PUBLICATION

Highlights of the 2015 OPPS and ASC Final Rule [Ober|Kaler]

November 13, 2014

On October 31, 2014, CMS published its 2015 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates final rule. This annual rule affects the 4,000 hospitals that are paid under the OPPS and the 5,300 participating ASCs. Some of the key payment elements of the rule are highlighted below.

A. Hospital Outpatient Payments

- ***OPPS Payment Rate Increase:*** CMS estimates that overall OPPS payments may increase by 2.3 percent, based on a projected hospital market basket increase of 2.9 percent minus adjustments for productivity and as required by law.
- ***Outlier Payments:*** Hospitals will receive outlier payments for services with costs that exceed 1.75 times the ambulatory payment classification (APC) payment rate and that exceed $2,775 plus the CY 2015 fixed dollar threshold of the APC payment.
- ***Adjustment for Cancer Hospitals:*** Cancer hospitals will continue to receive additional payments so that their payment-to-cost ratios (PCR) after factoring in the additional payments will equal the weighted average PCR for other OPPS hospitals based on the most recent cost report data. CMS set the target PCR at 0.89.
- ***Adjustment for Rural Hospitals:*** CMS continues the adjustment of 7.1 percent to the OPPS payments for select rural sole community hospitals, applicable to services paid under OPPS, devices reimbursed through the pass-through payment policy, and other items paid at charges reduced to cost.
- ***Comprehensive Ambulatory Payment Classifications (C-APC):*** CMS will implement an updated policy regarding C-APCs that was finalized in 2014. The new policy establishes a single payment for all related hospital items and services for patients receiving select primary procedures. CMS finalized 25 of the proposed 28 C-APCs and expects that the single comprehensive payment will incentivize the provision of efficient high quality care at a lower cost.
- ***Packaging of Items and Services in Payments for Primary Services:***

  - *Ancillary Services:* Under the 2015 final rule, and subject to a few exceptions, CMS will conditionally package ancillary services with a geometric mean cost of $100 or less prior to packaging into the payment for the primary services with which they are associated. When furnished by themselves, CMS will continue to reimburse for these services.
  - *Prosthetic Supplies:* Prosthetic supplies will be packaged just as implantable prosthetic devices are packaged when used in a surgical or other procedure. However, replacement prosthetic supplies will still be available through the DMEPOS Fee Schedule.
  - *Skin Substitutes:* To stabilize the high and low cost categories of skin substitutes, CMS will use a high/low cost threshold, based on the weighted average mean unit cost for all skin substitute products pulled from claims data. In addition, CMS will evaluate skin substitute applications to determine whether to use pass-through payment through the device pass-through process instead of the drug pass-through process.
- ***Off-Campus Provider-Based Departments:*** Hospitals will be required to report a modifier for services furnished in an off-campus provider-based department. Physicians and other eligible

practitioners must also report such services using the new place of service code on their professional claims. These new reporting standards are voluntary for 2015, and will become mandatory in 2016.
- ***Outpatient Department Drugs and Biologicals:*** Non-pass-through drugs and biologicals that are separately payable under OPPS will be reimbursed at the average sales price plus 6 percent.

B. Ambulatory Surgical Centers

The Consumer Price Index update for ASC payments will be 1.4 percent, after a productivity adjustment of .5 percent.

C. Community Mental Health Centers (CMHC)

- ***Outlier Payments:*** The CMHC outlier threshold rate will be 3.40 times the highest CMHC Partial Hospitalization Program APC payment rate for 2015.
- ***Partial Hospitalization Program Payments:*** The geometric mean per diem cost for CMHCs will be $100.15 for Level I (up to three services) and $118.54 for Level II (four or more services). The geometric mean per diem cost for hospital-based programs will be $185.87 for Level I and $203.01 for Level II.

D. Modifying the Requirement of a Physician Certification for Hospital Inpatient Admissions

CMS will require physician certification only for outlier cases and long-stay cases of 20 days or more, though an admission order will still be required for all inpatient admissions.

E. Recovery of Overpayments from Erroneous Payment Data for Medicare Advantage (MA) and Part D Sponsors

The final rule establishes a process to allow CMS to recover overpayments stemming from the failure of an MA organization or Part D sponsor to correct erroneous payment data after CMS requests the correction. CMS also finalized a three-tiered appeals process for MA organizations and Part D sponsors to appeal CMS's determination that the data is erroneous. The process will include reconsideration, an informal hearing, and an Administrator review.

Ober|Kaler's Comments

The final rule addresses hospital outpatient payment changes and a number of other subjects. To the extent that the rule focuses on hospital outpatient payments, CMS is plainly pursuing its long term goal of using increased packaging, including more items within a single APC payment. We can expect this trend to continue.