# CMS Finalizes Hospital Outpatient and Ambulatory Surgical Centers Policy and Payment Changes for 2015

The Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2015 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates final rule with comment period [CMS-1613-FC] on October 31, 2014.

The OPPS/ASC final rule is one of several rules for calendar year 2015 that reflect a broader Administration-wide strategy to deliver better care at lower cost by finding better ways to deliver care, pay providers, and use information. Provisions in these rules are helping to move our health care system to one that values quality over quantity and focuses on reforms such as measuring for better health outcomes, focusing on disease prevention, helping patients return home from hospital stays, helping manage and improve chronic diseases and fostering a more efficient and coordinated health care systems.

The CY 2015 OPPS/ASC final rule with comment period updates Medicare payment policies and rates for hospital outpatient department and ASC services and partial hospitalization services provided by community mental health centers (CMHCs), and refines programs that encourage high-quality care in these outpatient settings. This rule furthers the agency's goal of delivery system reform by moving the OPPS toward making payments for larger packages of items and services rather than making separate payments for each individual service. This reform provides incentives for facilities to deliver more efficient, higher quality care. In CY 2015, CMS is implementing a policy finalized last year regarding comprehensive Ambulatory Payment Classifications (C-APCs), with some refinements and updates. The new C-APC payment policy makes a single payment for all related or adjunctive hospital items and services provided to a patient receiving certain primary procedures that are either largely device dependent, such as insertion of a pacemaker, or represent single session services with multiple components, such as intraocular telescope implantation.

This Fact Sheet addresses the general payment provisions of the Hospital OPPS and ASC prospective payment system for CY 2015. A separate fact sheet addressing the quality provisions of the final rule with comment period can be found here: http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets.html.

**Overview**

More than 4,000 hospitals and over 70 CMHCs are paid under the OPPS. There are approximately 5,300 Medicare-participating ASCs paid under the ASC payment system.

The OPPS provides payment for most hospital outpatient department services, and partial hospitalization services furnished by hospital outpatient departments and CMHCs. OPPS payment amounts vary according to the Ambulatory Payment Classification (APC) group to which a service or procedure is assigned.

**Changes to Hospital OPPS Payments and Policies**

***Payment Update.*** Overall OPPS payments are estimated to increase by 2.3 percent for CY 2015. The increase is based on the projected hospital market basket increase of 2.9 percent minus both a 0.5 percentage point adjustment for multi-factor productivity and a 0.2 percentage point adjustment required by law and includes other payment changes, such as increased estimated total outlier payments.

***Comprehensive-APCs.*** In the CY 2014 OPPS/ASC final rule, CMS adopted a C-APC payment policy. A C-APC is an APC with a high cost primary service (generally includes the implantation of a device) that accounts for a higher percentage of the total costs of the hospital encounter. Under the CY 2014 policy, CMS created 29

C-APCs for which payment for the comprehensive service (primary service and all related items and services) was packaged into a single payment under the OPPS comparable to the single payment made under the inpatient prospective payment system for a hospital stay. CMS, however, delayed implementation of this policy to CY 2015 to provide the agency and hospitals with more time to evaluate and comment further on the policy.

In the CY 2015 OPPS/ASC proposed rule, CMS proposed several additional C-APCs, including some lower cost device dependent APCs not proposed last year and two new APCs for other procedures and technologies that are either largely device dependent or represent single session services with multiple components. We also proposed the restructuring and consolidation of some of the current device dependent APCs with similar costs based on the 2013 claims data. As a result of the proposed APC consolidation and restructuring, we proposed a total of 28 C-APCs for 2015 versus the 29 C-APCs that were described in the CY 2014 final policy. We also proposed modifying the higher payment (complexity adjustment) criteria for certain costly and frequent procedure combinations.

CMS is finalizing the C-APC policy as proposed for 25 out of the proposed 28 C-APCs. By providing a single comprehensive payment for services assigned to C-APCs, Medicare is providing the hospital with improved incentives to provide efficient and high quality care at lower cost. Three of the proposed APCs will not be converted into C-APCs because a significant number of higher cost non comprehensive services are often performed with the services assigned to these APCs, and a single payment for the comprehensive service would result in significant

underpayment for these select procedure combinations.

**Items and Services to be "Packaged" or Included in Payment for a Primary Service.**

***Ancillary Services.*** Under the OPPS, CMS currently pays separately for certain ancillary services, that is, services that are integral, supportive, dependent, or adjunctive to a primary service. These ancillary services are primarily minor diagnostic tests, but therapeutic services can also be ancillary services, and while they are often performed with a primary service, there are instances when they are provided alone.

For CY 2015, CMS will conditionally package all ancillary services assigned to APCs with a geometric mean cost of $100 or less prior to packaging as a criterion to establish an initial set of conditionally packaged ancillary service APCs. When these ancillary services are furnished by themselves, CMS will make separate payment for these services. Exceptions to the ancillary services packaging policy include preventive services, psychiatry-related services, and drug administration services.

***Prosthetic Supplies.*** CMS has finalized a proposal to package prosthetic supplies as it does implantable prosthetic devices, and all other supplies in the OPPS when used in conjunction with a surgical or other procedure. Replacement prosthetic supplies associated with an implantable prosthetic device would continue to be available outside of the hospital through the Durable Medical Equipment Prosthetic and Orthotics Supplies (DMEPOS) Fee Schedule.

***Skin Substitutes.*** "Skin substitutes" are a category of products that are applied to chronic wounds to promote healing. In the CY 2014 OPPS/ASC final rule with comment period, CMS unconditionally packaged skin substitutes into their associated surgical procedures as part of a broader proposal to package drugs and biologicals that function as supplies when used in a surgical procedure. There are two sets of skin substitute application procedure codes, one set of codes for high cost skin substitutes and another for low cost skin substitutes. Skin substitutes are divided into the high and low cost groups based on a cost threshold calculation. For CY 2015, CMS finalized its proposal to establish the high/low cost threshold using the weighted average mean unit cost (MUC) for all skin substitute products from claims data to promote more stable high and low cost categories.

CMS is also finalizing its proposal to evaluate skin substitute applications for pass-through payment through the device pass-through process rather than the drug pass-through process. This change aligns with the treatment of the similar implantable biological products that have been evaluated through the device pass-through process since 2010.

***Off-Campus Provider-Based Departments.*** CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other eligible practitioners to report these services using a new place of service code on professional claims. Data collection from hospitals will be voluntary in 2015 and required beginning on January 1, 2016.

***Hospital Outpatient Outlier Payment.*** CMS finalized a proposal that for a hospital to receive an outlier payment under the OPPS, the cost of a service must exceed the multiple threshold of 1.75 times the APC payment rate and exceed the CY 2015 fixed dollar threshold of the APC payment plus $2,775. CMS estimates that these thresholds would target an estimated 1 percent of total OPPS spending in outlier payments.

***Community Mental Health Center (CMHC) Outlier Payment.*** CMS will continue to set the CMHC outlier threshold at 3.40 times the highest CMHC Partial Hospitalization Program (PHP) APC payment rate (that is, APC 0173 (Level II Partial Hospitalization)) for CY 2015.

***Part B Drugs in the Outpatient Department.*** CMS will continue paying average sales price (ASP) + 6 percent for non-pass-through drugs and biologicals that are payable separately under the OPPS.

**Other 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). For CY 2015, the CPI-U update is projected to be 1.9 percent. The multifactor productivity (MFP) adjustment is projected to be 0.5 percent, resulting in an MFP-adjusted CPI-U update factor of 1.4 percent for CY 2015.

***Partial Hospitalization Program (PHP) Rates.*** CMS will update the two payment rates for CMHCs and the two payment rates for hospital-based PHPs. For CMHCs, **the final CY 2015** APC **geometric mean per diem cost will be $100.15 for Level I (three services) and $118.54 for Level II (four or more services). For hospital-based PHPs, the final CY 2015 APC geometric mean per diem cost will be $185.87 for Level I and $203.01 for Level II.**

**Other Policy Changes**

***CMS-Identified Overpayments Associated with Medicare Advantage and Part D Submitted Payment Data.*** CMS has finalized a process that will allow CMS to recover overpayments that result from erroneous payment data submitted by Medicare Advantage (MA) organizations or Part D prescription

drug plan sponsors. This payment recovery process would only be used in the limited circumstances when an MA organization or Part D sponsor fails to correct erroneous payment data after request from CMS to do so. CMS has also finalized an appeals process for MA organizations and Part D sponsors to seek review of CMS' determination that the payment data are erroneous. The appeals process will have three levels of review that would include reconsideration, an informal hearing, and an Administrator review.

***Revision of the Requirements for Physician Certification of Hospital Inpatient Services.*** CMS currently requires a physician certification, including an admission order and certain additional elements, for all inpatient admissions. CMS is finalizing its proposal to require the physician certification only for outlier cases and long-stay cases of 20 days or more. The admission order will continue to be required for all inpatient admissions when a patient has been formally admitted as an inpatient of the hospital.

The final rule will appear in the November 10, 2014 Federal Register and can be downloaded from the Federal Register at: http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1. The provisions in the rule will generally take effect on January 1, 2015. The public comment period will close on December 30, 2014.