this mismatch in status indicators hampers efforts to simulate the proposed rule.

2. Identification of Q1 codes that receive packaging when multiple occur

   It is not clear what logic CMS used to determine which CPT codes assigned to status indicator Q1 receive packaged costs when more than one code occurs on the claim. In the Claims Accounting Narrative, CMS states that the highest-weighted HCPCS/CPT code assigned status indicator Q1 would be retained for rate-setting, while the lower-weighted codes would be packaged. We followed this process, but were unable to replicate the rule. It does not appear that this is the logic CMS actually used to make this assignment. We tried to discover how CMS treated multiple HCPCS/CPT codes that are assigned status indicator Q1 when they are present on the same claim; specifically, we created and implemented other algorithms that we believe CMS might have used. After multiple 12-hour data runs, however, we still have not been able to determine the actual logic CMS used.

3. Incorrect Bypass Code List

The codes that CMS proposes for the CY 2014 bypass list appear to be incorrect. We suspect that CMS did not update the bypass code list to include the packaging of HCPCS/CPT codes it proposes to assign to status indicator Q1 along with all of the other newly unconditionally packaged codes included in Addendum P. For instance, some evaluation and management (E/M) CPT codes continue to be present on the bypass list, despite the fact that our analysis shows that the natural single-procedure claims have more packaging costs associated with them than CMS' bypass criteria allow. For example, 20-30% of the natural singles for CPT codes 99201-99205 and 99212, 99213, and 99215 have packaged costs associated with them, which violates CMS' own criteria for inclusion on the bypass list. We were able to analyze 171 of the 179 codes on the bypass list and found that more than 5% of the natural singles for 109 of the 171 codes (63.7%) included packaged costs after the Q1 codes were conditionally packaged. Therefore, none of these codes should be on CMS' bypass list according to its own criteria.

4. APC Visit 0634 Geometric Mean

We had limited success in identifying single-procedure claims and calculating the geometric mean cost for clinic visits CPT codes 99201-99215. Unfortunately, we were not able to reproduce the geometric mean cost for APC 0634. Our simulation, built up from single-procedure claims used to successfully replicate the HCPCS code-level geometric mean costs, results in a value of $98 for APC 0634. This is 10% higher than dollar amount reported by CMS for the rate-setting process.

The issues identified above are a subset of the multiple problems we encountered during our many attempts to replicate the CY 2014 OPPS Proposed Rule. This rule includes more sweeping changes than have been proposed in the past, and it is understandable that some of the rate-setting steps CMS utilized may have been inadvertently un-documented in the claims accounting narrative, the rule text, and the addenda files. If the process itself was flawed (rather than just being undocumented), however, it presents an even larger problem.

Due to the issues described above, we have been unable to provide many clients with the data analyses they require to form thoughtful, data-driven arguments to support their comments on CMS' CY 2014 OPPS Proposed Rule. In the time available and with the information released, it was virtually impossible for us to carve out certain portions of the rule for analysis due to the massive changes proposed for packaging. The status of any one HCPCS/CPT code, the order of operations used to determine the singles and pseudo-singles, and the presence of codes on the bypass list all interact to cause erroneous conclusions from any partial analysis.