CY 2013
Outpatient
Prospective Payment
System Proposed
Rule
CY 2013 Outpatient PPS Timelines

- Proposed rule was issued July 6
- To be published in July 30th Federal Register
- Comments due by Sept. 4th to CMS
- Final rule issued by Nov. 1, 2012
- Effective on Jan. 1, 2013
- We welcome your input and feedback!
Outpatient PPS Payment Update

• Proposed rule contains ACA-required productivity reduction of 0.8 percentage points and additional 0.1 percentage point reduction to CY 2013 market basket update of 3.0 percent.

• Results in proposed market basket update of
  • 2.1 percent for hospitals that publicly report data on 21 quality measures
  • A 0.1 percent update for hospitals that do not meet quality reporting requirements

• Proposed CY 2013 conversion factor is:
  • $71.537 if quality reporting met
  • $70.016 if quality reporting not met.
Quality Reporting:
• No new measures proposed for Hospital OP Quality Reporting (OQR) program. However, CMS intends to suspend 3 measures previously finalized for CY 2014 OQR program.
• ASC and IRF quality programs in the outpatient rule, but didn’t propose any program changes.

Electronic Health Records:
• CMS requests comments on when to allow EHR-based submission of HOPD quality measures.
• Extends ongoing voluntary Electronic Reporting Pilot to FY 2013.

Quality Improvement Organizations (QIOs):
• CMS proposes changes to QIO rules regarding:
  • beneficiary complaints, general quality of care reviews, shortening timeframes for submitting disclosure of information, active staff privileges requirement and photocopying reimbursement.
• As required by law, outpatient “hold-harmless” payments to sole community hospitals and rural hospitals with 100 or fewer beds expiring Dec. 31, 2012
  • The extension of this and other provisions of importance to rural hospitals remains an AHA priority

• CMS proposes to continue to apply a 7.1% payment increase for most rural SCH services and procedures paid under OPPS.
Geometric Mean Based Payment Weights

• CMS proposes to use geometric mean costs, rather than median costs, to determine the relative payment weight for an APC.

  Payment = APC payment weight \times conversion factor

• BBRA 1999 provides authority to make this fundamental change.
• CMS says time is right because geometric mean better reflects average costs of services than median; promotes payment system stability; consistent with inpatient PPS.
• Change is budget neutral to whole OPPS, but payment rates for individual services will fluctuate.
• CMS has files available to show impact of geometric mean by provider type as well as by service.
Supervision, a quick background

- In CY 2009 OPPS rule, CMS issued “restatement and clarification” of supervision policy; puts hospitals at risk of retroactive enforcement action.
  - In reality, this was NEW policy requiring direct supervision, including physical presence of supervising physician in HOPD.
- Advocacy led CMS to make **policy changes** including,
  - Enforcement delay for CAHs and small rural hospitals;
  - Nonphysician staff (NP/PA/CNS/CNM/LCSW) may supervise;
  - More flexible definition of “direct supervision”;
  - Two-tiered policy for 16 “nonsurgical extended duration therapeutic services;
  - HOP Panel process established to allow reduced supervision levels for some services.
- Continued support for provisions in S. 778
  - *Protecting Access to Rural Therapy Services Act of 2011*
CMS proposes an additional year of delay, through CY 2013, in the enforcement of the direct supervision rules for CAHs and small rural hospitals.

All other hospitals already required to be in compliance.

Intended to give CAHs/small rural hospitals an additional opportunity to become familiar with the Advisory Panel on Hospital Outpatient Payment (HOP Panel) process.

CMS states:

“[w]e expect that this will be the final year for the instruction, regardless of the services reviewed by the Panel during its summer meeting.”
HOP Panel to Meet in Late August

- CMS encouraged CAHs and small rural hospitals to testify before the HOP Panel.
- The AHA agrees.
  - in a recently released AHA Advocacy Action Alert, also strongly encouraged hospitals to request an opportunity to provide testimony during the August 27-29 HOP Panel meeting in Baltimore.
  - We believe that a number of hospitals and CAHs did make just such a request before the July 27 deadline.
CMS Clarifies Supervision of Physical, Occup. and Speech-Language Therapy

• In general, PT/OT/SLP are NOT subject to the direct supervision requirements.
  – Direct supervision requirements apply to outpatient therapeutic services paid to hospitals under the OPPS.
  – ….but PT/OT/SLP services furnished in HOPD are paid under Physician Fee Schedule, not OPPS.
• EXCEPTION: Small subset of “sometimes therapy” PT/OT/SLP services that are paid under OPPS when they are not furnished as therapy…these would be subject to direct supervision in hospitals and CAHs.
  • HCPCS 97597 Debridement
  • HCPCS 97598 Debridement
  • HCPCS 97602 Non-selective debridement
  • HCPCS 97605 Negative pressure wound therapy
  • HCPCS 97606 Negative pressure wound therapy
  • HCPCS 0183T Low freq, non-contact ultrasound
$10 per dose payment adjustment proposed for use of technetium-99 (Tc-99m), common radioisotope used in diagnostic imaging, when it has been produced in reactors that do not use highly enriched uranium (HEU).

Intended to support Administration policy promoting converting all medical isotope production to non-HEU sources.

The payment adjustment intended to cover the marginal cost of hospital conversion to the use of non-HEU sources of Tc-99m

Hospitals would be expected to be able to produce appropriate documentation of non-HEU source if audited.

Is $10 is enough of an incentive? Concerns around administrative risk and burden? Future availability of HEU sources?
Inpatient vs Outpatient Status

- CMS requests input on how to improve current instructions regarding IP versus OP status and clarify application of Medicare payment policies for hospitals and physicians.

- **ISSUE:** CMS failure to clearly differentiate its policy regarding when an inpatient versus outpatient stay is covered has led to disagreements between beneficiaries and the government, with hospitals and treating physicians caught in the middle.

- Huge concerns due to
  - Recovery Audit Contractor (RAC) audits of short stay inpatient cases and other auditor activities
  - Longer outpatient observation length of stay and increase in use of observation stays
  - Consumer group complaints regarding impact on coverage for SNF and increased beneficiary out-of-pocket costs

- Hospitals are left in an untenable position.
Inpatient versus Outpatient Status
Discussion Questions

• **Time based policy:** Establish a point in time after which an encounter becomes an inpatient stay if beneficiary is still receiving medically necessary care? Other possible “time-based” approaches?

• **Specify clinical criteria:** Establish more specific clinical criteria for admission and payment, such as adopting specific clinical measures?

• **Require prior authorization for payment of an admission?**

• **Better align payments with resources used:** Ways to align payment rates more closely with resources used by hospital when providing outpatient care versus inpatient care of short duration, so as to reduce payment disparities and influence financial incentives and disincentives to admit?

• **Can hospitals do a better job?** Responsibility of hospitals to use all the tools necessary to make appropriate initial admission decisions? E.g. 24/7 case management and UR review staff.
Discussion and Questions
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