

HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

HOPPS Hat Trick: Third Installment of 2011 Updates for HOPPS and ASC Payment Systems

December 30, 2010

On November 24, 2010, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the final calendar year (CY) 2011 updates to the Hospital Outpatient Prospective Payment System (HOPPS) and the ambulatory surgery center (ASC) payment system (the "Final Rule").¹ In earlier issues of *Health Reform IMPACT*,² we reported on the provisions of the Final Rule that implement the Health Reform³-driven restrictions relating to physician ownership of hospitals and GME/IME. In this issue of *Health Law Update*, we'll discuss the remaining highlights of the Final Rule, not all of which are Health Reform-driven.

The changes implemented by the Final Rule include an approximate 2.5% increase in reimbursement by CMS for hospital outpatient services and a 0.2% update for ASC services. CMS projects total payments of \$39 billion for Medicare patients in hospital outpatient departments during CY 2011 and total payments of \$4 billion under the ASC payment system.⁴ The Final Rule also includes the latest chapter in the somewhat controversial saga of CMS' rules on physician supervision requirements for hospital outpatient therapeutic services.

Physician Supervision Requirements for Hospital Outpatient Therapeutic Services

Elimination of Location Requirements And Substitution of Single "Immediate Availability" Standard. Much of the controversy surrounding the physician supervision rules for hospital outpatient therapeutic services started with the 2009 final HOPPS/ASC rule, in which CMS "clarified and restated" its supervision policy in a way that ran contrary to common practice at many hospitals. Specifically, CMS suggested that supervising physicians must be physically present in *all* hospital outpatient departments, even on-campus departments, in order to meet the direct supervision requirement. Up until that point, many hospitals had assumed (based on prior preamble commentary by CMS) that direct supervision was satisfied for on-campus

¹ 75 Fed. Reg. 71800 (November 24, 2010).

² See "*Auld Lang Syne' For Physician Ownership of Hospitals*," December 17, 2010, [available here](#), and "*GME/IME: Woe Is Me?*," December 28, 2010, [available here](#).

³ References to "Health Reform" or "Health Reform Legislation" mean the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act.

⁴ CMS Final 2011 hospital outpatient, ambulatory surgical center payment rule, Fact Sheet, November 2, 2010, available at https://www.cms.gov/apps/media/fact_sheets.asp

departments if the supervising physician was anywhere on the campus of the hospital (as opposed to being in the specific outpatient department).

In response to these concerns, CMS revised the supervision standard in the 2010 final HOPPS/ASC rule to permit, in the case of services furnished on a hospital's main campus, the supervisory physician (or qualified nonphysician practitioner) to be anywhere on the hospital campus. Now, however, in the Final Rule, CMS has removed all references to particular physical locations or physical boundaries, i.e., the reference to "on the same campus" or "in the off-campus provider-based department of the hospital," and has replaced them with a single inquiry of whether the supervising physician is "immediately available," meaning physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure. The new definition will apply to both hospitals and Critical Access Hospitals (CAHs) equally beginning CY 2011.

Nonsurgical Extended Duration Therapeutic Services. In the Final Rule, CMS provides some flexibility for the supervision requirements applicable to certain outpatient therapeutic services. CMS revises the supervision rules to allow for direct supervision at the initiation of a limited set of services, followed by general supervision for the remainder of the service.⁵ This new supervision rule applies only to certain "nonsurgical extended duration therapeutic services," which CMS describes as non-surgical services that can extend for a sizable period of time, that have a significant monitoring component typically performed by auxiliary personnel, and that typically have a low risk of complication requiring immediate availability of the physician (or qualified nonphysician practitioner) after assessment at the beginning of the service.⁶ CMS requires that, for these specific services, the transition to general supervision must be documented prominently in progress notes or in the medical record.

Independent Review Process. CMS also addresses in the Final Rule the heightened interest of the hospital industry and other stakeholders in the appropriate level of supervision for certain services, with some commenters asserting that certain individual outpatient services may require only general rather than direct supervision. While CMS continues to stand behind its policy that, in general, direct supervision is required for all outpatient therapeutic services, CMS did agree with commenters that there should be an independent mechanism in place to consider the appropriate level of supervision for individual services. As a result, in the CY 2012 HOPPS rulemaking, CMS will propose to establish an independent review process which will allow for an assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services.⁷

Delay In Enforcement For CAHs and Rural Hospitals. CMS also determines in the Final Rule that it is appropriate to extend CMS' decision not to enforce the requirement for direct supervision of

⁵ 75 Fed. Reg. at 72003. CMS defines initiation as the "beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under general supervision."

⁶ 75 Fed. Reg. at 72003; for complete list of nonsurgical extended duration therapeutic services see table at 75 Fed. Reg. at 72013.

⁷ 75 Fed. Reg. at 72012. CMS said the committee should include representatives of many types of providers including rural providers, and were considering the possibility of using CMS' Federal Advisory Panel on Ambulatory Classification Groups (the APC Panel) as the independent technical committee that would review requests for supervision levels. However, CMS believes it would be best to develop such a process through notice and comment rulemaking.

therapeutic services provided to CAH outpatients through CY 2011.⁸ In addition, CMS expresses concern about establishing policies that apply solely to CAHs because small rural hospitals also have the same types of resource constraints as the CAHs. As a result, CMS expands the scope of its decision not to enforce direct supervision of therapeutic services to include small rural hospitals having 100 or fewer beds for CY 2011.

Other Provisions Implemented by the Final Rule

Payment for Preventive Care Services. This Final Rule enacts provisions of the Health Reform Legislation addressing the coverage of preventive care services that become effective January 1, 2011.⁹ CMS finalizes its proposed rule, without modification, to waive beneficiary coinsurance and Part B deductibles for most preventive services, including the initial preventive physical exam and preventive services that have been “strongly recommended” or “recommended” by the United States Preventive Task Force for any indication or population. As part of the Final Rule, CMS includes tables of the procedure codes that will be recognized as “preventive services” for purposes of the hospital and ASC settings.

Cancer Hospital Payment Adjustment. In the CY 2011 proposed and Final Rule, CMS addresses provisions of the Health Reform Legislation that required CMS to study whether outpatient costs incurred by certain cancer hospitals exceed the outpatient costs incurred by other hospitals paid under HOPPS and, if such cancer hospitals are most costly, to make adjustments accordingly. However, after receiving comments, CMS opts to take more time to study the issues and has not finalized any payment adjustment for FY 2011.

Frontier Wage Provisions. This Final Rule also addresses and implements the Health Reform Legislation provisions requiring that CMS implement a floor on the area wage adjustment factor for hospital outpatient department services furnished on or after January 1, 2011 in a state in which at least 50% of the counties in the state are frontier counties, i.e., a county in which the population per square mile is less than six, which include Montana, Nevada, Wyoming, North Dakota and South Dakota.

Partial Hospitalization Programs. CMS also finalizes four separate partial hospitalization program (PHP) ambulatory payment classifications (APC), two for community mental health center (CMHC) PHPs, and two for hospital-based PHPs. The new payment classifications were a result of cost variations between services provided at CMHC PHPs and hospital-based PHPs. Specifically, although CMHC PHPs costs for services have been decreasing, CMS has continued to base PHP APC per diem rates only on hospital-based data due to a concern that including CMHC data would lower the overall PHP APC per diem rates and would result in paying hospital-based PHP programs a rate lower than what their cost structure reflects.

In the Final Rule, CMS expresses concern about the current payment rate for PHPs, stating that because CMHCs’ cost data significantly decreased again in 2010, CMS could no longer base PHP

⁸ See 75 Fed. Reg. at 72007. On March 15, 2010, following publication of the final 2010 HOPPS/ASC rule, CMS had issued a statement that it would not enforce the rules for supervision of hospital outpatient therapeutic procedures furnished in CAHs in 2010.

⁹ Note that CMS similarly discussed and implemented these provisions of the Health Reform Legislation as part of the CY 2011 Medicare Physician Fee Schedule Final Rule as discussed in our issue of *Health Reform IMPACT* dated November 22, 2010, [available here](#).

payment rates only on hospital-based data. CMS states that it is time to create more “appropriate payments that reflect the cost structure of each provider type.”

To address the fact that CMHCs have a lower cost structure than hospital-based PHP programs, CMS finalizes four separate PHP APC per diem payment rates, two for CMHC PHPs and two for hospital-based PHPs, which are based on the unique cost data of each provider. CMS will provide a two-year transition to CMHC rates that are based solely on CMHC data in order to allow providers time to adjust their business operations and protect beneficiaries’ access to care.¹⁰

Hospital Outpatient Quality Reporting. In the Final Rule, CMS finalizes new quality measures for the Hospital Outpatient Quality Reporting Data Program (the “Quality Reporting Program”). CMS chooses to adopt new quality measures for the Quality Reporting Program for three years at once in order to assist hospitals in planning and in order to give CMS sufficient time to develop, align and implement infrastructure necessary to collect data on the measure and make payment determinations. CMS also reserves the right to revise the quality measures in light of changing priorities and new legislation.

CMS has added four quality measures to the Quality Reporting Program, for a total of 15 measures to be reported for purposes of CY 2012 payment determination. The four new measures include three claims-based imaging efficiency measures, and one structural health information technology (HIT) measure. For CY 2013 payment determination, CMS has added eight new measures, including six chart-abstracted measures for timeliness and appropriate care in the emergency department, and one structural measure on use of electronic health records, for a total of 23 measures for CY 2013 payment determination.

In the Final Rule, CMS also implements a validation requirement for the Quality Reporting Program to ensure that hospitals are reporting data accurately. Specifically, CMS will validate data from 800 randomly selected hospitals each year, beginning with CY 2012 payment determination. For each selected hospital, CMS will randomly select up to 12 cases per quarter for validation purposes. The designated CMS contractor will ask each of the 800 hospitals to submit the relevant medical documentation relating to the randomly selected cases for each quarter. When the CMS contractor receives the relevant medical documentation, the contractor will re-abstract the same quality measure data elements the hospital previously abstracted and compare the two sets of data to determine whether they match. In order to receive the full OPPS payment update in CY 2010, CMS requires that hospitals attain at a minimum 75% validation score.

Pharmacy Overhead Costs. For CY 2011, CMS will pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at the average sales price (ASP) plus 5%. This change represents a redistribution of \$200 million from costs for coded and uncoded packaged drugs to separately payable drugs.

¹⁰ 75 Fed. Reg. at 71993; For CY 2011, the CMHC PHP APC rates will be calculated by taking 50% of the difference between the CY 2010 final hospital based medians and the CY 2011 final CMHC medians and adding that number to the CY 2011 final CMHC medians.

ASC Covered Surgical Procedures and Covered Ancillary Services. In the Final Rule, CMS adds six procedures to the list of ASC covered surgical procedures for CY 2011. CMS is also assigning two new procedures to office-based status for 2011.

If you have any questions about this issue of *Health Law Update*, please do not hesitate to contact any of the attorneys in our Healthcare Practice Group listed below.

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