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Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

Calendar Year 2012 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rules Released by CMS

By: Mark A. Stanley

CMS recently released its Calendar Year (CY) 2012 Proposed Rule for outpatient services furnished in hospitals and ASCs. Among the highlights in the proposed rule are an exception process for expansion of physician-owned hospitals, which is otherwise strictly limited by the Affordable Care Act (ACA), and modifications to the Hospital Value-Based Purchasing program. The proposed rule may be viewed here [PDF]. Comments on the Proposed Rule must be received by CMS no later than 5 PM EDT on **August 30, 2011**.

CMS anticipates that total payments under the OPPS for CY 2012 will be $41.9 billion, and that payments to ASCs will be $3.61 billion.

Proposed Changes to the OPPS

The proposed rule projects a market basket update for CY 2012 of 1.5 percent. This reflects the 2.8 percent market basket update projected for IPPS services, minus 1.3 percent in adjustments mandated by the ACA.

Among other changes, the proposed rule would:

- Increase OPPS payments to cancer hospital, in order to reflect CMS's conclusion that the reasonable cost of services provided in cancer hospitals significantly exceeds the cost of services furnished in other hospitals. Each cancer hospital would receive a hospital-specific payment adjustment that reflects the difference between such hospital's profit to cost ratio (PCR) and the average PCR of hospitals for services furnished under the OPPS. The projected 9 percent increase in payments to cancer hospitals would be applied

in a budget-neutral fashion and would therefore result in a decrease in payment to other providers.

- Set payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals at the manufacturer's average sales price plus 4 percent. The payment rate would not apply to new drugs and biologicals, which qualify for pass-through payment.
- Establish payment systems for partial hospitalization services furnished in (1) hospital-based programs, and (2) freestanding community mental health centers. Each system would be two-tiered: Level I reflecting days with three services; and Level II reflecting days with four or more services.
- Create an independent advisory review process regarding the appropriate levels of supervision (other than direct supervision) for services furnished in a hospital outpatient department. This advisory review process is a new wrinkle in CMS's ongoing attempt to establish supervision levels, starting with the CY 2010 OPPS final rule. For background on CMS's rulemaking on this issue, see "CMS Proposes Additional Changes to the Outpatient Physician Supervision Requirements."
- Add to the list of quality measures that are reported by providers in either CY 2012 or 2013 for purposes of CY 2014 payment. The rule would also modify the validation process for quality measures, by decreasing the number of hospitals randomly selected for validation from 800 to 450. The rule would create criteria to allow the selection of up to 50 additional hospitals for targeted validation of their reporting.

Payment to Ambulatory Surgical Centers

CMS anticipates a 0.9 percent update to ASC payments in CY 2012, which reflects a consumer price index for urban consumers of 2.3 percent minus a productivity adjustment of 1.4 percent.

The proposed rule would establish a quality reporting program for ASCs, which would begin with eight quality measures to be reported in CY 2012. The measures would include seven outcome and surgical infection control measures and one healthcare associated infection measure. CMS is also proposing to add three additional quality reporting measures in CY 2013. This would include measures

based on safe surgery checklist use, facility volume data for selected ASC surgical procedures, and influenza vaccination among healthcare personnel.

Physician-Owned Hospitals

The proposed rule would establish a process for physician-owned hospitals to expand facility capacity. The ACA prohibits expansion of such facilities, effective March 23, 2010. However, Section 6001(a)(3) of the ACA requires CMS to establish a process for granting exceptions to the general prohibition on expansion. The proposed rule would allow expansion of hospitals that satisfy certain inpatient admission, bed capacity, and bed occupancy criteria, and would also allow "high Medicaid facilities" to qualify for expansion. Hospitals would qualify based on data taken from the CMS Healthcare Cost Report Information System (HCRIS). In order to assist hospitals in determining whether they qualify for expansion, CMS will publicly post the relevant comparison data regarding average Medicaid admissions per county, average bed capacity per State, national average bed capacity, and average bed occupancy per State. The data will be made available here.

Hospital Value-Based Purchasing (HVBP) Program

The proposed rule would add one measure to the HVBP program's 12 existing clinical process of care measures. The new measure would relate to processes to guard against infections from urinary catheters. The rule would also establish a new weighting scheme for the Fiscal Year (FY) 2014 HVBP program. The rule would add a new outcome domain (weighted at 30 percent) and efficiency domain (weighted at 20 percent) for FY 2014. CMS would reduce the weighting for the clinical process of care domain from 70 percent to 20 percent, and retain the patient experience of care domain weighting of 30 percent. For more on the HVBP program, see "Quality & Efficiency: Key Themes in the Fiscal Year (FY) 2012 IPPS Proposed Rule."