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September 13, 2013

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1601-CN  
P.O. Box 8013  
Baltimore, MD 21244-1850

***RE: CMS-1601-CN, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Correction and Limited Extension of Comment Period; (Vol. 78, No.173), September 6, 2013.***

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2014 hospital outpatient prospective payment system (OPPS) corrected proposed rule. This is the second of two comment letters that the AHA is sending in response to the CY 2014 OPPS proposed rule. This letter addresses the AHA's recommendations related to proposed changes in OPPS packaging, comprehensive ambulatory payment classifications (APCs) and hospital outpatient visit coding and payment.

**The AHA appreciates CMS's efforts to correct errors that were included in the original CY 2014 OPPS analysis and to allow additional time for public comment on the proposals impacted by the corrections. However, we continue to have some reservations about the accuracy of the data that the agency has released. We also have major substantive concerns about CMS's proposals to increase the size of the APC bundle and to collapse the hospital visit codes. While the AHA generally supports payment reforms that lead to larger units of payment, such as bundled payment, we cannot support CMS's comprehensive APCs and packaging proposals for implementation in CY 2014. Our reservations about the data, the complexity of these proposals and the short timeframe until implementation cause us to be wary about the sweeping redistribution of funds across hospitals that would result from implementing these fundamental changes to the OPPS. Therefore, we believe that the hospital field and CMS would benefit from more time to analyze and validate the technical changes necessary to make these policies possible, as well as to study the impacts they would have on individual hospitals.**



**The AHA recommends that CMS not implement, at this time, its proposal to collapse the hospital outpatient visit codes to a single code for each type of visit. However, we would support the part of CMS's proposal to eliminate the distinction between new and established patient clinic visits.** Under the agency's proposal, the fully collapsed visit codes would incorporate too wide of a range of patient severity into a single APC payment rate by combining multiple unrelated services that reflect intrinsically different magnitudes of resource utilization. Thus, hospitals that provide care for disproportionately large numbers of patients on either end of the acuity spectrum would consistently, but unfairly, receive financial benefit or penalty because they would have no ability to code for different levels of resource use and intensity of services. In addition, we believe that, contrary to CMS's assertion, this proposal would actually increase hospitals' administrative burden because hospitals would have to maintain two coding systems for hospital visits, one for Medicare and another for other payers. While we oppose changes to the visit codes at this time, moving forward, CMS could investigate other related proposals such as a three-level coding structure for emergency department (ED) and clinic visits.

Thank you again for providing corrected data and extending the comment period for a portion of the rule. As always, we appreciate the opportunity to comment. Our detailed comments are attached. If you have any questions, please contact me or Roslyne Schulman, director for policy development, at (202) 626-2273 or [rschulman@aha.org](mailto:rschulman@aha.org).

Sincerely,

/s/

Rick Pollack  
Executive Vice President

Attachments

## AMERICAN HOSPITAL ASSOCIATION DETAILED COMMENTS

### INCREASING THE SIZE OF THE APC BUNDLE

CMS's CY 2014 proposed rule includes eight significant packaging proposals that would shift the OPSS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles, including introducing policies that could, over time, support movement toward bundled payment. These proposals include:

- identifying seven new categories of items and services whose costs would be packaged into the payment for other services to which they are integral, ancillary or supportive. These include: (1) drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; (2) drugs and biologicals that function as supplies or devices when used in a surgical procedure; (3) clinical diagnostic laboratory tests; (4) procedures described by add-on codes; (5) ancillary services (status indicator "X"); (6) diagnostic tests on the bypass list; and (7) device removal procedures; and
- establishing a set of 29 comprehensive APCs to replace 29 device-dependent services and making a single payment for the comprehensive service based on all OPSS-payable charges on the claim

**The AHA generally has supported efforts to package more services and create larger payment bundles. We believe, like CMS, that appropriately-sized bundles can provide incentives to improve efficiency and manage resources. However, for both overarching and more detailed reasons, we cannot support CMS's comprehensive APCs or packaging proposals at this time.**

These proposed policies entail very fundamental structural changes to the OPSS – they would package more than 2,400 additional current procedural terminology (CPT) codes – and as such, we attempted to replicate CMS's rate-setting methodology in order to better understand the individual impact of each of the agency's proposals. Although we have some concerns about the data and analysis behind the proposed policies, which we describe in more detail below, it does appear that the policies would have a substantial impact on all APC relative weights and consequently be largely redistributive. **We are concerned that these redistributions could have significant negative consequences for certain categories of hospitals. We also are concerned that implementing these proposals Jan. 1, 2014, would not allow hospitals enough time to fully understand how the proposals would affect their outpatient finances, making hospital budgeting for the upcoming year nearly impossible. In addition, we are concerned that neither CMS nor its Medicare Administrative Contractors (MACs) would be prepared to implement the proposed changes beginning Jan. 1, 2014. Perhaps a proposal on a more modest scale in future rule-making would have more promise.**

The AHA also has specific concerns about certain proposals. For example, CMS proposes that a lab test unrelated to a primary service would not be part of its packaging policy when the lab test is the only service provided on that date of service or when the lab test is provided on the same date of service as the primary service *but is ordered for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service* provided in the hospital outpatient setting. However, we do not believe that there is a way to determine that a lab test was ordered “for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service” using information from the hospital claim. Therefore, we are concerned that CMS would not be able to implement this proposal in an accurate manner.

In addition, the AHA appreciates CMS’s efforts to correct errors that were included in its original CY 2014 OPSS analysis and to allow additional time for public comment on the proposals impacted by the corrections. However, we continue to have some reservations about the accuracy of the data the agency has released. Shortly after the proposed rule was issued, the AHA, the Association of American Medical Colleges and the Federation of American Hospitals jointly commissioned The Moran Company (TMC) to review the proposed rule and attempt to validate CMS’s proposed rates and analyze the impact across providers and provider types. In its attempts to replicate the agency’s rate-setting methodology, TMC found numerous issues and inconsistencies. **Although some of the original problems that TMC identified in CMS’s analysis appear to have been corrected in CMS’s updated data release, namely the geometric mean cost for APC 0634 and a partial correction of a few of the status indicator inconsistencies, others issues TMC previously identified have not been resolved.** These include several more inconsistent status indicators in CMS’s published appendices and inconsistencies in the treatment of the hospital visit codes and the bypass list. A summary of these issues is included in Attachment A. Due to the complexity of the OPSS rate-setting policies, each of these issues interacts and differentially affects all the OPSS payment weights and rates. It is impossible for us to understand the magnitude of these errors and whether they have a material influence on the individual and combined policy impacts we have calculated. Also, we are concerned that even with the corrected data TMC still has not been able to replicate CMS’s analysis at the Healthcare Common Procedure Coding System (HCPCS) level as closely as it has in previous years, raising the possibility that other problems with the analysis remain undetected.

**We urge CMS not to implement its seven packaging proposals or comprehensive APCs for CY 2014. We believe that, given the fundamental changes and sweeping redistributions these proposals would entail, the hospital field and CMS would benefit from more time to analyze and validate the technical changes necessary to make these policies possible, as well as to study the impacts they would have on individual hospitals.** To that end, we encourage CMS in its OPSS final rule and, as appropriate, in subsequent months, to post more comprehensive information about the seven packaging and comprehensive APC proposals, including additional data corrections, the detailed assumptions it made in its methodology, more detailed impact analyses and more detail regarding relevant policy interactions. CMS also should share such information in public forums, such as through CMS town hall meetings and

teleconferences. The agency could re-issue any or all of its current proposals or propose new packaging policies in the coming years, and we believe the robustness of the proposals could benefit greatly from this additional time.

In addition, if CMS chooses to re-propose these policies in the future, we encourage the agency to move forward more gradually in increasing the size of the APC bundle, such as focusing on individual packaging proposals or comprehensive APCs but not all simultaneously. A step-wise approach would allow stakeholders to replicate and determine the impact of each new packaging proposal independently, without introducing interactions that inevitably occur when several proposals are implemented at once. If CMS re-proposes more than one of these significant changes in next year's proposed rule, it should provide sufficient and correct information to allow stakeholders to replicate and understand the impact of the proposals, separately as well as together.

The AHA notes that proposals to make significant changes to payment systems often result in redistribution and have multiple effects. Therefore, it is critical that hospitals and health systems understand the potential impact that this proposed policy could have on their revenue. **The AHA recommends that any time CMS proposes a significant policy change in the OPPS, a detailed impact analysis isolating the impact of each key policy change should be included to aid hospitals, health systems and other stakeholders in understanding and assessing the proposed changes.**

We note that this recommendation is consistent with the recommendation of CMS's Advisory Panel on Hospital Outpatient Payments (HOP Panel). On Aug. 27, the HOP Panel recommended "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."

**Specific Packaging Proposals.** As noted above, the AHA agrees, in concept, that some of the items and services that CMS has proposed for packaging deserve further consideration and, with additional analysis, could be considered for future rulemaking. For instance, it may be reasonable to consider moving forward with its proposal to package diagnostic tests on the bypass list and its proposal to package device removal procedures. Below are our detailed comments regarding several of CMS's specific packaging proposals and the comprehensive APCs.

***Clinical Diagnostic Laboratory Tests.*** Among the seven categories of items and services that CMS proposes to begin packaging are clinical diagnostic laboratory tests, which CMS proposes be conditionally packaged. That is, a lab test would be considered to be integral, ancillary, supportive, dependent, or adjunctive to a primary service provided in the hospital outpatient setting, and thus would have its cost packaged into the primary service, when it is provided on the same date of service as the primary service and *when it is ordered by the same practitioner*

*who ordered the primary service.* Conversely, CMS would consider a lab test to be unrelated to a primary service and, thus, not part of this packaging policy, when the lab test is the only service provided on that date of service or when the lab test is provided on the same date of service as the primary service *but is ordered for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service* provided in the hospital outpatient setting.

**We request that CMS clarify how it was able to determine from the CY 2012 claims data when a lab test was ordered “for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service.”** Hospitals bill using the UB-04 Form 1450, and there are four distinct fields to report the involvement of the physician on a hospital claim. However, all of these physician identifications apply to the hospital claim as a whole; there is no way to associate individual physicians with individual service lines. Therefore, AHA is concerned that in the proposed rule CMS may have over-packaged lab costs by assuming that all of the lab tests that occur on the same date of services as the primary service are related, even though they may, in fact, be entirely unrelated to the primary procedure. For instance, necessary lab services will often be scheduled on the same day as an unrelated primary procedure for patients who live in underserved rural areas in order to avoid these beneficiaries having to make multiple trips to the hospital.

**As noted above, we advise CMS against finalizing the lab packaging policy for CY 2014. However, if the agency moves forward with this policy in the future, it should establish revised billing instructions and additional operational policy clarifications well in advance of implementing the packaging policy so providers would be able to appropriately identify lab tests that are unrelated to a primary service and that should be paid separately.**

***Drugs and Biologicals that Function as Supplies or Devices when used in a Surgical Procedure.*** For 2014, CMS proposes to expand the existing packaging policy for implantable biologicals by unconditionally packaging into other services all drugs and biologicals that function as supplies or devices in a surgical procedure. The agency states that in 2014, the proposed policy would affect skin substitutes, which CMS claims are products similar to surgical dressings, used on wounds to stimulate the host to regenerate lost tissue and replace the wound with functional skin. **The AHA opposes packaging skin substitutes into the primary surgical procedure.**

While CMS intends for its packaging policies to promote more efficient resource use in hospitals, we are concerned that packaging skin substitutes would not support that goal. This is because these are not low-cost items, like surgical dressings, that are easily interchangeable in clinical use. While CMS claims these products are similar to surgical dressings, we disagree. Rather, they are much more like skin grafts. In order to achieve the best clinical outcome for wound healing, the most appropriate type of skin substitute must be matched to the specific size and type of wound. Using an inappropriate skin substitute can interfere in the process of wound healing and increase the risk of infection and other costly complications.

Further, there are significant cost differences between skin substitutes and surgical dressings. As CMS acknowledges, “prices for these products vary significantly from product to product.” The AHA believes that the specific skin substitute selected should be based on relevant clinical factors, using the physician’s medical judgment about which product would be best suited to the particular wound, rather than introducing economic incentives that could inappropriately influence such decisions by prioritizing price over clinical appropriateness. We believe that the local coverage decisions in place within the various MAC jurisdictions provide sufficient assurance that these products meet medical necessity requirements and are used in appropriate clinical circumstances.

***Comprehensive APCs.*** CMS proposes to create 29 comprehensive device-dependent APCs in which all the services described on the claim would be considered to be related to, or supportive of, a primary service and paid as a single comprehensive service. A new J1 status indicator, defining the primary service, would be assigned to 136 HCPCS codes that fall under these 29 comprehensive APCs.

The comprehensive APCs would not only package all otherwise packaged services and supplies (including those newly proposed for packaging in this proposed rule) but would also expand the scope of services covered under the OPSS to include items and services that are currently covered and paid separately under other Medicare payments systems. For example, room and board; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); laboratory services and therapy services included on the claim with the primary service would be considered adjunctive services that support the primary service and, therefore, would be OPSS services. Their costs would be included in determining the relative weights for the comprehensive APCs, and the single payment for the comprehensive APC would constitute payment for them. Consequently, these services would no longer be billed and paid under the separate fee schedules in which they currently fall. The proposed rule also notes that, to properly account for the money that would previously have been paid through other payment systems, CMS has included those payments when performing OPSS budget-neutrality calculations.

Given that a single claim can span multiple days (up to 30 days), we expect that many claims would contain items and services that are completely unrelated to the primary service. CMS should not simply assume that all services billed on the same claim are related. **As noted above, we urge CMS not to finalize this proposal for CY 2014. However, if the agency plans to re-propose comprehensive APCs in the future, we recommend that revised billing guidance be issued well in advance in order to establish a process by which hospitals can identify those services that are unrelated to a primary service, perhaps through the use of a modifier or another type of indicator. This would improve the accuracy of CMS’s data for rate-setting purposes by allowing CMS to determine which items and services should be packaged together for its comprehensive APCs, and which should be paid separately. Once CMS implements such a process to ensure that the rate-setting process is based on the best possible information, the AHA would be willing to analyze this proposal if CMS includes it in future proposed rulemaking.**

## **CODING AND PAYMENT FOR HOSPITAL OUTPATIENT VISIT SERVICES**

CMS proposes to significantly modify its longstanding policies related to hospital outpatient clinic and ED visits by “collapsing” the current several levels of codes for each of the three types of hospital visits – clinic visits (including CPT codes 99201-99205 codes for new patients and CPT codes 99211-99215 for established patients), Type A ED visits (CPT codes 99281-99285) and Type B ED visits (HCPCS codes G0380-G0385). CMS would replace these with one new HCPCS code representing a single level of payment for each of the three types of visits – GXXXC for clinic visits, GXXXA for Type A ED visits and GXXXB for Type B ED visits. The current CPT and HCPCS visit codes would no longer be recognized after 2013. CMS also would no longer recognize distinctions between new and established patients in clinic visits. Each of these new codes would be assigned to its own APC: APC 0634 for clinic visits, APC 0635 for Type A ED visits and APC 0636 for Type B ED visits. The payment rate for each visit type would be based on the total mean costs of level 1 through level 5 codes in the CY 2012 OPSS claims data for that respective visit type.

**The AHA recommends that CMS not implement, at this time, its proposal to collapse the hospital outpatient visit codes to a single code for each type of visit.** This proposal needs further refinement given errors in data and in stakeholder understanding of its impact. As detailed below, we are concerned that the proposed visit APCs incorporate too wide of a range of patient severity into a single APC payment rate by combining multiple unrelated services that reflect intrinsically different magnitudes of resource utilization. Providing absolutely no ability to code for different levels of resource use/intensity of services means that hospitals that provide care for disproportionately large numbers of patients on either end of the acuity spectrum would consistently, but unfairly, receive financial benefit or penalty. In addition, we believe that, contrary to CMS’s assertion, this proposal would actually increase hospitals’ administrative burden because hospitals would have to maintain two coding systems for hospital visits, one for Medicare and another for other payers. Also, we are concerned about a discrepancy in the data that relates specifically to APC 0634. We note that our recommendation is consistent with the recommendation made by the HOP Panel at its August 2013 meeting: “The Panel recommends 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.”

**Data Error.** One of the issues identified by TMC that remained uncorrected in CMS’s Aug. 28 release of corrected data relates directly to CMS’s calculation of the proposed hospital visit APCs. Specifically, there is an inconsistency in the way that the component CPT codes for the proposed hospital outpatient clinic visit, APC 0634 – CPT codes 99201-99205 and 99211-99215 – are treated for determining which single bills would be used to determine the geometric mean cost. To be analytically consistent, all of these component codes should be treated the same way. However, TMC discovered that only eight of the 10 codes proposed for APC 0634 are on the “bypass” list. Bypass codes, listed in Addendum N of the proposed rule, are services that are viewed as including only minor amounts of packaging and are used for determining single claims for rate-setting. This inconsistency is problematic because APC 0634 is the reference APC used

to establish the relative payment weights of all other APCs. Therefore, we have reservations about whether the payment weight for APC 0634 is set correctly; if it is not, it would affect the accuracy of all other proposed APC payment weights in the OPSS.

**Single Procedure Claim Bias Issue.** CMS’s proposed methodology also introduces a new level of bias into the ED visit code payment weights. This is not a data error, but rather is linked to an artifact of CMS’s long-standing OPSS methodology that uses only single procedure claims or “pseudo-single” claims (derived through the bypass code process) in its rate-setting. Under this methodology, CMS’s rate-setting process uses only about 60 percent of the claims submitted for payment. It is usually the more complex claims with multiple procedures and an array of packaged services that are eliminated from rate-setting. This has the effect of depressing payment rates because generally, the simpler, less-costly services are identified as “single procedures” and included in rate-setting, while the more complex, more-costly “multiple major procedure” claims are dropped. While the bias that arises from these dropped claims is real, it is generally not considered to be a matter of significant concern for hospitals overall as the entire OPSS is budget neutral, thus the distribution of payments within this payment system evens out overall. Moreover, this bias has been mitigated by the fact that hospitals currently can choose between five codes for ED services, representing five different escalating levels of intensity of service and increasing payment rates.

A second level of bias that is more concerning to AHA, however, occurs in the calculation of the payment weights and rates for the proposed new “collapsed” Type A and Type B ED visit APCs. TMC found that lower intensity ED visit codes are over-represented among the single procedure claims used for rate-setting, and the higher intensity codes are under-represented among the single procedure claims used for rate-setting. An example of this over- and under-representation for Type A ED visit is displayed below in Table 1. Thus, the distribution of the single procedure claims does not reflect the overall distribution in services reported for Type A ED visit services. The same situation exists for Type B ED visits. This has the effect of depressing the payment rate for each of the two ED APCs because the lower-cost codes are overrepresented in the rate-setting process.

**Table 1. “Single” Bias in APC 0635, Type A ED Visit Services**

<b>CPT Codes Used in APC 0635, Type A ED visit</b>	<b>Description of Code</b>	<b>“Single” Frequency Reported in CMS Cost Statistics File</b>	<b>Total Frequency Reported in CMS Cost Statistics File</b>	<b>Singles as a Percent of Total Frequency (calculated)</b>
99281	Level 1 ED visit	267,680	310,887	86.1%
99282	Level 2 ED visit	848,900	1,144,129	74.2%
99283	Level 3 ED visit	2,615,562	4,145,332	63.1%
99284	Level 4 ED visit	1,949,746	4,639,087	42.0%
99285	Level 5 ED visit	1,091,688	2,951,145	37.0%

This single code bias would be expected to affect providers who treat a disproportionately sicker Medicare population, such as trauma centers, in two ways. First, they would be harmed because the new APC 0635, Type A ED visit, contains only a single HCPCS code, GXXXA, which is skewed low due to this single code bias. Second, because this new HCPCS code inherently incorporates a greater amount of packaged costs due to CMS's proposed packaging policies, these providers, who typically also provide more ancillary services to care for their sicker patient population, would no longer be paid separately for services that are proposed to be packaged in 2014.

**The AHA is concerned that the payment bias created by CMS's ED visit coding proposal would unfairly penalize those essential specialized providers, such as trauma centers and major teaching hospitals, which historically provide care for a higher proportion of sicker and more complex Medicare beneficiaries.**

**Policy Concerns.** CMS states that its visit coding and payment proposal would:

1. incentivize hospitals to provide care in the most efficient manner due to the use of larger payment bundles;
2. reduce hospitals' administrative burden by obviating the need for hospitals to develop and maintain their own internal visit coding guidelines to distinguish among the five levels of resource use;
3. improve the accuracy of its payments by greatly expanding the volume of claims used for rate-setting purposes, thereby capturing a broader spectrum of extremely low to extremely high complexity cases; and
4. eliminate any hospital incentive to "up-code" patients for visits that do not clearly fall into a specific category.

Since April 2000, hospitals have been using the American Medical Association's (AMA) CPT evaluation and management (E/M) codes to report facility resources for clinic and ED visits. The AHA has made numerous requests to CMS to develop national guidelines for the reporting of hospital ED and clinic visits. However, despite considerable efforts by AHA and other organizations, CMS, for years, has not followed through on the commitment made at the outset of the OPSS to develop national coding guidelines for hospitals to report visit services.

CMS's CY 2014 visit proposal is a dramatic step, particularly since the agency has consistently stated its belief in previous years' OPSS regulations that hospitals are billing in an appropriate and consistent manner that distinguishes among different levels of visits based on their required hospital resources. For instance, in the CY 2012 final rule, CMS stated, "the stable distribution of clinic and emergency department visits reported under the OPSS over the past several years indicated that hospitals, both nationally in the aggregate and grouped by specific hospital classes, were generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguished among different levels of service based on the associated hospital resources."

We are aware of recent reports citing an upward shift in the intensity of services provided to Medicare beneficiaries in hospital EDs that are reflected in the level of coded ED visits. While some policymakers have alleged this trend is a result of “up-coding” of the intensity of services rendered or the inappropriate use of the health information technology to engage in medical record “cloning,” the AHA believes that these trends are explained by other factors. First, Medicare beneficiaries are, in general, getting sicker. Indeed, we have demonstrated in our [Issue Brief](#), “Sicker, More Complex Patients are Driving Up Intensity of ED Care,” that these shifts can be largely attributed to a number of causes, including:

- rising severity of illness among Medicare patients receiving ED services;
- increasing numbers of ED visits that include outpatient observation services due to mounting pressure to shift care from the inpatient to the outpatient setting;
- greater use of the ED by people dually eligible for Medicare and Medicaid, who tend to be sicker and have more chronic conditions; and
- increasing use of the ED by Medicare fee-for-service beneficiaries with behavioral health diagnoses who require a higher intensity of services.

In addition, the increased use of electronic health records (EHRs) generally improves providers’ ability to document the level of care being provided. Previously, documentation may not have been sufficient, leading providers to bill a lower level code than was actually warranted. The AHA believes that as the parties responsible for billing, hospitals and physicians need to know that the EHRs and other tools they purchase support compliance with current coding conventions and are not accidentally “leading” clinicians to document higher levels of care through templates, auto-fill options and reminders. As such, we have, in other forums, asked the Department of Health and Human Services to provide better guidance to the developers of EHRs and other automated tools to ensure that they support compliance with current coding conventions. We have also suggested that the Department of Justice work with the field to develop compliance guidance for hospitals.

CMS describes its proposal to collapse the visit coding structure down to three codes as “in line with our strategic goal of using large payment bundles to maximize hospitals’ incentives to provide care in the most efficient manner.” As we note above in our discussion of CMS’s several other proposals to increase the size of the APC bundle, the AHA has generally supported efforts to appropriately package additional items and services into larger payment bundles because we believe that large APC bundles can provide incentives to improve efficiency and manage resources. However, unlike the packaging proposals contained in this proposed rule, which are intended to incorporate the costs of supportive or dependent services into their primary service, this visit coding proposal would combine multiple unrelated services reflecting intrinsically different magnitudes of resource utilization into a single code with a single payment rate. We are concerned that the proposed visit APCs are too broadly defined and incorporate too wide of a range of patient severity into a single code and a single APC payment rate. The loss of the ability to code for different levels of resource use/intensity of services means that hospitals that provide care for disproportionately large numbers of patients on either end of the acuity spectrum would consistently, but unfairly, receive financial benefit or penalty. **We are**

**particularly concerned that this could financially disadvantage hospitals that furnish care to Medicare populations that are consistently sicker than average, such as trauma centers, teaching hospitals and cancer hospitals.**

**We also are concerned that the proposal could provide disincentives to providing the right care, in the right setting, at the right time.** For instance, paying a single Type A ED payment rate regardless of the intensity or complexity of a patient's condition would set the payment incentives in direct conflict with hospital programs that seek to reduce ED overcrowding by directing patients seeking primary care services to more appropriate non-ED locations. In clinic settings, a single APC clinic payment rate could result in the fragmentation of care for sicker patients with more complex conditions. Further, eliminating the distinct levels of visit services through the CPT and G-codes service also would represent an unfortunate loss for researchers and other interested stakeholders who use the current CPT codes to track over time differences in costs due to patient severity of illness or injury.

Additionally, CMS states that this proposal would reduce the administrative burden that Medicare payment policies place on hospitals by removing the need for hospitals to distinguish between levels of visit services and between new and established clinic patients, as well as the need to develop and apply hospital-specific visit coding guidelines. **The AHA appreciates CMS's interest in reducing hospitals' administrative burden. However, we are concerned that the opposite would prove true, and CMS's proposal to use Medicare-specific G-codes for clinic and Type A and B ED visits would, in fact, result in an *increased* administrative burden for hospitals.** Specifically, if one considers exclusively the issue of simplicity, a proposal that would collapse the codes would appear to be an improvement. **However, as providers have been using these hospital-specific guidelines for 13 years, most no longer find their use burdensome.** Hospitals regularly educate staff on the proper use and documentation of the guidelines and perform audits to ensure compliant coding practices. Additionally, many non-Medicare payers also accept the same facility-specific criteria as CMS, and use them in their audits. However, if CMS implements its proposal, other payers, who would be unlikely to accept the G-codes, would continue to require hospitals to use all current levels of CPT codes for visits. Thus, hospitals would have to maintain two coding systems for hospital visits, one for Medicare and another for other payers. It also would compromise CMS's own requirement for uniform charging since more granular CPT codes and charges would still be required by other payers.

**For all these reasons, the AHA believes CMS's proposal to collapse the hospital outpatient visit codes to a single code for each type of visit should not be implemented at this time. We do support CMS's proposal to eliminate the distinction between new and established patient clinic visits.** As we have indicated in previous OPSS comments, while current distinctions between new and established patients in the physician office visit codes exist, the same concepts do not apply to hospital resources. The AHA believes that hospital clinic visits should be recognized on the basis of hospital resources utilized during a specific visit and, therefore, not determined by whether the patient was registered as an inpatient or outpatient in the hospital within the past three years.

This single G-code proposal does not bundle in a productive way, and it results in inaccurate payments. Therefore, the AHA sees no compelling reason for CMS to make any other changes to its visit coding structure and payment policy for CY 2014. **However, if CMS is intent on making changes that would decrease the number of hospital outpatient visit codes and also reduce hospital administrative burden, we recommend that CMS partner with the AHA to request that the AMA CPT Editorial Panel create unique CPT codes for hospital reporting of ED and clinic visits based on hospitals' internally developed guidelines. This could include adopting a three-level coding structure – low, middle and high – for ED and clinic visits. These hospital-specific CPT codes could then be widely reported by hospitals to all payers. The AHA would be amenable to conducting further analysis on this issue.**

***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 OPSS 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 OPSS 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 OPSS proposed rule each year, The Moran Company attempts to match the OPSS published rates by replicating the OPSS 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 OPSS 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).<sup>1</sup> 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

APC Code	SI	Moran Computed			CMS Reported			Ratio: (Moran/CMS) -1		
		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.

<sup>1</sup> 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**

HCPCS			Moran Computed			CMS Reported			Ratio: (Moran/CMS) -1		
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 5<sup>th</sup>, 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.

HCPCS	Short Description	From Addendum B			From Cost Statistics File		
		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 J1 status indicators appear to be corrected. In the correction notice of September 5<sup>th</sup>, 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 5<sup>th</sup>.*