CY 2014 Outpatient Prospective Payment System Proposed Rule
CY 2014 Outpatient PPS Timelines

- Proposed rule was issued July 8
- Published in July 19th Federal Register
- Comments due by Sept. 6th to CMS
- Final rule issued by Nov. 1, 2013
- Effective on Jan. 1, 2014
- We welcome your input and feedback!
Proposed Rule for CY 2014 Hospital Outpatient PPS

Medicare Outpatient PPS and ASC Proposed Rule for CY 2014

Friday, August 2, 2013
Outpatient PPS Payment Update

• Proposed rule contains ACA-required productivity reduction of 0.4 percentage points and additional 0.3 percentage point reduction to CY 2014 market basket update of 2.5 percent.

• Results in proposed market basket update of
  • 1.8 percent for hospitals that publicly report data on 22 quality measures
  • A negative 0.2 percent update for hospitals that do not meet quality reporting requirements

• Proposed CY 2014 conversion factor is:
  • $72.728 if quality reporting met
  • $71.313 if quality reporting not met.
CMS estimates that the market basket update and all other policies in the proposed rule will result in the following per-case changes in payment:

<table>
<thead>
<tr>
<th>Category</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Hospitals</td>
<td>1.8%</td>
</tr>
<tr>
<td>Urban Hospitals</td>
<td>2.0%</td>
</tr>
<tr>
<td>Large Urban</td>
<td>2.3%</td>
</tr>
<tr>
<td>Other Urban</td>
<td>1.5%</td>
</tr>
<tr>
<td>Rural</td>
<td>0.9%</td>
</tr>
<tr>
<td>Sole Community</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other Rural</td>
<td>0.4%</td>
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</table>
Key Payment Policy Changes Proposed

- **Changes to Outpatient Visits:** Collapsing 20 hospital clinic visit, Type A emergency department (ED) and Type B ED visit codes into 3 new codes – one for each type of visit
- **New Comprehensive APCs:** Establishing 29 new “comprehensive” APCs for device-dependent services, making single payment based on all charges on claim
- **New Packaging Categories:** Identifying 7 new categories of items and services whose costs will be packaged into payment for other services to which they are integral, ancillary or supportive
- **Distinct New CCRs:** Using distinct cost-to-charge ratios (CCRs) for cardiac catheterization, CT scan and MRI to calculate OPPS payment weights
CMS proposes to **collapse current several levels of codes for each of three types of hospital visits:**

- 10 Clinic Visits (5 new and 5 established patient visit codes)
- 5 Type A ED visits
- 5 Type B ED visits

And replace with one new code representing a single level of payment for each type of visit.

- Current visit codes wouldn’t be recognized after 2013;
- New and established patient distinctions not recognized

Each of the three new codes assigned to a new APC

- Payment rate based on total mean costs of Level 1 through Level 5 codes in 2012 OPPS claims data
<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>CY 2013</th>
<th>PROPOSED CY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HCPCS code</td>
<td>APC</td>
</tr>
<tr>
<td>Clinic Visit</td>
<td>99201</td>
<td>0604</td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>0605</td>
</tr>
<tr>
<td></td>
<td>99203</td>
<td>0606</td>
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<tr>
<td></td>
<td>99204</td>
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<td></td>
<td>99205</td>
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<td></td>
<td>99211</td>
<td>0604</td>
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<td></td>
<td>99212</td>
<td>0605</td>
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<td></td>
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<tr>
<td></td>
<td>99214</td>
<td>0606</td>
</tr>
<tr>
<td></td>
<td>99215</td>
<td>0607</td>
</tr>
<tr>
<td>Type A ED Visit</td>
<td>99281</td>
<td>0609</td>
</tr>
<tr>
<td></td>
<td>99282</td>
<td>0613</td>
</tr>
<tr>
<td></td>
<td>99283</td>
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<td>0615</td>
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<tr>
<td></td>
<td>99285</td>
<td>0616</td>
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<tr>
<td>Type B ED Visit</td>
<td>G0380</td>
<td>0626</td>
</tr>
<tr>
<td></td>
<td>G0381</td>
<td>0627</td>
</tr>
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<td></td>
<td>G0382</td>
<td>0628</td>
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<td></td>
<td>G0383</td>
<td>0629</td>
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<td></td>
<td>G0384</td>
<td>0630</td>
</tr>
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</table>
Hospital Outpatient Visit Services

• CMS Rationale:
  – Incentivize efficient care
  – Reduce administrative burden
  – More accurate payment
  – Eliminate incentive for “up-coding”

• AHA Perspective
  – Still evaluating but this is a dramatic step, especially given CMS’s previous statements that hospitals billing visit services appropriately and consistently
  – Analyzing impact but some concern about how proposal will affect hospitals with higher case mix (e.g. trauma, cancer)
  – Interaction with Congressional “site-neutral” payment policy proposals?
Comprehensive APCs

• Proposal to create 29 “comprehensive” APCs to replace 29 existing device-dependent APCs
  – Each includes a primary service and all “adjunctive” services provided to support delivery of primary service
  – Single prospective payment made, based on cost of all codes on claim, subject to single beneficiary copayment, up to inpatient hospital deductible cap limit

• Key element: Policy expands scope of services covered under OPPS to include items/services now paid separately under other Medicare payment systems
  – Clinical lab services, room and board, DMEPOS, outpatient therapy services
  – CMS claims they’ve included payments for these when calculating budget neutrality under OPPS
New Categories of Packaged Services

• Proposes to package (rather than pay separately) 7 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

• Impact:
  – Changes payment rates for all separately paid procedures
  – Redistributes 4%, or $2 billion, under the OPPS
  – CMS claims to have included payments from other payment systems (e.g. CLFS) when calculating budget neutrality
Calculating Payments Using New CCRs

- CMS proposes to calculate the OPPS relative payment weights using three additional cost-to-charge ratios (CCRs)
  - Magnetic Resonance Imaging (MRI) scans
  - Computed Tomography (CT) scans
  - Cardiac catheterization
- Continue using a distinct CCR for implantable medical devices.
- Results: APC costs for CT, MRI, cardiac catheterization declining while costs for plain films, U/S and other imaging & cardiac procedures increasing.

<table>
<thead>
<tr>
<th>Calculated CCR</th>
<th>&quot;New&quot; Standard Cost Center (*)</th>
<th>Using Form 2552-96 CCRs Only</th>
<th>Using Form 2552-96 and Form 2552-10 CCRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>0.2915</td>
<td>0.5112</td>
<td></td>
</tr>
<tr>
<td>Cardiac Catheterization</td>
<td>*</td>
<td>0.1685</td>
<td>0.159</td>
</tr>
<tr>
<td>Radiology – Diagnostic</td>
<td>0.2025</td>
<td></td>
<td>0.2279</td>
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<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>*</td>
<td>0.1074</td>
<td>0.0959</td>
</tr>
<tr>
<td>CT Scan</td>
<td>*</td>
<td>0.0568</td>
<td>0.0502</td>
</tr>
<tr>
<td>Medical Supplies Charged to Patient</td>
<td>0.3389</td>
<td></td>
<td>0.3315</td>
</tr>
<tr>
<td>Implantable Devices Charged to Patient</td>
<td>*</td>
<td>0.4371</td>
<td>0.419</td>
</tr>
</tbody>
</table>
Outlier Payments

- Outlier payments are added to the APC amount to mitigate hospital losses when treating high-cost cases.
- Policy: Fixed-dollar outlier threshold & a percentage threshold
  - CMS proposes for CY 2014, to increase the fixed-dollar threshold for outliers to $2,775, which is $750 more than in CY 2013.
- Thus, to be eligible for an outlier payment in CY 2014, the cost of a hospital outpatient service would have to exceed:
  - 1.75 times the APC payment amount (the percentage threshold), and
  - be at least $2,775 more than the APC payment amount.
- When this thresholds met, outlier payment would be 50% of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.
Adjustment for No Cost/Full Credit and Partial Credit Devices

• Currently policy:
  – Payment reduced by:
    • 100% of device cost (device offset amount) when hospital receives replacement devices without cost/full credit and
    • 50% percent of offset amount, when hospitals receive partial credit of 50 percent or more of the cost of a specified device.

• Proposed revised policy:
  – Payment reduced by the exact full or partial credit a provider receives for a replaced device.
  – Hospitals must required to report the amount of the credit in the amount portion for value code “FD” (Credit Received from the Manufacturer for a Replaced Medical Device)
Drugs, biologicals and radiopharmaceuticals without pass-through status paid in one of two ways: packaged payment or separate payment (individual APCs).

- Depends on whether their cost per day exceeds “packaging threshold” amount. For CY 2014, proposed packaging threshold amount is $90.
- Exceptions to packaging threshold are “policy packaged” drugs – contrast agents, anesthesia drugs…

For CY 2014, CMS again proposes to pay for separately payable drugs and biologicals at the “statutory default” rate of ASP+6%
Transitional Pass-through Payments

• Congress created temporary additional, or “transitional pass-through payments,” for certain innovative medical devices, drugs and biologicals to ensure that Medicare beneficiaries access to new technologies.

• For CY 2014, CMS projects that pass-through payments will be 0.02 percent of total OPPS payments, or $11 million.
  – $10 million in pass-through payments for devices
  – $1 million for drugs and biologicals.

• Changes to the transitional pass-through pool must be budget neutral.
Cancer Hospital Adjustment

• CMS proposes to continue its cancer hospital update policy finalized in the 2012 OPPS final rule.
  – Policy would increase each of the 11 “exempt” cancer hospitals’ OPPS payments by percentage difference between its individual payment-to-cost ratio (PCR) and the weighted average PCR of the other hospitals paid under the OPPS (0.90).
  – The adjustment is made at cost report settlement and is budget neutral.
For hospital-based PHPs, the proposed CY 2014 per-diem costs would increase by approximately $27 for Level I PHP services and fall by approximately $20 for Level II PHP services, compared to the 2013 rates.

<table>
<thead>
<tr>
<th>Category</th>
<th>Hospital-Based PHPs</th>
<th>CMHC PHPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I (days with 3 services)</td>
<td>APC 0175 $212.85</td>
<td>APC 0172 $94.51</td>
</tr>
<tr>
<td>Level II (days with 4 or more services)</td>
<td>APC 0176 $215.13</td>
<td>APC 0173 $106.20</td>
</tr>
</tbody>
</table>
• CMS expresses interest in examining the payment structure for PHP services to determine alternative methodologies to pay for PHP services that would reduce unnecessary care while maintaining or increasing the quality of care.

• Public comments requested on the following topics:
  – Would payment based on an episode of care, or a per diem similar to the inpatient psychiatric facility PPS, result in more appropriate payment for PHP services than the current payment structure?
  – Does the current physician recertification requirement, which requires the first recertification as of the 18th day of PHP service, reflect current PHP treatment practices or should the regulation be changed to another standard that accords with best practices?
  – What requirements should be included in the written plan of treatment to better direct PHP resources toward appropriate discharge and follow-up with appropriate support services?
  – If CMS were to establish quality measures for PHP services and require quality data reporting, what should be included in those measures?
Five new measures proposed for Hospital Outpatient Quality Reporting (OQR) program:

- Influenza Vaccination Coverage Among Healthcare Personnel
- 2 Cataract Surgery Outcome Measures
- 2 Colonoscopy Follow Up Measures

Two OQR measures proposed for removal:

- Transition Record with Specified Elements Received by Discharged Emergency Department (ED) Patients
- Cardiac Rehabilitation Patient Referral From an Outpatient Setting
CMS proposes to require, as a new Medicare condition of payment, that individuals furnishing outpatient therapeutic services and supplies “incident to” the services of a physician or NPP, must do so in compliance with applicable state law.

- CMS cites several situations where Medicare was billed for “incident to” services that were performed by an individual who did not meet the state standards for furnishing those services.
- Because the current Medicare requirements for hospital outpatient therapeutic services do not explicitly make compliance with state law a condition of payment for services, the Medicare program has had limited recourse.
Collecting Data on Services Furnished in Off-Campus Provider-Based Departments

- CMS requesting comment on best means for collecting information on frequency, type and payment for services furnished in off-campus provider-based departments (PBDs) of hospitals
  - Cites reports of trend of hospitals acquiring physician practices and integrating those practices as hospital outpatient departments
  - Notes the Medicare Payment Advisory Commission’s concerns around increasing Medicare payments and beneficiary cost-sharing that can result from such acquisitions.
  - CMS is considering several potential methods, such as:
    - a new HCPCS modifier that would be reported with every code for services furnished in an off-campus PBD of a hospital via the Medicare physician and hospital outpatient claim forms.
    - asking hospitals to break out the costs and charges for their PBDs outpatient service cost centers on cost report.
CMS proposes to end its delay in enforcing direct supervision rules for CAHs & for small, rural PPS hospitals (with fewer than 100 beds)

- As of 1/1/14, minimum of “direct supervision” for all outpatient therapeutic services, unless:
  - service is on the list of services that may be furnished under general supervision (via HOP Panel Process) OR among 11 services on NSEDTS list (subject to two-tiered supervision; direct then general).

CMS states:
- “We believe it is appropriate to allow the enforcement instruction to expire at the end of CY 2013, to ensure the quality and safety of hospital and CAH outpatient therapeutic service paid by Medicare.”
• **AHA Response:** We are very disappointed that CMS has not heeded the concerns voiced by CAHs and small rural PPS hospitals that imposing its direct supervision policy is not only unnecessary but result in reduced access to care.
  – Inadequate numbers of physicians/NPPs in rural communities to provide direct supervision.
  – Hospitals will have no choice but to limit hours of operation or close programs due to inability to meet direct supervision rule.

• **AHA will again strongly urge CMS to extend the enforcement delay for at least another year, and we encourage hospitals to do the same.**
Discussion and Questions
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