PUBLICATION

CMS Publishes Proposed 2015 OPPS and ASC Payment Rule [Ober|Kaler]

July 24, 2014

On July 3, 2014, CMS posted the proposed CY 2015 outpatient perspective payment system (OPPS) and Ambulatory Surgical Center (ASC) payment rule, which was subsequently published in the Federal Register on July 14, 2014. Approximately 4,000 facilities are paid under the OPPS. In the proposed rule, CMS details the proposed changes to factors and amounts used to establish the payment rates for OPPS and ASC services. Some of the key payment elements of the proposed rule are highlighted below. CMS will accept comments until September 2, 2014.

Hospital Outpatient

- ***OPPS Payment Rate Increase:*** CMS proposes to increase the OPPS payment rates by an Outpatient Department (OPD) fee schedule increase factor of 2.1 percent. This update is estimated to result in total payments for CY 2015 reaching approximately $56.5 billion, $5.2 billion more than the CY 2014 payments. CMS plans to continue use of the 2.0 percentage point payment reduction for hospitals that fail to meet outpatient quality reporting standards.
- ***Quality Reporting Program:*** For the Hospital Outpatient Quality Reporting Program, CMS proposes to adopt a claims-based quality measure beginning in CY 2017. CMS also proposes removing a previously adopted measure from the CY 2016 measure set and making that measure voluntary, effective CY 2017. In addition, CMS proposes to refine the standards used to determine when to remove a measure because it is "topped-out," and to remove three measures for being "topped-out." It was further proposed that CMS would "formalize a review and corrections period for chart-abstracted measures." CMS also clarified the process for referring to extraordinary circumstance extensions and exceptions. Lastly, CMS proposes to update the validation procedures and to change the regulation to correct typographical errors.
- ***Outlier Payments:*** Under the proposed rule, CMS would only provide an outlier payment for hospitals that have cost of service amounts in excess of 1.75 times the APC payment rate, and in excess of the APC payment plus $3,100 (the CY 2015 threshold).

Ambulatory Surgical Center

- ***Payment Rate Increase:*** CMS proposes to increase the ASC payment rate by 1.2 percent, which would result in total payments for CY 2015 reaching approximately $4.086 billion.
- ***Quality Reporting Program:*** For the Ambulatory Surgical Center Quality Reporting Program, CMS proposes to add a new quality measure for CY 2017 and beyond. CMS also proposes to exclude a previously adopted measure for CY 2016 from the 2016 measure set, and to make it voluntary for CY 2017 reporting and thereafter. In addition, CMS proposes to establish the data collection time periods and submission deadlines for a previously adopted measure. Lastly, CMS clarified how it would refer to the extraordinary circumstance extensions and exemptions process.

Comprehensive Ambulatory Payment Classifications

In CY 2014, CMS finalized a rule to increase the types of items and services that would be combined into a single payment for a comprehensive primary service. However, the implementation of that rule was delayed until CY 2015. In the CY 2015 proposed rule, CMS adds new APCs and refines the original CY 2014 rule by restricting and consolidating some of the device dependent APCs. Under the proposed rule, CMS would create 28 Comprehensive-APCs. CMS also proposes to continue using the current definition of primary services as the services assigned to comprehensive APCs, and to continue to consider the entire hospital stay as "one comprehensive service for the provision of primary service into which all other services appearing on the claim would be packaged." The proposed rule would allow for a single payment based on all included charges. Finally, CMS proposes a "complexity adjustment" that would apply when a certain combination of primary procedures and other procedures, all assigned to Comprehensive APCs, are reported. The complexity adjustment would increase the payment to the next highest APC in the clinical group.

Packaging of Items and Services in Payments for Primary Services

CMS currently pays for ancillary services separately from the primary services with which they are associated. The CY 2015 proposed rule would move the OPPS closer to a comprehensive prospective payment system by conditionally packaging select ancillary services that are "integral, ancillary, supportive, dependent, or adjunctive to a primary service." For the initial set of conditionally packaged ancillary services, CMS proposes to conditionally package ancillary services assigned to APCs with a geometric mean cost of $100 or less, but when provided as stand-alone services, CMS would still make separate payments for them. CMS identified several exceptions to the packaging policy, including drug administration services, preventative services, psychiatry-related services, as well as psychotherapy and related services. This aspect of the proposed rule is a continuation of CMS's effort to bundle more services into single payments – the industry should expect this trend to continue.

Outpatient Department Drugs and Biologicals

CMS proposes to continue to pay the average sales price plus 6 percent for separately payable non-pass through drugs and biological, setting the payment rate for the drugs and biologicals to the rate they would receive in an office setting.

Adjustment for Cancer Hospitals

To ensure that their payment to cost ratio (PCR) equals the weighted average PCR for the other OPPS hospitals, CMS proposes to continue providing cancer hospitals with supplemental payments. CMS will use a target PCR of .89 to determine that adjustment.

Adjustment for Rural Hospitals

For services paid under the OPPS to select rural community hospitals, CMS proposes to continue using the 7.1 percent adjustment. The adjustment does not apply to "separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost."

Community Mental Health Center (CMHC) Outlier Payments

In accordance with its well-established policy, CMS proposes to continue making outlier payments to CHMCs of half of the amount by which the cost for partial hospitalization services exceeds 3.40 times the APC 0173 payment rate.

Partial Hospitalization Program Payments

CMS proposes to set the geometric mean per diem costs for CMHCs and for hospital-based partial hospitalization programs (HB PHPs) as follows:

- CHMC Level I – $97.43
- CHMC Level II – $114.93
- HB PHP Level I - $177.32
- HB PHP Level II $190.21

Off-Campus Provider-Based Departments

Starting in 2015, CMS proposes to collect data on services furnished in off-campus provider-based departments. To that end, CMS would require hospitals and physicians to use a modifier to report services provided in off-campus provider-based departments.

Ober\|Kaler's Comments: *At a minimum, CMS could use this data to identify those provider locations that are billing as provider-based but that may not have submitted an attestation as such. Submission of an attestation, although not required, forces providers to review their compliance with the provider-based criteria. Moving forward, entities billing as provider-based would be well-advised to ensure that they satisfy the provider-based criteria.*

Expansion of Physician-Owned Hospitals

Under the current rules, physician-owned hospitals must use filed cost report data to apply for an exception to the expansion prohibition. Correctly completed cost reports do not include Medicaid managed care admissions or discharges, and without those patients, some physician-owned hospitals have been unable to qualify for the expansion process. CMS proposes to allow hospitals to draw from additional sources of data that may reflect the percent of inpatient Medicaid admissions to qualify for an exception to the expansion prohibition. This aspect of the proposed rule would help those physician-owned hospitals that could not previously qualify for the expansion permits because their filed cost report data did not include Medicaid managed care admissions or discharges.

Modifying the Requirement of a Physician Certification for Hospital Inpatient Admissions

Under the current regulations, CMS requires a physician certification and admission order for all inpatient admissions. In the proposed rule, CMS would keep the admission order requirement, but modify the physician certification requirement so that they are only needed for outlier cases and long-stay cases of 20 days or more.

Establishing a Three-Level Appeals Process for Medicare Advantage (MA) and Part D Sponsors

This proposed appeals process would apply to overpayments identified by CMS that are associated with data submitted by MA organizations and Part D sponsors. The three levels would involve reconsideration, an informal hearing, and a review by the Administrator.

Ober\|Kaler's Comments: *Given that the final level of review is administrative in nature, one could question how meaningful the proposed appeals process will be for organizations and sponsors that seek to use the process to challenge agency policy.*