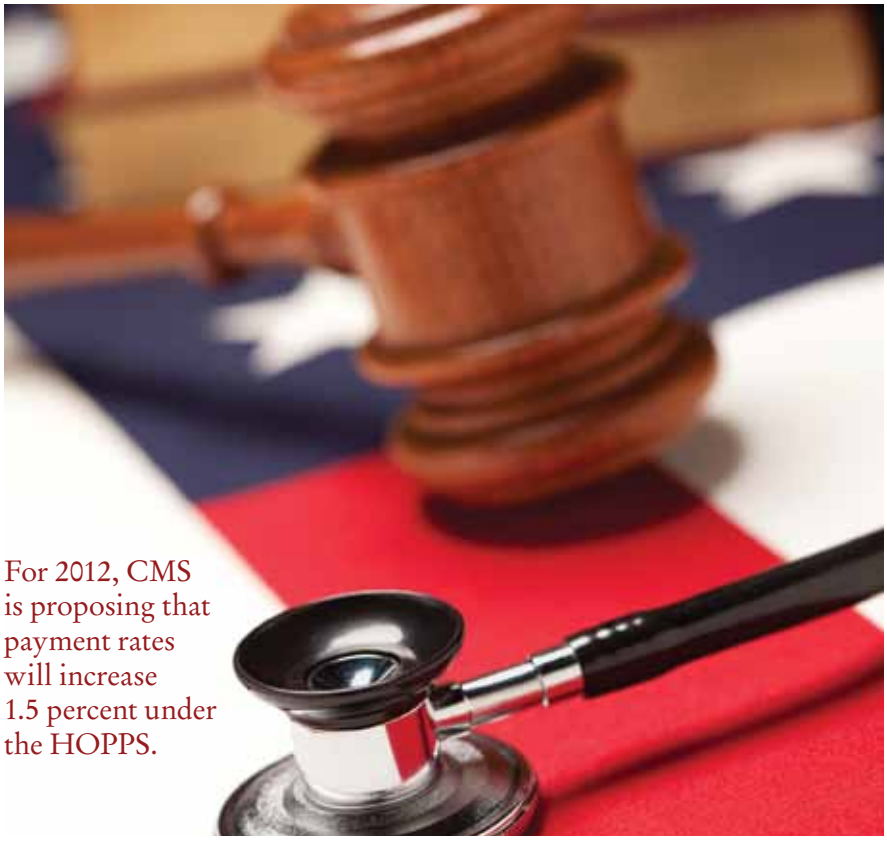
Highlights of Proposed 2012 HOPPS

On July 1, 2011, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2012 Hospital Outpatient Prospective Payment System (HOPPS) rule. For 2012, CMS is proposing that payment rates will increase 1.5 percent. This increase reflects a 2.8 percent increase in the hospital operating market basket, a -1.2 percent multifactor productivity (MFP) adjustment, and a 0.1 percentage point reduction required by the Affordable Care Act (ACA). Hospitals that fail to meet the quality reporting data requirements will receive an update that is reduced by 2.0 percentage points. CMS expects total Medicare payments to hospital outpatient departments will be approximately $41.9 billion.

CMS is proposing a payment rate of Average Sales Price (ASP)+4 percent for separately payable drugs, biologicals, and radiopharmaceuticals without pass-through status. However, the agency cautions that the final payment rate could be lower than ASP+4 percent after CMS finalizes its calculations with updated data later this year. Under the proposed rule, drugs, biologicals, and radiopharmaceuticals with pass-through status will continue to be reimbursed at ASP+6 percent, the rate applicable in physicians' offices, as required by statute. CMS proposes to continue pass-through status for 33 drugs and biologicals in 2012. Pass-through status of 19 drugs and biologicals would expire on Dec. 31, 2011, under the proposed rule.

CMS also proposes:

- To increase the packaging threshold for drugs and biologicals from $70 to $80 per day.
- To continue to pay separately for the same set of drug administration codes under the CY 2012 HOPPS as were paid separately in the CY 2011 HOPPS.
- To refer questions about supervision of specific services to the Ambulatory Payment Classification (APC) Panel. CMS is proposing that decisions based on APC Panel recommendations would be issued through sub-regulatory guidance.
- To not make any changes to the CY 2012 Hospital Outpatient Quality Reporting Program measures. In the CY 2011 final rule, CMS added new measures over a three-year period for the CY 2012, CY 2013, and CY 2014 payment determinations to assist hospitals in planning, meeting future reporting requirements, and implementing quality improvement efforts.
- To change the Medicare Electronic Health Record Incentive Program to allow eligible hospitals to report clinical quality measures for 2012 by participating in an electronic reporting pilot.
- To strengthen the Hospital Value-based Purchasing (HVBP) Program that was required by the ACA. The HBVP Program will tie a portion of a hospital's payment for inpatient stays under the IPPS in FY 2014 to its performance on a set of quality measure. CMS issued a final rule establishing this program in April 2011.



For 2012, CMS is proposing that payment rates will increase 1.5 percent under the HOPPS.

PHOTOGRAPH/ISTOCKPHOTO

An in-depth analysis of the proposed 2012 HOPPS rule is available on the members-only section of ACCC's website at: *http://www.accc-cancer.org/advocacy/pdf/2012-ACCC-ProposedOPPS-summary.pdf*.

Highlights of the MPFS Proposed Rule

On July 1, 2011, CMS issued a proposed rule that would update payment policies and rates for physicians and non-physician practitioners for services paid under the Medicare Physician Fee Schedule (MPFS) in 2012. In the 2012 proposed rule, CMS is significantly expanding the potentially misvalued code initiative.

The proposed rule projects a 29.5 percent reduction to physician payment rates in 2012 under the sustainable growth rate (SGR) formula. The current estimate of the conversion factor is $23.9635. In addition, the proposed rule would:

- Implement the third year of a four-year transition to practice expense (PE) relative value units (RVUs) calculated using Physician Practice Information Survey data
- Identify and revise potentially misvalued codes
- Expand the imaging multiple procedures payment reduction (MPPR) policy to the professional component of advanced imaging services
- Implement provisions affecting the Physician Quality Reporting System (PQRS), Electronic Prescribing (eRx) Incentive Program, and Electronic Health Records (EHR) Incentive Program
- Begin implementation of a value-based payment modifier.

On or after Jan. 1, 2012, CMS proposes that when a physician furnishes services to a beneficiary in a hospital's wholly-owned or wholly-operated physician practice and the beneficiary is admitted as an inpatient within three days (or in the case of non-IPPS

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The cumulative effect on total Medicare payments to physicians involved in cancer care if all of the proposals except the cut to the conversion factor take effect would be:

Specialty	Allowed Charges (Millions)	Combined Impact (Transition)	Combined Impact (Full)
Hematology/Oncology	$1,912	0%	-2%
Radiation Oncology	$1,968	-4%	-8%
Radiology	$4,722	-4%	-6%

hospitals, one day), the payment window will apply to *all* diagnostic series furnished and to any non-diagnostic services that are clinically related to the reason for the patient's inpatient admission—regardless of whether the reported inpatient and outpatient ICD-9-CM diagnosis codes are the same. Physician payment will be similar to the payment a physician receives when he or she provides a service in the outpatient department of a hospital. CMS will establish a new Medicare HCPCS modifier through subregulatory guidance, and the modifier will be required to be reported with HCPCS codes subject to the payment window policy.

An in-depth analysis of the proposed 2012 MPFS rule is available on the members-only section of ACCC's website at: *http://www.accc-cancer.org/advocacy/pdf/2012-PFS-proposed-summary.pdf*.

And the RAC Survey Says...

Results from a nationwide survey of more than 125 hospital providers found that 70 percent of hospitals have been audited by a Recovery Audit Contractor (RAC) since the inception of the program from CMS. Conducted by IVANS Inc., a health information company, the study found that 73 percent of providers surveyed "agreed" or "somewhat agreed" that RAC audits are helping reduce errors and fraud. Providers reported the following RAC-related worries—compliance concerns (31 percent), audit costs (26 percent), tracking claims (14 percent), and meeting audit deadlines (12 percent). Interestingly, 64 percent of providers who have been through an audit found the appeals process to be "fair." The top five reasons provider claims are denied? The claim was found medically unnecessary (52 percent), inpatient coding errors (32 percent), lack of documentation (25 percent), outpatient billing errors (13 percent), and outpatient coding errors (10 percent).

PHOTOGRAPH/FOTOLIA

CMS Demonstration to Let Labs Bill Medicare Directly

Medicare's two-year, $100 million demonstration, "The Treatment of Certain Complex Diagnostic Laboratory Tests," scheduled to begin Jan. 3, 2012, will allow participating laboratories that perform complex diagnostic tests on hospitalized Medicare beneficiaries to be reimbursed directly rather than through the hospital. The demonstration, mandated by the Affordable Care Act, is designed to test the affect of direct lab payments on Medicare costs and quality for complex diagnostic tests, such as gene protein expression. Labs that perform complex diagnostic tests may apply to participate in the demonstration.

Currently, when a test is ordered by the beneficiary's physician less than 14 days after the date of the patient's discharge from the hospital, the hospital must bill Medicare for the test provided by the lab. The hospital then pays the lab if the test was provided under a billing arrangement.

Under the CMS demonstration, the lab will bill Medicare directly for a complex clinical diagnostic lab test when the test is ordered within that same time frame—less than 14 days after the date of the patient's hospital discharge.

More information, including a demonstration test list, is available online at: *https://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.sp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1240611&intNumPerPage=10*.