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Centers for Medicare & Medicaid Services
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FACT SHEET

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CMS PROPOSES HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTERS POLICY AND PAYMENT CHANGES FOR 2014

The Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates proposed rule [CMS-1601-P] on July 8, 2013.

The proposed rule with comment period would update Medicare payment policies and rates for hospital outpatient department and ASC services, and update and streamline programs that encourage high-quality care in these outpatient settings consistent with policies included in the Affordable Care Act. Total CY 2014 OPPS payments are projected to increase by \$4.37 billion or 9.5 percent, and CY 2014 Medicare payments to ASCs are projected to increase by approximately \$133 million or 3.51 percent as compared to CY 2013.

Overview

More than 4,000 hospitals, including general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals are paid under the OPPS. There are approximately 5,000 Medicare-participating ASCs paid under the ASC payment system.

The OPPS is currently a hybrid of a prospective payment system and a fee-for-service system, with some payments representing costs packaged into a primary service and other payments representing the cost of a particular item, service, or procedure. Payment amounts vary according to the Ambulatory Payment Classification (APC) group to which a service is assigned. The OPPS includes payment for most hospital outpatient department services, and covers partial hospitalization services furnished by hospital outpatient departments and community mental health centers.

The CY 2014 OPPS/ASC rule proposes to expand the categories of related items and services packaged into a single payment for a primary service under the OPPS, in order to make the OPPS more of a prospective payment system. When the OPPS began in 2000, the payment system provided for the packaging of a limited number of items and services, such as anesthesia and

surgical supplies. CMS expanded the categories of included items and services in 2008 and 2009, by adding eight additional categories, including image processing services, and implantable biologicals. This proposed rule would further expand the categories of packaged items and services by adding seven additional categories of supporting services, thereby moving the OPSS closer to a prospective payment system that is more analogous to Medicare payment for hospital inpatient services and less like a rate-for-service payment model. In addition to packaging these seven categories, CMS is proposing to create 29 comprehensive APCs to replace 29 existing device-dependent APCs.

Proposed Changes to Hospital OPSS Payments and Policies

Proposed Payment Update. CMS proposes to update the OPSS market basket by 1.8 percent for CY 2014. The proposed hospital market basket increase published in the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) proposed rule is 2.5 percent. The Medicare statute requires a productivity adjustment reduction of 0.4 percentage points and a 0.3 percentage point reduction to the CY 2014 OPSS market basket, so the proposed CY 2014 OPSS market basket update would be 1.8 percent.

Proposed Items and Services to be “Packaged” or Included in Payment for a Primary Service. For 2014, CMS proposes to package seven new categories of supporting items and services. For many of these services, the OPSS will continue to make a separate payment if they are reported alone on a claim. The seven proposed categories are:

- (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) Certain clinical diagnostic laboratory tests;
- (4) Procedures described by add-on codes;
- (5) Ancillary services, such as a chest x-ray, that are assigned status indicator “X”;
- (6) Diagnostic tests on the bypass list, and
- (7) Device removal procedures.

In addition to packaging these seven categories, CMS is proposing to create 29 comprehensive APCs to replace 29 existing device-dependent APCs.

Collapsing Five Levels of Visits to One. In an effort to further our goals of using larger payment bundles to maximize hospitals’ incentives to provide care in the most efficient manner, discouraging upcoding, and to continue to set accurate payments, CMS is proposing to streamline the current five levels of outpatient visit codes. The proposal would replace them with a single Healthcare Common Procedure Coding System (HCPCS) code for each unique type of outpatient hospital visit; one for clinic and one for each type of emergency department visit (24 hour and non-24 hour). By collapsing the current five levels of codes to one level, CMS believes this proposal will remove incentives hospitals may have to provide medically unnecessary services or expend additional, unnecessary resources to achieve a higher level of visit payment under the OPSS, will reduce administrative burden and be easily adopted by hospitals, and will allow a large universe of claims to be utilized for rate setting.

Part B Drugs in the Outpatient Department. We propose to continue paying at ASP+6 percent for non-pass-through drugs and biologicals that are payable separately under the OPSS.

Other Proposed Payment Updates

ASC Payment Update. ASC payments are annually updated for inflation by the percentage increase in the consumer price index for all urban consumers (CPI-U). The Medicare statute specifies a multifactor productivity (MFP) adjustment to the ASC annual update. For CY 2014, the CPI-U update is projected to be 1.4 percent. The MFP adjustment is projected to be 0.5 percent, resulting in an MFP-adjusted CPI-U update of 0.9 percent for CY 2014. In addition, CMS is proposing that certain ancillary or adjunctive services that would be packaged under the OPSS for CY 2014 also would be packaged under the ASC payment system for CY 2014. Payments to ASCs that fail to meet ASC Quality Reporting Program requirements would be reduced by two percent.

Partial Hospitalization Program (PHP) Rates. CMS proposes to update the two payment rates for community mental health centers and the two payment rates for hospital-based PHPs. For community mental health centers, the **proposed CY 2014 APC geometric mean per diem cost for Level I (three services) would be \$94 and for Level II (four or more services), \$106. For hospital-based PHPs, the proposed update to the APC geometric mean per diem cost would be \$213 for Level I and \$215 for Level II.**

Proposed Quality Program Changes

Hospital Outpatient Quality Reporting (OQR) Program. CMS is proposing five new measures for the OQR program, affecting payment in CY 2016, with data collection beginning in CY 2014:

1. *Influenza Vaccination Coverage among Healthcare Personnel* (NQF #0431). This measure was also adopted for the ASC Quality Reporting Program for the CY 2016 and subsequent years payment determinations, as well as the Hospital Inpatient Quality Reporting (IQR) Program for the FY 2015 and subsequent years payment determinations.
2. *Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures* (NQF #0564).
3. *Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients* (NQF #0658).
4. *Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps -- Avoidance of Inappropriate Use* (NQF #0659).
5. *Cataracts -- Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery* (NQF #1536).

CMS proposes to remove two measures:

- *Transition Record with Specified Elements Received by Discharged ED Patients* (OP-19), because this measure cannot be implemented with the degree of specificity that would be needed to fully address safety concerns related to confidentiality without being overly burdensome.
- *Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting* (OP-24), due to continued difficulties with defining the measure care setting that would enable hospital outpatient

departments to collect information on patient referrals without creating undue burden on providers.

ASC Quality Reporting Program. CMS proposes to adopt four new measures for the ASC Quality Reporting Program for the CY 2016 payment determination and subsequent years. CMS proposes to collect the data on these measures via an online Web-based tool. CMS asks for public comment on alternative data collection strategies, such as through registries or other third party data aggregators, and via certified EHR technology.

Hospital Value-Based Purchasing (VBP) Program. The rule proposes to set performance and baseline periods for the catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infection (CLABSI), and surgical site infection (SSI) measures for the FY 2016 Hospital VBP Program. The proposed performance period would be January 1, 2014 through December 31, 2014, and the proposed baseline period would be January 1, 2012 through December 31, 2012. CMS proposed to adopt these measures for the FY 2016 Hospital VBP program in the FY 2014 IPPS/LTCH proposed rule.

The rule also proposes to create a second level independent CMS review process for hospitals that are dissatisfied with the result of an existing administrative appeal.

QIO changes. The rule seeks comment on proposed changes to the regulations governing eligibility for organizations to be Quality Improvement Organizations (QIOs) and the contracting process for QIOs. The proposed changes aim to improve QIOs' quality improvement initiatives and case review activities and improve the QIOs' ability to meet the needs of Medicare beneficiaries by incorporating changes to the QIO statute made by the Trade Adjustment Assistance Extension Act of 2011 (TAAEA).

Other changes. The proposed rule also addresses the Provider Reimbursement Determinations and Appeals policy, and would make changes to the Medicare EHR Incentive Program that would affect eligible professionals who reassigned their benefits to Method II Critical Access Hospitals.

CMS will accept comments on the proposed rule until September 6, 2013 and will respond to comments in a final rule to be issued by November 1, 2013. The proposed rule will appear in the July 19, 2013 Federal Register and can be downloaded from the Federal Register at:

<http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>

PROPOSED POLICY AND PAYMENT CHANGES TO THE MEDICARE PHYSICIAN FEE SCHEDULE FOR CALENDAR YEAR 2014

OVERVIEW

On July 8, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan. 1, 2014. Currently, Medicare only pays for primary care management services as part of a face-to-face visit. In the proposed rule, in order to support primary care, CMS proposes to make a separate payment to physicians for managing select Medicare patients' care needs beginning in 2015. The proposed rule also proposes changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), the Medicare Electronic Health Record (EHR) Incentive program, as well as changes to the Physician Compare tool on the Medicare.gov website. Finally, the rule continues the phased-in implementation of the physician value-based payment modifier (Value Modifier), created by the Affordable Care Act, that would affect payments to physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program.

This fact sheet discusses the proposed changes to payment policies and payment rates for services furnished under the PFS. A separate fact sheet, also issued today, discusses the proposed changes to the quality reporting programs, the Medicare EHR Incentive program, and the proposals for implementing the Value Modifier. That fact sheet is available at:

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-08-2.html>

BACKGROUND

Since 1992, Medicare has paid for the services of physicians, nonphysician practitioners (NPPs), and certain other suppliers under the PFS, a system that pays for covered physicians' services furnished to a person with Medicare Part B. Under the PFS, relative values are assigned to each of more than 7,000 services to reflect the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing that service. Each of these three relative value components is multiplied by a geographic adjustment factor to adjust the payment for variations in the costs of furnishing services in different localities. The resulting RVUs are summed for each service and then are multiplied by a fixed-dollar conversion factor to establish the payment amount for each service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment.

Sustainable Growth Rate (SGR): The proposed rule does not include any provisions on the physician fee schedule update or SGR as these calculations are determined under a prescriptive statutory formula that cannot be changed by CMS. The final figures are announced in the final rule in November. In March, CMS estimated the physician fee schedule update would be -24.4 percent. In prior years, Congress has taken action to avert a large reduction in physician fee schedule rates before they went into effect. The Administration supports legislation to permanently address the flaws in the SGR that would provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care. The percent change to the physician fee schedule conversion factor may be different than the update because of various required budget neutrality adjustments described in the rule.

PROVISIONS INCLUDED IN THE CY 2014 PFS PROPOSED RULE

Primary Care and Complex Chronic Care Management: Medicare continues to emphasize primary care management services with a proposal for separate payment for complex chronic care management services beginning in 2015. In last year's final rule, we established separate payment for transitional care management services for a beneficiary making the transition from a facility stay back to the community. We also solicited comment on establishing separate payment for advanced primary care—ongoing care management and continuous assessment that occurs outside of a face-to-face visit with a patient.

In this proposed rule, we emphasize advanced primary care through our proposal to pay separately for complex chronic care management services, beginning in CY 2015. Specifically, we propose to pay for non-face-to-face complex chronic care management services for Medicare beneficiaries who have multiple, significant chronic conditions (two or more). Complex chronic care management services include regular physician development and revision of a plan of care, communication with other treating health professionals, and medication management. Medicare will make separate payment to physicians through two G-codes for establishing of a plan of care and furnishing care management over 90-day periods. To be eligible for these services, we propose that beneficiaries also must have had an Annual Wellness Visit (or an Initial Preventive Physical Examination (IPPE), if applicable) -- as the Annual Wellness Visit can serve as an important foundation for establishing a plan of care. We also propose that a single practitioner furnish these services and that they must have the beneficiary's consent to receiving these services over a one-year period.

The proposed rule indicates that CMS intends to establish practice standards necessary to support payment for furnishing complex care coordination management services. Potential standards include access at the time of service to Electronic Health Records (EHR) that meet the HHS certification criteria and written protocols for many aspects of care management implementation,

such as specific steps for monitoring medical and functional patient needs. The rule solicits comment on the potential for CMS to recognize a patient-centered medical home (PCMH) designation by private organizations as one means for a practice to demonstrate that it has met the requisite practice standards. We plan to address policy regarding the practice standards, including PCMH recognition, through separate notice-and-comment rulemaking.

Telehealth Services: We are proposing to modify our regulations describing eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. We believe this change will more appropriately identify sites within urban HPSAs that have rural characteristics and improve access to telehealth services in shortage areas. In addition, we are proposing to add transitional care management services to the list of eligible Medicare telehealth services.

Revisions To The Practice Expense Geographic Adjustment: As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice cost components of each of more than 7,000 physicians' services. Also, the law requires that we assess the GPCIs every three years and adjust them as appropriate with a two-year phase-in of the new GPCIs. We are proposing new GPCIs using updated data. In addition, we are changing the weights assigned to each GPCI (work, PE and malpractice) consistent with the recommendations of the Medicare Economic Index (MEI) Technical Advisor Panel (see below) that increases the weight of work and reduces the weight of practice expense. These new GPCIs would be phased in over CY 2014 and CY 2015. These changes are budget neutral. The statutory work GPCI "floor" of 1.0 is scheduled to expire under current law on December 31, 2013. The proposed GPCIs reflect the elimination of the work "floor" and as a result 51 localities will have a work GPCI below 1.

Medicare Economic Index: CMS is proposing revisions to the calculation of the MEI, which is the price index used to update physician payments for inflation. The changes are in response to recommendations by a Technical Advisory Panel that met during CY 2012. Application of the MEI along with sustainable growth rate determines the total amount of payment made each year under the physician fee schedule. The proposed rule includes proposed changes in the RVU and GPCI weights assigned to work and practice expense so that the weights in the payment calculation would continue to mirror those in the MEI if the proposed revisions are adopted. As a result, the proposal is to re-distribute some payment to work from practice expense.

Misvalued Codes: Consistent with amendments to the Affordable Care Act, CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and make adjustments where appropriate. In the proposed rule, CMS is proposing to adjust payment

rates for more than 200 codes where Medicare pays more for services furnished in an office than in an outpatient hospital department or ASC. We generally expect the resource costs required to furnish a service to be higher in a hospital or ASC, which have to meet conditions of participation and conditions for coverage, respectively. Hospitals also must have stand-by capacity. We are proposing to limit the PFS payment in the situation described above to the total payment that Medicare would make to the practitioner and the facility when the service is furnished in a hospital outpatient department or ASC. In addition, for CY 2014, we are proposing potentially misvalued codes that we identified with the assistance of the Contractor Medical Directors based on their personal experience in paying for Medicare services.

Application of Therapy Caps to Critical Access Hospitals: The law applies two per beneficiary limits to outpatient therapy services—one for physical therapy and speech-language pathology services and another for occupational therapy services. Before the American Taxpayers Relief Act passed earlier this year, the caps did not previously apply in Critical Access Hospitals (CAH). We propose to apply the therapy cap limitations and related policies to outpatient therapy services furnished in a CAH beginning on January 1, 2014 to conform Medicare’s regulations to current law.

The proposed rule will appear in the July 19, 2013, Federal Register. CMS will accept comments on the proposed rule until Sept. 6, 2013, and will respond to them in a final rule with comment period to be issued on or about Nov. 1, 2013.

For more information, see: www.federalregister.gov/inspection.aspx#special

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