

December 7, 2006

Medicare Outpatient PPS, ASC and Physician Fee Schedule: The Final Rules for 2007

AT A GLANCE

The Issue:

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the outpatient prospective payment system (PPS) final rule, which sets payment rates for calendar year (CY) 2007. The key provisions in the final rule:

- Delay until 2009 CMS' proposed link between the outpatient payment update and reporting of quality data.
- Make significant changes to the evaluation and management codes and payment levels for hospital clinic, emergency department and critical care visits.
- Expand *inpatient* hospital quality reporting requirements for fiscal year (FY) 2008, as described in an AHA Quality Advisory found at <http://www.aha.org/aha/advisory/2006/061120-quality-adv.pdf>.

The final CY 2007 physician fee schedule, also released November 1, includes provisions that:

- Significantly revise the physician work and practice expense relative value units (RVUs) and implements a 5.0 percent reduction in the payment rate update for physician services.
- Prohibit independent laboratories from directly billing the Medicare carrier for the technical component (TC) of physician pathology services furnished to hospital patients.
- Reduce payments for 260 imaging services furnished in physician offices and imaging centers to the outpatient PPS payment amount for these services, as required by the *Deficit Reduction Act of 2005*.

The final outpatient PPS rule was published in the November 24 *Federal Register*, and is available at <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506FC.pdf>. The physician fee schedule final rule, available at <http://www.cms.hhs.gov/physicianfeesched/downloads/1321-fc.pdf?agree=yes&next=Accept>, was published December 1. Both rules take effect January 1, 2007.

Our Take:

We are pleased that CMS will develop quality measures specifically for the outpatient setting and has correctly given hospitals ample time to implement a reporting system for hospital outpatient services. We had concerns with CMS' earlier proposal because connecting outpatient payments to inpatient measures is an "apples to oranges" comparison that would undermine hospitals' efforts to make useful and reliable quality data available to the public. We will work with CMS through the Hospital Quality Alliance (HQA) and AQA (formerly known as the Ambulatory Quality Alliance) to implement a meaningful quality measurement system for the outpatient setting.

What You Can Do:

- ✓ Share this advisory with your senior management team, chief financial officer, billing and coding staff, nurse managers and key physician leaders.
- ✓ Model the impact of the final ambulatory payment classification (APC) changes on your expected 2007 Medicare revenue. A spreadsheet comparing the changes in APC payment rates and weights from 2001-2007 is available on the AHA's Outpatient PPS Web page at <http://www.aha.org/aha/issues/Medicare/OPPS/resources.html>. Please note that you must first log on as a member to view the spreadsheet.

Further Questions:

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TABLE OF CONTENTS

FINAL CHANGES TO THE OUTPATIENT PPS FOR 2007

PPS Update and Linkage to Quality Data Reporting	2
Recalibration of APC Weights	3
Revised Cost-to-Charge Ratio Methodology	4
Wage Index for 2006	4
Outlier Payments.....	4
Transitional Corridor Hold-harmless Payments.....	5
Rural Adjustment for Sole Community Hospitals.....	5
Transitional Pass-through Payments.....	5
Coding and Payment for Clinic and ED Visit Services.....	6
Payment for Medical Devices	8
Payment for Drugs, Biologicals and Radiopharmaceuticals	10
New Technology APCs	12
Observation Services	12
Inpatient-only Procedures	13
Partial Hospitalization Services	13
Beneficiary Coinsurance	13
Financial Impact on Hospitals.....	13

CHANGES TO THE ASC PAYMENT SYSTEM FOR 2007

ASC List Update.....	14
ASC Payment Rate Cap.....	14

OTHER CHANGES

Inpatient Quality Measures for FY 2008.....	14
Emergency Medical Screening in Critical Access Hospitals.....	14
Medicare Contracting Reform Mandate.....	15
Health Information Technology.....	15
Health Care Information Transparency Initiative	16

PHYSICIAN FEE SCHEDULE CHANGES FOR 2007

Independent Lab Billing for Physician Pathology Services.....	16
Reduction in Payment for Certain Imaging Procedures.....	17

BACKGROUND

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the outpatient prospective payment system (PPS) final rule for calendar year (CY) 2007. It includes payment policy and rates that apply to the outpatient PPS and ambulatory surgical centers (ASCs) for 2007. It also includes provisions that are not directly related to the outpatient PPS, such as inpatient quality measures for 2008 and Medicare contracting reform. The rule, available at <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506FC.pdf>, was published in the November 24 *Federal Register*.

In addition, the final 2007 physician fee schedule regulation also was released on November 1. The rule includes a 5.0 percent reduction to the physician fee schedule conversion factor to account for growth in volume and intensity of physician services. This payment reduction, which reflects current law requirements, will remain in place unless Congress enacts a temporary or permanent fix to the physician payment formula. The rule also makes changes to payments for pathology and imaging services.

Both final rules take effect January 1, 2007. The outpatient PPS rule adopts several recommendations offered by the AHA in our October 10 comment letter to CMS. That letter is available on the AHA's Web site at <http://www.aha.org/aha/letter/2006/061010-cl-1506p4125p.pdf>. The AHA's comment letter to CMS on the 2007 physician fee schedule is available at <http://www.aha.org/aha/letter/2006/061010-cl-1321p.pdf>.

AT ISSUE

FINAL CHANGES TO THE OUTPATIENT PPS FOR 2007

PPS UPDATE AND LINKAGE TO QUALITY DATA REPORTING

To arrive at the final 2007 outpatient PPS conversion factor of \$61.468, CMS increases the 2006 conversion factor of \$59.511 by 3.4 percent, the rate of change in the hospital market basket index, as required by law. In addition, the agency makes adjustments to ensure budget neutrality related to changes in the wage index, pass-through spending and other policy changes to arrive at the final 2007 conversion factor.

CMS, concerned about the rapid growth in hospital outpatient care expenditures, suggested that a "value-based purchasing program" might help to slow growth in outpatient services. **In the final rule, CMS decided not to implement a proposed "value-based purchasing program" that would have linked the outpatient PPS payment update to hospital reporting of *inpatient* quality measures in effect under the inpatient PPS quality reporting program.** This

decision is consistent with recommendations from the AHA and others that any link between quality reporting and payment for *outpatient* services should be based on *outpatient* quality measures. As a member of AQA (formerly known as the Ambulatory Quality Alliance), the AHA is helping to develop and test quality measures for the outpatient setting. Further, the AQA and the Hospital Quality Alliance (HQA) – of which the AHA is a founder – are examining how to measure quality across an outpatient episode of care.

Over the next two years, CMS intends to work quickly and collaboratively with stakeholders in the hospital community to develop and implement appropriate quality measures for the outpatient PPS. CMS states that in 2009 it will implement a 2.0 percentage point reduction to the outpatient PPS conversion factor update for those hospitals that do not meet the requirements for its outpatient quality reporting program.

RECALIBRATION OF APC WEIGHTS

The law requires that CMS review and revise at least annually the relative payment weights for ambulatory payment classifications (APCs). To recalibrate the relative APC weights for this rule, CMS used hospital claims for services furnished during 2005. In addition, CMS has historically used APC 0601, a mid-level clinic visit, to calculate relative weights. But for 2007, CMS has reconfigured the clinic visit APCs (described below under “Coding and Payment for Clinic and ED Visit Services”). Because of this change, CMS will use APC 0606 (level III clinic visit) as the basis for calculating relative weights for 2007 rather than APC 0601, which will no longer exist. After assigning APC 0606 a relative payment weight of 1.00, CMS determined the unscaled – not adjusted for budget neutrality – relative payment weight for each APC by dividing the median cost of the APC by the median cost for APC 0606.

The APC recalibration changes also must be budget neutral. To comply, CMS compared aggregate payments using the 2006 relative weights to aggregate payments using the 2007 weights. Based on the lower expected payments in this comparison, the rule *increases* the APC weights by a factor of about 1.36 (an increase of 36.4 percent), which is a much larger adjustment than in prior years. This is because the median cost of APC 0606, \$83.39, is much higher than the median cost of APC 0601, \$60.57. With a larger value, the unscaled relative weights are considerably lower and must be increased significantly by the budget neutrality adjustment.

CMS’ changes to the APC weights for 2007 continue to show significant volatility. For 2007, there are 862 APCs. Of this number, 732 existed in 2006. For 47 APCs, the 2007 weights will decrease by 10 percent or more; for 21 of these, the reduction is greater than 20 percent. In total, weights will be lower for 186 APCs. Conversely, weights will increase for 407 APCs, going up 10 percent or more for 113 of them. For 26 APCs, the rate will rise by at least 30 percent.

REVISED COST-TO-CHARGE RATIO METHODOLOGY

The final rule significantly changes the way the overall hospital-specific cost-to-charge ratio (CCR) is calculated. CMS uses the overall hospital CCR to set outlier thresholds and to estimate outlier and pass-through payments and in other services paid based on charges reduced to costs. The fiscal intermediaries (FIs) use overall CCRs to determine outlier payments and payments for certain other services. CMS recently discovered that it calculates the overall hospital CCR differently than the FIs. Compared with the CMS “traditional” overall CCR calculation, the FIs’ method includes allied health education costs and adds weighting by Medicare Part B charges. In comparing these two calculations, CMS determined that, on average, the FIs’ calculation resulted in higher overall CCRs (0.3309 compared to CMS’ 0.3040), which the agency said resulted in higher than necessary spending on outliers, among other implications.

In the final rule, CMS uses features of both methods by excluding allied health education costs and adopting weighting by Medicare Part B charges. Some hospitals will experience significant changes in their hospital-specific overall CCR calculations due to this change.

WAGE INDEX FOR 2006

For the outpatient final rule, CMS applies the FY 2007 inpatient PPS wage index (fully adjusted for differences in occupational mix) as published in the October 11 *Federal Register*. This includes the wage indices to be in effect through March 31, 2007, as well as those to be in effect on or after April 1, 2007, to accommodate the expiring reclassification provisions under Section 508 of the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA). CMS will continue the previously established outpatient PPS policies concerning phase-in of urban-to-rural changes due to the Core-based Statistical Areas, adoption of Medicare Geographic Classification Review Board decisions, and allowing non-inpatient PPS hospitals to apply for the out-migration wage index adjustment. As in prior years, the percentage of the APC payment to be adjusted by the wage index will be 60 percent.

OUTLIER PAYMENTS

Outlier payments are added to the APC amount to mitigate hospital losses when treating high-cost cases. For 2007, CMS sets the projected target for outlier payments at 1 percent of total outpatient PPS payments – the same as 2006. CMS again establishes separate thresholds for community mental health centers (CMHCs) and hospitals. Therefore, 0.15 percent of the 1 percent projected target would be allocated to CMHCs for partial hospitalization program services.

The rule continues to include both a fixed-dollar outlier threshold and a percentage threshold, but **CMS raises the fixed-dollar threshold to \$1,825 – \$575 more than in 2006 – to ensure that outlier spending does not exceed**

the reduced outlier target. This increase in the fixed-dollar threshold is largely due to the projected overpayment of outliers resulting from the change in the CCR methodology.

Thus, to be eligible for an outlier payment in 2007, the cost of a service must exceed 1.75 times the APC payment amount (the percentage threshold) *and* be at least \$1,825 more than the APC payment amount. When the cost of a hospital outpatient service exceeds these applicable thresholds, Medicare will make an outlier payment that is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

TRANSITIONAL CORRIDOR HOLD-HARMLESS PAYMENTS

As required by the *Deficit Reduction Act of 2005* (DRA), the final rule continues to phase-out the transitional corridor hold-harmless payments for rural hospitals with 100 or fewer beds that are not Sole Community Hospitals (SCHs). For 2007, when the outpatient PPS payment is less than the payment that the provider would have received under the previous reasonable cost-based system, the payment amount is increased by 90 percent of the difference between those two payment systems. This represents 5 percent less in hold-harmless payments than these hospitals received in 2006. CMS also clarifies that Essential Access Community Hospitals (EACHs) are considered to be SCHs under the law and therefore are ineligible for hold-harmless payments. Cancer and children's hospitals receive the hold-harmless payments on a permanent basis.

RURAL ADJUSTMENT FOR SOLE COMMUNITY HOSPITALS

Consistent with current policy, CMS will continue to increase payments to rural SCHs by 7.1 percent for all services paid under the outpatient PPS, with the exception of drugs, biologicals, brachytherapy seeds and services paid under the pass-through policy. The rule also clarifies that EACHs are treated as SCHs for purposes of receiving the 7.1 percent adjustment, assuming these entities otherwise meet the rural adjustment criteria. The adjustment is budget-neutral and is applied before calculating outliers and coinsurance.

TRANSITIONAL PASS-THROUGH PAYMENTS

In 1999, Congress created temporary additional or "transitional pass-through payments" for certain innovative medical devices, drugs and biologicals to ensure that Medicare beneficiaries had access to new technologies in outpatient care.

The statute provides a reduction of 2.0 percent in the conversion factor to finance payments for pass-through drugs and devices. For 2007, the final rule projects that pass-through payments will total about \$65.6 million, or 0.21 percent of total outpatient PPS payments. This represents a slight increase from the 2006 pass-through offset of 0.17 percent of total outpatient PPS payments. Changes to the transitional pass-through pool must be budget-neutral. Because CMS set aside

2.0 percent of the total outpatient payments for 2007, the difference, 1.79 percent, will be returned to the conversion factor.

CMS' estimate of pass-through spending represents such a small percentage of total outpatient PPS spending because there are only three pass-through device categories that will be eligible in 2007. Additionally, pass-through payments for drugs and biologicals have been effectively eliminated due to CMS' implementation of drug payment changes stipulated in the MMA.

CODING AND PAYMENT FOR CLINIC AND ED VISIT SERVICES

Background. Since April 2000, hospitals have been using evaluation and management Current Procedure Terminology (CPT) codes to report facility resources for clinic visits, emergency department (ED) visits and critical care services. Recognizing that the visit code descriptors were designed to reflect the activities of physicians and did not adequately describe the range and mix of services provided by hospitals, CMS instructed hospitals to develop internal hospital guidelines to determine the level of clinic or ED services.

In the past several years, different models for national coding guidelines for reporting facility services have been proposed and reviewed by CMS. In 2002, CMS specified that it would not create new codes to replace existing CPT visit codes for reporting hospital visits until national guidelines were developed, in response to the public's concern over implementing code definitions without national guidelines.

In 2003, the AHA and the American Health Information Management Association (AHIMA) submitted recommended guidelines based on the work of an independent expert panel comprised of representatives with coding, health information management, documentation, billing, nursing, finance, auditing and medical experience. CMS attempted to validate a modified version of the AHA/AHIMA guidelines; however, the agency's findings were inconclusive.

In the 2007 proposed rule, CMS proposed to establish new Health Care Procedure Coding System (HCPCS) level II G codes to describe hospital clinic visits, ED visits and critical care services. CMS proposed five levels of clinic visit G codes, five levels of ED visit G codes for two different types of EDs, and two critical care G codes.

The agency defined different types of hospital EDs, distinguished primarily by whether or not the ED is open 24 hours a day, 7 days a week (24/7). "Type A" EDs are those that, consistent with the CPT definition of an emergency department, are open 24/7 and meet the requirements as a "dedicated emergency department" under *Emergency Medical Treatment and Labor Act* (EMTALA) regulations. "Type B" EDs are those that do not meet CPT definitions of being open 24/7 but otherwise meet the EMTALA definition for a dedicated ED.

In response to the proposed rule, the AHA and AHIMA reconvened the Hospital Evaluation and Management Coding Panel (“expert panel”) to help develop the AHA and AHIMA’s comments. In their comment letter to CMS, the AHA and AHIMA opposed the implementation of new codes for hospital clinic and ED visits in the absence of accompanying national code definitions and national guidelines for their application. The AHA and AHIMA felt that creating temporary G codes without a fully developed set of national guidelines would increase confusion and require hospitals to manage two sets of codes – G codes for Medicare and CPT codes for non-Medicare payers – without the benefit of a standardized methodology or better claims data.

Codes and Coding Policy for 2007. In the final rule, CMS postpones finalizing the G codes for clinic visits and “type A” EDs until national visit coding guidelines have been established, when CMS indicates it will again consider their possible utility. **Therefore for 2007, CMS instructs providers to continue to use the CPT codes to bill for hospital clinic visits and for “type A” ED visits.**

However, CMS refines the definition of “type A” EDs to distinguish them from “type B”. A “type A” ED is a hospital-based facility or department that must be open 24 hours a day, 7 days a week and meet at least one of the following requirements:

- It is licensed by the state in which it is located as an emergency room or ED; or
- It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

For 2007, CMS finalizes and adopts five new G codes to describe hospital emergency visits provided in “type B” EDs. The definitions of these G codes are in Table 37 in the final rule. The new codes are intended to enable CMS to gather data to determine the relative resource costs of the services provided in “type B” EDs, as distinct from the emergency care provided in a 24/7 “type A” ED.

For critical care services, CMS instructs providers to continue to bill CPT codes 99291 (hosp. critical care, first 30-74 minutes) and 99292 (hosp. critical care, each additional 30 minutes), rather than the two G codes from the proposed rule. CPT 99291 and 99292 are assigned to APC 0617 (critical care). In addition, CMS creates a new G code, G0390 (trauma response team activation associated with hospital critical care service), effective January 1, 2007, which is assigned to APC 0618 (critical care with trauma response), with a median cost of \$491.66. This new G code may be reported and paid, in addition to the existing CPT codes for critical care, when there is a trauma activation that occurs that would permit reporting a charge under revenue code 68x.

Payment Policy for 2007. In 2006, the five levels of visit CPT codes are assigned to three APC payment levels. Because the three APC payment rates for clinic and ED visits are based on five levels of CPT codes, the two lowest levels of CPT codes (1 and 2) are assigned to the low-level visit APCs and the two highest levels of CPT codes (4 and 5) are assigned to the high-level visit APCs, with the single middle CPT level (3) assigned to the mid-level visit APCs.

In 2007, CMS creates five APC payment levels for clinic and ED visits, as they had proposed. They also create two payment levels for critical care – one for critical care without trauma activation and an additional payment when critical care is associated with trauma activation and response. Table 42 in the final rule displays the final assignment of CPT codes and other HCPCS codes to the new visit APCs for 2007.

In addition, for 2007, CMS will pay for “type B” ED visits at the clinic visit rates. CMS asserts that this is consistent with the agency’s current policy. In general, clinic visit APCs are paid less than emergency visit APCs. CMS will collect and analyze the hospital resource costs of visits to “type B” facilities in order to determine whether a proposal of an alternative payment policy may be warranted. The earliest that such a policy could be put into place would be in the final outpatient PPS rule for 2009.

CY 2007 Treatment of Guidelines. CMS notes that until national guidelines are established, hospitals should continue to use their own internal guidelines. CMS indicates that it hopes to receive additional input from the AHA and AHIMA and other stakeholders to address the areas of concern that are raised in the final rule, as well as other issues that the public has brought to its attention. The agency will communicate progress on the development of outpatient PPS visit guidelines through its Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> and may post other versions of draft guidelines to solicit additional public input during 2007. CMS reiterates its commitment to providing a minimum of 6-12 months notice to hospitals prior to implementing national guidelines. Therefore, the agency does not expect to implement national guidelines prior to 2008.

PAYMENT FOR MEDICAL DEVICES

Pass-through Devices. By law, devices are eligible for pass-through payments for two to three years. There are no categories of pass-through devices that will expire January 1, 2007, and one category will continue to be available – C1820 (generator, neurostimulator (implantable), with rechargeable battery and charging system). In addition, CMS establishes two new device categories in 2007 for transitional pass-through payment – L8690 (auditory osseointegrated device, external sound processor, replacement) and C1821 (interspinous process distraction device (implantable)).

Of the \$65.6 million that CMS estimates will go toward device pass-through payments in 2007, the agency projects \$44 million to be pass-through payments for the remaining current device category continuing into 2007, and \$21.6 million for the two new pass-through device categories and any additional categories that might become eligible in 2007.

Policies for Device-dependent APCs in 2007. CMS bases the payment rates for device-dependent APCs in 2007 on median costs calculated using claims with appropriate device C codes for devices reported on the claim. Unlike previous years in which the agency adjusted device-dependent APC payment rates to moderate decreases in median payment rates from one year to the next, CMS will not use any such adjustments for 2007. Table 18 in the rule displays the median costs used to set rates for device-dependent APCs.

In addition, in 2007 CMS will implement device-to-procedure code edits to address circumstances in which hospitals bill a device code but fail to also bill any procedure code with which the device could be used correctly. Table 19 in the rule lists the devices for which CMS will require the reporting of an associated procedure code. The devices also are posted on the CMS outpatient hospital Web site, along with a draft list of all the procedures with which they could be used appropriately and reported.

Payment Policy when Devices are Replaced without Cost. CMS finalizes its proposal to reduce the APC payment and beneficiary copayment for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. This is in response to device recalls and field actions that have taken place in recent years involving the failure of implantable devices. In these cases, CMS reports that manufacturers often offer to replace devices without cost to the hospital or to offer credit for the device being replaced if the patient required a more expensive device.

The new policy, which applies to services furnished in 2007, would only cover certain devices for which credit for the replaced device is given, or for which devices are replaced as a result of a warranty, field action, voluntary recall or involuntary recall, and certain devices which are provided free of charge. CMS calculates the amount of the reduction to the APC payment rate using the same method it uses to calculate the pass-through rate for implanted pass-through devices. The payment adjustment would be limited to the APCs listed in Table 20 of the rule when the purpose of the procedure is to replace a device identified in Table 21 and which the manufacturer furnished without cost or at full credit.

CMS implements the adjustment through the use of the existing FB modifier, whose definition is revised to read: "Item provided without cost to provider, supplier, or practitioner or credit received for replaced device (examples, but not limited to: covered under warranty, replaced due to defect, free sample)." In

cases in which the device being replaced is replaced without cost, the hospital will report a token device charge of less than \$1.01. In cases in which the device being inserted is an upgrade, the hospital will report the device charge as the difference between its usual charge for the device being replaced and the credit for the replacement device. The presence of the modifier will trigger an adjustment in payments for the APC in Table 20.

PAYMENT FOR DRUGS, BIOLOGICALS AND RADIOPHARMACEUTICALS

Drugs and Biologicals Eligible for Transitional Pass-through Payments.

In Table 22 of the final rule, CMS lists the 12 drugs and biologicals that will lose pass-through status after December 31. Table 23 lists 18 drugs and biologicals that have pass-through status in 2007. Current law requires that if a pass-through drug or biological is covered under a competitive acquisition program (CAP) contract, then the outpatient PPS payment rate is equal to the average price for the drug or biological under CAP, as calculated and adjusted by the Secretary of Health and Human Services. Pass-through drugs and biologicals not included in CAP are paid at the same rate as they would be if furnished in a physician office. For 2007, drugs and biologicals furnished in physician offices again will be paid at the rate of average sales price (ASP) plus 6 percent.

Of the 18 drugs and biologicals having pass-through status in 2007, 16 will be paid at ASP plus 6 percent and only two – HCPCS codes J2503 (Pegaptanib sodium injection) and J9264 (Paclitaxel injection) – will be paid at the CAP program rate. Updates to the ASP-based rates will be published quarterly and posted on CMS' Web site through 2007.

Drugs, Biologicals and Radiopharmaceuticals without Pass-through Status.

CMS currently pays for drugs, biologicals and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs).

Packaging Policy for Drugs, Biologicals and Radiopharmaceuticals. The MMA required that the threshold for establishing separate APCs for drugs and biologicals be set at \$50 per administration for 2005 and 2006. Therefore, in 2006, CMS paid separately for drugs, biologicals and radiopharmaceuticals whose median cost per day exceeded \$50 and packaged those whose median cost per day was less than \$50 into the procedures with which they were billed.

This MMA-mandated packaging threshold expires January 1, 2007. Starting in 2007, CMS will adjust the packaging threshold for inflation using the Producer Price Index for prescription drugs. Using this methodology, CMS establishes a 2007 packaging threshold of \$55.

The final rule continues the policy of exempting oral and injectible anti-emetic products from the packaging rule, making separate payment for all anti-emetic products. These products are listed in Table 25 of the rule.

Payment for Specified Covered Outpatient Drugs (SCODs). MMA provisions require special classification and payment of certain separately paid drugs, biologicals and radiopharmaceuticals that had previously (or before December 31, 2002) received pass-through payments. In 2007, the MMA requires that payment for these SCODs be equal to the average acquisition cost for the drug, subject to adjustment for drug handling and pharmacy overhead costs.

In the final rule, CMS maintains the payment for most separately payable drugs at ASP plus 6 percent, rather than implement its proposal to decrease drug payment to ASP plus 5 percent. The AHA and others had recommended that CMS not reduce payments for drugs below the ASP plus 6 percent rate these drugs would be paid in physician offices, stating that consistency in payments across settings is important. Therefore, for 2007, CMS will pay for the acquisition *and* pharmacy overhead and handling costs of SCODs at a *combined* rate of ASP plus 6 percent.

CMS will determine whether each SCOD will be separately paid or packaged once during the year; however, the agency will update the ASP-based payment rates on a quarterly basis as new ASP data are reported. Any SCODs with new payment rates will be posted on the CMS Web site. For the few drugs for which ASP data are not available, CMS will use the mean costs from the 2005 hospital claims data to determine payment rates until ASP data are available.

Payment for Radiopharmaceutical Agents. While CMS considers radiopharmaceuticals to be SCODs, the agency lacks ASP data on which to base the payment rates for them. In the final rule, CMS extends for one additional year its temporary policy of paying for separately payable radiopharmaceutical agents at the hospital's charge reduced to cost, instead of implementing its proposal to base payment on mean costs derived from the 2005 claims data. As with other SCODs, radiopharmaceutical payments are deemed to be inclusive of pharmacy overhead and handling costs. CMS intends to develop a suitable prospective payment methodology for radiopharmaceutical agents beginning in 2008.

Payment for New Drugs, Biologicals and Radiopharmaceuticals. For new drugs that have not yet been assigned a HCPCS code, CMS will continue to pay 95 percent of average wholesale price (AWP) for a new outpatient drug, biological or radiopharmaceutical for which a HCPCS code has not been assigned.

CMS also will continue to pay for new drugs and biologicals that have HCPCS codes but do not have pass-through status at the same ASP-based rate that they would receive in the physician office setting – ASP plus 6 percent. For those new drugs without ASP data, CMS will continue its current policy of paying at 95 percent of the drug's AWP.

Coding and Payment for Drug Administration. For 2007, CMS adopts the full set of CPT codes for drug administration services, rather than continue the 2006 drug administration coding structure with its combination of CPT and C codes. The AHA and others had supported this change in order to eliminate the burden of applying and maintaining two sets of codes for the same services – one set for Medicare and one set for other payers. However, because there is no comparable CPT code for HCPCS code C8957 (intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring the use of portable or implantable pump), CMS retains C8957 for use in 2007.

CMS also establishes six new APCs in 2007 to better distinguish costs related to infusions of different types and furnished over different lengths of time. Previously, payment for additional hours of infusion has been packaged due to the inability to use claims data to distinguish costs associated with infusions of different duration. However in 2005, codes used in the outpatient department distinguished between the first hour of infusion and additional hours of infusion. Using this newly available 2005 claims data, in 2007 CMS will assign CPT/HCPCS codes to six new drug administration level APCs, with payment rates based on the median costs from this 2005 claims data. The new drug administration APCs and their payment rates are described in Table 34 of the final rule.

Blood and Blood Products. For 2007, CMS generally sets payment rates for blood and blood product APCs based on their unadjusted median costs, as derived from 2005 claims data. Payment rates will be calculated using the same simulation methodology that CMS used in 2006. That is, CMS will use actual or simulated hospital blood-specific CCRs to convert charges to costs for blood and blood products. However, for seven products where the calculated 2007 payment rate would fall by more than 25 percent compared to its 2006 rate, CMS will provide a payment adjustment to limit the decrease to no more than 25 percent.

NEW TECHNOLOGY APCs

CMS re-assigns 22 services from new technology APCs to clinically appropriate APCs. These assignments are listed in Table 10 of the final rule.

OBSERVATION SERVICES

In 2006, CMS adopted coding changes and modified the outpatient code editor to simplify the reporting of observation services. Those changes shifted the determination of whether the observation services were separately payable or packaged from the individual provider to the outpatient PPS claims processing system.

For 2007, CMS increases payments for APC 0339 (observation) to \$442.81 (from \$425.08 in 2006). In addition, CMS will continue applying the criteria for separate payment for observation services and the coding and payment

methodology for observation services that were implemented in 2006 with one exception. As part of the proposed changes to the visit codes, direct admission to observation, when separately payable, will be assigned to APC 0604 (Level 1 clinic visits) with a 2007 payment rate of \$50.66. By contrast, in 2006, these services were assigned to APC 0600 with a payment rate of \$52.37.

INPATIENT-ONLY PROCEDURES

CMS removes 20 procedures from the inpatient-only list and assigns them to the clinically appropriate APCs, as shown in Table 46 of the rule.

PARTIAL HOSPITALIZATION SERVICES

For 2007, CMS will pay for partial hospitalization program (PHP) services at the per diem rate of \$233.37, which is a 5 percent reduction from the 2006 median per diem rate of \$245.65. CMS decided to implement this 5 percent reduction, rather than its proposed 15 percent reduction, in order to account for the downward direction of the PHP cost data and to address concerns about the implications of a 15 percent reduction in per diem payment for two consecutive years.

BENEFICIARY COINSURANCE

The final rule would decrease beneficiary liability for coinsurance for outpatient services. As required by law, for 2007 CMS maintains last year's maximum beneficiary coinsurance rate of 40 percent of the total payment to the hospital for that service. However, the average copayments for all outpatient services will drop from 27.5 percent in 2006 to 26.6 percent of total payments in 2007. Under Medicare law, the cap on coinsurance rates is to be reduced gradually until all services have a coinsurance rate of 20 percent of the total payment.

FINANCIAL IMPACT ON HOSPITALS

CMS estimates that the final rule will result in the following per-case change in payment from 2006 to 2007:

All Hospitals	3.0%
Urban Hospitals	3.1%
Large Urban	2.9%
Other Urban	3.2%
Rural	2.7%
Sole Community	2.6%
Other Rural	2.8%

Payments increase less than the market basket update of 3.4 percent due largely to three factors. First, hospitals lose 0.04 percent due to the increase in the pass-through estimate between 2006 and 2007. Second, CMS projects that actual outlier payments will exceed estimated payments in 2006, and, thus, it increases the outlier threshold in 2007, accounting for a reduction in average

payments of about 0.25 percent. Third, the temporary wage index increases provided by Section 508 of the MMA expired April 2006, accounting for an additional reduction of 0.17 percent.

CHANGES TO THE ASC PAYMENT SYSTEM FOR 2007

ASC LIST UPDATE

While CMS will not make any policy changes to the criteria for adding to or deleting items from the ASC list of approved procedures in 2007, the agency adds 21 procedures to the ASC list. These procedures are listed in Tables 47-B and 48 of the rule and would be assigned to one of the current nine ASC payment groups.

ASC PAYMENT RATE CAP

The final rule also implements the DRA requirement capping payment for ASC services at the outpatient PPS payment rate for surgical procedures performed at an ASC in 2007 when the ASC payment rate exceeds the outpatient PPS payment rate for the same procedure. The DRA cap applies to roughly 280 ASC procedures, which are identified in Addendum AA of the rule. The majority of procedures that are subject to the DRA cap fall under ASC payment group 1, the lowest paying APC group. These DRA cap procedures largely include procedures involving debridement, wound repair, skin grafts, fractures and dislocation treatment, and biopsies.

OTHER CHANGES

INPATIENT QUALITY MEASURES FOR FY 2008

The final rule also includes quality measures that hospitals must submit to qualify for a full market basket update for the fiscal year (FY) 2008 *inpatient* PPS. These additional measures for full payment in 2008 were adopted previously by the HCA as appropriate for public reporting on hospital inpatient care quality. The new measures include: patients' experience of care (measured with the HCAHPS survey); 30-day mortality rates for heart attack and heart failure; and care for surgical patients. Hospitals that fail to report these quality measures face a penalty of 2 percentage points from their inpatient update for 2008. More information about these new inpatient quality measures is available in the AHA's November 20 *Quality Advisory*, located at <http://www.aha.org/aha/advisory/2006/061120-quality-adv.pdf>.

EMERGENCY MEDICAL SCREENING IN CRITICAL ACCESS HOSPITALS

CMS changes the Critical Access Hospital (CAH) conditions of participation to allow a registered nurse with training and experience in emergency care and who is on-site at the CAH to serve as qualified medical personnel to screen

individuals who present to the CAH emergency department, if the nature of the patient's request is within the registered nurse's scope of practice, consistent with applicable state laws and such screening is permitted by the CAH's bylaws or rules and regulations. CMS clarifies that if the registered nurse begins the emergency medical screening and determines that the nature of the individual's condition is outside his/her scope of practice under state law, the appropriate authorized personnel must be contacted to see the patient within 30 minutes (or 60 minutes if the CAH is located in a frontier or remote area or permissible under the state's health plan) to conduct the emergency medical screening and provide stabilizing treatment.

MEDICARE CONTRACTING REFORM MANDATE

The MMA included "Medicare contracting reform" provisions intended to improve Medicare's administrative services to beneficiaries and health care providers and to bring standard contracting principles to Medicare, such as competition and performance incentives. The MMA provisions will phase-in the replacement of the current Medicare FIs and carriers with new Medicare Administrative Contractors (MACs). The transition to the new contracting program must be completed by October 2011.

The MMA contracting reform provisions repealed the ability of providers to nominate their FIs. In this rule, CMS adopts conforming changes to the regulations that will assign providers to the MAC that is contracted to administer the types of services billed by the provider within the geographic locale in which the provider is physically located. However, CMS also will allow large national hospital chains that were formerly permitted by CMS to nominate a FI, to request an opportunity to consolidate their Medicare billing activities to the MAC with jurisdiction over the chain's home office. Further, qualified chain providers that were formerly granted single FI status will not need to rerequest such privileges at this time.

One significant exception to the above pertains to suppliers of durable medical equipment, prosthetics, orthotics and supplies. CMS will continue to allow these suppliers to bill to the contractor assigned to the locale in which the beneficiary receiving the items or supplies resides.

HEALTH INFORMATION TECHNOLOGY

In the final rule, CMS summarizes the benefits of health information technology (IT) and reviews comments received regarding the agency's statutory authority to encourage the adoption and use of health IT, including possible inclusion in value-based purchasing and conditions of participation. A similar discussion was included in the inpatient final rule. While CMS does not make IT use a Medicare condition of participation, it reserves the right to revisit the issue in future rulemaking.

HEALTH CARE INFORMATION TRANSPARENCY INITIATIVE

In the final rule, CMS discusses development of a transparency initiative to provide comprehensive information on the quality and price of hospital and physician services and summarizes comments received on this initiative. On June 1, CMS published on its Web site the national average Medicare payment to hospitals for 30 common inpatient conditions and elective procedures. In addition, CMS included, by county, the range of payments made to hospitals in those areas along with the number of patients each hospital treated for specific conditions. Then on August 21, CMS posted Medicare charge and payment data for 61 procedures commonly performed in ASCs, including average charge and payment data for the nation and each county and state. Similar information for common hospital outpatient and physician services was released on November 20.

The agency intends to include more complete measures of health outcomes, patient satisfaction and volume of services, as well as more comprehensive measures of costs for an entire episode of care, and to do so in a meaningful and transparent way, to consumers and purchasers. CMS also indicated that this initiative will provide a national template for performance measures and a payment structure that aligns payment and performance.

PHYSICIAN FEE SCHEDULE CHANGES FOR 2007

The 2007 physician fee schedule final rule includes significant changes to the physician work and practice expense relative value units (RVUs) that are used to calculate payments for physician services. The completion of the “five-year review” of physician work RVUs resulted in significant increases in the physician work component for evaluation and management visit services. CMS also adopts a new and more accurate “bottom up” method for calculating practice expense RVUs. In addition, using the current statutory formula, CMS implements a 5 percent reduction in the 2007 physician fee schedule conversion factor. This results in a 2007 conversion factor of \$35.9848 (compared to \$37.8975 in 2006).

INDEPENDENT LAB BILLING FOR PHYSICIAN PATHOLOGY SERVICES

Starting in 2007, CMS will prohibit independent laboratories from directly billing the Medicare carrier for the technical component (TC) physician pathology services furnished to a hospital patient because CMS believes that its hospital prospective payment systems already reimburse the hospital for these services.

This policy was first proposed by CMS in 1999, but at the request of stakeholders, the agency delayed implementing the policy for one year to allow sufficient time for hospitals and independent labs to negotiate arrangements. Subsequent congressional action over the last six years has allowed for the

continuation of separate billing for TC services for a large number of hospitals that had arrangements with independent labs in place prior to CMS' 1999 proposal. In the MMA, Congress extended the grandfathering of these hospital arrangements through December 31, 2006.

In comments to CMS on the 2007 physician fee schedule proposed rule, the AHA urged CMS to use its administrative authority to continue this grandfather provision because these outsourced TC service costs were never incorporated into the inpatient and outpatient payment systems. However, CMS declined to do so and starting January 1, 2007, hospitals with arrangements with independent labs that had previously been grandfathered will now have to pay the labs directly for the services the lab provides to hospital patients. Since CMS believes that these costs are already included in the inpatient diagnosis-related groups, no additional payment will be provided to hospitals for these services.

The AHA will continue to advocate for enactment of the *Physician Pathology Services Continuity Act of 2006* (H.R. 6188 and S. 3609), as well as Section 202 of the *Health Care Access and Rural Equity Act of 2006* (H.R. 6030), which would permanently require Medicare to continue directly paying independent laboratories for the TC of physician pathology services furnished to hospital patients.

REDUCTION IN PAYMENT FOR CERTAIN IMAGING PROCEDURES

As required by the DRA, CMS will cap Medicare payment amounts for certain imaging services performed in physician offices at the amount paid to hospitals for similar services under the outpatient PPS. In identifying the list of services subject to this cap, CMS excludes:

- nuclear medicine services that are either non-imaging diagnostic or treatment services;
- all unlisted procedures;
- all mammography services;
- radiation oncology services that are not imaging or computer-assisted imaging services;
- all imaging services that are not separately paid under the outpatient PPS;
- certain non-invasive vascular diagnostic study codes (CPT 93875, 93922-93924, and 93965) which do not involve generation of an image; and
- any services for which fluoroscopy, ultrasound, or another imaging modality is included in the code whether or not it is used in the performance of the main procedure (for example, bronchoscopy with or without fluoroscopic guidance (CPT 31622)).

CMS will include carrier-priced services (such as PET). The full list of imaging services subject to the payment cap are in Addendum F of the final physician fee schedule rule; however, this table does not identify which services would actually receive payment cuts as a result of the DRA cap. However, based on our analysis, CMS reduces payments for 260 of the 653 services subject to the cap.