

For Immediate**Release:**

Friday, July 06, 2012

Contact:CMS Office of Public Affairs
202-690-6145**PROPOSED 2013 POLICY, PAYMENT CHANGES FOR HOSPITAL
OUTPATIENT DEPARTMENTS AND AMBULATORY SURGICAL CENTERS****OVERVIEW**

On July 6, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates for both hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) for calendar year (CY) 2013. The proposed rule seeks to promote higher quality and more efficient services for Medicare beneficiaries.

CMS projects that total payments for services furnished to Medicare beneficiaries in HOPDs during CY 2013 under the Hospital Outpatient Prospective Payment System (OPPS) will be approximately \$48.1 billion, while total CY 2013 payments under the ASC payment system will be approximately \$4.10 billion.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM**Background:**

Since August 2000, Medicare has paid hospitals for most services furnished in their outpatient departments under the OPPS. Medicare currently pays more than 4,000 hospitals – which includes general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals – for outpatient services under the OPPS. Medicare also pays community mental health centers (CMHCs) under the OPPS for partial hospitalization program (PHP) services. The OPPS payments cover facility resources including equipment, supplies, and hospital staff but do not pay for the services of physicians and nonphysician practitioners both of whom are paid separately under the Medicare Physician Fee Schedule (MPFS).

Services under the OPSS are classified into payment groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require the use of similar resources and a payment rate is established for each APC. The APC payment rates are adjusted for geographic cost differences, and payment rates and policies are updated annually through rulemaking. The final rule is generally issued by Nov. 1 each year and, unless otherwise specified, becomes effective Jan. 1 of the subsequent year.

Beneficiaries generally share in the cost of services furnished under the OPSS by paying either a 20 percent coinsurance or, for certain services, a copayment which under the Medicare law may not exceed 40 percent of the total payment for the APC. The copayment is gradually being replaced by the 20 percent coinsurance as the composition of APC groups is updated in response to policy changes or new cost data. CMS estimates that the overall beneficiary share of the total payments for Medicare covered hospital outpatient services will be about 21.6 percent in CY 2013.

Significant Proposals for CY 2013

Proposed Changes to Payment Rates under the OPSS in CY 2013

· Projected hospital outpatient payment rate increase due to the market basket update and required adjustments: CMS is proposing to increase OPSS payment rates by 2.1 percent. The rate increase is based on a statutory formula that equals the projected hospital market basket—an inflation rate for goods and services used by hospitals for hospital inpatient services paid under the hospital inpatient prospective payment system—of 3.0 percent less statutory reductions totaling 0.9 percent, including an adjustment for economy-wide productivity. In addition, the NPRM proposes to continue the statutory 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting (OQR) requirements.

· Change in payment methodology from median costs to geometric mean costs: CMS is proposing to use the geometric mean costs of services within an APC to determine the relative payment weights of services, rather than the median costs that have been used since the inception of the OPSS. CMS is proposing this change because geometric mean costs better reflect average costs of services than the median. Geometric means are the basis of the Inpatient Prospective Payment System. With more than a decade of experience under the OPSS, CMS believes hospital cost

reporting is now sufficiently improved to allow us to make this change to geometric mean costs. CMS' analysis shows that the proposed change to geographic mean costs would have a limited payment impact on most providers, with a small number experiencing payment gains or losses based on their service-mix.

· *Drugs and pharmacy overhead* - For CY 2013, CMS is proposing to pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at the statutory default of average sales price (ASP) plus 6.0 percent.

· *Inpatient/Outpatient Status* - The proposed rule provides an update on the Part A to Part B Rebilling Demonstration. Under current policy, hospitals are only allowed to bill for a limited list of Part B services following a denial of an inpatient stay as not reasonable and necessary. The demonstration allows hospitals to bill Medicare for all Part B services and be paid 90 percent of what would otherwise be allowable. The demonstration is in effect from 2012 through 2014. In addition, CMS is soliciting public comments on policy changes that could potentially be made that would provide more clarity regarding patient status for purposes of Medicare payment.

Proposed changes to Hospital Outpatient Quality Reporting Program

CMS is not proposing to add any new measures to those previously finalized for the CY 2014 and CY 2015 payment determinations. Thus, CMS is proposing to require reporting of 23 measures for the CY 2014 payment determination and 24 measures for the CY 2015 payment determination. CMS is proposing to defer data collection for one quality measure, OP-24 Cardiac Rehabilitation Patient Referral from an Outpatient Setting, for one year, and is confirming suspension of data collection for another, OP-19: Transition Record with Specified Elements Received by Discharged ED Patients. The proposed rule also clarifies CMS's determination that public reporting of the claims-based imaging efficiency measure OP-15 will be deferred until July 2013 at the earliest, as discussed in the CY 2012 OP/ASC final rule with comment period. CMS is also proposing program procedures affecting measure retirement, measure suspension, measure retention, and administrative forms.

AMBULATORY SURGICAL CENTERS

Background:

There are approximately 5,000 Medicare-participating ASCs. Since Jan. 1, 2008, ASCs have been paid under a revised ASC payment system that generally aligns payment in ASCs and hospital outpatient settings by basing ASC payment rates on the APC relative weights for similar services. Under the revised ASC payment system, CMS also adopted criteria that allowed for more procedures and services to be covered when furnished in an ASC.

The revised ASC payment rates were established to reflect the same relativity of resource use among procedures as under the OPSS, taking into consideration the lower costs of surgical procedures performed in ASCs and maintaining budget neutrality in the payment system. In general, the revised ASC payment rate for a covered surgical procedure is based on the APC relative payment weights for the same procedure under the OPSS. However, for device-intensive procedures (where the device accounts for more than 50 percent of cost), ASCs receive the same payment for the device as under the OPSS. For ASC procedures that are predominantly performed in physicians' offices, the ASC payment will generally be the lower of the amount paid for practice expense under the physician fee schedule or the amount paid under the standard ASC ratesetting methodology.

Significant Proposals for CY 2013

Proposed ASC payment rate updates: For CY 2013, CMS is proposing to increase ASC payment rates by 1.3 percent or by the consumer price index for urban consumers (CPI-U) of 2.2 percent minus a multifactor productivity adjustment of 0.9 percent, as required by the Affordable Care Act. CMS also estimates that for the third consecutive year, ASC payment rates in CY 2013 will be stable at 57 percent of payment rates for the same services at the proposed OPSS CY 2013 rates. CMS is asking for public comment on potential data that Medicare could collect to develop an inflation index that would explicitly measure ASC cost growth in place of the CPIU, which is a measure of general economy wide consumer inflation.

Proposed ASC quality measure reporting: In the OPSS final rule for CY 2012, CMS finalized an initial set of eight quality measures to be reported under the ASC Quality

Reporting (ASCQR) Program, and five of these measures will apply to encounters beginning Oct. 1, 2012. In April of this year, CMS issued a proposed rule for the Inpatient Prospective Payment System (IPPS) and Long-term Care Hospital Prospective Payment System (LTCH PPS) for fiscal year 2013 that included proposed administrative requirements for participation in the ASC program; these provisions will be addressed later this year in the IPPS/LTCH final rule.

In this proposed rule, CMS is proposing additional requirements for the ASCQR Program including, procedural requirements that apply to the reporting of quality data, a policy for updating measures, and data completeness requirements. CMS is also proposing a methodology for applying the 2 percent payment reduction when program requirements are not met. CMS previously finalized the measure sets that apply to CYs 2014-2016 and is not proposing to make any changes to these measure sets.

ELECTRONIC HEALTH RECORDS

CMS is proposing to extend the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs through 2013 without changes.

The proposed rule will appear in the July 30, 2012, Federal Register. CMS will accept comments on the proposed rule until September 4, 2012, and will respond to comments in a final rule to be issued by November 1, 2012.