

## CMS Issues Medicare Hospital Outpatient Prospective Payment System 2008 Final Rule

On November 1, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period updating the Medicare hospital Outpatient Prospective Payment System (OPPS) for calendar year (CY) 2008. CMS estimates hospitals will receive an overall average increase of 3.8 percent in Medicare payments for outpatient services in CY 2008. Among many provisions, this final rule implements the following:



- **Quality Reporting.** CMS reduced the number of consensus quality measures that hospitals must report from ten to seven, including five emergency department acute myocardial infarction transfer measures and two surgical care improvement measures. (CMS chose not to include the Hemoglobin A1c, heart failure, and community acquired pneumonia measures.) Hospitals must report on these measures for services rendered beginning April 2008, rather than January as initially proposed, or CMS will reduce the OPPS market basket update for CY 2009 by 2 percentage points.
- **Implements scaled-down “behaviorial offset” in IPPS payment rates.** The rule implements provisions of the health-extendors bill signed into law in September that partially relieves hospitals from CMS’ proposed 4.8 percent “behaviorial offset” to inpatient hospital prospective payment system (IPPS) rates over the next three years. Under the legislation and as implemented in this rule, the payment cuts are reduced from the proposed 1.2% to 0.6% in 2008. CMS proposed behavioral offset changes to address expected upcoding or changes in classification of discharges under the new Medicare severity-adjusted diagnosis-related groups (MS-DRGs) that do not reflect changes in case-mix. CMS also excludes rates for sole community hospitals and Medicare-dependent hospitals from these behavioral offsets.
- **Revised ASC.** The final rule establishes the policies for the revised payment system for ambulatory surgical centers (ASCs), effective January 1, 2008. Congress required CMS to revise the ASC payment system in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The final rule provides for a transition period for implementation of the rates calculated under this revised methodology.
- **Composite APCs.** The final rule begins adoption of the use of composite ambulatory payment classification (APC) groups, which provide one bundled payment for several major services or procedures provided during an encounter.

- **Expanded “packaged” payments.** CMS is extending the packaging approach for payment (in which ancillary services associated with a significant procedure are packaged and paid a single amount) to seven categories of supportive and ancillary services:
  1. Guidance services
  2. Image processing services
  3. Intraoperative services
  4. Imaging supervision and interpretation services
  5. Diagnostic radiopharmaceuticals
  6. Contrast media
  7. Observation services
- **Reduction in payment related to device credits.** The rule implements a reduction in payment for some device-dependent APC groups when a hospital receives a substantial device credit from a manufacturer toward the cost of a replacement device implanted in a procedure.
- CMS chose not to finalize its proposal to require hospitals to bill separately for pharmacy overhead costs, noting the operational challenges and administrative burden to hospitals described in public comments.
- As part of this rule, CMS also issued a new interim final rule with comment period related to emergency graduate medical education (GME) affiliations.

Atlanta ■ Washington ■ Dallas ■ Charlotte

One Atlantic Center  
Fourteenth Floor  
1201 West Peachtree Street, NE  
Atlanta GA 30309  
Tel: 404.572.6600  
Fax: 404.572.6999

Third Floor  
901 New York Avenue, NW  
Washington DC 20001  
Tel: 202.347.0066  
Fax: 202.624.7222

JP Morgan Chase Tower  
2200 Ross Avenue, Suite 3300  
Dallas TX 75201  
Tel: 214.721.8000  
Fax: 214.721.8100

Tenth Floor  
401 North Tryon Street  
Charlotte NC 28202  
Tel: 704.998.5480  
Fax: 704.998.5481

[www.pogolaw.com](http://www.pogolaw.com)

The final rule with comment period can be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/cms1392fc.pdf>. It will be published in the Federal Register on November 27, 2007.

**For information on topics covered in this alert, please contact:**

**Alan Parver** 202.624.7225 [aparver@pogolaw.com](mailto:aparver@pogolaw.com)  
**David Gross** 202.624.7337 [dgross@pogolaw.com](mailto:dgross@pogolaw.com)

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