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

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CMS has released its Calendar Year (CY) 2012 final rule with comment period for outpatient services furnished in hospitals and ASCs. In addition to establishing payment rates for CY 2012, the final rule also expands the measures to be reported under the Hospital Outpatient Quality Reporting Program, and modifies the Hospital Value-Based Purchasing program. The final rule also establishes an exception process for expansion of physician-owned hospitals, which is otherwise strictly limited by the Affordable Care Act (ACA). The final rule may be viewed here [PDF].

CMS anticipates that total payments under the OPPS for CY 2012 will be approximately $41.1 billion, and that payments to ASCs will be approximately $3.5 billion.

Changes to the OPPS

The final rule will increase payment rates under the OPPS by 1.9 percent in CY 2012. This reflects the 3.0 percent projected market basket update for IPPS services, minus 1.1 percent in adjustments mandated by the ACA.

Among other changes, the final rule will:

- Increase OPPS payments to cancer hospitals for outpatient services provided in CY 2012. Each cancer hospital will receive a hospital-specific payment adjustment that reflects the difference between such hospital's profit to cost ratio (PCR) and the target PCR as defined in the final rule. CMS estimates that

the adjustment to cancer hospital payment rates will increase payments to these hospitals by 11.3 percent. In response to comments, the payment increase will be in the form of an aggregate payment at cost report settlement, thus avoiding the budget-neutrality adjustment to non-cancer hospitals.

- Set payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at the manufacturer's average sales price plus 4 percent. The payment rate will not apply to new drugs and biologicals, which qualify for pass-through payment.
- Update payment systems for partial hospitalization services furnished in hospital-based programs and community mental health centers. Each system will be two-tiered: Level I, reflecting days with three services; and Level II, reflecting days with four or more services.
- Create a review process regarding the appropriate levels of supervision (other than direct supervision) for outpatient therapeutic services. The Ambulatory Payment Classification Panel will consider requests for changes in the required level of supervision. This 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 CY 2012 and 2013 for purposes of CY 2014 and CY 2015 payment determinations. The rule will also modify the validation process for quality measures, by decreasing the number of hospitals randomly selected for validation from 800 to 450. The rule will also permit CMS to select up to 50 additional hospitals for targeted validation based on criteria that reflect possible data quality concerns.

Payment to Ambulatory Surgical Centers

Under the final rule, payment rates to ASCs will increase by 1.6 percent in CY 2012. The increase reflects a consumer price index for urban consumers of 2.7 percent, minus a productivity adjustment of 1.1 percent.

The final rule also establishes a quality reporting program for ASCs that includes five quality measures to be reported in CY 2012. The program will initially include four outcome measures and one surgical infection control measure that will affect payment determinations in CY 2014. CMS has also added two structural measures to be reported beginning in CY 2013, including one measure based on safe surgery checklist use and another measure based on facility volume data for selected ASC surgical procedures.

Hospital Value-Based Purchasing (HVBP) Program

The final rule expands the HVBP program in Fiscal Year (FY) 2014 by adding a new clinical process measure to guard against infections due to urinary catheters. The final rule also establishes the performance periods and standards for FY 2014. Value-based incentive payments will be based on clinical processes of care, patient experiences, and outcomes. Clinical process of care measures will account for 45 percent of the hospital's total performance score. CMS has retained the 30 percent weighting for the patient experience domain. The outcome domain will be weighted at 25 percent of the total performance score in an effort to increase hospital focus on patient safety initiatives. For more on the HVBP program, *see* "Quality & Efficiency: Key Themes in the Fiscal Year (FY) 2012 IPPS Proposed Rule."

Physician-Owned Hospitals

The final rule establishes 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 final rule allows expansion of hospitals that satisfy certain inpatient admission, bed capacity, and bed occupancy criteria.

The final rule will appear in the November 30, 2011 *Federal Register*. CMS will accept comments on issues that are open for comment by January 3, 2012, and will respond to them in the CY 2013 rule.