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CY 2014 Medicare Outpatient Prospective Payment System (OPPS) Proposed Rule

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Outpatient PPS Proposed Rule

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- Available at: http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16555.pdf

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Topics for Today's Teleconference

- Market Basket Update
- Collapsing 5 E&M Codes into 1
- Collecting Data Re: Off-campus Provider-based Facilities
- Creation of New CCRs
- New Packaging Policy
- Creation of New "Comprehensive APCs"
- Inpatient-only List
- Pass-through Payments for Devices
- No Cost/Full Credit and Partial Credit Devices
- Pass-through Payments for Drugs & Biologicals
- Separately Payable Drugs/Biologicals Paid at ASP +6%
- Cancer Hospital Payments
- Physician Supervision
- "Incident to" Policy
- Clarification of Reopening of Predicate Facts
- Community Mental Health Centers (CMHCs)
- OQR/VBP/ASC Quality Programs Update

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CY 2014 OPPS Conversion Factor Update

- Use IPPS market basket projected increase = 2.5 percent
  - Less 2 percent if hospital doesn't submit quality data
- Less productivity adjustment = 0.4 percent
- Less ACA reduction = 0.3 percent
- Aggregate OPPS "update" = 1.8 percent

Source: 78 *Fed. Reg.* 43577-43578

Collapsing 5 Clinic & ED Visit Codes into 1 Code

- Currently 5 levels of clinic visits, Type A ED visits, and Type B ED visits, based on internal guidelines
- Proposal to establish 1 new code for each type of visit
- No longer recognize distinction between new and established patient clinic visits
- Why?
  - Strategic goal of using larger payment bundles to incentivize efficiency
  - Reduce administrative burden
  - Use large universe of claims for ratesetting
  - Eliminate incentives to "upcode" patients

Source: 78 *Fed. Reg.* 43615 - 43616

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Collapsing 5 Clinic & ED Visit Codes into 1 Code, cont.

- Would create new APC 634, paid at $88.31
  - 8.9% lower than current mid-level clinic visit (APC 606) payment of $96.96
  - Payment based on total mean cost of all 5 levels of E&M codes from 2012 claims
- CMS seeks comments on:
  - General proposal to collapse codes
  - High and low complexity cases
  - How to accommodate special cases not accommodated by new policy

Source: 78 *Fed. Reg.* 43615 - 43616

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Replacing Extended Assessment and Management (EAM) APCs into Single APC

- EAM = hospital visit with observation services of substantial duration
- Previously 2 APCs
- Proposed single new composite APC

Source: 78 *Fed. Reg.* 43562 - 43563

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Data Collection – Off-Campus Provider-Based Facilities

- Reference to MedPAC concerns about higher payments to hospital-based facilities than freestanding clinics
- Notes that CMS "expect[s] hospitals to have overall higher resource requirements"
- Considering collecting information on frequency, type, and payment for services furnished in off-campus provider-based departments, e.g.:
  - Claims-based approach (HCPCS modifier)
  - Break out costs & charges on cost report
- Wants comments on best way to collect this info

Source: 78 *Fed. Reg.* 43626 - 43627

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New Cost to Charge Ratios (CCRs)

- CMS motivation? Address charge compression & resulting distortion of relative weights
- CMS proposes new CCRs for:
  - Cardiac catheterization
  - CT scan
  - MRI
- Note: all would be lower than CCR from parent cost centers
- Also proposes to continue using distinct CCR for implantable medical devices (first used in 2013)

Source: 78 *Fed. Reg.* 43547-43550

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Proposed New Packaging Policy

- CMS proposes to expand packaging to seven categories of items and services:
  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. Clinical Diagnostic Laboratory Tests
  4. Procedures Described by Add-On Codes
  5. Ancillary Services (Status Indicator "X")
  6. Diagnostic Tests on the Bypass List
  7. Device Removal Procedures
- Why? To make OPPS more like a prospective payment and less like a fee schedule
- Proposes to revise and clarify regulatory language at 42 CFR 419.2(b)

Source: 78 *Fed Reg.* 43568-43576

Proposed Status Indicators

Proposed Items and Services	Proposed SI
Drugs, Biologicals, and Radiopharmaceuticals That Function as Supplies When Used in a Diagnostic Test or Procedure	N
Drugs and Biologicals That Function as Supplies or Devices When Used in a Surgical Procedure	N
Clinical Diagnostic Laboratory Tests	N
Procedures Described by Add-On Codes	N
Ancillary Services (Status Indicator “X”)	Q1
Diagnostic Tests on the Bypass List	Q1
Device Removal Procedures	Q2

Source: 78 *Fed Reg.* 43568-43576

Clarification on Packaged Supplies

- Annual review found many supplies that should be packaged, but are currently being paid based on the DMEPOS fee schedule
- CMS proposes to revise the status indicator for all supplies described by Level II HCPCS A-codes (except for prosthetic supplies)
  - Now these supplies would be unconditionally packaged

Source: 78 *Fed Reg.* 43568-43576

Additional Considerations

- Proposals would redistribute ~4% of the estimated 2013 base year OPPS expenditures
- CMS is considering additional packaging in CY 2015
- Requests comments on conditionally packaging all imaging services with any associated surgical procedure

Source: 78 *Fed Reg.* 43568-43576

Establishment of Comprehensive APCs

- CMS proposes to establish 29 new comprehensive APCs to replace 29 existing device-dependent APCs
- Comprehensive APC = a primary service and all adjunctive services provided to support the delivery of the primary service
- Proposal would:
  - Treat all individually reported codes as components of the comprehensive service and make a single prospective payment, and
  - Revise the definition of OPPS services and expand the scope of services covered under OPPS

Source: 78 *Fed Reg.* 43558-43561

Comprehensive APCs: Included Services

Included Services	Definition or HCPCS Code
Otherwise Packaged Services and Supplies	All services packaged in 2013, and all services proposed for unconditional or conditional packaging for 2014
Adjunctive Services	All services that are integral, ancillary, supportive, dependent, and adjunctive to the primary service
DMEPOS	DME, prosthetics, and orthotics, when used as supplies in the delivery of the comprehensive service
OPD Services Reported by Therapy Codes	042X, 043X and 044X
Add. Hospital Room and Board Revenue Centers in the Calculation of Covered Costs	012X, 013x, 015X, 0160, 0169, 0200 through 0204, 0206 through 0209, 0210 through 0212, 0214, 0219, 0230 through 0234, 0239, 0240 through 0243, and 0249
Hospital-Administered Drugs	All medications provided by the hospital for delivery during a comprehensive service pursuant to a physician order

Source: 78 *Fed Reg.* 43558-43561

Payment for Comprehensive APCs

- Claims processing system would make a single payment for the device-dependent comprehensive service whenever a HCPCS for a primary procedure appears on a claim (136 codes identified as primary procedures)
- All other services (excl. mammography, ambulance, pass-through services) would be conditionally packaged

Source: 78 *Fed Reg.* 43558-43561

Inpatient Only List

- Each year CMS reviews the current list of procedures on the inpatient list to identify any performed frequently in outpatient setting
- Complete list of codes to be paid only in the inpatient setting is available in Addendum E on CMS' website
- CMS is not proposing to remove any procedures from the inpatient list for CY 2014

Source: 78 *Fed Reg.* 43622

Pass-Through Payments for Devices

- CMS does not propose pass-through payments for any new devices for CY 2014
  - 3 devices categories will no longer be eligible in CY 2014: C1830, C1840, C1886
- CMS proposes a clarification of the integral and subordinate criterion, §419.66(b)(3)
  - "integral" = "the device is necessary to furnish or deliver the primary procedure with which it is used"

Source: 78 *Fed Reg.* 43594-43596

No Cost/Full Credit and Partial Credit Devices

- Under current policy, CMS reduces the payment for selected APCs when the hospital receives certain replacement devices w/o cost or w/full credit using modifiers “FB” or “FC”
- For CY 2014, CMS is proposing to reduce OPPS payment by the full or partial credit a provider receives
  - Hospitals would be required to report the amount of the credit for value code “FD”
  - No longer use “FB” and “FC”
- Does this present an administrative burden?

Source: 78 *Fed Reg.* 43596-43597

Pass-Through Payments for Drugs and Biologicals

- Proposes to pay at ASP+6 % for CY 2014 (equivalent to physician's offices and same as CY 2013)
- Proposes pass-through status will expire for 15 drugs and biologicals on December 31, 2013 (Table 19)
- Proposes to continue pass-through status for 18 drugs and biologicals (Table 20)

Source: 78 *Fed Reg.* 43598-43600

Payment Rate for Separately Payable Drugs and Biologicals

CY 2014 packaging threshold = $90 (up from $80 in 2013)

Proposed payment rate = ASP + 6% (continues CY 2013 policy)

- Requires no further adjustment, and represents the combined acquisition and pharmacy overhead payment for drugs and biologicals
- Uses statutory default rate of ASP + 6%

Source: 78 *Fed. Reg.* 43604-43609

Payments to Certain Cancer Hospitals

- The ACA requires an adjustment for 11 cancer hospitals with outpatient costs higher than those of other hospitals
- **Proposed adjustment for cancer hospitals** = difference between cancer hospital's payment to cost ratio (PCR) and weighted average PCR of other hospitals
- **Proposal**
  - Continue last year's policy of increasing each cancer hospital's PCR to equal PCR of other hospitals. CMS is proposing a target PCR of 0.90 (this year's estimated PCR of other hospitals)

Source: 78 *Fed. Reg.* 43582-43583

Supervision of Hospital Outpatient Therapeutic Services

- **Proposal to end nonenforcement policy for direct supervision of outpatient therapeutic services in CAHs and small rural hospitals beginning in 2014.**
  - CAHs and small rural hospitals would have to comply with direct supervision requirements for all therapeutic services **except** those CMS identifies as appropriate for general supervision.
  - **CMS seeks comments on** any potential impacts on access to care and quality of care for specific services that fit the general supervision exception.

Source: 78 *Fed. Reg.* 43623

Supervision Requirements for Observation Services

- After receiving many questions about whether Medicare requires multiple evaluations of the patient during the provision of observation services:
- CMS clarifies that once the supervising physician determines the patient is stable, documents it, and transitions the patient to general supervision, **general supervision may be furnished throughout the duration of the observation service**.

Source: 78 *Fed. Reg.* 43623 - 43624

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“Incident to” services

- CMS proposes to amend the conditions of payment for **“incident to”** hospital or CAH outpatient services to require individuals furnishing these services be in compliance with State scope of practice and other State rules related to health care delivery.

Source: 78 *Fed. Reg.* 43624 - 43626

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Clarification of Reopening of Predicate Facts

- **CMS' response to *Kaiser Foundation Hospitals v. Sebelius* (D.C. Cir. 2013)**: proposal to modify the reopening regulation to clarify that factual findings that affect reimbursement are subject to change **only** through timely appeal or reopening for the fiscal period in which the fact first arose or was determined by the intermediary; and
- The application of the fact is subject to change **only** through a timely appeal or reopening of a cost report for the fiscal period in which it was first used by the intermediary to determine reimbursement.

Source: 78 *Fed. Reg.* 43681- 43684

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Proposed Payment for PHP Services

- CMS proposes to calculate the payment rates for the 4 partial hospitalization (PHP) APCs using geometric mean per diem costs.
  - The proposed per diem costs are higher (by approx. $27) for Level I, but lower for Level 2 (by approx. $20) for hospital based PHPs than the final 2013 rates.
  - For CMHCs, the rates are higher (by approx $8 for Level I, but lower (by approx. $7) for Level II services. So relatively constant, but CMS estimates that **payments to CMHCs will decline by 3.8%** due to continuation of the 4 separate APC method.

Source: 78 *Fed. Reg.* 43620-43622

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Separate Threshold for Outlier Payments to CMHCs

- A portion (0.0018%) of the estimated 1.0% outlier target amount would be designated specifically for CHMCs for PHP outliers.
- 50% of the difference between the CMHC's cost for the services and the product of 3.40 times the APC 0173 payment rate.
- No dollar threshold for CMHC outlier payments.

Source: 78 *Fed. Reg.* 43622

Possible Future PHP Initiatives

- **CMS seeks comments on ways to change the payment structure for PHP services, including:**
  - Whether to base payment on an episode of care, or a per diem similar to the IPF PPS for PHP services;
  - Current requirements for physician certification/recertification;
  - Modifications to requirements for physician individualized written plans of treatment to better direct PHP resources toward appropriate discharge and follow-up with appropriate services; and
  - Quality measures that could be used for a PHP.

Source: 78 *Fed. Reg.* 43621- 43622

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Quality Measures/Programs for CY/FY 2016

- **Outpatient Quality Reporting (OQR) Program:**
  - Five measures proposed for inclusion
  - Two Measures proposed for removal (OP-19, OP-24)
- **Value Based Purchasing (VBP) Program:**
  - Performance and baseline periods proposed for CLABSI, CAUTI, and SSI measures
  - Additional independent CMS review process for hospitals that want to appeal their performance score
- **Ambulatory Surgical Center Quality Reporting (ASCQR) Program:**
  - Four measures proposed for inclusion
  - ASC's that fail to meet the reporting requirements will receive a 2.0 percentage point reduction in it's annual update

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Hospital Outpatient Quality Reporting (OQR) Program

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New Measures Proposed for CY 2016

NQF Number and Status	MAP Recommendation	Measure Identifier/Title
#0431	Support	OP-27: Influenza Vaccination Coverage Among Healthcare Personnel
#0564 (time-limited)	Support	OP-28: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
#0658 (time-limited)	Support Direction	OP-29: Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
#0659 (time-limited)	Support Direction	OP-30: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use
#1536 (time-limited)	Support	OP-31: Cataracts- Improvement in Patients Visual Function within 90 Days Following Cataract Surgery

Source: 78 *Fed. Reg.* 43648- 43651.

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Measures Proposed for Removal in CY 2016

Measure Identifier/Name
• OP-19: Transition Record with Specified Elements Received by Discharged Patients
• OP-24: Cardiac Rehabilitation Measures: Patient Referral from an Outpatient Setting

- MAP also recommended that one ED Measure, OP-22: Patient Left Without Being Seen, go through a phased removal from the OQR program since it is no longer NQF endorsed. CMS did not include this recommendation in the proposed rule

Source: 78 *Fed. Reg.* 43534 at 43646.

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Proposed Data Submission Timelines and Procedures for CY 2016

Chart Abstracted Measures	• Data submission timelines (4 months following the end of the calendar quarter) will be continued under the proposed rule • No chart abstracted measures have been proposed where patient level data is submitted directly to CMS for CY 2016
Claims Based Measures	• Data calculations will be based on a 12-month period from July 1, 2013 through June 30, 2014 • No claims based measures have been proposed for CY 2016
Web-based Measures	• Data must be submitted between July 1, 2015 and November 1, 2015 with respect to performance on measures for CY 2014. • This applies to four new measures in the CY 2014 proposed rule: OP-28, OP-29, OP-30, and OP-31
NHSN Measure (New data submission mechanism for OQR)	• Data on OP-27: Influenza Vaccination Coverage among Healthcare Personnel must be reported via the CDC NHSN by May 15 for the period October 1 through March 31.

Source: 78 *Fed. Reg.* 43654- 43656.

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Additional Proposed Changes to Reporting Requirements

- Starting CY 2014, CMS proposes to allow the Agency the ability to grant extraordinary circumstance waivers/extensions if there are systemic problems with data collection systems
- Starting CY 2015, CMS proposes to change the deadline for reconsideration requests from February 3 to the first business day in February of the affected payment year

Source: 78 *Fed. Reg.* 43657-43658.

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Value Based Purchasing (VBP) Program

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Two Proposed Additions for VBP in FY 2016

- Baseline and performance periods for CLABSI, CAUTI, and SSI measures for FY 2016
  - CMS proposes CY 2014 as the Performance period and CY 2012 as the baseline period for these measures
- Implementation of additional CMS review process
  - CMS proposes to include an additional Independent review process for hospitals dissatisfied with the outcome of their appeal

Source: 78 *Fed. Reg.* 43659.

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Ambulatory Surgical Center Quality Reporting (ASCQR) Program

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Proposed ASC Quality Measures for CY 2016

NQF Number and Status	MAP Recommendation	Measures
#0564 (time limited) Measure not endorsed for the ASC setting	Support	Complications within 30 days following cataract surgery requiring additional surgical procedures
#0658 (time-limited)	Support Direction	Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
#0659 (time-limited)	Support Direction	Endoscopy/Poly Surveillance: Colonoscopy interval for patients with a history of adenomatous polyps- avoidance of inappropriate use
#1536 (time-limited)	Support	Cataracts- improvement in patients visual function within 90 days following cataract surgery

Source: 78 *Fed. Reg.* 43662-43663.

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QUESTIONS?

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