Calendar Year 2015 OPPS Update

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The Centers for Medicare and Medicaid Services (CMS) released a final rule providing required adjustments to the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year (CY) 2015 on October 31, 2014. Ensuring an understanding of these changes will allow facilities, providers, and suppliers to see CMS's direction for 2015 and plan accordingly. The public comment period closed on December 30, 2014 and the final rule became effective on January 1, 2015.

The full list of CY 2015 OPPS changes is available on the CMS website at www.cms.gov.

OPPS Payment Update

For CY 2015, CMS payment rates to providers under the OPPS are expected to increase by 2.3 percent. It is approximated that 4,000 healthcare facilities are paid under the OPPS. These facilities include general acute care hospitals, children's hospitals, cancer hospitals, and community mental health centers. It is worth noting that there are over 70 community mental health centers which are only paid for partial hospitalization services under the OPPS.

OPPS Conversion Factor Update

Section 1833(t)(3)(C)(ii) of the Social Security Act requires CMS to annually update the conversion factor which is used to determine the payment rates under the OPPS. CMS will increase the CY 2014 conversion factor of $72.672 by 2.1 percent. For the CY 2015 OPPS, a full conversion factor of $74.176 is proposed. A reduction is applied to hospitals who fail to meet Hospital Outpatient Quality Reporting Program reporting guidelines.

Hospital Outpatient Outlier Payments

Per the final rule, "The OPPS provides outlier payments to hospitals to help mitigate the financial risk associated with high-cost and complex procedures, where a very costly service could present a hospital with significant financial loss." The final rule states that for a hospital to receive an outlier payment under this plan, the cost of a service must exceed the multiple threshold of 1.75 times the ambulatory payment classifications (APC) payment rate and exceed the CY 2015 fixed dollar threshold of the APC payment plus $2,775.

Rural Hospital Adjustments

According to the final rule, there were no significant impacts to CY 2015 payment policies for hospitals that are eligible for the rural adjustment or for the cancer hospital payment adjustment. CMS will continue the adjustment of 7.1 percent to the OPPS payments to certain rural sole community hospitals. This adjustment will include essential access community hospitals. The adjustment will apply to all services paid under the OPPS but will exclude separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

Cancer Hospital Payment Adjustments

Additional payments to cancer hospitals for CY 2015 will continue and have not changed from CY 2014. This is provided so that the cancer hospital's payment-to-cost ratio (PCR), after the additional payments, is equal to the weighted average PCR

for the other OPPS hospitals using the most recently submitted or settled cost report data. A target PCR of 0.89 will be used to determine the cancer hospital payment adjustment to be paid at cost report settlement.

Comprehensive APCs

A policy for comprehensive APCs, or C-APCs, was first finalized in the CY 2014 final rule. Comprehensive APCs are now being implemented in CY 2015 with modifications. Some lower cost device-dependent APCs are now included that were not discussed in the 2014 proposed rule. The purpose of C-APCs is to provide a single comprehensive payment for services assigned to C-APCs and provide the hospital with improved incentives to provide efficient and high quality care at a lower cost. Payment for the comprehensive service, which is defined as primary service and all related items and services, was packaged or "bundled" into a single payment under the OPPS. This will not only result in a single payment, but also a single beneficiary co-payment under the OPPS for the comprehensive service based on all charges on claim. This is likened to inpatient hospital payments made under the inpatient prospective payment system. Comprehensive APCs are sometimes unofficially referred to as "mini-DRGs" in the healthcare field.

ASC Payment Rates and Conversion Factor Update

The final rule increases payment rates under the ASC payment system by 1.4 percent. This increase is based on a projected consumer price index for all urban consumers update of 1.9 percent minus a multifactor productivity adjustment required by the Affordable Care Act that is projected to be 0.5 percentage point. The estimated total payment to ASCs for CY 2015 is approximated at $4.147 billion. This is an increase of approximately $236 million when compared to the estimated Medicare payments for CY 2014. The ASC conversion factor for CY 2015 is $43.918. This is a 1.2 percent increase from the CY 2014 conversion factor of $43.471. For ASCs that do not meet the quality reporting requirements, as defined by the ASC Quality Measure Reporting Program, there is a reduced conversion factor of $43.050.

Revision of Requirements for Physician Certification of Hospital Inpatient Services

Currently, CMS requires a physician certification for all inpatient admissions. For CY 2015, the final rule will require the physician certification only for outlier cases and long stay cases of 20 days or more. This will apply to hospital inpatient admission other than psychiatric inpatient services. CMS feels that the additional benefits, such as a program safeguard, of formally requiring a physician certification may not outweigh the associated administrative requirements placed on hospitals. The admission order will continue to be required for all inpatient admissions when a patient has been formally admitted as an inpatient of the hospital.

Off-Campus Provider-Based Departments

CMS will begin to collect data on services furnished in off-campus provider-based departments beginning in 2015 by requiring hospitals and physicians to report a HCPCS modifier for those services furnished in an off-campus provider-based department on both hospital and physician claims. The modifier will be reported on both the CMS-1500 claim form for physicians' services and the UB-04 form (CMS Form 1450) for hospital outpatient services.

This data collection will serve to assist in seeking a better understanding of how the growing trend toward hospital acquisition of physicians' offices and subsequent treatment of those locations as off-campus provider-based departments of hospitals affects payments under the Medicare physician fee schedule and the OPPS, as well as beneficiary cost-sharing obligations. It will also contribute towards determining the appropriateness of increased Medicare payment and beneficiary cost-sharing when physicians' offices become hospital outpatient departments.

Reference

Centers for Medicare and Medicaid Services. "Hospital Outpatient Prospective Payment—Final Rule with Comment Period and CY2015 Payment Rates." CMS-1613-FC. 2015. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html.

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