2013 Ambulatory Surgery Center and Outpatient Prospective Payment System Final Rule Summary

On Nov. 15, 2012, CMS released the 2013 hospital outpatient prospective and ambulatory surgery center payment systems final rule in the Federal Register. The rule revises the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year (CY) 2013, and describes the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and the ASC payment systems. In addition, CMS updates and refines the requirements for the ASC Quality Reporting (ASCQR) Program.

Ambulatory Surgery Centers (ASC)

Updates to the ASC Payment System
CMS increased payment rates under the ASC payment system by an adjusted consumer price index-urban (CPI-U) update factor of 1.3 percent. CMS also adjusted the CY 2013 ASC conversion factor ($42.627) by the wage adjustment for budget neutrality of 1.0002, in addition to the multifactor productivity (MFP)-adjusted update factor of 1.3 percent, which results in a proposed CY 2013 ASC conversion factor of $43.190.

CMS proposes a continuation of the established policy of basing the ASC update on the CPI-U. However, CMS is seeking public comment on the type of cost information that would be feasible to collect from ASCs in the future in order to determine if an alternative update or an ASC-specific market basket would be a better proxy for ASC cost inflation than the CPI-U.

CMS is basing the OPPS relative payment weights on geometric mean costs for CY 2013 (see HOPD section below for additional information). The ASC system would shift to the use of geometric means to determine relative payment weights under the ASC standard rate-setting methodology.

Update to List of ASC-Covered Surgical Procedures and Covered Ancillary Services
CMS has maintained the temporary office-based designations for the following codes:

- CPT code 0226T [anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed]
- CPT code 0227T [anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)]

Requirements for the Ambulatory Surgical Centers Quality Reporting Program
In the CY 2012 OPPS/ASC final rule with comment period, CMS finalized its proposal to implement the ASCQR program beginning with the CY 2014 payment determination. CMS adopted quality measures for calendar years 2014, 2015 and 2016 payment determination years and finalized some data collection and reporting timeframes for these measures. CMS also adopted policies with respect to the maintenance of technical specifications and updating of measures, publication of ASCQR program data, and for the CY

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2014 payment determination, data collection and submission requirements for the claims-based measures. CMS later issued proposals for administrative requirements, data completeness requirements, extraordinary circumstances waiver or extension requests, and a reconsideration process as part of the FY 2013 inpatient payment prospective system proposed rule.

**Payment Reductions for ASCs Failing to Meet ASCQR Program Requirements**

To implement the requirement to reduce the annual update for ASCs that fail to meet the ASCQR program requirements, CMS calculated the reduced national unadjusted payment rates. CMS states that application of the 2 percentage point reduction to the annual update factor, which currently is the CPI-U, may result in the update to the ASC payment system being less than zero for a year for ASCs that fail to meet the ASCQR program requirements. The reduced rates would apply beginning in CY 2014.

**ASCQR Program Quality Measures**

CMS does not propose any new measures for the ASCQR program. The list of measures previously finalized for the ASCQR program in the CY 2012 ASC/OPPS final rule is below.

<table>
<thead>
<tr>
<th>ASC Program Measurement Set Adopted in Previous Rulemaking</th>
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<tbody>
<tr>
<td>ASC-1: Patient burn*</td>
</tr>
<tr>
<td>ASC-2: Patient fall*</td>
</tr>
<tr>
<td>ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant*</td>
</tr>
<tr>
<td>ASC-4: Hospital transfer/admission*</td>
</tr>
<tr>
<td>ASC-5: Prophylactic intravenous (IV) antibiotic timing*</td>
</tr>
<tr>
<td>ASC-6: Safe surgery checklist use**</td>
</tr>
<tr>
<td>ASC-7: ASC facility volume data on selected ASC surgical procedures**</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Procedure</th>
<th>Corresponding HCPCS Codes</th>
</tr>
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<tbody>
<tr>
<td>Gastrointestinal</td>
<td>40000 through 49999, 40104, G0105, G0121, C9716, C9724, C9725, and 0170T</td>
</tr>
<tr>
<td>ASC- 8: Influenza vaccination coverage among health-care personnel***</td>
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</tbody>
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* New measure for the CY 2014 payment determination.
** New measure for the CY 2015 payment determination.
*** New measure for the CY 2016 payment determination.

Moving forward, CMS intends to expand any measure set adopted for the ASCQR program to further align ASC quality measure requirements with those of other reporting programs, including the hospital outpatient quality reporting (OQR) program, so that the burden for reporting will be reduced. While it is not required to adopt NQF-endorsed measures for the ASCQR, CMS prefers measures that have been NQF endorsed. CMS also states that it plans to apply the following principles in future measure selection and development for the ASCQR program:

- Support the national quality strategy’s three-part aim by creating transparency around the quality of care at ASCs to support patient decision-making and quality improvement.
- Move as quickly as possible to the use of primarily outcome and patient experience measures.
- Align measures across public reporting and payment systems under Medicare and Medicaid.
- Adopt electronic-specified measures so that data can be calculated and submitted via certified electronic health record technology with minimal burden, and use measures based on alternative sources of data that do not require chart abstraction or that use data already being reported by ASCs.
- Consider the measure application partnership’s recommendations in selecting quality and efficiency measures.
- Adopt measures developed with the input of providers and other stakeholders and that are aligned with best practices.

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Consider the HHS strategic plan and initiatives and the CMS strategic plan.

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 ASC setting, and intends to propose new measures that address clinical quality of care, patient safety, and patient and caregiver experience of care, in the future. CMS also seeks comment on the inclusion of procedure-specific measures for colonoscopy, endoscopy and anesthesia-related complications in the ASCQR program measure set.

Requirements for Reporting of ASC Quality Data
CMS has previously established that, to be eligible for the full CY 2014 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 (QDCs) on claims submitted for services furnished between Oct. 1 and Dec. 31, 2012. The claims would have to be paid by the administrative contractor by April 30, 2013, to be included in the data used for the CY 2014 payment determination.

For the CY 2015 payment determination and subsequent payment determination years, CMS proposes that an ASC must submit complete data on individual quality claims-based measures through a claims-based reporting mechanism by submitting the appropriate QDCs on the ASC’s Medicare claims. The data collection period for such claims-based measures would be the calendar year two years prior to a payment determination. CMS also proposes 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. For example, for the CY 2015 payment determination, the data collection period is Jan. 1 through Dec. 31, 2013, and claims would have to be paid by the administrative contractor by April 30, 2014.

In addition, CMS previously established that data completeness for claims-based measures for the CY 2014 payment determination will be determined by comparing the number of claims meeting measure specifications that contain the appropriate QDCs with the number of claims that would meet measure specifications, but did not have the appropriate QDCs on the submitted claims. For the CY 2015 payment determination and subsequent payment determination years, CMS proposes the same methodology for determining data completeness as was established for the CY 2014 payment determination. CMS notes that the claims used will include claims in which Medicare is either the primary or secondary payor.

CMS has also established that, for the CY 2014 and CY 2015 payment determination years, the minimum threshold for successful reporting be at least 50 percent of claims meeting measure specifications containing QDCs. CMS intends to increase this percentage for subsequent payment determination years as ASC’s become more familiar with reporting requirements for the ASCQR program.

Hospital Outpatient Departments (HOPD)

Updates Affecting OPPS Payments

Conversion Factor Update
CMS increased payment rates under the OPPS by 2.1 percent for CY 2013. The CMS conversion factor for CY 2013 of $71.537 is comprised of the fee schedule increase factor, the required wage index budget neutrality adjustment of approximately 1.0003, the cancer hospital payment adjustment of 1.000, and the adjustment of 0.04 percent of projected OPPS spending for the difference in the pass-through spending.
To calculate the CY 2013 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the Hospital Outpatient Quality Reporting (OQR) Program for the full CY 2013 payment update, CMS made all other adjustments discussed above, but will use a reduced fee schedule update factor of 0.1 percent (that is, the fee schedule increase factor of 2.1 percent further reduced by 2 percentage points for failure to comply with the hospital OQR requirements). This results in a reduced conversion factor for CY 2013 of $70.106 for those hospitals that fail to meet the hospital OQR requirements (a difference of $1.431 in the conversion factor relative to those hospitals that meet the hospital OQR requirements).

**Recalibration of APC Relative Weights**

For the CY 2013 OPPS, CMS recalibrated the APC relative payment weights for services furnished on or after Jan. 1, 2013, and before Jan. 1, 2014 (CY 2013), using some portion of approximately 95 percent of CY 2011 claims containing services payable under the OPPS.

CMS has historically based HOPD payments on median hospital costs for services in the APC groups. However, the agency established the cost-based relative payment weights of the CY 2013 OPPS using geometric mean costs.

**Expiration of Pass-Through Payment for Device**

CMS decided to sunset the C1749 *(endoscope, retrograde imaging/illumination colonoscope device)* pass-through status, effective Jan. 31, 2012. Beginning Jan. 1, 2013, CMS will package the C1749 device costs into the costs of the procedures with which the device is reported in the claims data.

**OPPS Policy and Payment Recommendations**

CMS explains that the Medicare Payment Advisory Commission (MedPAC), the Office of the Inspector General (OIG) and the Government Accountability Office (GAO) frequently make recommendations on OPPS policy and payment. Both the OIG and GAO have not made any recommendations nor issued any reports regarding OPPS policy or payment since the CY2012 OPPS/ASC final rule. MedPAC, however, recommended that Congress increase payment rates for the outpatient prospective payment system in 2013 by 1 percent. In addition, MedPAC recommended that Congress enact legislation to reduce payment rates for evaluation and management office visits provided in hospital outpatient departments to the rates paid for these services in physician offices. MedPAC also recommended that the secretary of HHS conduct a study by January 2015 to examine whether this policy change would reduce access by low-income patients to ambulatory physician and other services.

CMS has proposed payment updates for HOPDs under its statutory authority; however, as Congress has yet to accept the latter two recommendations nor enact legislation addressing these recommendations, CMS does not propose any changes to evaluation and management services paid under the OPPS.