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**CMS Proposes HOPD and ASC Payment Policy and Rate Updates  
for 2012**

By Christopher Anderson\*

On July 1, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule with policy and payment changes for Hospital Outpatient Departments (HOPDs) and Ambulatory Surgical Centers (ASCs). The proposed rule would affect Medicare payments commencing in calendar year (CY) 2012. The proposed rule will be published in the July 18, 2011, *Federal Register*. Highlights of the proposed rule include the following:

- *HOPD and ASC Payment Rates.* The proposed rule updates payment rates for services furnished to Medicare beneficiaries in HOPDs under the Outpatient Prospective Payment System (OPPS) and ASCs under the ASC payment system. The proposed rule projects an OPPS fee schedule increase factor for CY 2012 of 1.5%. As to ASCs, CMS is proposing to apply a 0.9% update for CY 2012. CMS estimates that hospitals for which disproportionate share hospital (DSH) payments are not available would experience a decrease in Medicare payment of 7.5% to 7.7% due to those hospitals furnishing a large number of psychiatric services (for which reimbursement under one of the principal ambulatory payment classifications (APCs) has declined).
- *Material Change to Cancer Hospital Rate.* The proposed rule applies an adjustment to each cancer hospital's OPPS payments that would increase OPPS payments to cancer hospitals as a class by 38.8%. Most cancer hospitals would no longer qualify for Transitional Outpatient Payments (TOPs). CMS estimates an overall net increase in total payments to cancer hospitals, after adjusting for the elimination of TOPs, of 9%.
- *Payments for Separately Payable Drugs and Biologicals.* CMS proposes paying for the acquisition and pharmacy overhead costs

of separately payable drugs and biologicals, other than new drugs and biologicals that have pass-through status, at the manufacturers' average sales price (ASP) plus 4%.

- *Payment for Partial Hospitalization Services.* The proposed rule determines the payment for partial hospitalization services in hospital-based programs and freestanding community mental health centers (CMHCs) by establishing two payment tiers—Level I for days with three services, and Level II for days with four or more services. A payment rate is proposed for each payment tier for CMHCs based on CMHC cost data, and a second payment rate is proposed for each payment tier for hospitals based on hospital data.
- *Outpatient Supervision Levels.* There are no changes proposed to hospital outpatient diagnostic supervision levels. CMS proposes to modify the manner in which the minimum levels of supervision for therapeutic services provided in hospital outpatient departments are determined by establishing the Ambulatory Payment Classification (APC) Panel as the independent review panel to make recommendations to CMS regarding whether individual outpatient hospital therapeutic services should be furnished under general, direct, or personal supervision. CMS is also proposing to add representatives of Critical Access Hospitals (CAHs) to the Panel solely for deliberations relating to supervision levels. Parties would be permitted to request a change to the supervision level assigned to services. CMS proposes to adopt the definitions of the terms "personal" and "general" supervision in Medicare Physician Fee Schedule for purposes of interpreting the requirements for providing services to hospital outpatients. CMS anticipates that it will extend the notice of nonenforcement for direct supervision in CAHs and rural hospitals through CY 2012. CMS also proposes changes to clarify that all hospital outpatient therapeutic services that are paid for under OPSS are subject to certain payment conditions including the provider-based and under arrangements rules. CMS specifically states its intent to prevent ASCs from furnishing hospital outpatient services under arrangements.
- *Medicare Electronic Health Record Incentive Program.* CMS proposes changes that would allow eligible hospitals and CAHs to report clinical quality measures (CQM) for 2012 by participating in an electronic reporting pilot or, alternatively, to continue to attest to CQM results as they did for the 2011 payment year.
- *Hospital Outpatient Quality Reporting (OQR) Program.* CMS proposes adding nine quality measures for purposes of the CY 2014 payment determination, and modifies the process for validating hospital reporting of chart-abstracted measures that was adopted for CY 2012 in the CY 2011 OPSS rule. CMS is proposing to reduce the number of hospitals randomly selected for the validation of chart-abstracted measures from 800 to 450. In addition, CMS proposes selecting up to fifty additional hospitals for targeted validation based on criteria that suggest data quality concerns (failing a validation requirement or providing a measure value that appears to be an outlier).
- *ASC Quality Reporting Program.* CMS proposes a quality reporting program for ASCs that includes eight quality measures beginning

in CY 2012 for the CY 2014 payment determination. ASCs would be required to report a quality data code on all claims. The proposed measures include seven outcome and surgical infection control measures and one healthcare-associated infection measure reported through the National Healthcare Safety Network. CMS also is proposing to add two structural measures for reporting in CY 2013 for the CY 2015 payment determination—one for safe surgery checklist use, and one for ASC facility volume data on selected ASC surgical procedures. CMS also is proposing to add one measure on influenza vaccination coverage among healthcare personnel for reporting beginning in CY 2013 for the CY 2016 payment determination.

- *Hospital Value-Based Purchasing Program (HVBP)*. CMS proposes to retain all thirteen of the clinical process-of-care and patient-experience-of-care measures and add one clinical process-of-care measure to guard against infections from urinary catheters. CMS is also proposing to establish the performance periods, standards, and a weighting scheme for the FY 2014 Hospital HVBP program and a review and correction process for the HVBP program.
- *Expansion of Physician-Owned Hospitals*. CMS proposes a process for certain physician-owned hospitals to apply for an exception to the prohibition on expansion of facility capacity. The proposed process mirrors the statutory criteria set forth in the Affordable Care Act. CMS estimates 265 physician-owned hospitals are eligible to apply for the exception. CMS notes a physician-owned hospital may apply once every two years and that the two-year rule will also apply to "high Medicaid facilities," which otherwise have a separate application process from other physician-owned hospitals.
- *Hospital Patient Notification Requirement*. CMS proposes rules reducing the categories of hospital outpatients who must receive written notice by the hospital if a hospital does not have a physician on-site 24/7. The proposed rule would only require a written notice be provided to those outpatients who receive observation services, surgery, or services involving anesthesia.

The proposed rule is available for public comment until Aug. 30, 2011.

CMS has issued a [press release](#) and a [fact sheet](#) to accompany the rule's release.

*\*We would like to thank Christopher Anderson, Esquire (Salem & Green, Sacramento, CA), for providing this email alert.*

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