# MEDICARE

# 2008 Medicare Update
## Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System

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# Outline – Hospital Outpatient Prospective Payment System (OPPS)

- Background
- Quality Measures
- Expanded Packaging
- Composite Ambulatory Payment Classification (APC) Groups
- Devices Replaced with Partial Credit
- Drugs and Biologicals
- Radiopharmaceuticals
- Positron Emission Tomography (PET) Scans
- Brachytherapy Sources

# Outline – Revised Ambulatory Surgical Center (ASC) Payment System

- Background
- Revised Payment Methodology
- Expanded List of ASC Procedures
- Device-Intensive Procedures
- ASC-Covered Ancillary Services
- Transition for Implementation of Revised Rates
- Updating the Revised ASC Payment System

# Questions or Considerations for the Council

- Suggestions for disseminating information to physicians and ASCs regarding the revised ASC payment system, particularly with respect to new ASC procedures

- Thoughts regarding efforts to encourage quality in ASCs, including suggestions for appropriate quality measures

- Recommendations for disseminating information to physicians regarding services that are not covered under the OPPS (inpatient only) and surgical procedures that are excluded from ASC payment

# Key Websites

- Outpatient Prospective Payment System:

  http://www.cms.hhs.gov/HospitalOutpatientPPS/

- Ambulatory Surgical Center Payment System:

  http://www.cms.hhs.gov/ASCPayment/

# Background: OPPS

- OPPS rates based on relative payment weights calculated for groups of services (APCs) that are similar in terms of clinical characteristics and resource costs

- CMS annually updates APC groups and weights using most recent:
  - Claims data
  - Cost reports
  - Wage indices

# CY 2008 OPPS/ASC Final Rule

- On public display – November 1, 2007
- Published in the *Federal Register* –November 27, 2007
- Public comments on OPPS and ASC treatment of new CY 2008 HCPCS codes accepted through January 28, 2008
- No changes for:
  - Clinic and emergency visits
  - Drug administration services
  - Ratesetting method for device-dependent APCs (no adjustment for charge compression)

# Quality Measures

- CY 2008 OPPS payments estimated to increase by approximately 10% from CY 2007 to $36 billion

- Seven reporting standards for ED AMI transfers and perioperative care are first step toward value-based purchasing
  - Proposed reporting standards for diabetes, heart failure, and community-acquired pneumonia not adopted

- By law, hospitals that fail to report will receive 2.0 percentage point reduction to payment update, beginning in CY 2009

# Expanded Packaging

- Since 2000, overall packaging has decreased and procedure groupings have grown smaller

- Smaller payment bundles provide payment incentives to increase service complexity

- Larger payment bundles promote efficiency and stability of payment over time, provide hospitals maximal flexibility to manage resources

- CY 2007 policy:  packaged services include low cost drugs and supplies, among others

# Expanded Packaging (cont.)

- CY 2008 policy:  extend current packaging to supportive and ancillary services
  - Guidance services
  - Image processing services
  - Intraoperative services
  - Imaging supervision and interpretation services
  - Diagnostic radiopharmaceuticals
  - Contrast agents
  - Observation services

# Composite APCs

- CMS encourages efficiencies by making one comprehensive payment for several major services performed together

- CY 2007 policy:  when patients undergo multiple major procedures in a single episode of care, hospitals receive payment for each component

- CY 2008 policy:  composite APCs for low dose prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, and extended assessment and management

# Devices Replaced with Partial Credit

- CY 2007 policy:  for expensive implantable devices replaced without cost or with full credit, reduce APC payment by amount of estimated device cost

- CY 2008 policy:  When hospitals receive <u>partial</u> credit toward cost of replacement device, reduce APC payment by 50% of estimated device cost
  - Partial credit must be 50% or more
  - Full credit/no cost policy to continue

# Drugs and Biologicals

- Medicare Modernization Act (MMA) mandates payment based on "average acquisition cost," including pharmacy overhead costs
- CY 2007 policy:  Average sales price (ASP)+6% for drugs over $55 per day
- CY 2008 policy: ASP+5% for drugs over $60 per day
  - Updated packaging threshold based on Producer Price Index (PPI) for prescription drugs
  - Hospital claims data indicate mean drug costs of ASP+3%, including acquisition and pharmacy handling costs
  - ASP+5% represents transition from CY 2007 payment of ASP+6% to claims-based payment in the future

# Radiopharmaceuticals

- Radiopharmaceuticals subject to MMA payment mandate of average acquisition cost
- CY 2007 policy:  all radiopharmaceuticals meeting $55 per day threshold paid at cost using hospital overall cost-to-charge ratio (CCR)
- CY 2008 policy:
  - Payment for <u>diagnostic</u> pharmaceuticals packaged into associated imaging procedures
  - Prospective payment rates for separately payable <u>therapeutic</u> radiopharmaceuticals based on mean costs from claims data (including handling costs)

# PET Scans

- CY 2007 policy:  PET/CT scans assigned to New Technology APC
  - Diagnostic radiopharmaceuticals (FDG) paid separately at charges reduced to cost
- CY 2008 policy:  reassign PET/CT scans to a clinical APC for nonmyocardial PET scans
  - FDG packaged into payment for PET and PET/CT as part of expanded packaging
- Multiple myocardial PET scan services continue to be paid through the same APC as single myocardial PET scan services

# Brachytherapy Sources

- CY 2007 policy:  paid at cost using hospital overall cost-to-charge ratio
- CY 2008 policy:  prospective payment based on source-specific median costs for brachytherapy sources as reflected in claims data
- Per the Tax Relief and Health Care Act of 2006, CMS created separate APCs with differential payments for stranded and non-stranded sources
- Eligible for outlier payments and the 7.1% rural adjustment

# ASC Payment System: Background

- Current system provides payment for more than 2,500 surgical procedures across 9 payment groups
  - Clinically disparate
  - Last rebased in March 1990 using 1986 data
  - Payments range from $333 to $1339
- MMA required CMS to revise payment system by January 1, 2008
- CMS issued NPRM outlining new payment methodology in August 2006
- Final revised methodology adopted in August 2, 2007 final rule

# ASC Final Rule Revised Payment Methodology

- OPPS relative payment weights multiplied by ASC conversion factor (CF) for CY 2008
- CY 2008 OPPS/ASC final rule provides updated final CY 2008 rates:
  - Payments range from $3.75 to $24,815.65
  - CY 2008 ASC conversion factor = $41.401
- Uses IPPS pre-reclassification wage indices with June 2003 OMB geographic localities
  - Labor-related factor is 50%
- Payment capped for new ASC procedures that are usually performed in the physician's office setting at the physician's office rate
- Beneficiary copayment 20%, except for screening flexible sigmoidoscopies and colonoscopies where the law requires 25%
- Many final payment policies parallel the OPPS, consistent with PPAC's recommendation that uniform payment policies should apply across settings

# ASC Final Rule Revised Payment Methodology (cont.)

- Per MMA, revised payment system must be budget neutral

- CY 2008 final rule implements budget neutrality adjustment of 65% of OPPS conversion factor
  - Accounts for shifts in site of service and lower costs in ASCs relative to hospital outpatient departments (consistent with GAO Report recommendations)

- In subsequent years, CMS will scale weights so that changes to OPPS weights do not increase or decrease aggregate ASC payments

# Expanded ASC Procedure List

- August 2, 2007 ASC final rule expands access to approximately 790 additional surgical procedures in the ASC setting
- Includes all surgical procedures except those that pose a significant safety risk or are expected to require an overnight stay
- CY 2008 OPPS/ASC final rule adds more procedures to the ASC list, bringing total to about 3,400 covered surgical procedures

# Device-Intensive Procedures

- As under OPPS, ASC payment for high-cost devices packaged into associated procedure payment – same payment for the device will be made under the OPPS and ASC payment systems
- Budget neutrality adjustment applied only to service component of ASC payment
- Same ASC policies as the OPPS related to full credit/no cost and partial device replacement apply
- Devices with OPPS pass-through status paid separately at contractor-priced rates

# Covered Ancillary Services

- Defined as services integral to and provided immediately before, during, or after covered surgical procedures

| Separately Paid Ancillary Service | Payment Methodology |
|---|---|
| Radiology services paid separately under OPPS | Lesser of ASC rate or MPFS non-facility practice expense |
| Drugs and biologicals paid separately under OPPS | OPPS payment methodology (ASP+5%) |
| Brachytherapy sources | OPPS prospective payment rates |

# Transition for Implementation of Revised Rates

- Four-year transition period for rates calculated according to revised methodology

- Payment based on blend of revised payment rates and CY 2007 payment rates:

    – CY 2008:  25/75

    – CY 2009:  50/50

    – CY 2010:  75/25

    – CY 2011:  100% revised rates

# Updating the Revised ASC Payment System

- ASC payment system will be updated annually in the OPPS/ASC rulemaking cycle, allowing for changes in medical practice and public comment each year
  - Consistent with PPAC's recommendation regarding a systematic and adaptable payment system for ASC services

- Conversion factor update beginning in CY 2010 based on Consumer Price Index for All Urban Consumers (CPI-U)

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