Outpatient Prospective Payment System Proposed Rule

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Agenda

Proposed Changes to the Hospital Outpatient PPS Payment Rates

- Payment Updates
- Quality Reporting
- OPPS Hold-harmless Payments
- Wage Index for Frontier States
- Physician Self-referral
- Direct Supervision
- AHA Questions for Discussion

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Payment Updates

- **The rule includes a mandated 0.25 percentage point reduction to the CY 2011 market basket update of 2.4 percent.**
- **The resulting market basket update for CY 2011 will be 2.15 percent.**
- **The update in 2011 for hospitals that do not meet quality reporting requirements would be 0.15 percent.**
- **CMS projects that total payment for services furnished in hospital outpatient departments will be approximately $40 billion in 2011.**

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Quality Reporting

- No new measures were added for 2011
  - Hospitals must continue to report on the 11 outpatient quality measures finalized in last year's final rule.
  - These existing 11 measures include five heart attack care measures for transfer patients, two surgical care measures and four measures of imaging efficiency.
- Hospitals that fail to meet the outpatient reporting requirements will receive a 2 percent reduction in their payment update.
- 2012 and beyond
  - CMS proposes the addition of quality measures over a three-year period. CMS proposes to add six new quality measures in 2012, seven quality measures in 2013 and another six measures in 2014.
  - The rule proposes a data validation process that would begin in 2012 and is similar to the process implemented under the inpatient PPS.

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Sun-setting of Hold-harmless Payments for Small Rural Hospitals and SCHs

- **As required by law, the agency would no longer provide hold-harmless outpatient payments to rural hospitals with 100 or fewer beds that are not sole community hospitals (SCHs) and SCHs.**
- **CMS will continue, however, to apply a 7.1 percent payment increase for most rural SCH services and procedures paid under the OPPS.**

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Wage Index Floor for Frontier States

- **The rule implements ACA requirement to establish a wage index floor of 1.0 for Medicare inpatient and outpatient PPS payments to hospitals in frontier states.**
- **CMS used Census Bureau data to propose the following states as eligible: Montana, Nevada, North Dakota, South Dakota and Wyoming.**

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Physician Self-Referral

- **CMS proposes to implement AHA-supported changes enacted in ACA to the "whole hospital" and "rural provider" exceptions in the physician self-referral law that will prohibit their use by new physician-owned hospitals and limit the ability of existing physician-owned hospitals to expand their capacity.**

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Self-Referral—Grandfather

MUST:

1. **Have physician owners or investors and Medicare provider agreement in effect no later than December 31, 2010;**
2. **Not expand facility beds, ORs, or procedure rooms beyond that for which the hospital was licensed as of March 23, 2010;**
3. **Comply with ownership reporting and disclosure requirements and put no conditions on a physician making or influencing referrals to or generating other business for the hospital**
4. **Comply with requirements to ensure that all ownership and investment interests in the hospital are *bona fide***
5. **Inform patients before admission if the hospital does not have a physician available on the premises during all hours and receive a signed acknowledgment that the patient understands this fact**
6. **Not have been converted from an ASC on or after March 23, 2010.**

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Direct Supervision, Background

- 2009: CMS issues a "*restatement and clarification*" of their current policy, indicating it had been in place since 2001.
  - Direct physician supervision required for all outpatient therapeutic services, both on-campus and off-campus.
  - A supervising physician must physically be in the same outpatient department at all times services are furnished.
- 2010: CMS revises its policy :
  - Allows certain non-physician practitioners to provide direct supervision, including PAs, NPs, CNSs, CNMs, LCSW, CPs.
  - For services in the hospital and for services in on-campus provider-based departments:
    - Supervising physician or NPP may be anywhere on the hospital's campus, as long as "immediately available."
- March 2010: CMS instructs its contractors not to review or enforce supervision requirements for CAHs during 2010.

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Direction Supervision, 2011 Proposed Policy

- For 2011, CMS proposes to permit a modified level of physician supervision for a few specified HOPD therapeutic services.
- 16 “nonsurgical extended duration therapeutic services”:
    - with a significant monitoring component that can extend for a sizable period of time
    - that are not surgical, and
    - that typically have a low risk of complication.
  - These service include:
    - observation services
    - various intravenous and subcutaneous infusions
    - various therapeutic, prophylactic or diagnostic injections
- These services would require direct supervision only for **initiation** of the service, followed by **general supervision** for the remainder.
- “General supervision” means the service is under a physician’s overall direction and control, but a physician is not required to be present when the service is furnished.

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Other Supervision Options CMS Considered but Rejected

- CMS considered **broadening list of services proposed for modified supervision:** chemotherapy & blood transfusion, but….
  - Due to concerns these services had a high chance of needing physician intervention, CMS would have required:
    - that hospitals create internal guidelines specifying a supervision level & protocols for staffing for each service on list.
    - CMS would've proposed minimum requirements, including:
      - annual review and approval by a governing committee,
      - periodic internal evaluation of implementation,
      - ability to make the guidelines available to Medicare program auditors if requested.
  - **CMS rejected this option** because they felt it would not ensure patient safety, and hospitals would find requirements onerous.
  - CMS seeking feedback from hospitals on this.

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Other Supervision Options CMS Considered but Rejected

- CMS also considered, but rejected, **explicitly excluding outpatient CAH services from all supervision requirements.**
- CMS **rejected** this approach because the agency believes that:
  - Medicare should purchase services from CAHs that are of the same basic level of safety and quality as from other hospitals.
  - Both small rural hospitals and CAHs have similar staffing and resource constraints.
- CMS also welcomes public comment on this topic.

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DISCUSSION

Questions for Discussion

- General comments/questions on OPPS proposed rule?
- Physician Supervision:
  - Will CMS' proposal for a modified level of supervision for certain services help small/rural hospitals and CAHs?
  - Are the proposed list of services adequate? Should the list be expanded? To what other services….chemo and blood transfusions, short durations services, surgical recovery…?
  - If an expanded list is needed, do you agree that a requirement for hospitals to develop internal supervision guidelines and protocols would be too onerous? Do such guidelines and protocols already exist in your hospital?
  - What do you think about the option CMS considered to exclude CAH's from supervision requirements? Do you believe doing so would harm beneficiary quality and safety?
  - Any other ideas/recommendations?

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