CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2453	**Date: April 26, 2012**
	Change Request 7780

SUBJECT: CY 2012 OPPS Payment Adjustment for Certain Cancer Hospitals

I. SUMMARY OF CHANGES: Section 3138 of the Affordable Care Act requires CMS to conduct a study to determine if, under the OPPS, outpatient costs incurred by 11 specified cancer hospitals exceed the costs incurred by other hospitals furnishing services under the OPPS. In addition, section 3138 of the Affordable Care Act provides that if the specified cancer hospitals' costs are determined to be greater than the costs of other hospitals furnishing services under the OPPS, CMS shall provide a payment adjustment to the 11 specified cancer hospitals that will appropriately reflect these higher outpatient costs. We determined that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. Therefore, consistent with Section 3138 of the Affordable Care Act, we adopted a policy beginning in CY 2012 to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the OPPS.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: May 29, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
N	4/10.6.3/Payment Adjustment for Certain Cancer Hospitals
N	4/10.6.3.1/Payment Adjustment for Certain Cancer Hospitals for CY 2012
R	4/70.7/Transitional Outpatient Payments (TOPs) for CY 2010 through February 29, 2012

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is

not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2453	Date: April 26, 2012	Change Request: 7780

SUBJECT: CY 2012 OPPS Payment Adjustment for Certain Cancer Hospitals

Effective Date: January 1, 2012
Implementation Date: May 29, 2012

I. GENERAL INFORMATION

A. Background: Section 3138 of the Affordable Care Act requires CMS to conduct a study to determine if, under the OPPS, outpatient costs incurred by 11 specified cancer hospitals exceed the costs incurred by other hospitals furnishing services under the OPPS. In addition, section 3138 of the Affordable Care Act provides that if the specified cancer hospitals' costs are determined to be greater than the costs of other hospitals furnishing services under the OPPS, CMS shall provide a payment adjustment to the 11 specified cancer hospitals that will appropriately reflect these higher outpatient costs.

B. Policy: We determined that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. Therefore, consistent with Section 3138 of the Affordable Care Act, we adopted a policy beginning in CY 2012 to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year. The target PCR for CY 2012, for purposes of the cancer hospital payment adjustment, is 0.91 for outpatient services furnished on or after January 1, 2012 through December 31, 2012.

The cancer hospital payment adjustment will be made through interim monthly payments which will replace the current interim monthly transitional outpatient payments (TOPs) to cancer hospitals. The requirement for TOPs will still be assessed after all payments, including the cancer hospital payment adjustment, have been made for a cost reporting period. The interim monthly payment amount for the cancer hospital adjustment will be calculated using the same methodology that is currently used to calculate interim monthly TOPs**,** i.e. contractors will pay 85% of the calculated monthly payment adjustment amount with the final payment adjustment amount calculated based on the provider's settled cost report.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7780.1	Medicare contractors shall calculate interim cancer hospital payment adjustment amounts for outpatient services furnished on or after January 1, 2012 through	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	December 31, 2012.										
7780.2	Medicare contractors shall discontinue the calculation of interim TOPs for cancer hospitals for services furnished on or after January 1, 2012 through December 31, 2012.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Charlotte Thompson at charlotte.thompson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev.2453,Issued: 04-26-12)

10.6.3 - Payment Adjustment for Certain Cancer Hospitals

(Rev. 2453, Issued: 04-26-12, Effective: 01-01-12, Implementation: 05-29 -12)

Section 3138 of the Affordable Care Act requires CMS to conduct a study to determine if, under the OPPS, outpatient costs incurred by 11 specified cancer hospitals exceed the costs incurred by other hospitals furnishing services under the OPPS. In addition, Section 3138 of the Affordable Care Act provides that if the specified cancer hospitals' costs are determined to be greater than the costs of other hospitals furnishing services under the OPPS, CMS shall provide a payment adjustment to the 11 specified cancer hospitals that will appropriately reflect these higher outpatient costs. We determined that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. Therefore, consistent with Section 3138 of the Affordable Care Act, we adopted a policy to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year.

The cancer hospital payment adjustment will be made through interim monthly payments with the final payment adjustment amount calculated based on the provider's settled cost report. The calculation for the monthly cancer hospital payment adjustment amount is described as follows:

Step 1 – Compute the cancer hospital target payment amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and adjust the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the target PCR for the calendar year.

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments (including reconciled outlier payments and the time value of money) and transitional pass-through payments for drugs, biological and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of Step 1, go to Step 4. No additional payment is due this month.

Step 3 – Subtract the result of Step 2 from the result of Step 1 and pay .85 times this amount.

Step 4 – When the result of step 2 is greater than the result of Step 1 for the final month of a provider's cost report period, do nothing more. When the result of Step 2 is greater than the result of Step 1 for any other month, store all Step 1 and Step 2 totals and include these totals with the totals for the next month's additional payment calculation.

10.6.3.1 - Payment Adjustment for Certain Cancer Hospitals for CY 2012

(Rev. 2453, Issued: 04-26-12, Effective: 01-01-12, Implementation: 05-29 -12)

The target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final

cost report settlement is 0.91 for hospital outpatient services furnished on or after January 1, 2012 through December 31, 2012.

70.7 - Transitional Outpatient Payments (TOPs) for CY 2010 through February 29, 2012

(Rev. 2453, Issued: 04-26-12, Effective: 01-01-12, Implementation: 05-29 -12)

Hold harmless transitional outpatient payments (TOPs) to small rural hospitals and rural sole community hospitals were scheduled to expire December 31, 2009. Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010 through December 31, 2010 and these providers will receive TOPs payments at 85 percent of the hold harmless amount until December 31, 2010. Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) further extended the hold harmless provision for rural hospitals with 100 or fewer beds and to all SCHs (and EACHs) regardless of bed size through December 31, 2011 at 85 percent of the hold harmless amount.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all SCHs and EACHs regardless of bed size.

Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2010 and February 29, 2012.

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments (including reconciled outlier payments and the time value of money) and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 4. No transitional payment is due this month.

Step 3 - If the hospital is a children’s hospital, a rural hospital with 100 or fewer beds, or a sole community hospital (including EACHs), subtract the result of step 2 from the result of step 1 and

pay .85 times this amount. If the hospital is not one of the hospital types listed above, no payment is made.

Step 4 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.