At Issue:
On July 3, the Centers for Medicare & Medicaid Services (CMS) released the outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) proposed rule for calendar year (CY) 2015. In addition to updating OPPS and ASC payment weights and rates, the rule includes proposals that would continue shifting the OPPS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles. Major proposals include:

- applying an adjusted OPPS market-basket update of 2.1 percent, which results from a statutorily required 0.6 percentage point reduction to the CY 2015 market-basket update of 2.7 percent;
- implementing 28 comprehensive ambulatory payment classifications (APCs) that package an expanded number of related items and services into a single payment for a comprehensive primary service under the OPPS;
- conditionally packaging ancillary services that have a geometric mean cost of $100 or less;
- creating a modifier that would be required to be reported with every code for physician and outpatient hospital service furnished in an off-campus provider-based department of a hospital; and
- revising the requirements for physician certification of hospital inpatient services.

The rule also proposes changes to the rural provider and hospital ownership exceptions to the physician self-referral law, and proposes an overpayment recovery process and makes technical corrections to the existing process to collect overpayments from Medicare Parts C and D plans. Comments on the proposed rule are due by Sept. 2. The final rule, expected by Nov.1, will take effect Jan. 1.

Our Take:
The AHA is carefully evaluating the provisions in the proposed rule. We are concerned that the proposal to track services furnished in off-campus, provider-based departments could be used as a means to justify implementing “site-neutral” payment reductions, such as the policies that Medicare Payment Advisory Commission and Congress have been pursuing in the context of federal budget cuts, which fail to recognize the extra costs hospitals bear for critical hospital-based safety-net services, providing 24/7 access to emergency care and stand-by capacity. With regard to the proposed changes to the physician certification requirements, while CMS has attempted to reduce the administrative requirements associated with inpatient hospital admissions, many questions remain as to how this proposal would impact the documentation required under the “two-midnight” policy. We will continue to work with CMS to obtain answers to these questions. The AHA also will continue to analyze the impact of this proposal on the claims raised in our lawsuit and hospital implementation of the two-midnight policy.

What You Can Do:
- Share this advisory with your chief financial officer and other members of senior management, billing and coding staff, nurse managers and key physician leaders.
- Model the impact of the APC changes on your expected CY 2015 Medicare revenue. Spreadsheets comparing the changes in APC payment rates and weights from 2013-2014 are available on the AHA’s OPPS webpage. To access these, AHA members must be logged on to the website.
- Consider submitting comments to CMS about the impact of the proposed rule on your hospital on or before the Sept. 2 deadline.

Further Questions:
Please contact Roslyne Schulman at rschulman@aha.org for more information about the proposed rule.
Medicare Outpatient PPS and ASC
Proposed Rule for CY 2015

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BACKGROUND

On July 3, the Centers for Medicare & Medicaid Services (CMS) released the outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) proposed rule for calendar year (CY) 2015. In addition to the regular updating of the OPPS and ASC payment weights, rates and policies, this year’s proposed rule includes several significant proposals that would continue shifting the OPPS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles, including implementing policies that could, over time, support movement toward bundled payment. For instance, CMS proposes to implement a revised comprehensive ambulatory payment classification (APC) policy, which, although finalized in CY 2014, was delayed until CY 2015. CMS also proposes to package the costs of all ancillary services with a geometric mean cost of $100 or less into the primary service with which they are billed.

In addition, the rule proposes to revise the requirements for physician certification of hospital inpatient services and to update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program. Other proposals would allow CMS to begin collecting data on services furnished in off-campus, provider-based departments and to establish a process to allow CMS to recover overpayments that result from the submission of erroneous payment data by a Medicare Advantage (MA) organization or Part D prescription drug plan sponsor.

CMS also applies an adjusted OPPS market-basket update of 2.1 percent, which results from a statutorily required 0.6 percentage point reduction to the CY 2015 market-basket update of 2.7 percent. However, CMS states that, taking into account estimated spending changes attributable to enrollment, utilization and case-mix, the projected total CY 2015 OPPS payments will increase by $5.2 billion, or 10.1 percent, so that total OPPS payments, including beneficiary cost-sharing, would be $56.5 billion in 2015.

A final rule, which will be released around Nov. 1, will take effect Jan. 1. Comments on the provisions of the OPPS and ASC proposed rule are due to CMS by Sept. 2.

This Regulatory Advisory highlights many of the rule’s proposals. In addition, the AHA offers members a more detailed summary prepared by Health Policy Alternatives.

PROPOSED CHANGES TO THE CY 2015 OPPS

PPS Update and Linkage to Hospital Quality Data Reporting

OPPS Update. The proposed rule includes an Affordable Care Act- (ACA) required productivity reduction of 0.4 percentage points and an additional 0.2 percentage point reduction to the CY 2015 market-basket update of 2.7 percent. This results in a proposed market-basket update of 2.1 percent for those hospitals that publicly report
data on 22 quality measures. The CY 2015 update for hospitals that do not meet quality reporting requirements would be reduced by 2.0 percentage points, to 0.1 percent.

CMS proposes a CY 2015 OPPS conversion factor of $74.176 for hospitals meeting quality data reporting requirements. To calculate the new amount, CMS increased the CY 2014 conversion factor of $72.672 by the adjusted hospital market-basket update of 2.1 percent, as required by law. To ensure budget neutrality, CMS also made adjustments to account for changes in the wage index (0.9998), the adjustment for rural sole community hospitals (SCHs) (1.0000), the payment adjustment for cancer hospitals (1.0000) and pass-through spending (0.01). Hospitals that do not report the quality data would receive a reduced conversion factor of $72.692.

CMS estimates that the market-basket update together with all other policies in the proposed rule will result in the following per-case changes in payment:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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**Recalibration of APC Weights**

CMS is required to review and revise, at least annually, the relative payment weights for APCs. In the proposed rule, CMS recalibrates the relative APC weights using hospital claims for services furnished during CY 2013. As it has done previously, for CY 2015, CMS standardizes all of the relative payment weights to the clinic visit APC 0634. That is, CMS proposes to calculate an “unscaled” – i.e., not adjusted for budget neutrality – relative payment weight by comparing the geometric mean cost of each APC to the geometric mean cost of the clinic visit APC 0634. CMS used APC 0634 because it is one of the most frequently performed services in the hospital outpatient setting. CMS assigns APC 0634 a relative payment weight of 1.00 and determines the unscaled relative payment weight for each APC by dividing the geometric mean cost of the APC by the geometric mean cost for APC 0634.

To comply with budget-neutrality requirements, CMS compares the estimated aggregate payment weights using the CY 2014 scaled relative payment weights to the estimated aggregate weights using the proposed CY 2015 unscaled relative payment weights. CMS proposes to calculate the weight scaler by dividing the CY 2014 estimated aggregate weight by the proposed CY 2015 estimated aggregate weight. The service-mix is the same in the current and prospective years because the agency uses the same set of claims for service volume in calculating the aggregate weight for each year. CMS notes that the CY 2014 OPPS scaled relative weights incorporate the estimated payment weight from packaged laboratory tests previously paid under the Clinical Laboratory Fee Schedule but paid under the OPPS beginning in CY 2014.
Based on this comparison, CMS adjusts the proposed CY 2015 unscaled relative payment weights by multiplying them by a proposed weight scaler of 1.322 (a 32.2 percent increase in the unscaled weights) to ensure that the proposed CY 2015 relative payment weights are budget neutral.

**Coding and Payment for Hospital Outpatient Visit Services**

**Clinic and Emergency Department (ED) Visit Services.** In the CY 2014 OPPS final rule, CMS collapsed the previous several levels of codes for hospital outpatient clinic visits and replaced them with one new code, Healthcare Common Procedure Coding System (HCPCS) code G0463, representing a single level of payment for all outpatient clinic visits. CMS assigned HCPCS code G0463 to APC 0634 with the payment rate based on the total geometric mean costs of the previous Level 1 through Level 5 clinic visit codes for new patients (Current Procedural Terminology (CPT) codes 99201-99205) and established patients (CPT codes 99211-99215) using the CY 2012 OPPS claims data. However, CMS did not finalize its proposal to similarly collapse the Type A and Type B ED visits codes. Rather, the agency maintained five levels of codes, CPT codes 99281 through 99285 and HCPCS codes G0380 through G0385, for each of these types of ED services.

For CY 2015, CMS proposes to continue the policy adopted in CY 2014 for clinic visits. HCPCS code G0463 will continue to be reported for each hospital outpatient clinic visit under the OPPS. CMS also proposes to continue to assign HCPCS code G0463 to APC 0634 and to use CY 2013 claims data to develop the proposed CY 2015 OPPS payment rate for HCPCS code G0463.

CMS does not propose any change in ED visit coding. Rather, for CY 2015, the agency proposes to continue to use its current methodology to recognize the existing five CPT codes for Type A ED visits, as well as the five HCPCS codes that apply to Type B ED visits, and to establish the CY 2015 proposed OPPS payment rates using its established standard process. CMS believes that additional study is needed to assess the most suitable payment structure for ED visits, including the number of visit levels necessary to ensure that the resources required to treat the most complex patients, such as trauma patients, are not underrepresented. Therefore, CMS intends to further explore the issues related to ED visits and may propose changes to the coding and APC assignments for ED visits in future rulemaking.

**Critical Care Services.** CMS proposes to continue its current policy to recognize the existing CPT codes for critical care services and establish a payment rate based on historical claims data. It also proposes to continue to implement claims processing edits that conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment.

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1 Type A EDs are open 24/7 while Type B EDs are not.
Device-dependent APCs

Device-dependent APC Policy Prior to CY 2015. Device-dependent APCs are populated by HCPCS codes for procedures that require that a device be implanted or used in the performance of the procedure. Historically, CMS has calculated the costs of device-dependent APCs using only claims data that include the full cost of the required device. Thus, for rate-setting purposes, CMS uses only the subset of single procedure claims that passed specified procedure-to-device and device-to-procedure edits.

As discussed further below, in the CY 2014 OPPS/ASC final rule, CMS redefined 29 of the current 39 device-dependent APCs as single complete services, assigned them to newly defined “comprehensive APCs” and provided all-inclusive payments for those services. However, CMS delayed the implementation of the comprehensive APCs until CY 2015. For the remaining 10 device-dependent APCs, CMS eliminated the use of procedure-to-device edits and device-to-procedure edits for these APCs, but also delayed implementation of this policy until CY 2015.

Proposed Policy for CY 2015. As planned, CMS proposes to no longer apply the procedure-to-device edits and device-to-procedure edits for any APC. Under this proposed policy, hospitals are still expected to adhere to the guidelines of correct coding and append the correct device code to the claim, when applicable. However, claims would no longer be returned to providers when specific procedure and device code pairings do not appear on a claim. CMS believes this is appropriate because of the experience hospitals now have had in coding and reporting these claims fully. In addition, for the more costly devices, CMS believes the comprehensive APCs will reliably reflect the cost of the device if it is included anywhere on the claim.

In addition, CMS proposes to refine the comprehensive APC policy it finalized in the CY 2014 rule for implementation in CY 2015. Under this refined comprehensive APC policy, described in more detail below, CMS would consolidate and restructure all 39 of the current device-dependent APCs into 26, rather than 29, comprehensive APCs. These APCs are listed in Table 5 in the proposed rule. Therefore, as a result of the proposed CY 2015 comprehensive APC policy, device-dependent APCs would no longer exist because these APCs will have all been converted to comprehensive APCs.

While CMS believes that device-to-procedure edits and procedure-to-device edits are no longer necessary, the agency responds to the concerns raised by stakeholders about the costs of devices being reported and captured. Therefore, for CY 2015, CMS proposes to create a claims processing edit that would require hospitals to report on their claims any of the device codes used in the previous device-to-procedure edits whenever any procedure code assigned to 26 proposed comprehensive APCs listed in Table 5 in the proposed rule is reported on the claim. This proposed claims processing edit is intended to ensure that device costs are captured by hospitals.

Comprehensive APCs

CY 2014 Comprehensive APC Policy. In the CY 2014 final OPPS rule, CMS finalized, but delayed until Jan. 1, 2015, a policy to replace 29 of the 39 existing device-dependent APCs with 29 new comprehensive APCs that would prospectively pay for the
most costly device-dependent services. A comprehensive APC is a new classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. CMS calculates a single payment for the entire hospital stay, defined by a single claim, regardless of the dates of service on the claim.

One important element of the comprehensive APC policy is that it revises the definition of OPPS services to expand the scope of services covered under the OPPS. For example, certain items and services typically paid in separate fee schedules, such as durable medical equipment, prosthetic and orthotic supplies (DMEPOS), laboratory services and therapy services, which are included on the claim with the primary service, are considered adjunctive services that support the primary service and therefore will be considered OPPS services. Their costs will be included in determining the relative payment weights for the comprehensive APCs and the single payment for the comprehensive APC constitutes payment for these services. That is, these services will no longer be billed and paid under separate fee schedules, as they are currently.

In addition, CMS created a “complexity adjustment” to recognize variation in the complexity of services that will be paid through comprehensive APCs. The methodology assigns certain combinations of primary procedures that are reported together, and that indicate a more complex and resource-intensive version of the primary procedure, to higher level comprehensive APCs.

CMS believes that comprehensive APCs will improve the validity of payments to more accurately reflect costs; improve transparency for the beneficiary, physicians and hospitals; reduce complexity and administrative burden; and increase flexibility for hospitals to develop increased efficiencies in the delivery of care. CMS notes that beneficiary copayments would be reduced for most comprehensive APC services because the beneficiary will owe a single coinsurance amount for the comprehensive APC and no coinsurance for the individual services included in the comprehensive APC. In addition, the single coinsurance amount would be capped by the statutory requirement that the beneficiary copayment cannot exceed the inpatient hospital deductible.

As noted above, while CMS created the comprehensive APCs and modeled the impact of the policy as if it were implementing it in CY 2014, the agency delayed the effective date until Jan. 1, 2015 to allow additional time for analysis, opportunity for public comment, and systems preparation.

Proposed 2015 Policy for Comprehensive APCs. The basic steps for calculating the comprehensive APC payment rates are described below. These steps indicate both how the rates published in this proposed rule were determined and how comprehensive APC cases would be identified and paid under the proposed policy.

For purposes of the comprehensive APC policy, CMS defines a “clinical family” of comprehensive APCs as a set of clinically related comprehensive APCs that represent different resource levels of clinically comparable services.
Step 1: Select primary ("J1") services. CMS selects HCPCS codes for primary services to be assigned to a comprehensive APC and designates them by status indicator “J1”, as listed in Addenda J and B to the proposed rule. As described below, in a change from the CY 2014 final rule, the CY 2015 proposed rule would package add-on codes into the comprehensive APCs and assign them status indicator “N” (unconditionally packaged), rather than assigning add-on codes status indicator J1. CMS further proposes to evaluate a limited set of add-on codes assigned to the current device-dependent APCs to consider whether a complexity adjustment is appropriate when these add-on codes are reported in conjunction with a primary service.

Step 2: Definition of the payment package (comprehensive service). The comprehensive APC packaging policy not only “packages” payment for all items and services typically packaged under the OPPS, but also packages payment for other items and services that are not typically packaged under the OPPS, except in the context of comprehensive APC payments. CMS proposes to define the comprehensive APC payment packaging policy as encompassing all covered outpatient department services on a hospital Medicare Part B claim that includes a primary service that is assigned to status indicator J1. CMS proposes to exclude from packaging only those services that cannot be covered OPD services or that cannot, by statute, be paid under the OPPS, such as ambulance services and self-administered drugs.

The proposed rule would consider the following services to be typically integral, ancillary, supportive, dependent or adjunctive to the primary service, and therefore packaged, when provided during the delivery of the comprehensive service:

- diagnostic procedures, laboratory tests and other diagnostic tests and treatments that assist in the delivery of the primary procedure;
- visits and evaluations performed in association with the procedure;
- uncoded services and supplies used during the service;
- outpatient department services that are similar to therapy and delivered either by therapists or non-therapists as part of the comprehensive service;
- DMEPOS, when provided as part of the outpatient service;
- all drugs, biologicals and radiopharmaceuticals, regardless of cost, except those drugs with pass-through payment status and those drugs that are usually self-administered, unless they function as packaged supplies; and
- any other components reported by HCPCS codes that are provided during the comprehensive service, except excluded services described below.

CMS notes that the CY 2014 final rule did not model a budget-neutrality adjustment for newly included services that would otherwise be paid under non-OPPS fee schedules (for example, therapy and DMEPOS). The CY 2015 proposed rule includes these new

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2 Add-on codes are procedures that are always performed in addition to a primary procedure, such as a code describing the additional debridement of infected skin, each additional 10 percent of the body surface.
costs (which CMS states are very low) in the proposed rule’s annual adjustment for CY 2015 budget neutrality.

The items and services that CMS would exclude from the comprehensive APC payment packaging policy, i.e., remain separately payable in CY 2015, are listed below:

- Ambulance services
- Diagnostic and mammography screenings
- Physical therapy, speech-language pathology and occupational therapy services - therapy services reported on a separate facility claim for recurring services
- Pass-through drugs, biologicals and devices
- Preventive services including:
  - Annual wellness visits providing personalized prevention plan services
  - Initial preventive physical examinations
  - Pneumococcal, influenza, and hepatitis B vaccines and administrations
  - Mammography screenings
  - Pap smear screenings and pelvic examination screenings
  - Prostate cancer screening tests
  - Colorectal cancer screening tests
  - Diabetes outpatient self-management training services
  - Bone mass measurements
  - Glaucoma screenings
  - Medical nutrition therapy services
  - Cardiovascular screening blood tests
  - Diabetes screening tests
  - Ultrasound screenings for abdominal aortic aneurysm
  - Additional preventive services
- Self-administered drugs – drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service
- Services assigned to OPPS status indicator “F” (certain certified registered nurse anesthetist services, Hepatitis B vaccines and corneal tissue acquisition)
- Services assigned to OPPS status indicator “L” (influenza and pneumococcal pneumonia vaccines)
- Certain Part B inpatient services – ancillary Part B inpatient services payable under Part B when the primary “J1” service for the claim is not a payable Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with only Medicare Part B)

**Step 3: Ranking of primary services and initial comprehensive APC assignments.** CMS designates each hospital outpatient claim with a single unit of a single primary service assigned to status indicator “J1” as a single major procedure claim. These represent about 80 percent of the CY 2013 “J1” claims. The proposed rule ranks each status indicator J1 primary service (single unit only) based on the comprehensive geometric mean costs of all items and services in the comprehensive APC payment bundle. As noted above, add-on codes are included as packaged services rather than being treated as separate J1 services as they were in the CY 2014 final rule.
For the approximately 20 percent of claims with more than one primary service (including those with multiple units of the same primary service) assigned to status indicator J1, CMS would designate one of the J1 services as the primary service for the claim, based on the cost-based ranking, and then would assign all of the multiple J1 procedures on the claim (including all packaged services) to the comprehensive APC to which the primary service is assigned. If the multiple J1 services on the claim map to different comprehensive APCs, CMS designates the J1 service assigned to the comprehensive APC with the highest geometric mean cost as the primary service for that claim. If the multiple J1 services map to the same comprehensive APC, CMS uses a HCPCS-level comparison to identify the most costly primary service for that claim. The comprehensive APC assignment of each J1 procedure is confirmed by verifying that the APC assignment remains appropriate when considering the clinical similarity.

**Step 4: Complexity adjustments and determination of final comprehensive APC groupings.** For CY 2015, CMS proposes less stringent criteria for the complexity adjustment than were finalized in the CY 2014 OPPS final rule. Certain combinations of comprehensive services on a claim would be recognized for higher payment using complexity adjustments. Qualifying J1 service code combinations, or code combinations of J1 services and certain add-on codes, would not be paid under the comprehensive APC to which the designated primary service is first assigned, but would instead be reimbursed under a higher paying comprehensive APC in the same clinical family of comprehensive APCs.

CMS proposes to evaluate each single primary service designated for a claim in combination with each of the other J1 procedure codes reported on the claim (or certain add-on codes) to determine if they meet the complexity adjustment criteria. CMS would consider the code combination to be a complex and costly form of the primary service, and, thus, qualify for the complexity adjustment when the following criteria are satisfied:

- **Frequency Threshold** – There are at least 25 claims reporting the same code combination within the OPPS claims; and
- **Cost Threshold** – The comprehensive geometric mean cost of the complex code combination exceeds the comprehensive geometric mean cost of the lowest significant HCPCS code assigned to the comprehensive APC by more than two times.

Code combinations satisfying these criteria would be moved to the next-higher-cost comprehensive APC within the clinical family, unless: (1) the APC reassignment is not clinically appropriate; (2) the reassignment would create a two-times rule violation in the receiving APC; or (3) the primary service is already assigned to the highest-cost APC within the comprehensive APC clinical family. CMS would not create new APCs with a geometric mean cost that is higher than the highest-cost comprehensive APC in a clinical family just to accommodate potential complexity adjustments.
As discussed above, CMS also proposes to evaluate certain add-on codes that are assigned to the current device-dependent APCs (listed in Table 5 of the proposed rule) for a possible complexity adjustment when they are reported with a designated primary J1 service. CMS believes that these add-on codes represent services that may include additional medical device costs that would result in significantly more complex and costly procedures. CMS would use the same criteria as outlined above, testing claims reporting one unit of a single primary J1 service and any number of units of a single add-on code, to determine which combinations of primary service and add-on codes qualify for a complexity adjustment.

The proposed policies would result in 52 complexity adjustments, as listed in Addendum J to the proposed rule.

Additional Proposed Comprehensive APCs. As discussed above, for CY 2015, CMS proposes to restructure and consolidate the current device-dependent APCs into 26 comprehensive APCs, including some procedure code reassignments, to improve clinical and resource homogeneity. In addition, CMS proposes to create two additional comprehensive APCs, comprehensive APC (C-APC) 0067, single-session cranial stereotactic radiosurgery (SRS), and C-APC 0351, intraocular telescope implantation, for a total of 28 comprehensive APCs. CMS also proposes to reassign current procedural technology (CPT) codes 77424 and 77425, codes describing intraoperative radiation therapy treatment (IORT), to C-APC 0648 (Level IV Breast and Skin Surgery).

Proposed Reconfiguration and Restructuring of the Comprehensive APCs. CMS proposes to reorganize, combine and restructure the comprehensive APCs to improve resource and clinical homogeneity among the services assigned to certain comprehensive APCs and to eliminate APCs for clinically similar services, but with overlapping geometric mean costs. These changes from what CMS had modeled in the CY 2014 final rule include:

- **Endovascular clinical family (renamed Vascular Procedures, VASCX).** CMS proposes to combine C-APCs 0082, 0083, 0104, 0229, 0319 and 0656 to form three proposed levels of comprehensive endovascular procedure APCs: C-APC 0083 (Level I Endovascular Procedures); C-APC 0229 (Level II Endovascular Procedures); and C-APC 0319 (Level III Endovascular Procedures).
- **Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices (AICDP).** CMS proposes to combine C-APCs 0089, 0090, 0106, 0654, 0655 and 0680 to form three proposed levels of C-APCs within a broader series of APCs for pacemaker implantation and similar procedures. These include: APC 0105 (Level I Pacemaker and Similar Procedures), a non-comprehensive APC; C-APC 0090 (Level II Pacemaker and Similar Procedures); C-APC 0089 (Level III Pacemaker and Similar Procedures); and C-APC 0655 (Level IV Pacemaker and Similar Procedures).
- **Event Monitoring.** CMS proposes to delete this clinical family, which had only one C-APC (C-APC 0680 (Insertion of Patient Activated Event)) with a single
CPT code 33282. CMS would reassign CPT code 33282 to C-APC 0090, which contains clinically similar procedures.

- **Urogenital Family.** CMS proposes to employ two levels, instead of three, for Urogenital Procedures and reassign several codes from APC 0195 to C-APC 0202 (Level V Female Reproductive Procedures).

- **Orthopedic Surgery (renamed Arthroplasty Family).** CMS proposes to re-assign several codes from APC 0052 to C-APC 0425, renamed “Level V Musculoskeletal Procedures Except Hand and Foot.”

- **Electrophysiologic Procedures.** CMS proposes to employ three levels, using the currently inactive APC 0086 instead of APC 0444, in order to have consecutive APC grouping numbers for this clinical family. CMS would re-name APC 0086 “Level III Electrophysiologic Procedures.” CMS would replace composite APC 8000 with proposed C-APC 0086.

- **New clinical Families.** CMS proposes to establish three new clinical families: Gastrointestinal Procedures (GIXXX) for gastrointestinal stents, Tube/Catheter Changes (CATHX) for insertion of various catheters, and Radiation Oncology (RADTX), which would include C-APC 0067 for single session cranial SRS.

Table 1 below lists the 28 APCs proposed under the 2015 comprehensive APC policy.

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<th>Clinical Family(^3)</th>
<th>Proposed 2015 Comprehensive APC</th>
<th>Comprehensive APC Title</th>
<th>Proposed 2015 APC Geometric Mean Cost</th>
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\(^3\) **Clinical Family Descriptor Key:** AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices; BREAS = Breast Surgery; CATHX = Tube/Catheter Changes; ENTXX = ENT Procedures; EPHYS = Cardiac Electrophysiology; EYEXXX = Ophthalmic Surgery; GIXXX = Gastrointestinal Procedures; NSTIM = Neurostimulators; ORTHO = Orthopedic Surgery; PUMPS = Implantable Drug Delivery Systems; RADTX = Radiation Oncology; UROGN = Urogenital Procedures; VASCX = Vascular Procedure.
<table>
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<tr>
<th>Clinical Family&lt;sup&gt;3&lt;/sup&gt;</th>
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**Composite APCs**

To moderate growth in volume and spending in the OPPS, CMS in CY 2008 established 11 composite APCs that would pay a single rate for larger bundles of major, and previously separately paid, services that are commonly performed in the same hospital outpatient encounter. For CY 2015, CMS proposes to continue the composite APC payment policies for extended assessment and management services, low-dose rate prostate brachytherapy services, mental health services, and multiple imaging services and proposes to update the payment rates using more recent OPPS claims data. However, CMS proposes to discontinue the composite APC payment policies for cardiac electrophysiologic evaluation and ablation services (APC 8000) and to pay for these services through comprehensive APC 0086 (Level III Electrophysiologic Procedures). In addition, CMS proposes to effectuate the policy finalized in CY 2014 to discontinue the cardiac resynchronization therapy services composite APC and replace it with comprehensive APC 0108 (Level II ICD and Similar Procedures).

**New Categories of Packaged Services**

In CY 2008, CMS began to package seven categories of minor ancillary services associated with significant procedures into a single payment for the procedure. The seven categories are:

1. Guidance services;
2. Image processing services;
3. Intraoperative services;
4. Imaging supervision and interpretation services;
5. Diagnostic radiopharmaceuticals;
6. Contrast media; and
7. Observation services.

In CY 2014, CMS began to package the costs of an additional five categories of items and services into the payment for other services to which they are integral, ancillary or supportive. The five categories are:

1. Drugs, biologicals and radiopharmaceuticals that function as supplies in a diagnostic test or procedure;
2. Drugs and biologicals that function as supplies or devices when used in a surgical procedure, including skin substitutes;
3. Clinical diagnostic laboratory tests;
4. Procedures described by add-on codes (with the exception of add-on codes for drug administration services and add-on codes assigned to device-dependent APCs); and
5. Device removal procedures.

In CY 2015, CMS proposes to revise the add-on code packaging policy established in CY 2014. In addition, CMS proposes to begin to package (rather than pay separately) two additional categories of items and services – ancillary services and prosthetic supplies – in order to advance the agency’s strategic goal of making the OPPS more like a prospective payment system and less like a per-service fee schedule.

1. Proposed Revisions of the Packaging Policy for Procedures Described by Add-On Codes. Add-on codes are procedures that are always performed in addition to a primary procedure, such as a code describing the additional debridement of infected skin, each additional 10 percent of the body surface. In the CY 2014 OPPS final rule, CMS packaged all procedures described by add-on codes in the OPPS, with the exception of add-on codes for drug administration services and add-on codes assigned to device-dependent APCs. For CY 2015, CMS proposes to package all of the procedures described by add-on codes that are currently assigned to device-dependent APCs, which will be replaced by comprehensive APCs. The device-dependent add-on codes that CMS is proposing to package in CY 2015 are included in Table 9 in the proposed rule.

2. Ancillary Services. CMS proposes to conditionally package certain ancillary services for CY 2015. Under conditional packaging, however, when these ancillary services are furnished by themselves, CMS would make a separate payment for them. For the initial application of this policy in CY 2015, the agency would package ancillary services that have a geometric mean cost of less than or equal to $100 (prior to the application of the conditional packaging status indicator). In future years, CMS states that it may package ancillary services assigned to APCs with geometric mean costs higher than $100.

CMS proposes to exclude certain services from this packaging policy even though they have geometric mean costs of $100 or less. Specifically, preventive services listed in Table 10 in the proposed rule would continue to be paid
separately. In addition, CMS would continue to pay separately for certain psychiatry and counseling-related services because these services are similar to a visit and CMS does not currently consider them to be ancillary services. Finally, CMS also would pay separately for certain low-cost drug administration services as the agency is currently examining various alternative payment policies for drug administration services, including the associated drug administration add-on codes.

The APCs that CMS proposes for conditional packaging as ancillary services in CY 2015 are included in Table 11 in the proposed rule. The HCPCS codes that are being proposed for conditional packaging as ancillary services for CY 2015 are displayed in Addendum B to the proposed rule.

3. **Prosthetic Supplies.** CMS proposes to designate prosthetic supplies, which are paid currently under the DMEPOS Fee Schedule, as covered outpatient department services payable under the OPPS and package their costs into the surgical procedure that implants a prosthetic device and with which they are billed. CMS states that these supplies are integral to the overall function of the implanted prosthetic and hospitals typically purchase all of the components necessary for the performance of the system as a single unit.

**Wage Index**

The area wage index adjusts payments to reflect differences in labor costs across geographic areas. CMS, historically, has adopted the final fiscal year (FY) inpatient prospective payment system (PPS) wage index as the CY wage index for adjusting OPPS payments. Thus, the wage index that applies to a particular hospital under the inpatient PPS also applies to that hospital under the OPPS. In this rule, the agency proposes to use the final FY 2015 inpatient PPS wage indices for calculating CY 2015 OPPS payments. CMS also proposes that 60 percent of the APC payment would continue to be adjusted by the wage index.

As with the FY 2015 inpatient PPS wage index, the CY 2015 outpatient PPS wage index would be based on the most recent labor market areas that were issued by the Office of Management and Budget (OMB) on Feb. 28, 2013 in OMB Bulletin No. 13-01 and include an updated list of core based statistical areas (CBSAs) that reflect the OMB’s 2010 standards and 2010 Census data. CMS proposes to apply the same wage index transition periods to the OPPS as it proposed for the inpatient PPS. These transitions would be applicable to all hospitals that experience negative impacts due to the proposed implementation of the new CBSAs. The agency indicates that these transition periods are consistent with the transition period it implemented in the FY 2005 inpatient PPS rulemaking process when CMS updated the areas to reflect 2000 Census data. See our [Regulatory Advisory](#) on the FY 2015 inpatient PPS proposed rule for more information on the proposed new labor market delineations and transition periods.

**Outlier Payments**

Outlier payments are added to the APC amount to mitigate hospital losses when treating high-cost cases. CMS again proposes to establish separate thresholds for
community mental health centers (CMHCs) and hospitals. For CY 2015, CMS proposes to set the projected target for outlier payments at 1 percent of total OPPS payments – the same as in CY 2014. It proposes to allocate 0.47 percent of outlier payments to CMHCs for partial hospitalization program (PHP) services.

The rule continues to include both a fixed-dollar and a percentage outlier threshold, but in CY 2015 CMS proposes to increase the fixed-dollar threshold for outliers to $3,100, which is $200 more than in CY 2014, to ensure that outlier spending does not exceed the outlier target.

Thus, to be eligible for an outlier payment in CY 2015, the cost of a hospital outpatient service would have to exceed 1.75 times the APC payment amount (the percentage threshold), and it would have to be at least $3,100 more than the APC payment amount. When the cost of a hospital outpatient service exceeds these applicable thresholds, Medicare would make an outlier payment that is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

Payment for Drugs, Biologicals & Radiopharmaceuticals without Pass-through Status
The proposed payment rates for drugs, biologicals and radiopharmaceuticals without pass-through status in the rule are based on April 2014 average sales price (ASP) data. Updates to the ASP-based rates will be published quarterly and posted on CMS’s website through CY 2015.

CMS currently pays for drugs, biologicals and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment or separate payment (individual APCs).

Packaging Policy for “Threshold-Packaged” and “Policy-Packaged” Drugs, Biologicals and Radiopharmaceuticals. For CY 2015, CMS proposes to keep the packaging threshold for “threshold-packaged” drugs, including nonimplantable biologicals and therapeutic radiopharmaceuticals, at $90 per day, the same as in CY 2014. Therefore, drugs costing less than $90 would have their cost packaged in the procedure with which they are billed, such as a drug administration procedure. Drugs costing more than $90 would be paid separately through their own APC.

There are exceptions to this threshold-based packaging policy for certain “policy-packaged” drugs, biologicals and radiopharmaceuticals. Consistent with current CMS packaging policy, the agency proposes to continue to package the costs of all contrast agents; anesthesia drugs; non-pass-through diagnostic radiopharmaceuticals; drugs, biological, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure, regardless of whether they meet the $90 per day threshold.

Proposed High-Low-Cost Threshold for Packaged Skin Substitutes. In the CY 2014 OPPS final rule, CMS unconditionally packaged the cost of skin substitute products into their associated surgical procedures as part of a broader policy to package drugs and

American Hospital Association
biologicals that function as supplies when used in a surgical procedure. CMS also finalized a methodology that divides the skin substitutes into a high-cost group and a low-cost group for packaging purposes in order to ensure adequate resource homogeneity among APC assignments for the procedures that involve the application of skin substitutes. The high-low-cost skin substitute threshold for CY 2014 is $32 per square centimeter (cm). Skin substitutes that had an ASP plus 6 percent amount above $32 per square cm were classified in the high-cost group and those below $32 per square cm were classified in the low-cost group.

Due to concerns raised by manufacturers of skin substitutes regarding the implications of using ASP to establish the high-low-cost categories, CMS proposes an alternative approach for CY 2015. Specifically, CMS proposes to establish the high-low-cost threshold of $27 per square cm, based on the weighted average mean unit cost (MUC) for all skin substitute products using CY 2013 claims. Therefore, skin substitutes with a MUC above $27 per square cm would be classified in the high-cost group and those with a MUC at or below $27 per square cm would be classified in the low-cost group. Table 39 in the proposed rule shows the current high-low-cost status for each skin substitute product and the proposed 2015 high-low-cost status based on the weighted average MUC threshold of $27.

Payment for Drugs and Biologicals without Pass-Through Status that are not Packaged. For CY 2015, CMS proposes to continue its CY 2014 policy and pay for separately payable drugs and biologicals at the “statutory default rate” of ASP plus 6 percent. CMS proposes that this payment requires no further adjustment and represents the combined acquisition and pharmacy overhead payment for drugs and biologicals.

While CMS determines annually whether each outpatient drug will be paid separately or packaged for the entire calendar year, the agency proposes to continue to update the ASP-based payment rates for separately paid drugs on a quarterly basis as new ASP data are reported. Any separately paid drugs with new payment rates will be posted on the CMS website.

Transitional Pass-through Payments
Congress created temporary additional, or “transitional pass-through payments,” for certain innovative medical devices, drugs and biologicals to ensure that Medicare beneficiaries have access to new technologies in outpatient care. For CY 2015, CMS projects that pass-through payments will be 0.03 percent of total OPPS payments, or $15.5 million. This includes $10.5 million in pass-through payments for devices and $5 million for drugs and biologicals.

Changes to the transitional pass-through pool must be budget neutral and, as a result, CMS proposes to adjust the conversion factor by 0.01 percent, the difference between the 0.02 percent estimate of pass-through spending for CY 2014 and the 0.03 percent estimate of CY 2015 pass-through spending.
Supervision of Hospital Outpatient Therapeutic Services
For the first time in six years, the proposed rule does not include a section on supervision of outpatient therapeutic services. As of Jan. 1, 2014, CMS ended the direct supervision enforcement moratorium for critical access hospitals (CAHs) and small rural hospitals. This means that all hospitals and CAHs must currently comply with CMS’s direct supervision requirements.

However, hospitals that are concerned about the Medicare supervision policy still have opportunities to influence the policy by making presentations to the Advisory Panel on Hospital Outpatient Payments (HOP Panel) and making recommendations regarding the level of supervision necessary for individual outpatient therapeutic services. The HOP Panel, which meets twice a year, advises CMS regarding the appropriate level of supervision for hospital outpatient therapeutic services. The next meeting of the HOP Panel is scheduled for Aug. 25 and 26.

For more information about this upcoming meeting, please refer to the AHA’s June 18 Action Alert. Stay tuned for upcoming opportunities to submit comments to CMS on its preliminary decisions about the HOP Panel’s August recommendations. For more background, including AHA advocacy efforts on supervision of outpatient therapeutic services in CAHs and other hospitals, please refer to AHA’s CY 2009-2014 OPPS/ASC regulatory advisories, AHA’s CY 2009-2013 OPPS/ASC proposed rule comment letters and to the AHA’s recently released Advocacy Action Alert and Fact Sheet.

Hospital Outpatient Quality Reporting (OQR) Program
The Tax Relief and Health Care Act of 2006 required CMS to establish a program under which hospitals must report data on the quality of outpatient care in order to receive the full annual update to the OPPS payment rate. Hospitals failing to report the data incur a reduction in their annual payment update factor of 2.0 percentage points.

CMS proposes to add one new measure to the OQR for CY 2017. CMS also proposes to add quantitative criteria for assessing “topped out” measure performance. Using these new criteria, CMS proposes to remove three measures from the CY 2017 OQR program. CMS also proposes to transition one measure from required to voluntary reporting. The list of finalized and proposed OQR measures can be found in Appendix A of this advisory. Lastly, CMS proposes to formalize a data correction process, and to update the OQR data validation process.

New Measure for CY 2017. For the CY 2017 OQR program, CMS proposes to add OP-32, Facility 7-Day risk-standardized hospital visit rate after outpatient colonoscopy. This measure includes all-cause, unplanned hospital admissions, ED visits and observation stays within seven days of a colonoscopy procedure. CMS proposes to calculate the measure using Medicare claims data from a 12-month period from July three years before payment determination through June of the following year. For CY 2017, that data reporting period is July 1, 2014 through June 30, 2015. As with the hospital readmission measures used in the inpatient quality reporting (IQR) program, each hospital’s performance would be scored as a risk-adjusted ratio of predicted hospital visits to expected hospital visits. The measure excludes colonoscopies concurrent with
high-risk upper gastrointestinal procedures and patients with a history of inflammatory bowel disease or diverticulitis. Detailed measure specifications are available on CMS’s Measure Methodology website under “Hospital Outpatient Colonoscopy.”

In the proposed rule, CMS indicates that colonoscopy is a high-volume procedure, and that it wishes to reduce adverse patient outcomes associated with the procedure. In support of adopting the measure, CMS cites evidence suggesting that hospital visit rates after outpatient colonoscopy range from 0.8 to 1.0 percent in the seven to 14 days after the procedure. The agency also suggests that providers are often unaware of hospitalizations following colonoscopy, and that the reporting of this measure would fill an information gap.

However, OP-32 is not yet endorsed by the National Quality Forum (NQF) and was only conditionally supported by the Measure Applications Partnership (MAP). The MAP is an ACA-mandated, multi-stakeholder group convened to provide pre-rulemaking input on measures before they are proposed for federal programs. As recommended by the MAP, the AHA will urge CMS to obtain NQF endorsement of the measure before implementing it in the OQR program.

**Topped Out Measure Criteria.** CMS states that, in previous years, it has used several general criteria to determine whether measures should be removed from the OQR program, including a consideration of whether measure performance is “topped out,” or “measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.” However, CMS now proposes to adopt quantitative criteria for identifying topped out measures. These proposed criteria are the same as those used in the hospital value-based purchasing (VBP) program and recently proposed for the hospital IQR program. Specifically, the agency proposes that an OQR measure would be “topped out” and eligible for removal from the program if national measure data meet two criteria:

- The difference in performance between the 75th and 90th percentile is statistically insignificant; and
- The coefficient of variation (CV) is less or equal to 0.10. CV is a statistic with a score ranging from 0 to 1 reflecting the variation of scores across a sample. The larger the CV, the greater the variation in performance across entities.

**Proposed Measure Removal.** Using its proposed new criteria for “topped out” measures, CMS proposes to remove three measures from the CY 2017 OQR program:

- OP-4: Aspirin at arrival;
- OP-6: Timing of antibiotic prophylaxis; and
- OP-7: Prophylactic antibiotic selection for surgical patients.

The agency suggests that there is “little room for improvement” on the measures across all hospitals, and that removing the measures from the OQR would relieve hospitals of data collection burden.
Voluntary Reporting of OP-31. In the CY 2014 OPPS final rule, despite the AHA’s objections, CMS added OP-31 (Improvement in Patient’s Visual Function within 90 Days following Cataract Surgery) to the CY 2016 OQR program. The measure assesses the percentage of cataract surgery patients whose visual function has improved within 90 days of surgery. Improvement in visual function is assessed by comparing a patient’s results on a visual function instrument before and after surgery. Measure data collection was scheduled to begin on Jan. 1, 2014. However, the agency subsequently delayed data collection of OP-31 until April 1, 2014 to allow additional time to finalize the measure specifications.

The AHA and other groups raised significant concerns about the feasibility and accuracy of OP-31 both in comments on the CY 2014 OPPS proposed rule and in subsequent communications to CMS. During the first quarter of CY 2014, hospitals also reported significant operational issues with implementing the measure. In response, CMS suspended the collection of OP-31 for the remainder of CY 2014 on April 2, 2014. In this proposed rule, CMS proposes to exclude OP-31 altogether from the CY 2016 OQR program. Moreover, it proposes that the collection and reporting of OP-31 will not be required for CY 2017 and subsequent years. However, hospitals would have the option of reporting OP-31 measure data on a voluntary basis.

Future OQR Measures. The current OQR program measure set includes measures that assess process of care, imaging efficiency patterns, care transitions, ED throughput efficiency, use of health information technology, care coordination, patient safety and volume. For future payment determinations, CMS solicits comment on expanding the current measure set to include electronic clinical quality measures (eCQMs), partial hospitalization program (PHP) measures, behavioral health care measures, and other measures that align with the National Quality Strategy and the CMS Quality Strategy domains.

eCQMs. CMS currently includes one electronically specified eCQM in the OQR Program: OP-18, Median Time from ED Arrival to ED Departure for Discharged ED Patients. In the proposed rule, CMS states that health information exchange and the use of certified electronic health records (EHRs) can effectively and efficiently help providers improve internal care delivery practices, support management of patient care across the continuum, and support the reporting of eCQMs. CMS also states that it recognizes that considerable work needs to be done by measure owners, health information technology developers, and implementers to make this possible. This work includes completing e-specifications for measures, pilot testing, reliability and validity testing, and implementing such specifications in certified EHR technology to capture and calculate the results. The AHA applauds the identification of a framework for consideration of new eCQMs in OQR.

PHP and other Behavioral Health Measures. In the CY 2014 outpatient PPS proposed rule, CMS solicited comment on whether it should implement quality reporting for PHPs, and what types of measures it should use for PHP quality reporting. While CMS does
not propose to initiate PHP quality reporting in this year’s proposed rule, the agency again solicits comment on quality reporting for PHPs. Specifically, CMS asks whether PHP measures should be incorporated into the OQR program rather than separately reported in a stand-alone program, citing evidence that PHP utilization has been declining. Additionally, CMS requests comment on whether PHPs should report three specific measures currently reported in the Program for Evaluating Payment Patterns Electronic Reports (PEPPERS) developed under the Comprehensive Error Rate Testing (CERT) program. Detailed information about all three of the measures can be found in the PEPPER for PHP user guide:

- **30-day readmission.** The measure assesses the proportion of initial (or “index”) PHP episodes of care for which a resumption of care occurred within 30 days to either the same or different PHP. The PEPPER user guide suggests that higher rates of PHP readmission could indicate that patients are being prematurely discharged from PHPs, or that the discharge planning process could be strengthened.

- **Group therapy.** The measure assesses the proportion of PHP episodes of care where only group therapy (revenue code 0915) is billed. The PEPPER user guide states that using only group therapy may indicate PHPs are not providing individualized plans of care.

- **No individual psychotherapy.** The measure assesses the proportion of PHP episodes of care that do not have units of individual psychotherapy (revenue code 0914) or psychiatric testing (revenue codes 0900 or 0918). The PEPPER user guide suggests that not using individual psychotherapy may indicate that PHPs are not providing a sufficient intensity of services to meet patient needs.

All three of the above measures were reviewed by the MAP in January 2014 for potential inclusion in future OQR programs. The MAP did not support any of them, citing concerns that none of the measures is NQF-endorsed. The MAP also indicated that the therapy measures are backed by limited evidence of the relative value of individual versus group therapy, and that the readmission measure is poorly defined.

Finally, CMS solicits comment on behavioral health care measures “specific to behavioral health in the outpatient setting, including measures addressing depression and alcohol abuse.” The proposed rule does not list any specific measures the agency is considering, but invites comments on those that may be applicable to the hospital outpatient settings measured by the OQR program.

**Data Reporting.** CMS proposes no changes to the general data submission timeframes and methods for the measures finalized in previous rules. However, the proposed rule clarifies the reporting of the health care personnel (HCP) influenza vaccination measure (OP-27) that CMS added to the OQR in the CY 2014 outpatient PPS final rule. The HCP measure also must be collected for the hospital IQR program, and the AHA and others previously raised concerns about the burden of separately collecting and reporting HCP flu vaccination status for inpatient and outpatient settings. In response, in April 2014, CMS and the Centers for Disease Control and Prevention issued
Operational Guidance for collecting the HCP influenza vaccination measure. The guidance states that facilities should collect and report a single vaccination count by CMS Certification Number. That single count would include both inpatient and outpatient settings, and could be used to fulfill requirements for both the OQR and IQR programs.

Review and Corrections Process. CMS requires hospitals to collect chart-abstracted OQR measures on a quarterly basis. Hospitals must then submit measure data four months after the end of each quarter. CMS states that it “generally” provides the rates for chart-abstracted measures 24 to 48 hours after hospitals submit the data. CMS indicates that hospitals are permitted to review this information, determine whether any corrections are necessary and submit corrections, as long as those changes are submitted before the data submission deadline.

CMS proposes to make the formal OQR data review and corrections process for chart-abstracted data concurrent with the OQR data submission period. That is, hospitals would be expected to review and submit any corrections to chart-abstracted measures during the measure submission period and before the measure submission deadline. After the measure data submission deadline, hospitals would not be permitted to change their submitted data. CMS would continue to urge hospitals to submit data as early as possible in the submission period in order to accommodate review and correction activities.

Validation. CMS proposes only minor modifications to its previously finalized OQR data validation processes. First, CMS proposes that for CY 2017, a hospital could be eligible for validation if it submits at least one case to the Hospital OQR Program Clinical Data Warehouse during the quarter with its most recently available data. For example, if a validation sample is drawn in December 2014, then the most recent available data would be from the second quarter of 2014. This is because the data submission deadline for second quarter data is Nov. 1, 2014.

Second, CMS proposes to give hospitals the option to either submit paper copies of patient charts for validation or to securely transmit electronic versions of medical information. The electronic versions of medical information could be transmitted using either electronic media (e.g., CD, DVD, flash drive) or PDFs submitted using a Secure File Transfer Protocol on QualityNet. Finally, CMS proposes that hospitals identify the medical record staff person responsible for submitting validation records for the hospital OQR program.

Collecting Data on Services Furnished in Off-campus Provider-based Departments
In the proposed rule, CMS cites recent reports of increasing trends of hospitals acquiring physician practices and integrating those practices as hospital outpatient departments. The agency also notes concerns from the Medicare Payment Advisory Commission (MedPAC) around increasing Medicare program payments and beneficiary cost-sharing that can result from such acquisitions. Consequently, CMS proposes to begin collecting information in CY 2015 that would allow it to analyze the frequency,
type and payment for services furnished in off-campus provider-based hospital outpatient departments.

Specifically, CMS proposes to create a modifier that would be reported with every code for physician services and outpatient hospital services furnished in an off-campus provider-based department of a hospital. The modifier would be reported on both the CMS-1500 claim form for physicians’ services and on the Uniform Bill-04 form (CMS form 1450) for hospital outpatient services. CMS defines a “campus” to be the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office.

The AHA understands CMS’s interest in learning more about this rapidly changing environment. **However, we are concerned this information could be used as a means to justify implementing “site-neutral” payment reductions, such as the policies that MedPAC and Congress have been pursuing in the context of federal budget cuts, which fail to recognize the extra costs hospitals bear for critical hospital-based safety net services, providing 24/7 access to emergency care and stand-by capacity.** Instead, policymakers should recognize that this trend of hospitals acquiring physician practices and integrating those practices as hospital outpatient departments may reflect efforts by hospitals and health systems to provide more integrated care and improve care coordination that focuses on appropriate utilization, efficiency and outstanding measureable outcomes. **In addition, we will explore how much additional administrative burden this proposed Medicare-only information collection approach would cause for hospitals and physicians.**

**Rural Adjustment for Sole Community Hospitals**
CMS proposes to continue increasing payments to rural sole community hospitals, including essential access community hospitals, by 7.1 percent for all services paid under the OPPS, with the exception of drugs, biologicals, services paid under the pass-through policy and items paid at charges reduced to costs. The adjustment is budget neutral to the OPPS and applied before calculating outliers and coinsurance.

**Cancer Hospital Adjustment**
CMS proposes to continue its cancer hospital update policy finalized in the CY 2012 OPPS final rule. Using the most recently submitted or settled cost report data, this policy would increase each of the 11 “exempt” cancer hospitals’ OPPS payments by the percentage difference between its individual payment-to-cost ratio (PCR) and the weighted average PCR of the other hospitals paid under the OPPS (0.89). The adjustment is made at cost report settlement and is budget neutral.

**Partial Hospitalization Program (PHP)**
CMS will continue to use four separate APCs to pay for PHP services, including two APCs for services furnished in hospital-based PHPs and two APCs for services furnished in a CMHC. Payments for hospital-based PHP services are calculated using
only hospital data, and payment for CMHC PHP services are calculated using only CMHC claims data. The proposed rates are in Table 2 below.

**TABLE 2: PROPOSED CY 2015 PHP RATES FOR HOSPITALS AND CMHCS**

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<th>Proposed 2015 Per-Diem Costs for PHP Services</th>
<th>Hospital-Based PHPs</th>
<th>CMHC PHPs</th>
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<tr>
<td>Level I (days with 3 services)</td>
<td>APC 0175 $169.36</td>
<td>APC 0172 $93.06</td>
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<tr>
<td>Level II (days with 4 or more services)</td>
<td>APC 0176 $181.66</td>
<td>APC 0173 $109.77</td>
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For hospital-based PHPs, the proposed CY 2015 per-diem payment would fall by $20.79 for Level I PHP services and fall by $31.98 for Level II PHP services, compared to the CY 2014 rates.

**Modification of Current Process for Accepting New and Revised CPT Codes**

CPT and Level II HCPCS codes are used to report procedures, services, items and supplies under the OPPS. CPT codes are established by the American Medical Association (AMA) and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect the OPPS are published both through the annual rulemaking cycle and through the OPPS quarterly update Change Requests (CRs). CMS releases new Level II HCPCS codes to the public or recognizes the release of new CPT codes by the AMA and makes these codes effective for reporting on Medicare claims outside of the formal rulemaking process via OPPS quarterly update CRs.

CMS proposes to make changes to the process used to establish APC assignments and status indicators for new and revised CPT codes. The OPPS proposed rule is published prior to the publication of new and revised CPT codes that are generally made public in the fall of each year, with a Jan. 1 effective date. As a result, CMS is unable to include these codes in the OPPS proposed rules. Instead, CMS currently assigns the new CPT and Level II HCPCS codes to interim status indicator and APC assignments. These interim assignments are finalized in the OPPS final rule. This quarterly process (summarized in Table 14 of the proposed rule) offers hospitals access to codes that may more accurately describe items or services furnished and provides payment or more accurate payment for these items or services in a timelier manner than if CMS waited for the annual rulemaking process. CMS annually solicits public comments on these new codes and finalizes proposals related to these codes through its annual rulemaking process.

In the CY 2015 proposed rule, CMS proposes that for new and revised CPT codes received from the AMA CPT Editorial Panel too late for inclusion in the proposed rule for a year, CMS would delay adoption of the new and revised codes for that year, and instead, adopt coding policies and payment rates that conform, to the extent possible, to the policies and payment rates in place for the previous year. CMS proposes to create HCPCS G-codes to describe the predecessor codes for any codes that were revised or deleted as part of the annual CPT coding changes. If CMS does not receive the code for a wholly new service in time to include proposed APC and status indicator...
assignments in the proposed rule for a year, CMS would establish interim APC and status indicator assignments for the initial year. However, if certain CPT codes are revised in a way that would not affect the cost of inputs (for example, a grammatical change to CPT code descriptors), CMS would use these revised codes and continue to assign those codes to their current APC.

CMS recognizes that the use of HCPCS G-codes may place an administrative burden on those providers that bill for services under the OPPS and the ASC payment system and is hopeful that the AMA CPT Editorial Panel ultimately will be able to adjust its timelines and processes so that most, if not all, of the annual coding changes can be addressed in the proposed rule. CMS proposes to implement the revised process for CY 2016, but will consider alternative implementation dates to allow time for the AMA CPT Editorial Panel to adjust its schedule to avoid using numerous HCPCS G-codes. CMS invites public comments on this proposal and is interested in several specific topics, such as the appropriateness of the proposed process, timing and potential alternatives to using HCPCS G-codes that would allow addressing the annual CPT code changes through notice and comment rather than an interim final rulemaking.

**Beneficiary Coinsurance**

CMS proposes to decrease beneficiary liability for coinsurance for outpatient services. As required by law, CMS maintains last year’s maximum beneficiary coinsurance rate of 40 percent of the total payment to the hospital for that service. However, CMS estimates that the average copayments for all outpatient services would drop to 20.1 percent of total payments in CY 2015. Under Medicare law, the cap on coinsurance rates is to be reduced gradually until all services have a coinsurance rate of 20 percent of the total payment.

**PROPOSED CHANGES FOR THE CY 2015 ASC PAYMENT SYSTEM**

The proposed rule includes the annual review and update to the ASC list of covered surgical procedures and covered ancillary procedures, as well as updated payment rates. CMS also reviews excluded surgical procedures, new procedures and procedures with revised coding to identify any that meet the criteria for designation as ASC-covered. In addition, the proposed rule implements the ACA requirement to reduce the annual update under the ASC payment system by a productivity adjustment.

**Updates and Changes to ASC Payment Policy**

Updating the ASC Conversion Factor. The ACA requires that, beginning in CY 2011, the annual inflation update under the ASC payment system (the Consumer Price Index for all Urban Consumers (CPI-U)) must be reduced by a productivity adjustment. For CY 2015, CMS estimates the CPI-U to be 1.7 percent and the productivity adjustment to be negative 0.5 percentage point. Therefore, CMS proposes to apply to the ASC conversion factor a net update of 1.2 percent. In addition, for the CY 2015 ASC payment system, CMS proposes to calculate and apply the pre-reclassification hospital wage index to ASC payments, just as the OPPS wage index adjustment is calculated...
and applied to the OPPS payments. CMS proposes to apply a 0.9983 ASC wage index budget-neutrality adjustment in calculating the CY 2015 ASC conversion factor.

The net CPI-U update, together with the wage adjustment for budget neutrality, results in a proposed CY 2015 ASC conversion factor of $43.918. In contrast, the proposed CY 2015 OPPS conversion factor is $74.176.

ASCs that fail to meet their quality reporting requirements will have their conversion factor reduced by 2.0 percentage points. The net update for ASCs not meeting quality reporting requirements would thus be negative 0.8 percent, which, together with the wage adjustment for budget neutrality, results in a proposed reduced CY 2105 ASC conversion factor of $43.050. By contrast, the reduced OPPS conversion factor is $72.692.

**Updating the ASC Relative Payment Weights for CY 2015.** CMS updates the relative payment weights in the ASC payment system each year using the national OPPS relative payment weights (and physician fee schedule (PFS) non-facility practice expense amounts, as applicable) for that same calendar year and uniformly scales the ASC relative payment weights for each year to make them budget neutral. For CY 2015, CMS proposes to use an ASC scale of 0.9142.

**ASC-covered Surgical Procedures.** CMS proposes to add 10 surgical procedures to the list of ASC-covered surgical procedures. There procedures are listed in Table 48 in the proposed rule.

**Surgical Procedures Designated as Office-based.** Office-based procedures are procedures that CMS determines are performed predominantly (more than 50 percent of the time) in physicians’ offices. They are paid at the lower of the Medicare PFS non-facility practice expense relative value unit amount or the amount calculated using the ASC standard rate-setting methodology for the procedure.

For CY 2015, CMS proposes to permanently designate two additional procedures as “office-based” procedures (see Table 49 of the proposed rule). In addition, CMS proposes to retain the temporary office-based status of seven of the eight procedures assigned this designation in the CY 2014 final rule. Table 50 in the proposed rule lists the payment indicator for each of the ASC-covered surgical procedures with proposed temporary office-based status in CY 2015.

**ASC-Covered Surgical Procedures Designated as Device-Intensive.** As discussed above, CMS proposes to create 28 comprehensive APCs under the OPPS. Because a comprehensive APC would treat all individually reported codes as representing components of the comprehensive service, CMS proposes to make a single prospective payment based on the cost of all individually reported codes that represent the provision of a primary service and all adjunctive services provided to support the delivery of the primary service.
However, while the OPPS claims processing system can be configured to make a single payment for the comprehensive service whenever a HCPCS code that is assigned to a comprehensive APC appears on the claim, the ASC claims processing system does not allow for this. Therefore, CMS proposes to vary the ASC payment policy from the proposed OPPS payment policy for these comprehensive APCs. CMS proposes that all separately paid ancillary services provided integral to surgical procedures that map to a comprehensive APC would continue to be paid separately under the ASC payment system, instead of being packaged into the payment for the comprehensive APC as under the OPPS. However, as the proposed OPPS relative weights for comprehensive APCs include the costs for ancillary services, CMS proposes to avoid duplicate payment for these separately paid ancillary services when they are furnished in an ASC setting. Thus, CMS proposes to base the ASC payment rates for these services on the CY 2015 OPPS relative weights that have been calculated using the standard APC rate setting methodology for the primary service, rather than on the relative payment rates based on the proposed comprehensive service.

**ASC Quality Reporting (ASCQR) Program**

The ACA required CMS to establish a program under which ASCs must report data on the quality of care delivered in order to receive the full annual update to the ASC payment rate. ASCs failing to report the data will incur a reduction in their annual payment update factor of 2.0 percentage points beginning with the CY 2014 update.

For CY 2017, CMS proposes to add one new measure to the ASCQR program, and to transition another measure from required to voluntary reporting. CMS also proposes a new policy for removing previously adopted ASCQR program measures. The list of finalized and proposed ASCQR measures can be found in Appendix B of this advisory. Lastly, CMS proposes to change the submission deadline for submitting ASC-8 (HCP influenza vaccination).

**New Measure for CY 2017.** For the CY 2017 ASCQR program, CMS proposes to add ASC-12, Facility 7-Day risk-standardized hospital visit rate after outpatient colonoscopy. ASC-12 is the same measure proposed for the CY 2017 OQR program as OP-32, except that ASC-12 will be reported for ASCs. As with OP-32, CMS proposes to calculate ASC-12 using Medicare claims data from a 12-month period from July three years before payment determination through June of the following year. For CY 2017, that data reporting period is July 1, 2014 through June 30, 2015. Additional details on the proposed measure can be found in the hospital OQR program section of this advisory.

**Voluntary Reporting of ASC-11.** Against the AHA’s recommendation, CMS added ASC-11 (Improvement in Patient’s Visual Function within 90 Days following Cataract Surgery) to the CY 2016 ASCQR program in the CY 2014 OPPS final rule. The same measure also was added to the hospital OQR as OP-31. As with OP-31, CMS has already suspended ASC-11 from the CY 2016 ASCQR program, and proposes to make reporting of ASC-11 voluntary beginning with the CY 2017 program. Additional details on this measure can be found in the OQR program section of this advisory.
Measure Removal Policy. While CMS does not propose to remove any measures from the ASCQR at this time, it does propose to adopt the same policy for measure removal that it uses for the hospital IQR program. The policy is outlined in greater detail below.

Measure Removal for Patient Safety Concerns. CMS proposes that any measure whose continued reporting may lead to patient harm would be immediately removed from the ASCQR. This removal could occur without the use of formal rulemaking. The agency states that it would notify ASCs and the public of the measure removal using existing communications channels, and then use subsequent rulemaking to confirm the measure’s removal from the program.

Other Measure Removal Criteria. For measures whose continued use does not pose a patient safety concern, CMS proposes to use the regular rulemaking process to remove a measure from the ASCQR. CMS proposes to use the following criteria in considering whether to remove a measure from the ASCQR program:

- Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (“topped out” measures);
- Availability of alternative measures with a stronger relationship to patient outcomes;
- Measure does not align with current clinical guidelines or practice;
- The availability of a more broadly applicable (across settings, populations, or conditions) measure for the topic;
- The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic;
- The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic; and
- Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

Quantitative Topped Out Measure Criteria. In addition to the general “topped out” measure criterion described above, CMS proposes to adopt quantitative criteria for identifying topped out measures. These proposed criteria are the same as those used in the hospital VBP program and proposed for the hospital OQR and hospital IQR programs. These criteria are described in the OQR program section of this advisory.

HCP Influenza Vaccination Reporting. CMS proposes only one notable change to its previously finalized data reporting and other administrative requirements for the ASCQR program. In the CY 2014 OPPS final rule, the agency added ASC-8 Influenza Vaccination Coverage Among Healthcare Personnel to the ASCQR program for CY 2016 payment determination. The agency also finalized a data reporting timeframe of Oct. 1, 2014 through March 31, 2015, but did not specify a data submission deadline. In this year’s rule, the agency proposes a submission deadline of May 15, 2015, which is aligned with the submission deadline for the hospital IQR and OQR programs.
Other Proposed Changes for CY 2015

Physician Certification of Hospital Inpatient Services Other than Psychiatric Inpatient Services

Section 1814(a)(3) of the Social Security Act provides that Medicare Part A payment will be made only for such services “which are furnished over a period of time, if a physician certifies that such services are required to be given on an inpatient basis.” CMS previously interpreted this to require a physician certification for all inpatient admissions. The AHA challenged this interpretation in its lawsuit on the inpatient “two-midnight” policy, arguing that the physician certification should be required only for certain long-term stays.

In an attempt to address the litigation, CMS now proposes to alter its previous interpretation and require a physician certification only for cases that are 20 inpatient days or more, or are considered outlier cases. The physician certification would continue to include:

- The reasons for: (1) continued hospitalization of the patient for medical treatment or medically required diagnostic study, or (2) special or unusual services for outlier cases;
- The estimated time the patient will need to remain in the hospital; and
- The plans for post-hospital care, if appropriate.

CMS also reiterates that an order from a physician or other qualified practitioner, as specified in 42 CFR 412.3, is still necessary for all inpatient admissions. Therefore, CMS will continue to require that a physician order for inpatient admission be present in the medical record and be supported by physician admission and progress notes in order for the hospital to be paid for hospital services under Medicare Part A.

While CMS has attempted to reduce the administrative requirements associated with inpatient hospital admissions, many questions remain as to how this proposal would impact the documentation required under the two-midnight policy. We will continue to work with CMS to obtain answers to these questions. The AHA also will continue to analyze the impact of this proposal on the claims raised in the two-midnight lawsuit and hospital implementation of the two-midnight policy.

Changes to the Rural Provider and Hospital Ownership Exceptions to the Physician Self-Referral Law Expansion Prohibition

The ACA limited the use of the physician self-referral exceptions for hospitals with physician ownership or investment. Only existing physician-owned hospitals may use the "whole hospital" and rural exceptions to the ban on self-referral subject to certain conditions. Implementing rules and conditions have been published in segments across the last several years, frequently through the OPPS/ASC payment notices. The last and final segment of required regulations contained the criteria and process to obtain an exception to the ban on growth by grandfathered physician-owned hospitals. The
criteria for granting a request to expand closely mirrored the statute. They relate to whether:

- There is significant growth in the area population;
- Hospital bed capacity is low and bed occupancy is high in the area;
- Medicaid inpatient admissions at the requesting hospital are at or above the annual percent level in other hospitals in the county; and
- The requesting hospital does not discriminate against federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries.

A simplified set of criteria were established for high Medicaid facilities. Allowable data sources for the various calculations required by the criteria were limited to Medicare cost reports (HCRIS) and Census data. The process for requesting permission to grow also was straightforward and, consistent with the statute, provided opportunity for community and public notice and written comment. It applied to all hospitals requesting permission, including high Medicaid hospitals, and included:

- Notice of a request to expand must be posted on the hospital’s website from the point of request through to a final decision by CMS.
- Notice of a request also is posted on CMS’s website, announced through its hospital list serve, and a notice published in the Federal Register with a 30-day comment period.
- The requesting hospital’s application is considered complete at the end of the 30 days if no comments are received. If comments are received, CMS provides them to the requesting hospital which then has 30 days to provide documentation and information to CMS to rebut the comments.
- Once the application is certified as complete, CMS must render a decision no later than 60 days after that certification. Decisions are posted on CMS’s website, including the identification of the hospital and the size expansion approved.

In this year’s notice, CMS proposes to allow certain supplemental internal and external data sources to judge whether a requesting physician-owned hospital meets the criteria for an expansion exception due to the limitations of HCRIS data or the availability of certain provider cost reports needed for comparison purposes. Chief limitations identified include lack of data on Medicaid managed care admissions or discharges in HCRIS. To avoid manipulation of the process, allowable supplemental internal data sources are sources generated, maintained or under the control of HHS, such as Healthcare Cost and Utilization Project. Allowable external data sources are those generated, maintained or under the control of a state Medicaid agency. In the case of both internal and external supplemental data sources, they must be reliable, transparent, and generate or maintain data that are accurate, complete and objectively verifiable for the expansion exception process. Finally, data from both internal and external sources must be readily available and accessible to the requesting hospital, comparison hospitals and to CMS. The use of supplemental data by a physician-owned hospital
hospital would delay action on its request by 180 to 360 days in order to allow time to validate the supplemental data.

The AHA continues to support the use of standardized data sets (predominantly the CMS HCRIS and the Bureau of the Census) to determine eligibility for a grandfathered physician-owned hospital to expand. Use of common data sets for all requests will minimize inconsistent application of the eligibility criteria. This expansion of supplemental data sources is consistent with the AHA’s expectations and proposed revisions to the processing of expansion requests should provide sufficient opportunity to ensure that such supplemental data are used in a valid and consistent manner.

**CMS Identified Overpayments Associated with Erroneous Payment Data Submitted by Medicare Advantage Organizations and Medicare Part D Sponsors**

CMS proposes a mechanism to collect overpayments to Part C and Part D plan sponsors in the limited circumstances not already covered by existing processes. As such, CMS is closing a gap in its processes with technical corrections to its rules. CMS collects certain payment data from Part C and Part D plans to calculate risk adjustment of plan payments and cost-reconcile Part D subsidies. “Erroneous payment data” are data that should not have been submitted to CMS either because the data are inaccurate or because the data are inconsistent with Part C and Part D requirements. Generally, such errors are corrected voluntarily by plans, but where that does not occur, this process would address recovering any resulting overpayments to a plan. The proposed mechanism includes data correction procedures, payment adjustment calculation, collection of overpayments, and review and appeal procedures.

**Next Steps**

The AHA encourages members to submit comments to CMS outlining how the agency’s proposals will affect their facilities.

Comments are due to CMS by Sept. 2 and may be submitted electronically at [http://www.regulations.gov](http://www.regulations.gov). Follow the instructions for “Comment or Submission.” Attachments can be in Microsoft Word, WordPerfect or Excel; however, CMS prefers Microsoft Word. CMS also accepts written comments (an original and two copies) via regular or overnight/express mail.

**Via regular mail:**
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1613-P
P.O. Box 8013
Baltimore, MD 21244-1850

**Via overnight or express mail:**
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1613-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Further Questions

Please contact Roslyne Schulman, director of policy, at rschulman@aha.org for more information about the proposed rule.
## Appendix A: Finalized and Proposed Hospital OQR Program Measures, CY 2014 – CY 2017 Payment Determination

<table>
<thead>
<tr>
<th>Measure</th>
<th>CY 2014</th>
<th>CY 2015</th>
<th>CY 2016</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac Care (Chart-Abstracted, Collected by Hospitals via CART / vendor, submitted via QualityNet#)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-1: Median time to fibrinolysis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-2: Fibrinolytic therapy received within 30 minutes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-3: Median time to transfer to another facility for acute coronary intervention</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-4: Aspirin at arrival</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Removal¹</td>
</tr>
<tr>
<td>OP-5: Median time to electrocardiogram (ECG)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-24: Cardiac rehabilitation patient referral from an outpatient setting</td>
<td>Suspended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cataract Surgery (Chart-Abstracted, Reported by Hospitals via QualityNet web-based tool)</strong></td>
<td></td>
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<tr>
<td>OP-31: Cataracts—Improvement in patient’s visual function within 90 Days following cataract Surgery</td>
<td>Suspended</td>
<td></td>
<td></td>
<td>Voluntary reporting¹</td>
</tr>
<tr>
<td><strong>Emergency Department Throughput (Chart-Abstracted. OP-18, OP-19 and OP-20 collected by Hospitals via CART / vendor. # OP-22 reported via QualityNet web-based tool)</strong></td>
<td></td>
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</tr>
<tr>
<td>OP-18: Median time from ED arrival to ED departure for discharged ED patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-19: Transition record with specified elements received by discharged ED patients</td>
<td>Suspended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-20: Door to diagnostic evaluation by a qualified medical professional</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-22: ED Left without being seen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Endoscopy (Chart-Abstracted, Reported by Hospitals via QualityNet web-based tool)</strong></td>
<td></td>
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<tr>
<td>OP-29: Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-30: Endoscopy/Poly Surveillance: Colonoscopy interval for patients with a history of adenomatous polyps—Avoidance of inappropriate use</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Healthcare Associated Infections (Collected by Hospitals, Submitted via NHSN)</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>OP-27: Influenza vaccination coverage among health care personnel (HCP)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td><strong>Hospital Visit Rates (Claims-Based, Calculated by CMS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-32: Facility 7-Day risk-standardized hospital visit rate after outpatient colonoscopy</td>
<td>X¹</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Measure</td>
<td>CY 2014</td>
<td>CY 2015</td>
<td>CY 2016</td>
<td>CY 2017</td>
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<tr>
<td><strong>Imaging Efficiency (Claims-Based, Calculated by CMS)</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>OP-8: MRI lumbar spine for low back pain</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-9: Mammography follow-up rates</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-10: Abdomen CT – Use of contrast material</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-11: Thorax CT – Use of contrast material</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-13: Cardiac imaging for preoperative risk assessment for non-cardiac low risk surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-14: Simultaneous use of brain CT and sinus CT</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-15: Use of brain CT in the emergency department for atraumatic headache³</td>
<td>Suspended</td>
<td>Suspended</td>
<td>Suspended</td>
<td>Suspended</td>
</tr>
<tr>
<td><strong>Pain Management (Chart-Abstracted, Collected by Hospitals via CART or vendor, submitted via QualityNet#)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-21: ED- Median time to pain management for long bone fracture</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Stroke (Chart-Abstracted, Reported by Hospitals via CART or vendor, submitted via QualityNet#)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-23: ED- Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Surgery (Chart-Abstracted, Collected by Hospitals via CART or vendor, submitted via QualityNet#)</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>OP-6: Timing of antibiotic prophylaxis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Remova l¹</td>
</tr>
<tr>
<td>OP-7: Prophylactic antibiotic selection for surgical patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Remova l¹</td>
</tr>
<tr>
<td><strong>Structural Measure (Submitted by Hospitals via QualityNet web-based tool)</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>OP-12: The ability for providers with health information technology (HIT) to receive laboratory data electronically directly into their qualified/certified EHR System as discrete searchable data</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-17: Tracking clinical results between visits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>OP-25: Safe Surgery Checklist use</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OP-26: Hospital outpatient volume data on selected outpatient surgical procedures</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

# CART is the CMS Abstraction and Reporting Tool. Hospitals may also elect to have measure collection and submission performed by third-party vendors.

¹ Proposed in the CY 2015 OPPS proposed rule.

² Per CMS announcement on April 2, 2014.

³ While CMS has the specifications to calculate OP-15, the measure remains suspended from public reporting as of the CY 2014 OPPS Final Rule.
### Appendix B: Finalized and Proposed ASCQR Program Measures, CY 2014 – CY 2017 Payment Determination

<table>
<thead>
<tr>
<th>Measure</th>
<th>CY 2014</th>
<th>CY 2015</th>
<th>CY 2016</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reported by ASCs through the inclusion of Quality Data Codes (QDCs) on Medicare Part B Claims, and subsequently calculated by CMS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASC-1: Patient burns</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ASC-2: Patient falls</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant</td>
<td>X</td>
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<td>ASC-4: Hospital transfer / admission</td>
<td>X</td>
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<tr>
<td>ASC-5: Prophylactic intravenous antibiotic timing</td>
<td>X</td>
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<tr>
<td><strong>Cataract Surgery (Chart-abstracted, submitted by ASCs via QualityNet web-based tool)</strong></td>
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<tr>
<td>ASC-11: Cataracts—Improvement in patient’s visual function within 90 Days following cataract surgery</td>
<td>Suspended ²</td>
<td>Voluntary Reporting ¹</td>
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<tr>
<td><strong>Endoscopy (Chart-abstracted, submitted by ASCs via QualityNet web-based tool)</strong></td>
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<tr>
<td>ASC-9: Endoscopy/Poly Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients</td>
<td>X</td>
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<td>ASC-10: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use</td>
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<td><strong>Healthcare Associated Infection (collected and submitted by ASCs via NHSN)</strong></td>
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<td>ASC-8: Influenza Vaccination Coverage Among Healthcare Personnel</td>
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<td><strong>Hospital Visit Rates (Claims-Based, Calculated by CMS)</strong></td>
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<td>ASC-12: Facility 7-Day risk-standardized hospital visit rate after outpatient colonoscopy</td>
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<td><strong>Structural Measures (Collected and submitted by ASCs via QualityNet web-based tool)</strong></td>
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<td>ASC-6: Safe Surgery Checklist Use</td>
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<td>ASC-7: ASC Facility Procedural Volumes on Selected ASC Procedures</td>
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</table>

¹ Proposed in the CY 2015 OPPS proposed rule.
² Per CMS announcement on April 2, 2014.