CY13 OPPS Proposed Rule Fact Sheet

Introduction
The Centers for Medicare & Medicaid Services (CMS) released a proposed rule with comment period that updates payment rates for hospital outpatient services paid under the Medicare outpatient prospective payment system (OPPS) and establishes relative payment weights and amounts for services furnished in ambulatory surgical centers (ASCs) for the calendar year 2013 (CY13) ASC payment system. These proposed changes will be applicable to services furnished to Medicare beneficiaries beginning January 1, 2013. CMS also proposes to update the requirements for both the Hospital Outpatient Quality Reporting (OQR) Program, as well as the ASC Quality Reporting (ASCQR) program. CMS also proposes revisions to the electronic reporting pilot for the Electronic Health Record (EHR) Incentive Program and the various regulations governing Quality Improvement Organizations (QIOs). Comments on the proposal are due September 4, 2012.

CY12 OPPS Final Updates Impact Table
The table below reflects the impact of the final rule on hospitals after all CY13 updates have been made. CMS provides a more comprehensive list in Table 45 of the proposed rule.

CY13 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	2.1
Urban Hospitals	2.1
Rural Hospitals	2.2
Teaching Status	
Non-Teaching	2.3
Minor	1.9
Major	2.0

Under the proposal, CMS estimates that total payments, including beneficiary cost-sharing for CY13 to facilities paid under the OPPS, would be approximately ***$48.1 billion***, an increase of approximately $4.6 billion compared to CY12 payments.

OPPS Payment Rate Updates

Section 1833(t)(3)(C)(ii) of the Social Security Act (the Act) requires CMS to update the conversion factor used to determine payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. The OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges. Section 1833(t)(3)(F)(i) of the Act, as amended by the Affordable Care Act (ACA), requires that the OPD fee schedule increase factor be reduced by the productivity adjustment for 2012 and subsequent years. The productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (MFP), which is proposed at ***0.8 percent*** for FY13. Additionally, sections 1833(t)(3)(F)(ii) and 1833(t)(3)(G)(ii)of the Act requires that the OPD fee schedule increase factor be reduced by ***0.1 percent*** for CY13.

CMS proposes to increase payment rates under the OPPS by an OPD fee schedule increase factor of ***2.1 percent*** for the CY13 OPPS. This reflects the 3.0 percent proposed estimate of the hospital inpatient market basket percentage increase, minus the proposed 0.8 percent MFP adjustment, and the additional 0.1 percent reduction required by the ACA.

Hospitals that fail to meet the reporting requirements of the Hospital OQR Program will continue to be subject to a further reduction of an additional ***2.0 percent*** from the OPD fee schedule increase factor adjustment to the conversion factor that would be used to calculate the OPPS payment rates. As a result, those hospitals would receive an OPD fee schedule increase factor of ***0.1 percent*** (3.0 percent, which is the proposed estimate of the hospital inpatient market basket percentage increase, less the proposed 0.8 percent MFP adjustment, less the 0.1 percent additional adjustment, less 2.0 percent for the Hospital OQR Program reduction).

The table below reflects the CY13 OPPS proposed payment update calculations for hospitals that submit quality data and those that do not.

Impact of Proposed CY13 OPPS Updates

Market Basket Increase	(Minus) MFP Adjustment	(Minus) ACA Reduction	**FY13 Payment Increase**
3.0	0.8	0.1	**2.1**

Impact of Proposed CY13 OPPS Updates (No Quality Data)

Market Basket Increase	(Minus) MFP Adjustment	(Minus) ACA Reduction	(Minus) Hospital OQR Reduction	**FY13 Payment Increase**
3.0	0.8	0.1	2.0	**0.1**

To set the OPPS conversion factor for CY13, CMS proposes to increase the CY12 conversion factor of $70.016 by 2.1 percent. CMS would further adjust the conversion factor for CY13 to ensure that any revisions it makes to the updates for a revised wage index and rural adjustment are made on a budget neutral basis. CMS calculated an overall ***proposed budget neutrality factor of 1.0003*** for wage index changes by comparing proposed total estimated payments from its simulation model using the proposed FY13 IPPS wage indices to those payments using the current (FY12) IPPS wage indices, as adopted on a calendar year basis for the OPPS. Since CMS

is not proposing to make a change to its rural adjustment policy for CY13, the ***proposed budget neutrality factor for the rural adjustment is 1.0000***. CMS calculated an overall proposed budget neutrality factor of 1.0003 for wage index changes.

For the proposed rule, CMS estimates that pass-through spending for both drugs and biologicals and devices for CY13 would equal approximately $84 million, which represents 0.18 percent of total projected CY13 OPPS spending. Finally, ***estimated payments for outliers would remain at 1.0 percent of total OPPS payments for CY13***.***The proposed conversion factor for CY13 is $71.537***.

To calculate the proposed CY13 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the Hospital OQR Program for the full CY13 payment update, CMS proposes to make all other adjustments discussed above, but using a proposed reduced OPD fee schedule update factor of 0.1 percent (that is, the proposed OPD fee schedule increase factor of 2.1 percent, further reduced by 2.0 percent for failure to comply with the Hospital OQR requirements). This would result in a ***proposed reduced conversion factor for CY13 of $70.106*** (a difference of -$1.431 in the conversion factor relative to those hospitals that met the Hospital OQR requirements).

Outpatient Outlier Threshold Policy Update

For CY12, the fixed-dollar threshold is $1,900. For CY13, CMS has estimated a ***proposed fixed-dollar threshold of $2,400.*** CMS proposes that the hospital outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC Payment amount and exceeds the APC payment rate plus the $2,400 fixed-dollar threshold. CMS estimated that a proposed fixed-dollar threshold of $2,400, combined with the proposed multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments. CMS is proposing to continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the proposed fixed-dollar threshold of $2,400 are met.

If a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. For hospitals that fail to meet the Hospital OQR Program requirements, CMS proposes to continue the policy implemented in CY10, which compares the hospitals' costs to the reduced payments for purposes of outlier eligibility and payment calculation.

Adjustment for Rural SCHs and EACHs

In the CY06 OPPS final rule with comment period (70 FR 68556), CMS finalized a payment increase for rural sole community hospitals (SCHs) of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and devices paid under the pass-through payment policy. This increase was made after CMS found that a difference in cost by APC existed between hospitals in rural areas and hospitals in urban areas. This adjustment for rural SCHs is budget neutral and applied before calculating outliers and

copayments. CMS provided the same 7.1 percent adjustment to rural SCHs, including essential community access hospitals (EACHs), again in CY08 through CY11. For CY13, CMS is proposing to continue an adjustment of 7.1 percent to the OPPS payments to certain rural SCHs, including EACHs. This adjustment would apply to all services paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

CY13 Proposed PHP APC Update

For CY13, CMS proposes to develop the relative payment weights that underpin the OPPS using geometric means rather than the current median-based methodology. This proposal to base the relative payment weights on geometric means would also apply to the per diem costs used to determine the relative payment weights for the four Partial Hospitalization Program (PHP) Ambulatory Payment Classifications (APCs). As with the current median-based methodology, the PHP APC payment rates would continue to be calculated by computing a separate per diem cost for each day of PHP services. When there are multiple days of PHP services entered on a claim, a unique cost would continue to be computed for each day of care. However, a geometric mean would be used to calculate the per diem costs rather than a median. The process would still be repeated separately for CMHCs and hospital-based PHPs using that provider's claims data for the two categories of days with 3 services and days with 4 or more services.

For CY13, using CY11 claims data, CMS computed proposed CMHC PHP APC geometric mean per diem costs for Level I (3 services per day) and Level II (4 or more services per day) services using only CY11 CMHC claims data, and proposed hospital-based PHP APC geometric mean per diem costs for Level I and Level II services using only CY11 hospital-based PHP claims data.

The proposed CY13 geometric mean per diem costs for the PHP APCs are shown below (Tables 32 and 33 of the final rule).

APC	Group Title	Final Median Per Diem Costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	$87.76
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$111.89

APC	Group Title	Final Median Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$182.66
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$232.74

Hospital Outpatient Quality Reporting Program Updates

CMS has implemented quality measure reporting programs for multiple settings of care. These programs promote higher quality, more efficient health care for Medicare beneficiaries. The quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Reporting (Hospital OQR) Program (formerly known as the Hospital Outpatient Quality Data Reporting Program), has been generally modeled after the quality data reporting program for hospital inpatient services known as the Hospital Inpatient Quality Reporting (Hospital IQR) Program (formerly known as the Reporting Hospital Quality Data for Annual Payment Update Program). Both of these quality reporting programs for hospital services have financial incentives for the reporting of quality data to CMS. For the Hospital OQR Program, CMS is not proposing any new measures for CY13.

Proposed Process for Retention of Hospital OQR Program Measures Adopted in Previous Payment Determinations

In past rulemakings, CMS has proposed to retain previously adopted measures for each payment determination on a year-by-year basis and invited public comments on the proposal to retain such measures for all future payment determinations unless otherwise specified. For the purpose of streamlining the rulemaking process, beginning with this rulemaking, CMS proposes that when it adopts measures for the Hospital OQR Program beginning with a payment determination and subsequent years, these measures are automatically adopted for all subsequent year payment determinations unless it proposes to remove, suspend, or replace the measures.

Suspension of One Chart-Abstracted Measure for the CY14 and Subsequent Years Payment Determinations

In the 2012 IPPS/LTCH PPS final rule, CMS adopted a policy to immediately suspend collection of a measure when there is a reason to believe that continued collection of the measure raises patient safety concerns. For CY14 and subsequent year payments, CMS confirmed that it suspended the collection of the *OP-19: Transition Record with Specified Elements Received by Discharged Patients* measure. CMS adopted the measure for the Hospital OQR Program for the CY13 payment determination, with data collection beginning with January 1, 2012, encounters. However, since data collection for this measure began, concerns have been raised about the current measure specifications, including potential privacy concerns which may lead to potential patient harm in the form of family violence. After consideration of these issues and internal review of the measure specifications, CMS decided to suspend until further notice data collection for OP-19, effective with January 1, 2012, encounters. When NQF completes its maintenance review on this measure, and CMS has incorporated the necessary changes to the measure specifications in its measure manual, it anticipates being able to resume data collection, and will notify hospitals of changes in the suspension status of the measure for Hospital OQR via e-mail blast.

Deferred Data Collection of OP-24: Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting for the CY14 Payment Determination

In the CY12 OPPS/ASC final rule with comment period, CMS finalized *OP-24: Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting* for CY14 payment

determination, and indicated that the applicable quarters for data collection for this measure would be first and second quarter CY13. In order for CMS to adhere to this data collection schedule, it would need to publish the measure specifications in the July 2012 release of the *Hospital OQR Specifications Manual*. Further, in order to implement standardized data collection on a national scale, CMS must include detailed abstraction instructions for chart-based measures in its *Specifications Manual*. These instructions will not be completed and tested in time to include in the July 2012 release of the manual, which includes collection instructions for measures beginning January 1, 2013. Therefore, CMS is proposing to defer the data collection for this measure to January 1, 2014, encounters. CMS also proposes that the measure would not be used for the CY14 payment determination, and that its first application would be for the CY15 payments.

Hospital OQR Program Measures for the CY14 Payment Determination and Subsequent Years

CMS is not proposing any additional measures for the CY14 payment determination year. Readers are referred to the following OPPS/ASC final rules with comment periods for a history of measures adopted for the Hospital OQR Program, including lists of: 11 measures finalized for the CY11 payment determination; 15 measures finalized for the CY12 payment determination; 23 measures finalized for the CY13 payment determination; and 26 measures finalized for the CY14 and CY15 payment determinations.

Proposed Chart-Abstracted Measure Requirements for CY14 and Subsequent Payment Determination Years

For the chart-abstracted measures for which CMS is proposing to collect data for the CY14 payment determination, the applicable quarters for data collection would be as follows: third quarter CY12, fourth quarter CY12, first quarter CY13, and second quarter CY13 for hospitals that are continuing participants. Newly participating hospitals would follow reporting requirements as outlined in the CY12 OPPS/ASC final rule with comment period, and in section XV.G.1.of this proposed rule. For the CY15 payment determination, CMS proposes that the applicable quarters for previously finalized chart-abstracted measures would be as follows: third quarter CY13, fourth quarter CY13, first quarter CY14, and second quarter CY14.

Quality Measures for CY15 Payment Determination

CMS previously finalized 26 measures for the CY15 Hospital OQR Program measure set in the 2012 OPPS/ASC rulemaking. Because CMS has suspended data collection for the OP-19 measure until further notice, CMS is proposing to retain the 25 measures previously adopted for the CY14 payment determination for CY15 and subsequent year payment determinations.

The table below contains the previously adopted measures that CMS proposes to retain for the CY14, CY15, and subsequent year payment determinations under the Hospital OQR Program.

Hospital OQR Program Measures Adopted for the CY14, CY15, and Subsequent Year Payment Determinations
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention

OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data
OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low Risk Surgery
OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache
OP-16: Troponin Results for Emergency Department Acute Myocardial Infarction (AMI) Patients or Chest Pain Patients (with Probable Cardiac Chest Pain) Received Within 60 Minutes of Arrival
OP-17: Tracking Clinical Results Between Visits
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
OP-19: Transition Record with Specified Elements Received by Discharged ED Patients
OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
OP-21: ED- Median Time to Pain Management for Long Bone Fracture
OP-22: ED Patient Left Without Being Seen
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
OP-24: Cardiac Rehabilitation Patient Referral from an Outpatient Setting
OP-25: Safe Surgery Checklist Use
OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures

Procedure Category	**Corresponding HCPCS Codes**
Gastrointestinal	40000 through 49999, G0104, G0105,G0121,C9716, C9724, C9725, 0170T
Eye	65000 through 68999, 0186, 0124T, 0099T, 0017T, 0016T, 0123T, 0100T, 0176T, 0177T, 0186T, 0190T, 0191T, 0192T, 76510, 0099T

Nervous System	61000 through 64999, G0260, 0027T, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0062T
Musculoskeletal	20000 through 29999, 0101T, 0102T, 0062T, 0200T, 0201T
Skin	10000 through 19999, G0247, 0046T, 0268T, G0127, C9726, C9727
Genitourinary	50000 through 58999, 0193T, 58805
Cardiovascular	33000 through 37999
Respiratory	30000 through 32999

Possible Quality Measures under Consideration for Future Inclusion in the Hospital OQR Program

CMS seeks to develop a comprehensive set of quality measures to be available for widespread use for informed decision making and quality improvement in the hospital outpatient setting. Therefore, through future rules, it intends to propose new measures that help further goals of achieving better health care and improved health for Medicare beneficiaries who receive health care in hospital outpatient settings. In addition, CMS is considering initiating a call for input to assess the following measure domains: clinical quality of care; care coordination; patient safety; patient and caregiver experience of care; population/community health; and efficiency. CMS believes this approach will promote better care while bringing the Hospital OQR Program in line with other established quality reporting and pay for performance programs such as the Hospital IQR and ASCQR Programs.

Randomly Selected Hospitals

In the CY12 OPPS/ASC final rule with comment period, similar to its approach for the CY12 payment determination, CMS adopted a policy to validate chart-abstracted patient-level data submitted directly to CMS from randomly selected hospitals for the CY13 payment determination. For the CY13 payment determination, CMS reduced the number of randomly selected hospitals from 800 to 450, and proposes to continue this policy for the CY14 payment determination and for subsequent years. In the CY12 OPPS/ASC final rule**,** CMS also finalized its intent to select an additional 50 hospitals selected based on specific criteria designed to measure whether the data these hospitals have reported raises a concern regarding data accuracy. At this time, CMS is not proposing any additional targeting criteria to use in selecting the additional 50 hospitals it includes in the validation process for CY14 payment determination or in subsequent years.

Proposed Methodology for Encounter Selection for the CY14 Payment Determination and Subsequent Years

For each selected hospital (random or targeted), CMS is proposing to continue the approach it adopted in the CY12 OPPS/ASC final rule with comment period for the CY14 payment determination and subsequent years. For CY14, for each selected hospital (random or targeted), CMS would continue to validate up to 48 randomly selected patient encounters (12 per quarter; 48 per year) from the total number of encounters that the hospital successfully submitted to the OPPS clinical warehouse. If a selected hospital has submitted less than 12 encounters in one or more quarters, only those encounters available would be validated. For each selected encounter, a designated CMS contractor would request that the hospital submit the complete supporting

medical record documentation that corresponds to the encounter. CMS proposes to conduct a measures level validation by calculating each measure within a submitted record using the independently abstracted data, and then comparing this to the measure reported by the hospital; a percent agreement would then be calculated.

To receive the full OPPS OPD fee schedule increase factor for CY14, CMS proposes that hospitals must attain at least a 75 percent reliability score, based upon the proposed validation process. CMS would use the upper bound of a two-tailed 95 percent confidence interval to estimate the validation score. CMS proposes to calculate the validation score and use the same medical record documentation submission procedures and the same methodology it finalized for the CY12 and CY13 payment determinations.

Proposed CY12 Packaged Revenue Codes

As it did for CY12, CMS reviewed for CY13 the changes to revenue codes that were effective during CY11 for purposes of determining the charges reported with revenue codes but without HCPCS codes that it would propose to package for CY13. CMS believes that the charges reported under the revenue codes listed in the Table 3 of the final rule continue to reflect ancillary and supportive services for which hospitals report charges without HCPCS codes. Therefore, for CY13, CMS is proposing to continue to package the costs that it derives from the charges reported without HCPCS codes under the revenue codes listed in Table 3 for purposes of calculating the geometric mean costs on which the proposed CY13 OPPS/ASC payment rates are based.

APC Updates

New Technology APCs

CMS generally keeps a procedure in the new technology APC to which it is initially assigned until it has collected sufficient data to enable it to move the procedure to a clinically appropriate APC. However, in cases where it finds that its original new technology APC assignment was based on inaccurate or inadequate information, or where the new technology APCs are restructured, it may, based on more recent resource utilization information (including claims data) or the availability of refined new technology APC cost bands, reassign the procedure or service to a different new technology APC that more appropriately reflects its cost. Consistent with its current policy, for CY13, CMS proposes to retain services within new technology APC groups until it gathers sufficient claims data to enable it to assign the service to a clinically appropriate APC.

The table below lists the HCPCS G-codes and associated status indicators that CMS is proposing to reassign from new technology APCs 1505, 1506, and 1508 to APC 0661 for CY13.

CY12 HCPCS Code	CY12 Short Descriptor	CY12 SI	CY12 APC	Proposed CY13 SI	Proposed CY13 APC
G0417	Sat biopsy prostate 21-40	S	1505	X	0661

G0418	Sat biopsy prostate 41-60		1506	X	0661
G0419	Sat biopsy prostate: >60	S	1508	X	0661

Calculation of Composite APC Criteria-Based Costs

As discussed in the CY08 OPPS/ASC final rule with comment period, CMS believes it is important that the OPPS enhance incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible. For CY08, CMS developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. Under the OPPS, CMS currently has composite policies for extended assessment and management services, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation services, mental health services, multiple imaging services, and cardiac resynchronization therapy services. For CY13, CMS proposes to continue its composite policies for these services. The following table displays the proposed and current costs of the extended assessment and management, low dose rate (LDR) prostate brachytherapy, and cardiac electrophysiologic evaluation and ablation composite APCs.

Composite APC	**CY13 Proposed Cost**	**Current Amount**
8002	$446	$393
8003	$813	$721
8001	$3,362	$3,340
8000	$11,458	$11,313

The proposed rule's Table 9 lists the proposed groups of procedures upon which CMS would base composite APC 8000 for CY13.

- *Mental Health Services Composite APC (APC 0034)*
  CMS is proposing that when the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services exceeds the maximum per diem partial hospitalization payment, those specified mental health services would be assigned to APC 0034 (Mental Health Services Composite). CMS is proposing to continue to set the payment rate for APC 0034 at the same rate as it is proposing to pay for APC 0176 (Level II Partial Hospitalization [4 or more services] for Hospital-Based PHPs), which is the maximum partial hospitalization per diem payment, and that the hospital would continue to be paid one unit of APC 0034.

- *Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)*
  For CY13, CMS is proposing to continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology.

The proposed CY13 payment rates for the five multiple imaging composite APCs (APC 8004, APC 8005, APC 8006, APC 8007, and APC 8008) are based on costs calculated from a partial year of CY11 claims available for this CY13 OPPS/ASC proposed rule that qualified for composite payment under the current policy (that is, those claims with more than one procedure within the same family on a single date of service).

Table 10 of the proposed rule lists the HCPCS codes that will be subject to the multiple imaging composite policy and their respective families and approximate composite APC median costs for CY13.

Extended Assessment and Management Composite APCs

For CY13, CMS proposes to continue the extended assessment and management composite APC payment methodology and criteria for APCs 8002 and 8003 finalized for CY09 throughCY12. CMS continues to believe that the composite APCs 8002 and 8003 and related policies provide the most appropriate means of paying for these services. CMS also proposes to calculate the costs for APCs 8002 and 8003 using the same methodology that it used to calculate the costs for these APCs for the CY08 OPPS. That is, it would use all single and "pseudo" single procedure claims from CY11 that met the criteria for payment of each composite APC, and apply the standard packaging and trimming rules to the claims before calculating the proposed CY13 costs. ***The proposed CY13 cost resulting from this methodology for composite APC 8002 is approximately $446***, which was calculated from 17,072 single and "pseudo" single bills that met the required criteria. ***The proposed CY13 cost for composite APC 8003 is approximately $813***, which was calculated from 255,231 single and "pseudo" single bills that met the required criteria.

Proposed Pass-Through Payments for Devices

Under the OPPS, a category of devices are eligible for transitional pass-through payments for at least 2, but not more than 3 years.

Device Pass-through Category	**Established for Pass-through Payments**	**Eligibility Term Ends**	**Payment Expiration Date**
C1830	October 1, 2011	End of CY13	December 31, 2013
C1840	October 1, 2011	End of CY13	December 31, 2013
C1886	January 1, 2012	End of CY13	December 31, 2013

Device pass-through categories C1830 and C1840 were established for pass-through payments on October 1, 2011, and will reach the end of their eligibility term as of the end of CY13. Also, device pass-through category C1886 was established for pass-through payments on January 1, 2012, and will also reach the end of its eligibility term as of the end of CY13. Therefore, CMS proposes a pass-through payment expiration date for device categories C1830, C1840, and C1886 of December 31, 2013. Beginning January 1, 2014, these device categories will no longer be eligible for pass-through payments, and their respective device costs would be packaged into

the costs of the procedures with which the devices are reported in the claims data.

Proposed Drugs and Biologicals with Expiring Pass-through Status in CY12

CMS is proposing that the pass-through status of 23 drugs and biologicals would expire on December 31, 2012, as listed in Table 22 of the proposed rule (see below). All of these drugs and biologicals will have received OPPS pass-through payment for at least two years and no more than three years by December 31, 2012. These drugs and biologicals were approved for pass-through status on or before January 1, 2011. Table 22 contains the proposed pass-through status of 23 drugs and biologicals that would expire on December 31, 2012.

TABLE 22.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS WILL EXPIRE DECEMBER 31, 2012

Proposed CY13 HCPCS Code	Proposed CY13 Long Descriptor	Proposed CY13 SI	Proposed CY13 APC
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	N	N/A
C9279	Injection, ibuprofen, 100 mg	N	N/A
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	K	9367
J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg	K	1413
J0588	Injection, incobotulinumtoxin A, 1 unit	K	9278
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	K	9269
J0775	Injection, collagenase clostridium histolyticum, 0.01 mg	K	1340
J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram	K	9274
J0897	Injection, denosumab, 1 mg	K	9272
J1290	Injection, ecallantide, 1 mg	K	9263
J1557	Injection, immune globulin (Gammaplex), intravenous, nonlyophilized (e.g. liquid), 500 mg	K	9270
J3095	Injection, telavancin, 10 mg	K	9258
J3262	Injection, tocilizumab, 1 mg	K	9264
J3357	Injection, ustekinumab, 1 mg	K	9261
J3385	Injection, velaglucerase alfa, 100 units	K	9271
J7183	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	N	N/A
J7335	Capsaicin 8% patch,per 10 square centimeters	K	9268

J8562	Fludarabine phosphate, oral, 10 mg	K	
J9043	Injection, cabazitaxel, 1 mg	K	1339
J9302	Injection, ofatumumab, 10 mg	K	9260
J9307	Injection, pralatrexate, 1 mg	K	9259
J9315	Injection, romidepsin, 1 mg	K	9265
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	K	9273

The 21 drugs and biologicals that CMS is proposing to continue on pass-through status for CY13 or that have been granted pass-through status as of July 2012 are displayed in Table 23 of the proposed rule.

Cancer Hospitals

Payment Adjustment

For CY13, CMS proposes to continue its policy to provide additional payments to cancer hospitals so that the hospital's payment-to-cost ratio (PCR) with the payment adjustment is equal to the weighted average PCR for the other OPPS hospitals using the most recent submitted or settled cost report data. Based on those data, a proposed target PCR of 0.91 would be used to determine the CY13 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment amount associated with the cancer hospital payment adjustment would be the additional payment needed to result in a proposed PCR equal to 0.91 for each cancer hospital.

Conversion Factor Update

The difference in the CY13 estimated payments due to applying the proposed CY13 cancer hospital payment adjustment relative to the CY12 final cancer hospital payment adjustment does not have a significant impact on the budget neutrality calculation. Therefore, CMS is proposing to apply a proposed budget neutrality adjustment factor of 1.0000 to the conversion factor to ensure that the cancer hospital payment adjustment is budget neutral.

Supervision of Hospital Outpatient Therapeutic Services

In the proposed rule, CMS clarifies the application of the supervision regulations to physical therapy, speech-language pathology, and occupational therapy services that are furnished in OPPS hospitals and CAHs. CMS also proposes to extend the enforcement instruction for CAHs and certain small rural hospitals for one final year through CY13.

Ambulatory Surgical Centers

Payment Rate Updates

The ASC payment system is updated annually by the consumer price index for all urban consumers (CPI-U). For CY13, CMS is proposing to increase payment rates under the ASC payment system by an MFP-adjusted CPI-U update factor of ***1.3 percent***. The following table displays the CY13 proposed rate update calculations under the ASC payment system.

CPI-U update	(Minus) MFP	**MFP-Adjusted**

	Adjustment	**CPI-U Update**
2.2 %	0.9%	**1.3 %**

CMS is also are proposing to adjust the ***CY12 ASC conversion factor ($42.627)*** by the wage adjustment for ***budget neutrality of 1.0002*** in addition to the MFP-adjusted update factor of 1.3 percent, which results in a ***proposed CY13 ASC conversion factor of $43.190***. Based on this update, CMS estimates that total ASC payments, including beneficiary cost-sharing, for CY13 would be approximately ***$4.103 billion***, an increase of approximately ***$211 million*** compared to estimated CY12 payments.

Proposed Payment Reduction for ASCs That Fail to Meet the ASCQR Program Requirements

The HHS secretary is authorized to implement the revised ASC payment system "in a manner so as to provide for a reduction in any annual update for failure to report on quality measures." Any ASC that does not submit quality measures will incur a 2.0 percent reduction to any annual increase provided under the revised ASC payment system for such year. This reduction would apply beginning with the CY14 payment rates. A reduction for one year cannot be taken into account in computing any annual increase factor for a subsequent year. To implement the requirement to reduce the annual update for ASCs that fail to meet the ASC quality reporting program (ASCQR) Program requirements, CMS is proposing to calculate two conversion factors: a full update conversion factor and an ASCQR Program reduced update conversion factor.

ASCQR Program Quality Measures

In the CY12 OPPS/ASC final rule with comment period, CMS finalized its proposal to implement the ASCQR Program beginning with the CY14 payment determination and adopted measures for the CY14, CY15, and CY16 payment determinations. CMS also finalized its policy to retain measures from one calendar year payment determination to the next so that measures adopted for a previous payment determination year would be retained for subsequent years.

CY14 Final Measures

CMS adopted the following five claims-based measures for the CY14 payment determination for services furnished between October 1, 2012, and December 31, 2012:

- Patient Burns (NQF #0263)
- Patient Fall (NQF #0266)
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (NQF #0267)
- Hospital Transfer/Admission (NQF #0265)
- Prophylactic Intravenous (IV) Antibiotic Timing (NQF #0264)

CY15 Final Measures

For the CY15 payment determination, CMS retained the five claims-based measures it adopted for the CY14 payment determination and adopted the following two structural measures:

- Safe Surgery Checklist Use

- ASC Facility Volume Data on Selected ASC Surgical Procedures

CMS specified that reporting for the structural measures would be between July 1, 2013, and August 15, 2013, for services furnished between January 1, 2012, and December 31, 2012, using an online measure submission web page available at: https://www.QualityNet.org.

CMS did not specify the data collection period for the five claims-based measures for the CY15 payment determination.

CY16 Final Measures

For the CY16 payment determination, CMS finalized the retention of the seven measures from the CY15 payment determination (five claims-based measures and two structural measures). It also adopted the following NQF-endorsed measure, for a total of eight measures:

- Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431), a process of care, healthcare-associated infection measure

CMS specified that data collection for the influenza vaccination measure would be via the National Healthcare Safety Network from October 1, 2014, through March 31, 2015. CMS did not specify the data collection period for the claims-based or structural measures. Considering the time and effort required to develop, align, and implement the infrastructure necessary to collect data on the ASCQR Program measures and make payment determinations, and the time and effort required on the part of ASCs to plan and prepare for quality reporting, at this time CMS is not proposing to delete or add any quality measures for the ASCQR Program for the CY14, CY15, and CY16 payment determination years, or to adopt quality measures for subsequent payment determination years.

Form, Manner, and Timing for Claims-Based Measures for the CY14 and CY15 Payment Determination and Subsequent Years

To be eligible for the full CY14 ASC annual payment update, an ASC must submit complete data on individual quality measures through a claims-based reporting mechanism by submitting the appropriate quality data codes on the ASC's Medicare claims. The data collection period for the CY14 payment determination is established as the Medicare fee-for-service ASC claims submitted for services furnished between October 1, 2012, and December 31, 2012. In the FY13 IPPS/LTCH PPS proposed rule, CMS proposed that claims for services furnished between these dates would have to be paid by the administrative contractor by April 30, 2013, to be included in the data used for the CY14 payment determination. CMS believes that this claim paid date would allow ASCs sufficient time to submit claims while allowing sufficient time for CMS to complete required data analysis and processing to make payment determinations and to supply this information to administrative contractors.

For the CY15 payment determination and subsequent payment determination years, CMS proposes that the data collection period for claims-based measures will be for the calendar year two years prior to a payment determination. CMS is also proposing that the claims for services furnished in each calendar year would have to be paid by the administrative contractor by

April 30 of the following year of the ending data collection time period to be included in the data used for the payment determination. Thus, for example, for the CY15 payment determination, the data collection period would be claims for services furnished in CY13 (January 1, 2013, through December 31, 2013), which are paid by the administrative contractor by April 30, 2014.

Regulatory Impact Analysis

CMS estimates that the effects of the proposed OPPS payment provisions will result in expenditures exceeding $100 million in any 1 year, and that the total increase from the proposed changes in this proposed rule in expenditures under the OPPS for CY13 compared to CY12 would be approximately ***$700 million***. Considering its estimated changes in enrollment, utilization, and case-mix, CMS estimates that the OPPS expenditures for CY13 would be approximately ***$4.571 billion*** relative to CY12. The total increase (from proposed changes in this proposed rule, as well as enrollment, utilization, and case-mix changes) in expenditures under the ASC payment system for CY13 compared to CY12 would be approximately ***$211 million***.

Comments

CMS will accept comments on the proposed rule until September 4, 2012.

Publication Information

Read the proposed rule, published in the July 30, 2012, *Federal Register*.