Illinois Hospital Association

July 25, 2007

Technical Bulletin #294: Medicare Outpatient Prospective Payment System, Medicare Ambulatory Surgery Payment System, Medicare Professional Services Payments, Other Medicare Outpatient Services Payment Systems, Critical Access Hospital Qualifying Criteria, CMS Proposed and Final Rules for FY2008

During the month of July, the Centers for Medicare and Medicaid Services (CMS) published a mix of proposed rules governing Medicare payments for outpatient services provided in calendar year (CY) 2008. These include: the proposed 2008 Hospital Outpatient Prospective Payment System (OPPS) rule, a proposed FY2008 Ambulatory Surgery Centers (ASC) payment rule, as well as a final rule designed to better align the ASC payment system with the system governing payments for similar procedures performed in hospitals. This rule was put on public display on July 16, with a scheduled Federal Register publication date of August 2. For your reference, these rules can be viewed at:

www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage
www.cms.hhs.gov/ASCPayment/

Also, on July 12, CMS published in the Federal Register proposed Medicare payment changes for 2008 for Ambulance services, End-Stage Renal Disease services and Physician Services. All of the aforementioned rules are effective for services rendered on or after January 1, 2008. For your information, the following synopsis is provided:

HOSPITAL OUTPATIENT SERVICES:

- This rule is scheduled for publication in the Federal Register on August 2.
- As these are proposed rules, there is a comment period. **CMS will accept comments as long as they are received no later than 5:00 pm, September 14.**
- The update factor used to calculate the APC rates is 3.3%; this factor represents the full market basket increase and is applied in accordance with the Medicare Modernization Act of 2003. However, when combined with other factors such as the budget neutrality adjustment and the increase in the outlier threshold, the effective rate of increase is 3.5%. **The proposed conversion factor amount for FY2008 is $63.693.**
- CMS proposes to use the final FY2008 hospital inpatient wage index to calculate the outpatient payment rates and co-insurance amounts. The inpatient final rule is scheduled to be published no later than August 1.
- CMS proposes that hospitals begin to report ten hospital quality measures in 2008 in order to receive the full payment update in FY2009. These measures, which were adopted by the Hospital Quality Alliance, include five emergency department acute myocardial infarction measures, two surgical care improvement measures and one measure each for the treatment of heart failure, community-acquired pneumonia and diabetes. In CY 2009, hospitals that fail to report outpatient data for any of these measures would receive a 2% reduction in their payment update.

- CMS is also proposing to increase the size of the OPPS payment "bundles" as recommended by the Medicare Payment Advisory Commission (MedPAC). This proposal would provide greater flexibility to hospitals when implementing efficient care. Currently, certain items and services, including low-cost drugs, anesthesia services, operating and recovery room usage, implantable devices and medical supplies are packaged in the payment for associated APCs. CMS is proposing to package payment for seven additional categories of supportive and ancillary services in order to encourage hospital efficiencies in selecting the most clinically appropriate diagnostic and treatment approaches.

- Also, CMS is proposing to establish a new category of APC, the "composite" APC, for which a single payment would be made for multiple major procedures performed during a single hospital encounter. The proposal sets up two of these composite APCs: one for low dose rate prostate brachytherapy and one for cardiac electrophysiological evaluation and ablation.

- In order to maintain its current statutory target of 1% of total outpatient payments, CMS is increasing the fixed dollar threshold that would have to be met in order for a claim to qualify for an outlier payment. **Therefore, to qualify for an outlier payment in FY2008, the cost of a service must exceed both 1.75 times the APC payment rate and the APC payment rate plus a $2,000 fixed dollar threshold.** If the cost of the claim does satisfy both criteria, the actual outlier payment will equal 50% of the difference between the cost and 1.75 times the APC payment rate.

- Pursuant to Section 411 of the Medicare Modernization Act, transitional corridor payments are extended through December 31, 2008 for rural hospitals with less than 100 beds and sole community hospitals located in rural areas. **However, in accordance with the Deficit Reduction Act of 2005 (DRA), the percentage paid to hospitals in FY2008 is reduced to 85% from the current 90%.**

- CMS proposes to reduce payment for pass-through drugs and biologicals from the current "average sales price + 6%" in FY2007 to "average sales price + 5%" in FY2008.

- The proposed per diem rate for partial hospitalization for FY2008 is $179.88; this is a substantial decrease (approximately 23%) from the final rate in FY2007 ($233.65).

AMBULATORY SURGICAL SERVICES:

- CMS essentially killed two birds with one stone in the publications: a finalized ASC payment rule for FY2007 linking that payment system with the existing OPPS and a proposed ASC payment rule for FY2008 building upon the changes implemented in the prior year.

- The final FY2007 rules permits payments to ambulatory surgery centers for any surgical procedure that CMS determines does not pose a safety risk to Medicare beneficiaries and does not require an overnight stay. Consequently, the final rule adds an additional 790 surgical procedures for FY2008. Then in the proposed FY2008 OPPS/ASC rule, more procedures are added, resulting in over 3,300 outpatient surgical procedures now covered under the revised ASC payment system.

- The rule provides that payments for ASC procedures will be 65% of the payment that would have been made if the procedure were performed in a hospital outpatient department. **Therefore, the conversion factor for the ASC APCs is set at 65% of the OPPS APC conversion factor in 2008 or $41.400.**

- The new ASC payment rates will be transitioned over four years, beginning in FY2008, with full implementation in 2011. Therefore, the blend of "old ASC" payments and "new ASC" payments will be 75% / 25% in FY2008, 50% / 50% in FY2009, 25% / 75% in FY2010 with 100% transition in FY2011.

- The proposed rule limits payment for ASC services generally performed in private physicians' offices to the lower of the ASC rate or the physician fee schedule (RBRVS) rate.

PROFESSIONAL SERVICES PAYMENTS (RBRVS):

In the July 12 Federal Register, CMS published proposed changes to the work and practice expense relative value units used in the computation of Medicare payments for professional services. This proposal is in accordance with current law that requires CMS to perform a 5-year review of relative value units, and incorporate changes according to current practices. However, that publication did not address payment amounts. The Federal Register contained the proposed revisions to the Medicare Resource-Based, Relative Value Scale (RBRVS) physician fee schedule and conversion factor effective January 1, 2008. In addition to providing the data and methodology for computing Medicare Part B payments for physician services, this fee schedule takes on added importance for your facility for the following reason: It provides the basis for calculating payments for Medicare hospital outpatient rehabilitation services. As you may recall, the Medicare outpatient prospective payment system specifically excludes outpatient therapy procedures (physical, occupational and speech) from the APC payment methodology. The Balanced Budget Act of 1997 established the Medicare physician fee schedule as the basis for calculating Medicare payments for these hospital-based outpatient services. The "Non-Facility" column references in the fee schedule are used in determining these payment rates. Following are highlights:

- As these are proposed rules, there is a comment period. **CMS will accept comments as long as they are received no later than 5:00 pm, September 7.**

- In accordance with the Medicare Modernization Act of 2003 (MMA), the proposed rule sets the update to payments for professional services in FY2008 at -9.9%.

- Payments made under the RBRVS fee schedule can be increased by 1.5% for those physicians who report quality data in accordance with CMS instructions.

- The work component values for anesthesia services are proposed to increase by 32%.

- The proposed rule does not contain a specific amount for the adjustment factor; this is to be published specifically in the final rule. **However, the final FY2007 conversion factor was $37.8975; applying the MMA-mandated decrease of 9.9% to that factor results in an FY2008 conversion factor of $34.1457.** For hospital-based services, the **Fully Implemented**, **Facility** column is used to calculate the Practice Expense payment.

- **For Illinois, these are the CY 2008 Proposed Geographic Practice Cost Indices (GPCI):**

Locality:	Work GPCI	Practice Expense GPCI	Malpractice GPCI
Chicago	1.026	1.103	1.905
Suburban Chicago	1.018	1.092	1.642
East St. Louis	0.989	0.929	1.773
Rest of Illinois	0.975	0.877	1.207

AMBULANCE SERVICES:

- As these are proposed rules, there is a comment period. **CMS will accept comments as long as they are received no later than 5:00 pm, September 7.**

- The proposed rule provides that payments for various levels of ambulance services will increase by the full market basket percentage in FY2008. While the exact increase will not be published until the release of the final rule, it is estimated that this increase will equal 3.3%

END-STAGE, RENAL DIALYSIS PAYMENTS:

- As these are proposed rules, there is a comment period. **CMS will accept comments as long as they are received no later than 5:00 pm, September 7.**

- The base composite rate for hospital-based, renal dialysis treatments is $136.68.

- The proposed drug add-on adjustment for FY2008 is 15.5%, an increase from the 14.9% currently in effect in FY2007.

- The proposed rule continues the application of the 60% labor portion of the rate. For your reference, the following are the proposed wage index values for Illinois in FY2008:

AREA	WAGE INDEX
Bloomington/Normal	0.9839
Champaign/Urbana	0.9908
Chicago/Naperville/Joliet	1.1156
Danville	0.9452
Decatur	0.8519
Kankakee	1.2428
Lake County	1.0857
Peoria	0.9795
Rockford	1.0191
Rock Island	0.9316
St. Louis	0.9413
Springfield	0.9437
Rural	0.8800

EXTENSION OF THERAPY CAPS:

- The Deficit Reduction Act of 2005 (DRA) established an “exceptions process,” by which providers would be exempt from the application of the caps through December, 2007. The proposed rule establishes that in accordance with the DRA, this exceptions process is no longer applicable for services provided on or after January 1, 2008.

- The therapy cap for FY2008 will equal the current cap amount increased by the medical economic index. That amount is estimated to be $1,840.

CRITICAL ACCESS HOSPITAL RELOCATION REGULATIONS:

Almost lost in the plethora of rules and figures presented in the OPPS proposed rule is a section addressing proposed changes affecting critical access hospitals. The provisions addressed here establish guidelines for situations in which a CAH is co-located with another facility (i.e., a rehabilitation or psychiatric facility) or enforcement of the 35-mile distance requirement. However, the proposed rule is silent on one regulation that has been the subject of much discussion over the past year or so and that is the qualifying criteria with which a critical access hospital must comply if it engages in a hospital replacement or re-location project. Specifically, there are concerns, not only among Illinois CAHs, but nationally as well, over CMS’ interpretive guidelines relating to the 75% rule. A critical access hospital that re-locates or expands must demonstrate that it will retain at least 75% of its services, 75% of its employees and 75% of its patients in the new facility. CMS then requires that the hospital’s CEO attest to that fact.

While numerous discussions regarding this rule and its impact on our critical access hospitals have taken place in the past year, no recent directives from CMS have been published in regulation. The Illinois

Hospital Association may like take the opportunity to raise this issue again with CMS as part of its association comment letter on the OPPS rule which will be sent within the next few weeks. In this proposed rule, CMS, itself, states that it believes that the critical access program is intended "…to maintain hospital-level services in rural communities while ensuring access to care." A very rigid interpretation and implementation of this 75% rule for re-location or replacement of a CAH by CMS would appear contrary to its intent as prescribed in its own rule.

IHA hopes this information is useful to you. **As is the case with all CMS proposed Medicare payment rules, if your facility intends to comment directly, please forward a copy of your comments to IHA.** However, if you have specific questions, please feel free to contact me at the address and phone number listed below.

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