

CMS Moves On Bundled Primary Procedure Pay

The Centers for Medicare and Medicaid Services (CMS) is moving ahead with plan to shift hospital outpatient payments to a more complete prospective payment system that bundles payments for certain primary procedures, the agency revealed in the 2015 hospital outpatient prospective payment system (HOPPS) proposed rule. CMS' newly proposed rule made adjustments to the 2014 proposal, which entails a single payment for all related or adjunctive hospital services provided to a patient during certain primary procedures, such as intraoperative radiation therapy (IORT), breast brachytherapy and single session cranial stereotactic radiosurgery (SRS).

The proposed rule that affects more than 4,000 hospitals, including general acute care hospitals and cancer hospitals, cements the Agency's plan to shift to the new comprehensive-Ambulatory Payment Classification (C-APC) group policy. Under the policy, categories of related items and services will be packaged into a single payment for a comprehensive primary service. The shift makes the HOPPS more consistent with a prospective payment system, moving away from the current hybrid of a prospective payment and fee schedule.

In the 2014 payment rule, CMS created 29 comprehensive-APCs but delayed their implementation to give the agency and hospitals time to evaluate the payment shift. The 2015 proposed rule suggests adding several comprehensive-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. But CMS also proposes to restructure and consolidate some of the current device-dependent APCs with similar costs based on 2013 claims data. As a result, CMS now proposes a total of 28 comprehensive-APCs.

The 2015 proposed rule also includes a new policy for ancillary services. Under HOPPS, CMS currently pays separately for services that are ancillary, or 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. For 2015, CMS proposes conditional packaging of all ancillary services assigned to APCs with a geometric mean cost of \$100 or less, as a criterion to establish an initial set of conditionally packaged ancillary service APCs. In cases in which these ancillary services are furnished by themselves, CMS proposes to make separate payment for the services only. This proposal does not include any radiation oncology procedures.

The 2015 HOPPS payment rule also proposes to:

- Update and streamline programs that encourage high-quality care in outpatient settings.
- Provide a 2.1 percent HOPPS market basket increase for 2015 based on the projected hospital market basket increase of 2.7 percent minus both a 0.4 percentage point adjustment for multi-factor productivity and a 0.2 percent adjustment required by law.
- Begin collection of data on services furnished in off-campus provider-based departments beginning in 2015 by requiring hospitals and physicians to report a modifier for those services furnished in an off-campus provider-based department on both hospital and physician claims.

AAPM will submit written comments to CMS in mid-August. The 2015 final rule will be published on or around November 1st.