CY12 OPPS Final Rule Fact Sheet

Introduction

The Centers for Medicare & Medicaid Services (CMS) released a final rule with comment period that updates payment rates for hospital outpatient services paid under the Medicare outpatient prospective payment system (OPPS) and establishes relative payment weights and amounts for services furnished in ambulatory surgical centers (ASCs) for the calendar year 2012 (CY12) ASC payment system. These final changes will be applicable to services furnished on or after January 1, 2012. CMS also proposes to update the requirements for both the Hospital Outpatient Quality Reporting (OQR) Program, as well as the ASC Quality Reporting System, and make additional changes to the provisions of the Hospital Inpatient Value-Based Purchasing (VBP) Program. The final rule is effective January 1, 2012. Comments on the proposal are due January 3, 2012.

CY12 OPPS Final Updates Impact Table

The table below reflects the impact of the final rule on hospitals after all CY12 updates have been made. CMS provides a more comprehensive list in Table 59 of the final rule.

CY12 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	1.9
Urban Hospitals	1.9
Rural Hospitals	1.5
Teaching Status	
Non-Teaching	1.9
Minor	1.8
Major	1.9

OPPS Payment Rate Updates

CMS is required to update the conversion factor used to determine payment rates under the OPPS on an annual basis by applying the outpatient department (OPD) fee schedule increase factor. The OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges. Section 1833(t)(3)(F)(i) of the Social Security Act (the Act), as amended by the Affordable Care Act (ACA), requires that the OPD fee schedule increase factor be reduced by the productivity adjustment for 2012 and subsequent years. The productivity adjustment is equal to the 10-year moving average of changes in annual

economy-wide, private nonfarm business multifactor productivity (MFP), which is 1.0 percent for FY12. The OPD fee schedule increase factor will be further reduced by a 0.1 percent adjustment, as mandated by the ACA.

Thus, CMS applies an OPD fee schedule increase factor of 1.9 percent for the CY12 OPPS. This reflects the 3.0 percent final estimate of the hospital market basket increase, minus the 1.0 percent MFP adjustment, and the additional 0.1 percent reduction mandated by the ACA provisions. Hospitals that fail to meet the reporting requirements of the Hospital OQR Program will continue to be subject to a further reduction of an additional 2.0 percent from the OPD fee schedule increase factor adjustment to the conversion factor that would be used to calculate the OPPS payment rates. Overall, CMS estimates that the OPPS rates for CY12 will have a positive effect for providers paid under the OPPS, resulting in a 1.9 percent estimated increase in Medicare payments. Excluding payments to cancer and children's hospitals (because their payments are held harmless to the pre-OPPS ratio between payment and cost) and removing payments to community mental health centers (CMHCs) suggest that these changes **will result in a 1.9 percent estimated increase in Medicare payments to all other hospitals**.

To set the OPPS conversion factor for CY12, CMS increased the CY11 conversion factor of $68.876 by 1.9 percent. CMS further adjusted the conversion factor for CY12 to ensure that any revisions it makes to the updates for a revised wage index and rural adjustment are made on a budget neutral basis. CMS calculated an overall budget neutrality factor of 1.0005 for wage index changes. Since CMS is not making a change to the rural adjustment policy for CY12, the budget neutrality factor for the rural adjustment is 1.0000. The CY12 budget neutrality adjustment factor for cancer hospitals is 0.9978.

The OPD fee schedule increase factor of 1.9 percent for CY12, along with the required wage index budget neutrality adjustment of approximately 1.0005, the cancer hospital payment adjustment of 0.9978, and the adjustment of 0.07 percent of projected OPPS spending for the difference in the pass-through spending result in a conversion factor for **CY12 of $70.016**, which reflects the full OPD fee schedule increase, after including the required ACA adjustments.

The reduced market basket conversion factor for those hospitals that fail to meet Hospital OQR program requirements for the full CY12 payment update is **$68.616**. This calculation reflects all of the ACA adjustments, including the reduced OPD fee schedule update factor of -0.1 percent.

Outpatient Outlier Threshold Policy Update

CMS maintains the target outlier percent of 1.0 percent of estimated aggregate total payment under the OPPS and has a fixed-dollar threshold so that OPPS outlier payments are made only when the hospital would experience a significant loss for supplying a particular service. For CY12, based on updated data, CMS has established a **fixed-dollar threshold of $1,900** which, together with a multiple threshold of 1.75, will enable it to meet its target outlier payment of 1 percent of total OPPS spending. For CY12, CMS will apply the overall cost-to-charge ratios (CCRs) from the July 2011 Outpatient Provider-Specific File with a CCR adjustment factor of 0.9903 to approximate CY12 CCRs to charges on the final CY10 claims that were adjusted to approximate CY12 charges (using the final 2-year charge inflation factor of 1.0794). CMS

simulated aggregated CY12 hospital outlier payments using the costs for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payment would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY11 OPPS payments. CMS estimates that a fixed-dollar threshold of $1,900, combined with the multiple threshold of 1.75 times the APC payment rate, will allocate 1.0 percent of estimated aggregated total OPPS payments to outlier payments.

Essentially, CMS will continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the final fixed-dollar threshold of $1,900 are met. If a community mental health center's (CMHC's) cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. CMS estimates that this threshold will allocate 0.12 percent of outlier payments to CMHCs for partial hospitalization program (PHP) outlier payments.

Adjustment for Rural SCHs and EACHs

In the CY06 OPPS final rule with comment period (70 FR 68556), CMS finalized a payment increase for rural sole community hospitals (SCHs) of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and devices paid under the pass-through payment policy. This increase was made after CMS found that a difference in cost by APC existed between hospitals in rural areas and hospitals in urban areas. This adjustment for rural SCHs is budget neutral and applied before calculating outliers and copayment. CMS provided the same 7.1 percent adjustment to rural SCHs, including essential community access hospitals (EACHs), again in CY08 through CY11. **For the CY12 OPPS, CMS finalizes its policy of a budget neutral 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.** In the CY12 OPPS proposed rule, CMS noted that it intends to reassess the 7.1 percent adjustment in the near future by examining differences between urban and rural hospitals' costs using updated claims, cost reports, and provider information.

CMS did not receive any public comments regarding the proposed continuation of the 7.1 rural adjustment. Therefore, it is finalizing its CY12 proposal, without modification, to apply the payment adjustment to rural SCHs, including EACHs, for all services and procedures paid under the OPPS in CY12, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs because it continues to believe that the adjustment is appropriate for application in CY12.

Partial Hospitalization Program (PHP) Service Payments

In the CY12 OPPS/ASC proposed rule, to develop the proposed payment rates for the PHP APCs CMS used CY10 claims data and computed median per diem costs in the categories of days with

3 services and days with 4 or more services. It also proposed to determine (1) the relative payment weights for PHP services provided by CMHCs based on cost data derived solely from CMHCs and (2) the relative payment weights for hospital-based PHP services based exclusively on hospital cost data. After consideration of the public comments received, CMS finalizes its CY12 proposal, without modification, to update the four PHP per diem payment rates based on the median cost levels calculated using the most recent claims data for each provider type. **The updated PHP APCs median per diem costs for PHP services that CMS is finalizing for CY12 are shown below (Tables 44-45 of the final rule).**

APC	Group Title	Final Median Per Diem Costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	$97.64
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$113.83

APC	Group Title	Final Median Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$160.74
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$191.16

CMS will calculate the CMHC PHP APC per diem payment rates for Level I and Level II services using only CMHC data and calculate the hospital-based PHP APC per diem payment rates for Level I and Level II services using only hospital-based PHP data. CMS notes that the data continue to show the decline in costs for CMHCs, and it believes that the proposed median per diem costs for CMHCs accurately reflect the cost data of the CMHCs.

Hospital Outpatient Quality Reporting Program Updates

CMS has implemented quality measure reporting programs that promote higher quality, more efficient health care for Medicare beneficiaries for multiple settings of care. The Hospital OQR program for hospital outpatient care has financial incentives for the reporting of quality data to CMS. For CY12, CMS proposes to add nine new quality measures to the current list of 23 measures to be reported by hospital outpatient departments, bringing the total number of measures to 32 for the CY14 payment determination. After consideration of comments received, CMS is not finalizing the surgical site infection measure. It is also not finalizing the five diabetes care measures at this time. However, CMS intends to re-propose these measures at a future date.

CMS is finalizing the following measures:

One new chart-abstracted measure

- **Cardiac Rehabilitation Measure: Cardiac Rehabilitation Patient Referral from an Outpatient Setting (NQF #0643)**

Two New Structural Measures

- **Safe Surgery Checklist Use measure**
- **Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures**

The complete measure set (26 measures) for the Hospital OQR Program CY14 payment determination, including the 23 measures it previously adopted in the CY11 OPPS/ASC final rule with comment period, can be found on pages (1138-1140) of the final rule.

CMS proposed that all of the measures finalized for the CY14 payment determination continue to be used for the CY15 payment determination. Since CMS did not receive any comments objecting to the retention of the CY14 measures, it will finalize the retention of these 26 measures for the CY15 payment determination. In the CY12 OPPS final rule, CMS also proposed to adopt an additional hospital-acquired infection (HAI) measure entitled Influenza Vaccination Coverage among Healthcare Personnel (HCP) (NQF # 0431). This measure is currently collected by the CDC via the National Healthcare Safety Network (NHSN). Due to the significant impact of HCP influenza vaccination on patient outcomes, CMS believes this measure is appropriate for measuring the quality of care in hospital outpatient departments. **After consideration of comments received, CMS is not finalizing the HCP Influenza Vaccination measure for CY15 payment determination in the final rule, but intends to propose a HCP Influenza Vaccination measure for the CY16 payment determination once measure refinements and operational issues have been addressed.** The complete measure set for the Hospital OQR Program CY15 payment determination, can be found in a table on pages (1149-1151) of the final rule.

In the OPPS proposed rule, CMS provided a list of potential measurements that it is considering for future Hospital OQR payment determinations (beginning with CY15) for which it solicited public comment. CMS received many comments on measures and measurement topics considered for the future, and will take them into consideration during its future measure selection activity.

Randomly Selected Hospitals

In the CY12 proposed rule, CMS proposed to validate chart-abstracted data submitted directly to CMS from randomly selected hospitals for the CY13 payment determination (similar to its approach for the CY12 payment determination). To reduce hospital burden and to facilitate efforts to reallocate resources in the event that it finalizes the targeting proposal, for the CY13 payment determination**, CMS proposed to reduce the number of randomly selected hospitals from 800 to 450.** In addition to proposing to randomly select 450 hospitals for validation, **CMS also proposed to select up to an additional 50 hospitals based upon targeting criteria.** After consideration of the public comments received, **CMS finalized these proposals without modification.**

Encounter Selection and Validation Score Calculation

For each selected hospital (random or targeted), CMS proposed **to validate up to 48 randomly selected patient encounters (12 per quarter; 48 per year) from the total number of**

encounters that the hospital successfully submitted to the OPPS Clinical Warehouse. For each selected encounter, a designated CMS contractor would request that the hospital submit the supporting medical record documentation that corresponds to the encounter, then conduct a measures level validation by calculating each measure within a submitted record using the independently abstracted data and then comparing this to the measure reported by the hospital; a percent agreement would then be calculated. **To receive the full OPPS OPD fee schedule increase factor for CY13, CMS proposed that hospitals must attain at least a 75 percent reliability score,** based upon the proposed validation process. Because CMS did not receive any comments on its proposal regarding validation score calculation, **it is finalizing this proposal without modification**.

New CY12 Packaged Revenue Codes

CMS finalizes the proposed packaged revenue codes for CY12 without modification. The final packaged codes are included below in Table 2.

TABLE 2.—CY12 Packaged Revenue Codes

Revenue Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Svcs
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices; Other Implants
0279	Medical/Surgical Supplies and Devices; Other Supplies/Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals

0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling
0621	Medical Surgical Supplies – Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies – Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies – Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies – Extension of 027X; FDA Investigational Devices
0630	Pharmacy – Extension of 025X; Reserved
0631	Pharmacy – Extension of 025X; Single Source Drug
0632	Pharmacy – Extension of 025X; Multiple Source Drug
0633	Pharmacy – Extension of 025X; Restrictive Prescription
0681	Trauma Response; Level I Trauma
0682	Trauma Response; Level II Trauma
0683	Trauma Response; Level III Trauma
0684	Trauma Response; Level IV Trauma
0689	Trauma Response; Other
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0762	Specialty services; Observation Hours
0801	Inpatient Renal Dialysis; Inpatient Hemodialysis
0802	Inpatient Renal Dialysis; Inpatient Peritoneal Dialysis (Non-CAPD)
0803	Inpatient Renal Dialysis; Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
0804	Inpatient Renal Dialysis; Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
0809	Inpatient Renal Dialysis; Other Inpatient Dialysis
0810	Acquisition of Body Components; General Classification
0819	Inpatient Renal Dialysis; Other Donor
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite

	or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance – 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

Ambulatory Surgical Centers

Payment Rate Updates

The ASC payment system is updated annually by the consumer price index for all urban consumers (CPI-U). For CY12, based on updated data, the CPI-U for the 12-month period ending with the midpoint of CY12 is now estimated to be 2.7 percent. The ACA requires that the annual ASC payment update be reduced by a productivity adjustment. The multifactor productivity (MFP) adjustment (using the revised IGI series to proxy the labor index used in the MFP forecast calculation as discussed and finalized in the CY12 MPFS final rule with comment period) is 1.1 percent, resulting in an MFP-adjusted CPI-U update factor of 1.6 percent. **Therefore, CMS would apply a 1.6 percent MFP-adjusted update to the CY11 ASC conversion factor**.

After consideration of the public comments received, CMS is applying its established methodology for determining the final CY12 ASC conversion factor. Using more complete CY10 data for the final rule than was available for the proposed rule, CMS calculated a wage index budget neutrality adjustment of **1.0004**. **The final ASC conversion factor of $42.627** is the product of the CY11 conversion factor of **$41.939** multiplied by the wage index budget neutrality adjustment of **1.0004** and the MFP-adjusted CPI-U payment update of **1.6** percent.

Proposed ASC Quality Reporting Program

The HHS secretary is authorized to implement the revised ASC payment system "in a manner so as to provide for a reduction in any annual update for failure to report on quality measures." Any ASC that does not submit quality measures will incur a 2.0 percent reduction to any annual increase provided under the revised ASC payment system for such year. A reduction for one year cannot be taken into account in computing any annual increase factor for a subsequent year. A quality data reporting program for ASCs was not implemented in the CY11 OPPS/ASC final rule with comment period because CMS determined that it would be more appropriate to give some time for ASCs to acquire some experience with the revised ASC payment system implemented for CY08 before implementing new requirements, such as public reporting of quality measures.

In preparation for proposing an ASC quality reporting program, in the CY11 OPPS/ASC proposed rule, CMS requested public comment on the following measures under consideration for ASC quality data reporting:

- Patient Fall in the ASC
- Patient Burn
- Hospital Transfer/Admission
- Wrong Site, Side, Patient, Procedure, Implant
- Prophylactic IV Antibiotic Timing
- Appropriate Surgical Site Hair Removal
- Surgical Site Infection (SSI)
- Medication Administration Variance (MAV)
- Medication Reconciliation
- VTE Measures: Outcome/Assessment/Prophylaxis

In addition to preparing to propose implementation of an ASC quality reporting program, CMS developed a plan to implement a value-based purchasing (VBP) program for payments under the Medicare program. CMS noted that it does not currently have express statutory authority to implement an ASC VBP Program, but will develop the program and propose it through rulemaking should there be legislation authorizing it to do so.

CMS finalizes the ASC Quality Reporting Program, with data collection to begin on October 1, 2012. Also, based on comments received, CMS will delay required data submission until October 1, 2012, for the CY14 payment determination.

In the CY12 OPPS proposed rule, CMS proposed to adopt measures for three CY payment determinations for the ASC Quality Reporting Program (CY14, CY15, and CY16). To the extent that it finalizes some or all of the measures for future payment determinations, CMS noted that it would not be precluded from adopting additional measures or changing the list of measures for future payment determinations through annual rulemaking cycles so that it may address changing program needs arising from new legislation or from changes in HHS and CMS priorities. CMS believes this proposed process will assist ASCs in planning, meeting future reporting requirements, and implementing quality improvement efforts. It also provides CMS more time to develop, align, and implement the infrastructure necessary to collect data on the measures and make payment determinations. In the final rule, CMS finalizes its proposal to adopt quality measures for the CY14, CY15, and CY16 payment determinations.

In selecting proposed measures for the ASC Quality Reporting Program and other quality reporting programs, CMS has focused on measures that have a high impact on and support HHS and CMS priorities for improved healthcare outcomes, quality, safety, efficiency, and patient satisfaction. The goal for the future is to expand any measure set adopted for ASC quality reporting to address these priorities more fully and to align ASC quality measure requirements with those of other reporting programs as appropriate. CMS prefers to adopt measures that have been endorsed by the National Quality Forum because it is a national multi-stakeholder organization with a well documented and rigorous approach to consensus development. CMS's

CY14 measure proposals for ASCs align closely with those discussed in its Report to Congress, *Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan*, and with those proposed for future consideration in the CY11 OPPS/ASC proposed rule. The proposed measures also fall within the parameters of the ASC Quality Reporting Program framework.

CY14 Final Measures

In the proposed rule, CMS determined that the initial adoption of claims-based measures would ease the data collection burden on ASCs while providing sufficient time for ASCs to gain experience with quality reporting. Therefore, CMS proposed seven claims-based measures and 1 NHSN-based reporting measure for the first year of the ASC Quality Reporting Program. CMS also noted that if one or more of these measures are finalized as proposed, ASCs would need to begin submitting these QDCs on any Medicare Part B claims pertaining to the measures on January 1, 2012, in order to report this measure for purposes of the CY14 payment determination.

The initial measure set that CMS proposed for the CY14 payment determination address outcome measures and infection control process measures. Six of the eight initial proposed measures are recommended by the ASC Quality Collaborative (ASC QC) and are NQF-endorsed. The seventh measure is appropriate for measuring ambulatory surgical care, NQF-endorsed, currently in use in the Physician Quality Reporting System, and is similar to a measure that is being utilized in the Hospital OQR Program, and therefore aligns across settings in which outpatient surgery is performed. The eighth measure is an outcome measure of surgical site infection to be submitted in 2013 via the CDC's NHSN. Hospital inpatient departments will begin reporting this measure to the CDC under the Hospital Inpatient Quality Reporting Program in 2012, and CMS also proposed that hospital outpatient departments begin reporting the measure to the CDC under the Hospital OQR Program in 2013. Thus, this measure would be aligned across quality reporting programs for facilities performing surgery.

In the final rule, CMS adopts only five claims-based measures total using the QDC data collection mechanism for the CY14 payment determination. Based on comments received, CMS is finalizing the data submission for these five claims-based measures to begin on October 1, 2012.

The final ASC Quality Measures for the CY14 payment determination are:

- **Patient Burns (NQF #0263)**
- **Patient Fall (NQF #0266)**
- **Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (NQF #0267)**
- **Hospital Transfer/Admission (NQF #0265)**
- **Prophylactic Intravenous (IV) Antibiotic Timing (NQF #0264)**

CY15 Final Measures

For the **CY15 payment determination, CMS is retaining the five claims-based measures** finalized for the CY14 payment determination, and adding **the following two structural** measures, for a total of seven measures:

- **Safe Surgery Checklist Use**
- **ASC Facility Volume Data on Selected ASC Surgical Procedures**

CMS is finalizing the second proposed measure, ASC Facility Volume Data on Selected ASC Surgical Procedures, with a modification. CMS will further group the codes for commonly performed procedure types within the six broad categories. This information will be provided in an upcoming Specifications Manual release.

CY16 Final Measures

For the **CY16 payment determination, CMS is finalizing the retention of the seven measures finalized in the CY15 payment determination, and adopting the following NQF-endorsed HAI measure, for a total of eight measures: Influenza Vaccination Coverage among Healthcare Personnel (HCP) (NQF #0431)**

CMS is finalizing this measure with a modification. Because NQF's final review and an endorsement decision are pending with respect to the CDC's revised measure proposal, and at the request of commenters, CMS is changing the data collection timeframe from what it proposed. Data collection via NHSN will begin on October 1, 2014, and continue through March 31, 2015. Details for submission of this measure will be proposed in future rulemaking.

In the proposed rule, CMS provided a list of future measurement areas that it is considering for future ASC Quality Reporting Program payment determinations, and invited public comment on these quality measures and measurement topics so that it may consider proposing to adopt them for future ASC Quality Reporting Program payment determinations beginning with the CY15 payment determination. CMS thanks commenters for their input and recommendations for future measurement topics, and will take them into consideration in future measure selection efforts for this program.

Hospital Value-Based Purchasing (Hospital VBP) Program Proposals

The ACA mandates the establishment of a hospital inpatient value-based purchasing program under which value-based incentive payments are made to hospitals meeting performance standards. Value-based incentive payments under the Hospital Inpatient Value-Based Purchasing Program (Hospital VBP Program) are made to hospitals for discharges occurring on or after October 1, 2012. These incentive payments will be funded for FY13 through a reduction of 1.0 percent to the FY13 base operating DRG payment amount for each discharge, and this amount will rise to 1.25 percent in FY14. CMS issued the Hospital Inpatient VBP Program Final Rule in the May 6, 2011, *Federal Register*, which implemented the Hospital VBP Program.

FY13 Measures

For the FY13 Hospital VBP Program, CMS adopted 13 measures that it has already adopted for the Hospital IQR Program, categorized into two domains: clinical process of care and the patient experience of care. CMS adopted a 3-quarter performance period from July 1, 2011, through March 31, 2012, for these measures. To determine whether a hospital meets the proposed performance standards for these measures, CMS will compare each hospital's performance

during this performance period to its performance during a 3-quarter baseline period from July 1, 2009, through March 31, 2010.

CMS also finalized a methodology for assessing the total performance of each hospital based on performance standards under which CMS will score each hospital based on achievement and improvement ranges for each applicable measure. CMS will calculate a total performance score for each hospital by combining the greater of the hospital's achievement or improvement points for each measure to determine a score for each domain, weighting each domain score (which will be 70 percent for the clinical process of care and 30 percent for the patient experience of care), and adding together the weighted domain scores. CMS will then convert each hospital's total performance score into a value-based incentive payment using a linear exchange function.

FY14 Measures

For the FY14 Hospital VBP Program, CMS proposed to retain all 13 of the measures that it adopted for the FY13 Hospital VBP Program, which include 12 clinical process of care measures and the patient experience of care survey. CMS also proposed adding the following measure to the clinical process of care domain:

- SCIP-Inf-9: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2

After consideration of the public comments received, **CMS finalizes its proposal for the FY14 Hospital VBP Program, to retain the 13 clinical process of care measures, including SCIP-Inf-9, and the patient experience of care measure, composed of 8 dimensions of the HCAHPS survey.** Set out **in the table below are the finalized clinical process of care measures, the patient experience of care measure, and the mortality measures that will be included in the FY14 Hospital VBP Program**.

Clinical Process of Care, Patient Experience of Care and Outcome Measures for the FY14 Hospital VBP Program	
Clinical Process of Care Measures	
Measure ID	**Measure Description**
Acute myocardial infarction	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Heart Failure	
HF-1	Discharge Instructions
Pneumonia	
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
Healthcare-associated infections	
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time

SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
SCIP-Inf-9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
Surgeries	
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Patient Experience of Care Measures	
Measure ID	**Measure Description**
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey
Outcome Measures	
Measure ID	**Measure Description**
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate
MORT-30 PN	Pneumonia (PN) 30-Day Mortality Rate

Minimum Numbers of Cases and Measures for the Outcome Domain for the FY14 Hospital VBP Program

CMS proposed that in order to receive a score on a mortality measure, the hospital would need to report a minimum of 10 cases, and in order to receive a score on an AHRQ composite measure, a hospital would need to report a minimum of 3 cases. CMS also proposed that hospitals be evaluated based on the presence or absence of hospital-acquired condition (HAC) occurrences, regardless of the number of Medicare cases a hospital treats, as long as the hospital submits at least one Medicare claim during the performance period. CMS anticipated that all participating hospitals will submit at least one Medicare claim during the performance period, which would be sufficient for the hospitals to receive a score on seven of the eight HAC measures. Because CMS believed that every domain is an important component of an accurate total performance score, it proposed that, in order for a hospital to receive a total performance score and be included in the FY14 Hospital VBP Program, the hospital must have enough cases and measures to report on all four domains (if finalized).

After considering comments, **CMS finalizes its proposal that a hospital must report a minimum of 10 cases to receive a score on a mortality measure. CMS is not finalizing any proposals in the CY12 OPPS proposed rule relating to the HAC, AHRQ, and Medicare spending per beneficiary measures at this time because data on these measures will not have been made publicly available on Hospital Compare for at least one year prior to the time when the performance period for these measures would start under the Hospital VBP Program**. CMS intends to adopt these measures for future years of the Hospital VBP Program and will take comments into account as it develops future policies. Further, because CMS is suspending the effective date of the Medicare spending per beneficiary measure, the number of finalized domains will be three instead of four.

The minimum number of measures that a hospital must report in order to receive a score on the outcome domain is two. CMS will normalize outcome domain scores in order to make fair comparisons in that domain between hospitals **with scores on two mortality measures and those hospitals reporting sufficient data on all three**. Also, hospitals must report the minimum number of cases and measures on all finalized domains in order to receive a total performance score in FY14.

Domain Weighting for FY14 Hospital VBP Program

Because CMS is suspending the effective date of the HAC and AHRQ measures in the Hospital VBP Program, the outcome domain will only have three measures for the FY14 program. Therefore, CMS believes that it is necessary to reduce the weight applied to this domain. Taking this into account, and the fact that it is not finalizing an efficiency domain (Medicare spending per beneficiary measure) CMS is adopting a weighting methodology that increases the weight of the clinical process of care domain, as had been supported by some commenters who requested a reduction to the weight of the outcome domain. CMS is also reducing the weight of the outcome domain to account for the fact that it will only include three measures. For these reasons, for **FY14, CMS finalizes a weighting of 25 percent for the outcome domain, 45 percent for the clinical process of care domain, and 30 percent for the patient experience of care domain**.

Performance Periods and Baseline Periods for FY14 Measures

The Secretary is required to establish a performance period for the Hospital VBP Program for a FY that begins and ends prior to the beginning of such fiscal year. **For the FY14 Hospital VBP Program, CMS finalized a 9-month (3-quarter) performance period from April 1, 2012, to December 31, 2012, for the clinical process of care and patient experience of care domain measures**. This 3-quarter performance period will allow CMS to notify hospitals of the amount of their value-based incentive payment at least 60 days before the start of FY14. Since CMS believes that baseline data should be used from a comparable 3-quarter period, the baseline period for these measures for FY14 will be April 1, 2010, to December 31, 2010.

Proposed Policies for the Supervision of Outpatient Services

In the CY00 OPPS final rule with comment period, CMS established the hospital OPPS and indicated that direct supervision is the standard for all hospital outpatient therapeutic services covered and paid by Medicare in hospitals and in provider-based departments of hospitals. In the CY11 OPPS/ASC final rule, CMS provided a comprehensive review of the history of the supervision policies for both outpatient therapeutic and diagnostic services from the inception of the OPPS through CY10. In that rule, CMS further adjusted the direct supervision standard to increase flexibility for hospitals while maintaining an appropriate level of quality and safety and consistent with the intent of the statutory provision. In addition, in response to concerns expressed by the industry about appropriate levels of supervision for certain services furnished in various settings, CMS stated its intent to create through the CY12 rulemaking cycle an independent advisory review process to consider stakeholder requests for assignment of supervision levels other than direct supervision for specific outpatient hospital therapeutic services.

In that rule, CMS proposed policies for the independent review process and to establish the Federal Advisory APC Panel as the independent review body. The Panel will be charged with recommending a supervision level (general, direct, or personal) for services requested for review to ensure an appropriate level of quality and safety for delivery of a given service, as defined by a CPT code. So that there is broad representation of the types of hospitals that are subject to the supervision rules for payment, CMS proposed to add two to four members to the panel who would be representative of critical access hospitals, so that there is broad representation of the types of hospitals that are subject to the supervision rules for payment.

Under the OPPS final rule, the APC Panel will be the entity that will advise and make independent recommendations to CMS regarding the appropriate supervision level for individual hospital outpatient therapeutic services. CMS believes that it will be important to obtain advice that carries the weight of a Federal advisory recommendation. In addition to being already established and funded, the Federal advisory APC Panel will, of necessity, be inclusive and well-balanced because it is subject to the FACA rules. CMS believes that CAHs and small rural PPS hospitals may, at times, face similar resource constraints such as workforce shortages, which could lead to difficulty in meeting certain supervision standards. CMS believes that it would be appropriate for both small rural PPS hospitals and CAHs to have added representation on the Panel in a manner that would be balanced under the FACA rules. Therefore, as part of its final policy it is adding four new seats to the Panel. Two of which will be designated for representatives of CAHs, and the other two will be designated for representatives of small rural PPS hospitals.

APC Updates

New Technology APCs

The table below lists the HCPCS codes and associated status indicators that CMS is reassigning from a new technology APC to a different new technology APC for CY12

CY11 HCPCS Code	CY11 Short Descriptor	CY11 SI	CY11 APC	Final CY12 SI	Final CY12 APC
G0417	Sat biopsy prostate 21-40	S	1506	S	1505
G0418	Sat biopsy prostate 41-60	S	1511	S	1506
G0419	Sat biopsy prostate: >60	S	1513	S	1508

Composite APC Calculation

For CY08, CMS developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and result in the provision of a complete service. CMS will modify some aspects of its established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging

services. It will also create a new composite APC for cardiac resynchronization therapy services. CMS adopts this proposal with modification.

Extended Assessment and Management Composite APCs

CMS adopts as final, without modification, its CY12 proposal to continue to include composite APCs 8002 and 8003 in the OPPS and to continue the extended assessment and management composite APC payment methodology and criteria that it finalized for CY09 through CY11. CMS applied the standard packaging and trimming rules to the claims and calculated the median costs for APCs 8002 and 8003 using all single and "pseudo" single procedure claims from CY10 that meet the criteria for payment of each composite APC. **The final CY12 median cost resulting from this methodology for APC 8002 is approximately $393**, which was calculated from 18,447 single and "pseudo" single bills that met the required criteria**. The final CY12 median cost for composite APC 8003 is approximately $721**, which was calculated from 247,334 single and "pseudo" single bills that met the required criteria.

Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

Temporary additional payments (or "transitional pass-through payments") are provided for certain drugs and biologicals (also referred to as biologics). CMS proposed that the pass-through status of the 19 drugs and biologicals (listed In Table 26 of the proposed rule) would expire on December 31, 2011. All of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2011, and were approved for pass-through status on or before January 1, 2010.

CMS finalizes, without modification, its proposal to expire the pass-through status of these 19 drugs and biologicals, listed in Table 32 of the final rule. The table lists the drugs and biologicals for which pass-through status will expire on December 31, 2011, the status indicator, and the assigned APC for CY12.

TABLE 32.—Proposed Drugs and Biologicals for which Pass-Through Status Will Expire December 31, 2011

CY12 HCPCS Code	CY12 Long Descriptor	CY12 SI	CY12 APC
A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	N	N/A
A9583	Injection, gadofosveset trisodium, 1ml	N	N/A
C9250	Human plasma fibrin sealant, vaporheated, solvent-detergent (Artiss), 2ml	K	9250
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	K	9360
C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	N	N/A
C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	N	N/A

C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	K	9363
C9364	Porcine implant, Permacol, per square centimeter	N	N/A
J0598	Injection, C-1 esterase inhibitor (human), Cinryze, 10 units	K	9251
J0641	Injection, levoleucovorin calcium, 0.5 mg	K	1236
J0718	Injection, certolizumab pegol, 1 mg	K	9249
J1680	Injection, human fibrinogen concentrate, 100 mg	K	1290
J2426	Injection, paliperidone palmitate, 1 mg	K	9255
J2562	Injection, plerixafor, 1 mg	K	9252
J7312	Injection, dexamethasone intravitreal implant, 0.1 mg	K	9256
J8705	Topotecan, oral, 0.25 mg	K	1238
J9155	Injection, degarelix, 1 mg	K	1296
J9328	Injection, temozolomide, 1 mg	K	9253
Q0138	Injection, Ferumoxytol, for treatment of Iron deficiency anemia, 1 mg	K	1297

Regulatory Impact Analysis

CMS estimates the total increase in expenditures under the OPPS for CY12 compared to CY11 to be approximately $600 million from changes in this final rule with comment period. CMS also estimates the total increase in expenditures under the ASC payment system for CY12 to be approximately $45 million compared to CY11.

Comments

CMS will accept comments on the final rule until January 3, 2012.

Read the final rule in the November 30, 2011, *Federal Register*.