

## DEPARTMENT OF HEALTH & HUMAN SERVICES

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# FACT SHEET

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## **PAYMENT, POLICY PROPOSALS FOR HOSPITAL OUTPATIENT SERVICES IN 2008 EMPHASIZE VALUE-BASED PURCHASING**

### **Overview**

On July 16, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to update the hospital Outpatient Prospective Payment System (OPPS) effective for services furnished during calendar year (CY) 2008 to people with Medicare. In addition to proposing payment changes for services in hospital outpatient departments (HOPDs), the proposed rule includes provisions that would encourage higher quality care through the reporting of quality measures and would improve efficiency through payment for larger bundles that would give hospitals greater flexibility in deciding how to provide care by expanding payment bundles.

The proposed rule also contains the proposed CY 2008 payment rates for services performed in Ambulatory Surgical Centers (ASC). A separate fact sheet issued today summarizes a final rule revising the ASC payment system and the ASC provisions in this proposed rule.

### **Background**

Medicare expenditures for Part B services have grown rapidly over the past several years due in significant part to increases in spending for hospital outpatient services. Recent experience has shown that both the number and the complexity of procedures furnished to each Medicare beneficiary is growing rapidly. The CMS Office of the Actuary predicts that payments (including beneficiary coinsurance) under the OPPS will increase by 10.5 percent to about \$35 billion in CY 2008 from \$31.6 billion in CY 2007. Although hospital outpatient spending typically accounts for about 13 percent of total Part B spending, it accounted for one-third of the increase in the 2007 Medicare premium.

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The proposed reforms in this rule address this growth by focusing the OPSS on value-based purchasing, proposing incentives to improve quality and promote efficiency. Specifically, this rule includes an expansion of CMS' efforts to measure and reward quality through the adoption of quality measures specific to the HOPD. This rule also encourages efficiencies by focusing provider attention on how hospital outpatient services are provided, proposing larger payment bundles that would give hospitals greater flexibility in managing their resources. Both efforts focus on value, working to contain growth in OPSS expenditures, to improve quality, and ultimately, to make health care more affordable and accessible for Medicare beneficiaries.

### **Proposed OPSS/ASC Rule Provisions Affecting Hospital Outpatient Departments**

#### ***Quality Proposal:***

Linking Payment Updates To Quality Measures: The Tax Relief and Health Care Act of 2006 (TRHCA) requires the Secretary of Health and Human Services to develop measures to make it possible to assess the quality of care (including medication errors) furnished by hospitals in outpatient settings. These measures must reflect consensus among affected parties and, to the extent practicable, include measures developed by one or more national consensus-building entities. Hospitals that are paid under the Inpatient Prospective Payment System (IPPS) are required to report the applicable outpatient quality measures for services furnished in the hospital outpatient department (HOPD) in CY 2008 in order to receive the full OPSS market basket update in CY 2009. The reporting requirement applies only to hospitals in the fifty states and the District of Columbia (excluding Maryland hospitals which are not paid under the IPPS).

In this rule, CMS is proposing new measures that are specific to hospital outpatient services. Hospitals that fail to report data for these outpatient-specific measures would incur a reduction in their annual OPSS payment update factor in CY 2009 by 2.0 percentage points. This proposal encourages value by tying the payment incentives to participation in quality reporting. A similar quality reporting program for hospital inpatient services, implemented in fiscal year (FY) 2005 has been overwhelmingly successful. Fewer than four percent of hospitals did not receive the full IPPS update amount for FY 2007 because they failed to report quality measures.

Proposed Quality Measures for CY 2008: To receive the full OPSS payment update for CY 2009, CMS is proposing that hospitals report data to support the following 10 measures specifically chosen for hospital outpatient care:

1. Emergency Department Transfer (Acute Myocardial Infarction) - Aspirin at Arrival

2. Emergency Department Transfer (Acute Myocardial Infarction) - Median Time to Fibrinolysis
3. Emergency Department Transfer (Acute Myocardial Infarction) - Fibrinolytic Therapy Received Within 30 Minutes of Arrival
4. Emergency Department Transfer (Acute Myocardial Infarction) - Median Time to Electrocardiogram (ECG)
5. Emergency Department Transfer (Acute Myocardial Infarction) - Median Time to Transfer for Primary PCI
6. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
7. Perioperative Care: Timing of Antibiotic Prophylaxis
8. Perioperative Care: Selection of Prophylactic Antibiotic
9. Empiric Antibiotic for Community-Acquired Pneumonia
10. Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

Expansion of Quality Measures for CY 2009 or Subsequent Years: This proposed rule seeks public comment on a number of other quality measures that CMS is considering for use in CY 2009 or future years to assess the care provided by HOPDs. These measures are, for the most part, either currently in use or were developed for use in settings other than outpatient departments. Inpatient or ambulatory versions of these measures have all been either recommended by a subgroup of the National Quality Forum (NQF) for endorsement, are pending endorsement by the NQF, or are currently endorsed by the NQF. They attempt to capture the diversity of services provided to adult patients with different clinical conditions in hospital outpatient settings. Specifically, these measures address care provided to cancer patients, patients presenting with diabetes, pneumonia, chest pain, syncope, or depression, and patients receiving services related to bones, eyes, and problems associated with aging. Some of the measures relate to acute care provided in a hospital outpatient setting, and others assess care that a hospital outpatient clinic might provide on an ongoing basis.

***Proposal to Increase the Size of the OPSS Payment Bundles:***

Current Policy: As a prospective payment system, the OPSS encourages hospitals to focus on efficiency in their provision of services by grouping services that share clinical and resource characteristics into Ambulatory Payment Classification (APC) groups for payment purposes. Hospitals have some flexibility in managing their resources in providing care because a single APC payment, based on the national median cost from historical hospital claims data for all the services assigned to the group, provides a single payment for the cost of the primary service and the packaged costs of items directly

related to or required to perform that service. Common current examples of packaged items and services include low cost drugs, anesthesia, implantable devices, and medical supplies.

During the evolution of the OPSS over the past seven years, significant attention has been concentrated on service-specific payment for services furnished to particular patients, rather than on creating incentives for the efficient delivery of services, possibly through encounter or episode-of-care-based payment. Overall packaging included in the clinical APCs has decreased, and the procedure groupings have become smaller as the focus has shifted to refining service-level payment. The Medicare Payment Advisory Commission (MedPAC) has recommended broadening the OPSS payment bundles to encourage efficient resource use. In its March 2007 report, the MedPAC noted that growth in complex OPSS services, which it found may be more profitable to hospitals, has increased significantly over the past several years. Larger payment bundles provide incentives for efficiency and promote the stability of payment for services over time, while reducing any payment incentive to increase service complexity.

Proposed Expanded Packaging for CY 2008: In order to further efficiencies within the OPSS payment structure, CMS is proposing to extend the current packaging approach to additional services, so that these additional services would be paid through larger payment bundles. In those uncommon cases in which some of these services are furnished alone, Medicare would continue to pay for them separately. CMS has identified seven categories of supportive ancillary services that are integral to the performance of primary diagnostic and treatment procedures. For CY 2008, CMS is specifically proposing to package payment for the following seven categories of supportive ancillary services into the primary diagnostic or treatment procedure with which they are performed:

- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Diagnostic radiopharmaceuticals
- Contrast agents
- Observation services

Proposed Composite APCs for CY 2008: CMS also is proposing to encourage efficiencies by introducing one bundled payment for several major services through composite APCs. Composite APCs may encourage even greater hospital efficiencies than expanding packaging by making a single payment for the totality of hospital

outpatient care provided in an encounter. CMS is proposing to pay for two types of care, specifically low dose rate prostate brachytherapy and cardiac electrophysiologic evaluation and ablation, through composite APCs which have a single payment rate assigned to each composite APC. Under existing policy, although the patient experiences this type of care as a single comprehensive service, coding conventions require that several HCPCS codes be reported and CMS pays each component service separately under a different APC. In the case of low dose rate prostate brachytherapy or cardiac electrophysiologic evaluation and ablation, the OPSS proposal would provide a single payment for the comprehensive service. Separate payment would continue for brachytherapy sources as required by statute.

Other proposals affecting payment for hospital outpatient services include:

- Continuing to pay separately for brachytherapy sources, basing payment on the source-specific median costs for brachytherapy sources, as reflected in claims data. Stranded and non-stranded sources would be paid differentially.
- Reducing the payment for certain device-dependent APCs when a hospital receives a partial credit from the manufacturer toward the cost of a replacement device implanted in a procedure.
- Setting payment for the acquisition and overhead costs of certain separately payable drugs and biologicals at the manufacturer's average sales price (ASP) plus 5 percent.
- Providing payment for separately payable therapeutic radiopharmaceuticals based on mean costs derived from hospital claims data.

In this proposed rule, CMS also proposes a change that restricts the ability of a critical access hospital (CAH) or necessary provider CAH to operate provider-based facilities that are within 35 miles (15 in the case of mountainous terrain and if accessible only by secondary roads) of another hospital or CAH or a necessary provider CAH to co-locate with other hospitals.

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