CMS Adopts Medicare Outpatient Payment Rules for CY 2013

The Centers for Medicare and Medicaid Services (CMS) has released the calendar year (CY) 2013 final rule for the Medicare Outpatient Prospective Payment System (OPPS). The final rule reflects the annual update to the Medicare fee-for-service outpatient payment rates and policies based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress.

The rule also includes provisions that update the payment rates and policies for Ambulatory Surgical Centers; update quality reporting program requirements for inpatient rehabilitation hospitals; update the Electronic Quality Reporting Pilot that is part of the Electronic Health Record Incentive Program; and update the Quality Improvement Organization regulations.

A copy of the final rule and other resources related to the OPPS are available on the CMS Web site at https://www.cms.gov/Medicare/Medicare‐Outpatient‐Regulations-and‐Notices‐Items/CMS‐1589‐FC.html.

The major hospital OPPS-related sections of the final rule are summarized below. Program changes are effective for services provided on or after January 1, 2013.

**OPPS Payment Rate:** CMS’ final rule rate updates, along with adjustments for budget neutrality, result in an outpatient conversion factor of $71.313 for CY 2013 compared to $70.016 for CY 2012, a 1.9% increase. The final rate is the result of a 2.6% marketbasket increase (proposed at 3.0%), an Affordable Care Act (ACA)-mandated productivity marketbasket reduction of 0.7 percentage points (proposed at 0.8 percentage points), an ACA-mandated pre-determined marketbasket reduction of 0.1 percentage point, and slightly positive adjustments to maintain program budget neutrality.

Absent from the final rule is guidance as to how CMS will implement the 2.0% sequestration reduction to all lines of Medicare payment authorized by the Budget Control Act of 2011 and set to take effect in 2013 unless congress intervenes.

**Wage Index and Labor-Related Share:** The labor-related portion of the OPPS conversion factor is adjusted for differences in area wage levels using a wage index. CMS did not propose and is not adopting any major changes to the wage index and labor share used under the OPPS. CMS will use the federal fiscal year 2013 Inpatient PPS (IPPS) wage indexes including all reclassifications and add-ons, application of the rural floor, and adjustments for budget neutrality. CMS will continue to apply the wage index to a labor-related share of 60%.

A complete list of the final OPPS wage indexes is available on the CMS Web site at https://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Payment/HospitalOutpatientPPS/Hospital‐Outpatient‐Regulations‐and‐Notices‐Items/CMS‐1589‐FC.html.

**Changes to the APC Payment Weights:** CMS is adopting its proposal to change the how the Ambulatory Payment Classification (APC) payment weights are calculated for CY 2013. The change modifies the basis of the weight calculation from median-based hospital costs for services in the APC groups to geometric mean-based costs. CMS believes this change will make the weights more reflective of service costs and bring greater consistency between the methodologies used to calculate weights under the OPPS and IPPS, allowing the agency to make better cross-system comparisons and examine issues of payment parity between the two payment systems.

The CY 2013 APC relative weights and payment rates are available in Addenda A and B of the final rule on the CMS Website at https://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Payment/HospitalOutpatientPPS/Hospital‐Outpatient‐Regulations‐and‐Notices‐Items/CMS‐1589‐FC.html.
A comparison of the current APC payment rates to the newly adopted rates shows that the rates for 38% of the 426 APCs with payment weights will change by plus 5% or more. The payment rates for 13% of the APCs with payment weights will change by minus 5% or more. The remaining 49% have payment rates that change by less than +/-5% when compared to the current rates. This comparison factors in all changes to the APCs for CY 2013, including the adopted change that modifies the basis of the weight calculation to mean-based costs.

**Outlier Payments:** To maintain total outlier payments at 1.0% of total OPPS payments, CMS will maintain the CY 2012 outlier fixed-dollar threshold of $2,025 for CY 2013. Outlier payments will be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus the fixed-dollar threshold.

**Cancer Hospital Payment Adjustment and OPPS Conversion Factor Budget Neutrality:** CMS will continue a policy adopted last year which provides a payment increase to the 11 hospitals identified as exempt cancer hospitals if their outpatient costs are determined to be greater than the costs of other hospitals paid under OPPS. This payment adjustment is applied in a budget neutral manner and required the OPPS conversion factor applicable to all hospitals to be reduced by 0.22% in CY 2012. Because this budget neutrality adjustment was first applied last year, there is no year-to-year change in the conversion factor as a result of continuing this payment policy. The level of reduction applied last year will remain in the conversion factor until CMS makes a change to this policy.

**Expiration of Hold-Harmless Payments to Small Rural Hospitals and Continuation of the 7.1% Add-On for SChs and EAcHs:** The outpatient hold-harmless payment policy applicable to rural hospitals with 100 or fewer beds that was extended for one-year by the Middle Class Tax Relief and Job Creation Act of 2012 will expire on December 31, 2012. CMS does not have the authority to extend these payments beyond CY 2012 without authorizing legislation. Sole Community Hospitals (SChs) and Essential Access Community Hospitals (EAcHs) will continue to receive the 7.1% payment increase established by CMS in CY 2006 for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and devices paid under the pass-through payment policy.

**Physician Supervision Requirements for Outpatient Services in Hospitals and CAsHs:** CMS is adopting its proposal to extend, through CY 2013, the non-enforcement of the direct supervision requirement related to outpatient therapeutic services for Critical Access Hospitals (CAsHs) and small rural hospitals with 100 or fewer beds. CMS first adopted this non-enforcement policy in CY 2011 when the agency revised and further defined several policies related to the physician supervision of outpatient services. The delay in enforcing this supervision requirement on CAsHs and small rural hospitals will provide the Federal Advisory APC Panel, established in CY 2012, with additional time to continue its assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services. CMS does not plan to extend the non-enforcement policy beyond CY 2013.

**Updates to the Hospital OQR Program:** CMS did not propose and is not adopting any major changes or expansion to the Hospital Outpatient Quality Reporting (OQR) Program for CY 2014 payment determinations and beyond. CMS is confirming the suspension of data collection for the measure OP-19: Transition Record with Specified Elements Received by Discharged Emergency Department Patients. Also, CMS is adopting its proposal to defer data collection for one year, until January 1, 2014, for the measure OP-24: Cardiac Rehabilitation Patient Referral from an Outpatient Setting. This measure will be used for CY 2015 payment determinations rather than CY 2014 determinations as previously adopted.

As adopted in previous rulemaking, for CY 2013 payment determinations, hospitals were required to successfully report on a total of 23 quality measures. As a result of previously and newly adopted OQR Program changes, hospitals must successfully report on a total of 24 measures for CY 2014 payment determinations and 25 measures for CY 2015 payment determinations. A complete list of OQR Program measures for CY 2014 and CY 2015 payment determinations is available on pages 915-916 of the display copy of the final rule *Federal Register*. Hospitals that do not successfully participate in the OQR Program are subject...
to a 2.0 percentage point reduction to the OPPS marketbasket update for the applicable year—the reduction factor has not changed.

**Clarifications to Current Policy as to when Medicare will pay for an Inpatient Admission:** In the final rule, CMS provides an expansive summary of the approximately 350 public comments received on potential clarifications/changes to the agency’s current policies regarding the circumstances under which Medicare will pay for an inpatient admission.

In part, CMS raised this issue for comment based on concerns over recent increases in denials of short stay inpatient claims by federal claims review contractors, such as Recovery Audit Contractors (RACs), when it has been determined that the care setting billed was inappropriate (not medically necessary). Under current rules, when inpatient payment is denied, there are limited circumstances under which a hospital is allowed to re-bill for outpatient payment. As a result of current policy, CMS states that it has observed and may have concerns with increases in the length of time for which patients receive observation services as hospitals have sought to avoid the financial risk associated with potential inpatient claims denials.

CMS did not respond to the comments received, but stated that all comments will be taken into consideration as the agency considers potential future actions to provide more clarity and consensus regarding patient status for purposes of Medicare payment. The complete discussion of this issue including the public comment summary is available on pages 744-771 of the display copy of the final rule *Federal Register*.

In addition to the comment summary on patient status for the purposes of Medicare payment, CMS is currently exploring, on a limited basis, more expansive re-billing options as part of a recently launched Part A to Part B Rebilling Demonstration Project. CMS provides an overview/update on the demonstration program in the final rule.

The OPPS payment rules will be officially published in the November 11, 2012 *Federal Register*. A display copy of the final rule *Federal Register* and other resources related to the OPPS are available on the CMS web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1589-FC.html.