



# VCU Medical Center

## Office of Health Innovation

### Final Rule: 2013 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Centers (ASC)

**Description:** Describes the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system.

This final rule with comment period is effective on January 1, 2013.

#### Major Provisions:

**OPPS Update:** For CY 2013, CMS is increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of **1.8 percent**. This increase is based on the final hospital inpatient market basket percentage increase of 2.6 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus the multifactor productivity (MFP) adjustment of 0.7 percentage points, and minus a 0.1 percentage point adjustment required by the Affordable Care Act.

**Ambulatory Surgical Center Payment Update:** For CY 2013, CMS is increasing payment rates under the ASC payment system by **0.6 percent**. This increase is based on a projected CPI-U update of 1.4 percent minus a multifactor productivity adjustment required by the Affordable Care Act that is projected to be 0.8 percent. Based on this update, CMS estimates that total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2013 will be approximately \$4.074 billion, an increase of approximately \$310 million compared to estimated CY 2012 payments.

**Geometric Mean-Based Relative Payment Weights:** CMS has discretion under the statute to set OPPS payments based upon either the estimated mean or median costs of services within an Ambulatory Payment Classification (APC) group, the unit of payment. To improve their cost estimation process, for CY 2013 CMS is using the geometric mean costs of services within an APC to determine the relative payment weights of services, rather than the median costs that they have used since the inception of the OPPS. Analysis shows that the change to means will have a limited payment impact on most providers, with a small number experiencing payment gain or loss based on their service-mix.

**Payment of Drugs, Biologicals, and Radiopharmaceuticals:** For CY 2013, payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals that do not have pass-through status (i.e., specified covered outpatient drugs) will be set at the statutory default of **average sales price (ASP) plus 6 percent**.

**Supervision of Hospital Outpatient Therapeutic Services:** CMS is clarifying the application of the supervision regulations to physical therapy, speech-language pathology, and occupational therapy

services that are furnished in OPPS hospitals and critical access hospitals (CAHs). (Notably, CMS does not have separate supervision rules for OPPS hospitals and CAHs for these therapy services.) In addition, in this final rule CMS notes that it **will extend the enforcement instruction one final year through CY 2013**. This additional year, which CMS expects will be the final year of the extension, will provide additional opportunities for stakeholders to bring their issues to the Hospital Outpatient Payment Panel.

**Outpatient Status:** In the proposed rule, CMS expressed concern about recent increases in the length of time that Medicare beneficiaries spend as outpatients receiving observation services. CMS did not respond to any specific stakeholder comments in the final rule but indicated that the agency will conduct extensive outreach with stakeholders before making any future proposals.

**Electronic Health Record (EHR) Incentive Program:** CMS is extending the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs through 2013, exactly as finalized for 2012. CMS recently issued a final rule (77 FR 53968) for Stage 2 of the Medicare and Medicaid EHR Incentive Programs.

**Hospital Outpatient Quality Reporting (OQR) Program:** The rule finalizes CMS's proposal to exclude new OQR measures for CY14 and CY15 payment determinations. Also: 1) suspends data collection for OP-19, which requires the collection & release of personal medical information for discharged emergency department (ED) patients; 2) defers data collection for OP-24, which requires hospitals to determine whether cardiac rehab patients were previously referred to a cardiac rehab center by an ambulatory care provider; and 3) removes OP-16, which requires the collection of Troponin results for ED acute myocardial infarction or chest pain patients within 60 minutes of arrival.

**Ambulatory Surgical Center Quality Reporting (ASCQR) Program:** For the ASCQR Program, CMS addresses the public comments received as a result of its solicitation in the proposed rule on the approach for future measure selection and development as well as certain measures for future potential inclusion in the ASCQR Program measure set. CMS is finalizing its approach to future measure selection and development for the ASCQR Program. For the CY 2015 payment determination and subsequent years' payment determinations, CMS is adopting requirements for claims-based measures regarding the dates for submission and payment of claims and data completeness. CMS is also finalizing its policy regarding how the payment rates will be reduced in CY 2014 and in subsequent calendar years for ASCs that fail to meet program requirements, and is clarifying its policy on updating measures.