

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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## **FACT SHEET**

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### **CMS ISSUES HOSPITAL OUTPATIENT DEPARTMENT AND AMBULATORY SURGICAL CENTER POLICY AND PAYMENT CHANGES FOR 2014**

The Centers for Medicare & Medicaid Services (CMS) issued the final Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates final rule with comment period [CMS-1601-FC] on November 27, 2013.

The final rule with comment period updates Medicare payment policies and rates for hospital outpatient department and ASC services, and updates and streamlines 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 \$4.4 billion or 9.5 percent, and CY 2014 Medicare payments to ASCs are projected to increase by approximately \$143 million or 5.3 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, and there are approximately 5,000 Medicare-participating ASCs paid under the ASC payment system.

The OPPS is currently best described as a hybrid of a prospective payment system and a fee schedule, 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 final rule with comment period expands 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 packaged items and services in 2008 and 2009, by adding a number of additional categories, including image processing services, and implantable biologicals. CMS had proposed to package an additional seven categories of services for 2014. However, based on public comments, CMS decided not to finalize packaging of two of the seven proposed categories. This final rule with comment period expands the categories of packaged items and services by adding five additional categories of supporting services, thereby moving the OPPS closer to a prospective payment system that is more analogous to Medicare payment for hospital inpatient services and less like a fee schedule.

In addition to packaging these five categories, CMS proposed to create 29 comprehensive APCs to replace 29 existing device-dependent APCs for 2014. After considering public comment, CMS is finalizing this policy with a delayed implementation date of CY 2015.

### **Changes to Hospital OPPS Payments and Policies**

*Payment Update.* The final rule with comment period updates the OPPS market basket by 1.7 percent for CY 2014. The final 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) final rule is 2.5 percent. The Medicare statute requires a productivity adjustment reduction of 0.5 percentage points and a 0.3 percentage point reduction to the CY 2014 OPPS market basket, so the final CY 2014 OPPS market basket update is 1.7 percent.

*Items and Services to be “Packaged” or Included in Payment for a Primary Service.* For 2014, CMS finalizes five new categories of supporting items and services rather than the seven proposed. For certain cases, a separate payment would be made if the item or service is furnished on a different date of service as the primary service. The five final 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; when used in a surgical procedure, including skin substitutes. Skin substitutes will be classified as either high cost or low cost and will be packaged into the associated surgical procedures with other skin substitutes of the same class;
- (3) Certain clinical diagnostic laboratory tests;
- (4) Certain procedures described by add-on codes;
- (5) Device removal procedures.

In addition to packaging these five categories, CMS finalizes its proposal to create 29 comprehensive APCs to replace 29 existing device-dependent APCs, but with a modification to

apply a complexity adjustment for the most complex multiple device claims. CMS is delaying the implementation of these comprehensive APCs until CY 2015.

*Collapsing Five Levels of Visits to One.* The final rule with comment period streamlines the current five levels of outpatient clinic visit codes, replacing them with a single Healthcare Common Procedure Coding System (HCPCS) code describing all clinic visits. A single code and payment for clinic visits is more administratively simple for hospitals and better reflects hospital resources involved in supporting an outpatient visit. The current five levels of outpatient visit codes are designed to distinguish differences in physician work.

The final rule with comment period does not finalize the proposal to replace the current five levels of codes for each type of emergency department visits. CMS intends to consider options to improve the codes for these services in future rulemaking.

*Part B Drugs in the Outpatient Department.* The rule finalizes the proposal to continue paying at ASP+6 percent for non-pass-through drugs and biologicals that are payable separately under the OPDS.

### **Other Payment Updates**

*ASC Payment Update.* ASC payments are updated for inflation annually 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 1.7 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 2014. The annual update is reduced by two percent for ASCs that fail to meet ASC Quality Reporting Program requirements.

*Partial Hospitalization Program (PHP) Rates.* The rule finalizes the proposal 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 final CY 2014 geometric mean per diem cost for Level I (three services) is \$99 and for Level II (four or more services), \$112. For hospital-based PHPs, the final CY 2014 geometric mean per diem cost is \$191 for Level I and \$214 for Level II.

### **Quality Program Changes**

*Hospital Outpatient Quality Reporting (OQR) Program.* The rule finalizes four new measures for the OQR program, affecting the CY 2016 payment determination and subsequent years, with data collection beginning in CY 2014:

1. *Influenza Vaccination Coverage among Healthcare Personnel (OP-27)(NQF #0431).* This measure was adopted previously for the Hospital Inpatient Quality Reporting (IQR) Program for the FY 2015 payment determination and subsequent years.
2. *Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average-Risk Patients (OP-29) (NQF #0658).* This measure was also adopted for the ASC Quality Reporting Program for the CY 2016 payment determination and subsequent years.

3. *Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (OP-30) (NQF #0659)*. This measure was also adopted for the ASC Quality Reporting Program for the CY 2016 payment determination and subsequent years.
4. *Cataracts -- Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery (OP-31) (NQF #1536)*. This measure was also adopted for the ASC Quality Reporting Program for the CY 2016 payment determination and subsequent years.

The final rule also removes two measures for the CY 2015 payment determination and subsequent years:

- *Transition Record with Specified Elements Received by Discharged ED Patients (OP-19) (NQF# 0649)*, because this measure cannot be implemented with the degree of specificity needed to fully address stakeholders' concerns without being overly burdensome to both hospitals and CMS.
- *Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting (OP-24) (NQF# 0643)*, due to continued difficulties accurately applying the measure to the hospital outpatient setting without creating undue burden on providers.

Additionally, the final rule codifies several administrative requirements and clarifies that the extraordinary circumstances waiver/extension includes certain systemic issues.

*ASC Quality Reporting (ASCOR) Program.* The final rule adopts the same two colonoscopy measures, as well as the cataract measure, for the ASCQR Program as were added to the Hospital OQR program for the CY 2016 payment determination and subsequent years.

*Hospital Value-Based Purchasing (VBP) Program.* The rule sets performance and baseline periods for the catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), and surgical site infection (SSI) measures for the FY 2016 Hospital VBP Program. The final performance period is January 1, 2014 through December 31, 2014, and the final baseline period is January 1, 2012 through December 31, 2012.

The rule also creates a second level independent CMS review process for hospitals that are dissatisfied with the result of their existing administrative appeal.

*OPO Conditions for Coverage.* The rule finalizes the proposal to eliminate the requirement for Organ Procurement Organizations (OPOs) to meet all three of the outcome measures. OPOs will be in compliance with the outcome measures if they meet two out of the three outcome measures. These OPOs are performing satisfactorily and should not be decertified based solely on their failure to meet one outcome measure. The change will avoid any unnecessary disruptions to the nation's organ procurement services and continue the flow of donor organs to individuals on the waiting lists.

QIO changes. The rule finalizes changes to the regulations governing eligibility for organizations to be Quality Improvement Organizations (QIOs) and the contracting process for QIOs. The revisions are designed 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 final rule also addresses the Provider Reimbursement Determinations and Appeals policy, and makes changes to the Medicare EHR Incentive Program that affect eligible professionals who reassign their benefits to Method II Critical Access Hospitals.

The final rule with comment period and final rules will appear in the December 10, 2013 *Federal Register* and can be downloaded from the *Federal Register* at:  
<http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

The due date for comments is January 27, 2014.