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Details for: PROPOSED 2009 POLICY, PAYMENT CHANGES FOR HOSPITAL OUTPATIENT DEPARTMENTS AND

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PROPOSED 2009 POLICY, PAYMENT CHANGES FOR HOSPITAL OUTPATIENT DEPARTMENTS AND AMBULATORY SURGICAL CENTERS

OVERVIEW

On July 3, 2008, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates for both hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) for calendar year (CY) 2009. The update to ASC rates constitutes the second year of a four-year transition to align these rates with those paid to HOPDs and minimize the impact of financial incentives on decisions about treatment settings. The proposed rule also seeks to promote higher quality, efficient services for people with Medicare by proposing improvements to the Hospital Outpatient Quality Data Reporting Program (HOP QDRP).

CMS projects that total payments for services furnished to people with Medicare during CY 2009 under the Outpatient Prospective Payment System (OPPS) will be \$28.7 billion, compared with projected payments of \$26.9 billion in CY 2008, while total projected CY 2009 payments under the ASC payment system will be approximately \$3.9 billion, compared with projected payments of \$3.5 billion in CY 2008.

BACKGROUND

Outpatient Prospective Payment System: Since August 2000, Medicare has paid hospitals for most services furnished in their outpatient departments under the Outpatient Prospective Payment System (OPPS). Medicare currently pays more than 4,000 hospitals and CMHCs for outpatient services under the OPPS, including general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities,

long-term acute care hospitals, children's hospitals, and cancer hospitals. The OPSS payments cover the costs of facilities, equipment, supplies, and hospital staff, but do not pay for the services of physicians and nonphysician practitioners who are paid separately under the Medicare Physician Fee Schedule (MPFS). Beneficiaries share in the cost of services under the OPSS by paying either a 20 percent coinsurance rate or, for certain services, a copayment required under the Medicare law not to exceed 40 percent of the total payment for the APC. The statutory copayment is gradually being replaced by the 20 percent coinsurance as payment rates for the APCs increase. CMS estimates that the beneficiary share of the proposed total payments for Medicare covered outpatient services will be about 23 percent in CY 2009.

The OPSS groups services that are clinically similar and involve similar resource use into ambulatory payment classifications (APCs). The APC payment rates are adjusted for geographic cost differences, and payment rates and policies are updated annually through rulemaking. The final rule is generally issued by November 1 each year and, unless otherwise specified, becomes effective January 1 of the subsequent year.

In addition to the APC payments, the OPSS allows for temporary (two to three-year) add-on payments to ensure beneficiary access to certain new devices that lead to substantial clinical improvements in care, while cost data are collected to determine how to incorporate payment for these technologies into payment for existing or new APCs. The system also allows for additional payment (called an outlier payment) when the cost of furnishing an item or service in the APC group exceeds 1.75 times the APC payment rate, as well as a fixed dollar threshold estimated to be \$1,800 for CY 2009 in the proposed rule.

Ambulatory Surgical Centers (ASCs): Since January 1, 2008, ASCs have been paid under a revised ASC payment system. Previously, a limited number of surgical services were included on the ASC list for payment in ASCs. The procedures on the ASC list were assigned to one of nine payment groups based on estimates of the costs incurred by the ASC to perform the procedure. The revised ASC payment system allows Medicare to pay for many more surgical services in an ASC and the payment is set at a percentage of the payment rates for the same service under the OPSS. For device-intensive services (where device costs account for 50 percent or more of the total cost of the service), ASCs receive the same payment for the device cost as would be made under the OPSS. For new ASC services that are predominantly performed in physicians' offices, the ASC payment is capped at the amount the physician is paid under the Medicare Physician Fee Schedule for practice expenses for doing the same service in an office. To minimize potential disruptions in patient care and administrative burden, the revised ASC payment rates are being phased in over four years. CY 2009 will be the second year of the transition.

The prior ASC payment system was designed to pay for surgical procedures that could be safely provided in a less intensive ambulatory setting than the hospital. Over time, ASCs have become well-established and the revised payment system will now pay for a broader array of surgical procedures, including procedures that are either more extensive or less intensive than those paid under the prior ASC payment system, to provide broad access to surgical procedures in all settings that are clinically appropriate to the needs of patients. This change added approximately 800 procedures to the ASC list of covered surgical procedures for CY 2008. Only those surgical procedures that would be expected to pose a significant safety risk to beneficiaries or that are expected to require an overnight stay following the procedure in the ASC are excluded from coverage. The range of payments for ASC services also expanded from \$333 to \$1339 under the previous system to approximately \$4 to \$24,816 under the CY 2008 revised ASC payment system.

SIGNIFICANT PROPOSALS FOR CALENDAR YEAR 2009**Outpatient Prospective Payment System:**

CMS projects that proposed CY 2009 payment rates under the OPSS will result in a 3.2 percent increase in Medicare payment for providers paid under the OPSS.

Proposals to Strengthen Ties between Payment and Quality:

- *Payment reduction for failure to report quality measures* – As required by law, CMS is proposing to reduce the proposed CY 2010 market basket inflation update for those hospitals that fail to successfully report required quality measures beginning in CY 2009 by two percentage points. The proposed reduction would not apply to payments for pass-through drugs and devices, separately payable drugs and biologicals, separately payable therapeutic radiopharmaceuticals, and services assigned to New Technology APCs. CMS is also proposing to reduce the beneficiary copayment amount for services furnished in hospitals that have not met their reporting requirements so that beneficiaries share in the reduction of payments to these hospitals.
- *New quality measures to be reported* – CMS is proposing to add four imaging efficiency measures that would be calculated using Medicare claims data, increasing the number of measures that must be reported from 7 in CY 2008 to 11 in CY 2009, in order for hospitals to receive the full market basket updates in CY 2010. For consideration for future OPSS updates, CMS is also seeking public comment on eighteen additional potential quality measures in areas including cancer care, emergency department throughput, screening for fall risk, and management of certain clinical conditions such as depression, stroke and rehabilitation, osteoporosis, asthma, and community-acquired pneumonia.
- *Validation of quality reporting* – CMS is also proposing to implement a data validation approach for CY 2010 starting with January 2009 encounters. This proposed validation approach would randomly select 800 reporting hospitals and validate the accuracy of reported data by selecting 50 records per selected hospital on an annual basis.

Proposed Changes to Ambulatory Payment Classifications:

- *New APCs for certain Type B emergency department visits* – The great majority of hospital emergency departments, classified as Type A emergency departments, offer services 24 hours per day, 7 days per week. However, Medicare recognizes a subset of emergency departments, classified as Type B emergency departments, which offer emergency-level services but are not open 24 hours per day, 7 days per week. Currently, CMS pays for emergency visits provided in Type B emergency departments at the same rate as a non-emergency visit to the outpatient department. CMS now has data that show most emergency visits in Type B emergency departments are more expensive than clinic visits but less costly than emergency visits in Type A emergency

departments, and is proposing to create four new APCs for Type B emergency department visits that would be paid based on claims data from these providers. As the costs for the most intensive emergency visits are approximately the same between Type A and B emergency departments, CMS would use a single APC for these visits.

- *Composite APCs for multiple imaging services* – CMS is proposing to establish five imaging composite APCs based on the families of codes used in the MPFS for the multiple imaging procedure payment reduction policy under that system. These composite APCs, which would provide a single APC payment when two or more imaging procedures using the same imaging modality were provided in a single session, would encourage imaging efficiencies under the OPPS. The proposed new imaging composite APCs include:
 - Ultrasound;
 - Computed tomography (CT) and computed tomographic angiography (CTA) without contrast;
 - CT and CTA with contrast;
 - Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) without contrast; and
 - MRI and MRA with contrast.

Proposals for Payment of Certain Services:

Device-dependent APCs – CMS is proposing to set the payment rates using the established device-dependent APC ratesetting methodology based on claims that include the full costs of required implanted devices.

- *Drugs and pharmacy overhead* – CMS is proposing to pay for separately payable drugs and biologicals based on hospitals' reported costs at the average sales price (ASP) plus 4 percent. CMS is also proposing to modify the Medicare cost report to establish two cost centers for reporting drugs with high and low pharmacy overhead costs. This would allow CMS to estimate drug and pharmacy overhead costs more accurately in future ratesetting.
- *Drug administration services* – CMS is proposing to restructure the drug administration APCs from a 6-level into a 5-level structure to more closely align payment to hospital claims data and eliminate unnecessary APCs.
- *Nuclear medicine procedures* – CMS is proposing to set the payment rates for nuclear medicine procedures based on the established ratesetting methodology using claims that include a charge for a required diagnostic radiopharmaceutical or other radioactive product.
- *Therapeutic radiopharmaceuticals* – CMS is proposing to provide payment for separately payable therapeutic radiopharmaceuticals that submit ASP information through the existing ASP process at ASP+4 percent as the best proxy for therapeutic radiopharmaceutical average acquisition and handling costs. If ASP information is not available, CMS is proposing that payment would be based upon mean costs from hospital claims data.

- *Brachytherapy sources* – CMS is proposing to pay for brachytherapy sources based on median unit costs, as calculated from claims data; according to the standard OPPS payment methodology. _
- *Implantable biologicals* – CMS is proposing to package payment for implantable biologicals without pass-through status to make payment for implantable biological devices consistent with payment for implantable nonbiological devices.

Proposed Change for Partial Hospitalization Services, including services provided by CMHCs: CMS is proposing two separate Partial Hospitalization Program (PHP) rates: one for days with three services (\$140) and one for days with four or more services (\$174). CMS is also proposing to continue the CMHC multiple outlier threshold at 3.4 times the APC payment amount for CY 2009.

Ambulatory Surgical Center Payment System:

Proposed Changes to the ASC List of Covered Surgical Procedures – CMS is proposing to add nine surgical procedures to the list of procedures for which Medicare will pay when performed in an ASC. These include three procedures for which the American Medical Association's CPT (Current Procedural Terminology) Editorial Panel has created new codes and descriptors, and six procedures that were previously excluded from payment under the ASC payment system.

CMS is also proposing to add five procedures to the list of office-based procedures (subject to payment at the lesser of the office practice expense payment to the physician or the standard ASC rate), and to update the list of device-intensive procedures and covered ancillary services and their rates, consistent with proposals in the OPPS update.

Proposed Payment Adjustments and Annual Updates – The revised ASC payment rates were set to reflect the same relativity of resource use among services as under the OPPS, taking into consideration the lower costs of ASC services and the requirement for budget neutrality in CY 2008, the first year of the revised payment system. Any changes CMS proposes to make to the ASC payment system for CY 2009 will not increase or decrease aggregate Medicare spending. The law does not allow an inflation update to the ASC payment system for CY 2009.

CMS will accept comments on the proposed rule until September 2, 2008, and will respond to comments in a final rule to be issued by November 1, 2008.

For more information on the CY 2009 proposals for the OPPS and ASC payment system, please see the CMS Web site at:

OPPS: <http://www.cms.hhs.gov/HospitalOutpatientPPS/>

ASC payment system: <http://www.cms.hhs.gov/ASCPayment/>

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