

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

FACT SHEET

FOR IMMEDIATE RELEASE
July 3, 2014

Contact: CMS Media Relations
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CMS PROPOSES HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTERS POLICY AND PAYMENT CHANGES FOR 2015

The Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2015 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates proposed rule [CMS-1613-P] on July 3, 2014.

The proposed rule 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. This proposal would continue the progress made so far in moving the OPPS from what currently resembles a hybrid of a prospective payment system and a fee schedule, to a more complete prospective payment system. CMS is proposing a policy finalized in the CY 2014 OPPS/ASC final rule with comment period regarding comprehensive APCs, for which implementation was delayed until CY 2015. CMS is proposing refinements and updates to this policy to make a single payment for all related or adjunctive hospital services provided to a patient in the furnishing of certain primary procedures, such as insertion of a pacemaker.

This Fact Sheet addresses the general payment provisions of the Hospital OPPS and ASC payment system for CY 2015. A separate fact sheet addressing the quality provisions of the proposed rule can be found here: <http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets.html>.

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 5,300 Medicare-participating ASCs paid under the ASC payment system.

The OPSS provides payment for most hospital outpatient department services, and covers partial hospitalization services furnished by hospital outpatient departments and community mental health centers. OPSS payment amounts vary according to the Ambulatory Payment Classification (APC) group to which a service or procedure is assigned.

Proposed Changes to Hospital OPSS Payments and Policies

Proposed Payment Update. CMS proposes to update the OPSS market basket by 2.1 percent for CY 2015. The increase is based on the projected hospital market basket increase of 2.7 percent minus both a 0.4 percentage point adjustment for multi-factor productivity and a 0.2 percentage point adjustment required by law.

Comprehensive-APCs.

In the CY 2014 OPSS/ASC final rule, CMS adopted a Comprehensive-APC policy to expand the categories of related items and services packaged into a single payment for a comprehensive primary service under the OPSS, in order to make the OPSS more consistent with a prospective payment system. CMS created Comprehensive-APCs to prospectively pay under the OPSS for high cost device dependent services in 29 device dependent APCs using a single payment for the hospital stay. However, CMS delayed implementation of this policy to CY 2015 to provide CMS and hospitals with more time to evaluate and comment further on the policy.

In the CY 2015 OPSS/ASC proposed rule, we are proposing several additional Comprehensive-APCs, including some lower cost device dependent APCs not proposed last year and 2 new APCs for other procedures and technologies that are either largely device dependent or represent single session services with multiple components. We are also proposing the restructuring and consolidation of some of the current device dependent APCs with similar costs based on the 2013 claims data. After the APC consolidation and restructuring we are proposing a total of 28 Comprehensive-APCs for 2015 versus the 29 Comprehensive-APCs that were described in the CY 2014 final rule.

Proposed Items and Services to be “Packaged” or Included in Payment for a Primary Service.

Under the OPSS, CMS currently pays separately for services that are ancillary, that is, they are integral, supportive, dependent, or adjunctive to a primary service. These ancillary services are primarily minor diagnostic tests, but therapeutic services can also be ancillary services.

For CY 2015, CMS proposes conditional packaging of all ancillary services assigned to APCs with a geometric mean cost of \$100 or less (prior to applying the conditional packaging status indicator to the services within these APCs), as a criterion to establish an initial set of conditionally packaged

ancillary service APCs. When these ancillary services are furnished by themselves, CMS proposes to make separate payment for these services only. Exceptions to the ancillary services packaging policy include preventive services, psychiatry-related services, and drug administration services. Psychotherapy and related services are excepted because these services are similar to visits and drug administration is excepted because we are considering alternatives for drug administration services including the associated add-on codes.

Off-Campus Provider-Based Departments. CMS proposes to begin collecting data on services furnished in off-campus provider-based departments beginning in 2015 by requiring hospitals and physicians to report a modifier for those services furnished in an off-campus provider-based department on both hospital and physician claims.

Hospital Outpatient Outlier Payment. CMS proposes that for a hospital to receive an outlier payment under the OPSS, the cost of a service must exceed the multiple threshold of 1.75 times the APC payment rate and exceed the CY 2015 fixed dollar threshold of the APC payment plus \$3100. CMS estimates that these thresholds would pay at the proposed target of 1 percent of total OPSS spending in outlier payments.

Community Mental Health Center (CMHC) Outlier Payment. CMS is proposing to continue to set the CMHC outlier threshold at 3.40 times the highest CMHC Partial Hospitalization Program (PHP) APC payment rate (that is, APC 0173 (Level II Partial Hospitalization)) for CY 2015.

Part B Drugs in the Outpatient Department. CMS is proposing to continue paying average sales price (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 2015, the CPI-U update is projected to be 1.7 percent. The MFP adjustment is projected to be 0.5 percent, resulting in an MFP-adjusted CPI-U update of 1.2 percent for CY 2015.

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 2015 APC geometric mean per diem cost for Level I (three services) would be \$97.43 and for Level II (four or more services), \$114.93. For

hospital-based PHPs, the proposed update to the APC geometric mean per diem cost would be \$177.32 for Level I and \$190.21 for Level II.

Other Proposed Policy Changes

Proposed Overpayment Recovery and Appeals Process for Medicare Part C and Medicare Part D. CMS is proposing a process that would allow CMS to recover overpayments that result from the submission of erroneous payment data by a Medicare Advantage (MA) organization or Part D prescription drug plan sponsor in the limited circumstances where the plan fails to correct those data upon request by CMS. CMS is also proposing an appeals process for MA organizations and Part D sponsors to seek review of CMS's determination that the payment data are erroneous. The appeals process would have three levels of review that would include reconsideration, an informal hearing, and an Administrator review.

Revision of the Requirements for Physician Certification of Hospital Inpatient Services. CMS currently requires a physician certification, including an admission order and certain additional elements, for all inpatient admissions. CMS found that for shorter stays and non-outlier stays, the admission order is a sufficient safeguard from both a beneficiary and Trust Fund protection standpoint. Therefore, CMS is proposing that the admission order would continue to be required for all admissions, but the physician certification would only be required for outlier cases and long-stay cases of 20 days or more.

CMS will accept comments on the proposed rule until September 2, 2014 and will respond to comments in a final rule to be issued on or around November 1, 2014. The proposed rule will appear in the July 14, 2014 Federal Register and can be downloaded from the Federal Register at: <http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

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CMS PROPOSES HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTERS QUALITY CHANGES FOR 2015

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Proposed Quality Program Changes

Hospital Outpatient Quality Reporting (OQR) Program. CMS is proposing to remove three measures -- a cardiac care measure (OP-4: Aspirin at Arrival (NQF #0286)) and two prophylactic antibiotic surgery measures (OP-6: Timing of Prophylaxis Antibiotics and OP-7: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)) as performance is high with little variation between hospitals. CMS is proposing the addition of one claims-based measure (OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy) for the CY 2017 payment determination and subsequent years. CMS also proposes to change one chart-abstracted measure (OP-31: Cataracts -- Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536)) from required to voluntary reporting.

CMS also is proposing modifications to the Hospital OQR Program validation process and formalization of a review and corrections period.

ASC Quality Reporting Program. CMS continues to propose measure alignment across the Hospital OQR and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs. Therefore, we are proposing the addition of one outcome measure (Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient

Colonoscopy) and the transition of one outcome measure (Cataracts -- Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536)) to voluntary reporting for both the Hospital OQR and ASCQR Programs.

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