American Hospital Association

SPECIAL BULLETIN

Friday, November 2, 2007
This bulletin is three pages.

CMS RELEASES 2008 OUTPATIENT PPS/ASC FINAL RULE

Physician fee schedule final rule also released

The Centers for Medicare & Medicaid Services (CMS) yesterday released the outpatient prospective payment system (OPPS)/ambulatory surgical center (ASC) final rule for calendar year (CY) 2008. It also includes several changes to the inpatient prospective payment system (IPPS). Below are the rule's highlights.

OPPS Highlights:

- The rule includes a 3.3 percent market basket update for OPPS services, with hospitals projected to receive $36 billion for outpatient services in 2008.
- Hospitals must begin reporting on seven hospital outpatient quality measures in April 2008 in order to receive the full payment update in 2009. These measures, which were preliminarily adopted by the Hospital Quality Alliance, include five emergency department acute myocardial infarction measures and two surgical care improvement measures. In 2009, hospitals that fail to report data for these measures would receive a 2 percent reduction in their payment update.
- CMS will encourage efficiencies within the OPPS by:
    - Increasing the size of the outpatient PPS payment bundles. CMS finalized its proposal to package the costs of seven additional categories of items and services that the agency considers to be ancillary and supportive into the primary procedure. These include guidance services, image processing services, intra-operative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents and observation services.
    - Creating "composite" ambulatory payment classifications (APCs) that would provide one bundled payment for several major services provided on the same date of service during a single encounter. CMS finalized its proposal to create composite APCs for low-dose rate prostate brachytherapy and cardiac electrophysiologic evaluation and ablation. CMS also created two new composite APCs for extended outpatient visits with observation care.
- The agency continues to phase out the hold-harmless outpatient payment for certain rural hospitals with 100 or fewer beds by reducing from 90 percent to 85 percent the additional payment made to these hospitals.
- CMS will pay for certain separately payable drugs and biologicals at the rate of average sales price (ASP) plus 5 percent – a 1 percent reduction from 2007. The agency noted that this is a transitional policy, and that in 2009 it will adopt a relative ASP percent based on mean costs from claims.

American Hospital Association

SPECIAL BULLETIN

Friday, November 2, 2007
This bulletin is three pages.

- As recommended by the AHA, CMS withdrew its proposal requiring hospitals to bill separately for pharmacy overhead charges in addition to the cost of the pharmaceutical. CMS cited concern about the administrative burdens that hospitals would face in reporting drugs provided in the hospital outpatient department.
- CMS will reduce its fixed-dollar threshold for outliers to $1,575 in 2008 from the current $1,825.
- In response to concerns raised about potentially reduced access to services that would result from CMS' proposed 24 percent reduction in the per diem payment rate for partial hospitalization program (PHP) services, in the final rule CMS mitigates its proposed rate reduction by establishing a $203 per diem rate for PHP services in 2008. This PHP per diem rate still represents a 13 percent reduction from the current rate of $233.

ASC Highlights:
In this OPPS final rule, CMS reviewed many of the coverage and payment policies included in the August 2 ASC final rule and made updates to reflect more recent payment and utilization data and changes recommended by commenters.

- In order to make ASC payment changes budget neutral, CMS finalized its proposal to pay ASC services at a rate that is 65 percent of the hospital outpatient department rate for corresponding services. CMS used updated 2008 OPPS and physician fee schedule data, updated 2006 utilization data, and an updated geographic wage adjustment policy to calculate its final 2008 ASC conversion factor of $41.401.
- CMS made several additions and deletions to the list of allowed ASC procedures based on recommendations in comments.
- In order to allow physicians to refer patients for certain ancillary services to ASCs in which they have a financial interest, CMS excluded certain additional radiology and imaging services and outpatient prescription drugs from the definition of services covered under the self-referral prohibition that are paid for separately under the new ASC payment system and are "integral" to the surgical procedure.
- CMS revised the list of ASC services that will be designated as "office-based." Payments for office-based procedures are capped at the rate they would be paid if performed in physicians' offices.
- CMS finalized its proposal to make beneficiaries liable for the facility charges for procedures provided in the ASC that are excluded from CMS' list of approved-ASC procedures.

IPPS Highlights:
CMS also made several fiscal year (FY) 2008 IPPS changes in this rule.

- CMS included a correction notice for FY 2008 IPPS to reflect the reduction in the documentation and coding behavioral offset from 1.2 percent to 0.6 percent as required by P.L 110-90, which the president signed September 29. The rule contains the new

American Hospital Association

SPECIAL BULLETIN

Friday, November 2, 2007
This bulletin is three pages.

standard payment amounts and the new outlier threshold of $22,185 – a $275 reduction in the 2008 threshold.
- CMS also removed entirely the behavioral offset reduction from the hospital-specific rates for Sole Community Hospitals and Medicare Dependent Hospitals because the agency believes it lacks the legal authority to apply a documentation and coding adjustment to the hospital-specific rates.
- CMS, through an interim final rule with comment period, modified the regulations for emergency Medicare graduate medical education affiliated groups to provide continuing relief to home and host hospitals affected by disruptions in residency programs in the emergency areas declared after Hurricanes Katrina and Rita.

Other Changes:
- CMS finalized two changes to the Medicare requirements for Critical Access Hospitals (CAH) that participate under a grandfathered "necessary provider" CAH designation.
  - CMS will no longer permit a necessary provider CAH to enter into co-location arrangements with hospitals unless such arrangements were in effect on or before January 1, 2008 and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change.
  - CMS clarified that if a CAH operates a provider-based facility that was created after January 1, 2008, it must comply with the CAH distance requirement of a 35-mile drive to the nearest hospital (or 15 miles in the case of mountainous terrain or secondary roads). Rural health clinics are excluded from this requirement.
- CMS finalized its proposal to require hospitals to complete and document Medicare patients' medical histories and physical examinations conducted after admission and prior to surgery or a procedure requiring anesthesia services. CMS also will require post-anesthesia evaluations of patients before discharge or transfer from the post-anesthesia recovery area.

Physician Fee Schedule Final Rule Highlights:
CMS also released yesterday the physician fee schedule rule for CY 2008. The rule does not include the series of proposed self-referral changes that were in the proposed rule. CMS reports receiving a high volume of comments on those proposals and is taking additional time to "present a coordinated, comprehensive approach" for a future rulemaking.

Next Steps:
The OPPS/ASC final rule includes numerous important policy changes that the AHA is reviewing... watch for an AHA Regulatory Advisory with further details. Meanwhile, the 1,970-page rule is available at www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage and will be published in the November 27 *Federal Register*. Comments are requested in a number of areas and will be due to CMS within 60 days of the final rule's publication. The final rule takes effect January 1, 2008.