

DEPARTMENT OF HEALTH & HUMAN SERVICES  
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 OPPS 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 OPPS Payments and Policies**

*Proposed Payment Update.* CMS proposes to update the OPPS 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 OPPS market basket, so the proposed CY 2014 OPPS 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 OPPS 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 OPPTS, 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 OPPTS.

### **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 OPPTS 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 reassign 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>.