The government on Aug 8 issued a proposal for revamping ambulatory surgery center (ASC) payments. The new system, to start in 2008, would peg ASC payments to hospital outpatient rates and expand the list of procedures approved for Medicare payment in ASCs. The reforms are designed to make payments more accurate without costing Medicare more, according to the Centers for Medicare and Medicaid Services (CMS). Updates were also proposed for 2007.

“The goal is to help Medicare beneficiaries get care in the most appropriate setting by addressing payment differences that may favor one setting over another,” CMS Administrator Mark McClellan, MD, PhD, said at a press conference.

But ASC leaders are dismayed that Medicare is proposing to pay ASCs only 62% of what hospitals would get for the same procedures.

The Federated Ambulatory Surgery Association (FASA) said the proposed reimbursement rate “will put a damper on ASC services,” causing Medicare beneficiaries to “lose access to the patient-centered care ASCs provide.” FASA said it is particularly concerned about single-specialty ASCs that specialize in GI and pain management procedures. Such procedures are now paid at about 89% of the hospital rate.

“Dropping that to 62% would be a huge cut,” and a single-specialty center couldn’t make up for it with other procedures, says Kathy Bryant, FASA’s president. She said it also would be a significant issue for patients because these are high-volume procedures, and pushing them back into the hospital could cause capacity problems.

The American Association of Ambulatory Surgery Centers (AAASC) said the proposal “would have a chilling effect” on ASCs that focus on Medicare patients. It says the reimbursement rate is set too low, and the plan “falls far short” of giving Medicare patients the choices commercially insured patients have.

Highlights of the proposals:

Expanded list of ASC procedures
In a move long-awaited by the ASC community, Medicare would greatly expand the procedures approved for ASC payment.

• For 2007, 14 procedures would be added to the current list (see list). Among these are transcatheter placement of intravascular stents (except coronary, carotid, and vertebral vessel) and some vertebroplasties.

• For 2008 and beyond, CMS would take a new approach, excluding from ASC payment only surgical procedures that pose a significant safety risk or require an overnight stay. Procedures excluded would include those involving major blood vessels, major or prolonged invasion of body cavities, significant blood loss, or procedures defined as inpatient only in the hospital outpatient prospective payment system.

That would mean about 750 more procedures would be eligible for ASC payment. But two-thirds, or about 500, are performed mostly in physicians’ offices, CMS notes. To make sure Medicare isn’t paying ASCs more for procedures that could be done safely in physicians’ offices, CMS would limit ASC payments for those procedures to the physicians’ office rate.

“We definitely think this [approach] is a step in the right direction,” Bryant says, noting FASA was still analyzing the criteria CMS proposes for exclusions and noting

<table>
<thead>
<tr>
<th>CPT</th>
<th>Short descriptor</th>
<th>ASC pay group</th>
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<tbody>
<tr>
<td>13102</td>
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<td>21356</td>
<td>Treat cheek bone fracture</td>
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<tr>
<td>22520</td>
<td>Percut vertebroplasty, thor</td>
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<td>Percut vertebroplasty, lumbar</td>
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<td>43761</td>
<td>Reposition gastrostomy tube</td>
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</tr>
<tr>
<td>46946</td>
<td>Ligation of hemorrhoids</td>
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that the safety of procedures can change over time. "We don’t know if these are good
criteria. We would rather have a more flexible approach."

**Revised ASC payment system**

The new ASC payment system would be launched Jan 1, 2008, as required in the
2003 Medicare Modernization Act, probably with a 2-year transition. CMS proposes
basing ASC rates on the hospital outpatient prospective payment system, using
weights. The ASC weights would be multiplied by a conversion factor to come up
with the payment rate.

The new ASC system, like the hospital outpatient system, would use ambulatory
payment classifications (APCs). But ASC payments would be lower than hospital out-
patient payments for the same procedures, "recognizing the lower costs associated with
performing procedures in the ASC setting," CMS says. CMS says ASCs have lower
costs because they don’t have to maintain emergency departments, meet federal regu-
lations for emergency care, and operate 24 hours a day 7 days a week.

For 2008, the revised ASC rates would work out to be 62% of the hospital outpatient
rates, CMS estimates.

FASA says this is not enough for some ASCs to stay in business, and that will cost
Medicare because more patients will need to have their procedures in the hospital,
which is a more costly setting.

FASA favors a plan introduced by Sen Mike Crapo (R-Idaho) and Rep Wally
Herger (R-Calif) that recommends ASC rates be 75% of hospital outpatient rates,
among other changes.

FASA plans to work with CMS and Congress over the next year “to make sure we
get the new payment system right,” Bryant says.

More specifics of the proposed changes:

- ASC payment groups would expand from the current 9 groups to the same 221
  APC groups used for hospital outpatient payments.
- ASC payment rates under the expanded list would range from $3.68 to $16,146,
  compared with the range of $333 to $1,339 under the current payment structure.
- For 2008, CMS proposes phasing in the new ASC payment rates as a 50-50 blend of
  the 2007 and 2008 payment rates. The new ASC payment system would be fully
  implemented in 2009. Starting in 2010, the ASC conversion factor would be updat-
  ed using the Consumer Price Index.
- Medicare patients would continue to have a 20% copay for ASC facility services.

**Other proposed changes**

for 2007

The proposed rule would also:

- carry out a requirement of the Deficit Reduction Act of 2005 to cap 2007 ASC pay-
  ment rates for procedures at the hospital outpatient rate for the same procedure. (A
  study found ASCs were paid more for some procedures than hospitals.)
- continue the current $50 add-on payment for approved new technology intraocu-
  lare lenses (NTIOLs) over 5 years after the effective date for an active NTIOL class.
  CMS also proposes changes in the process for establishing new classes of NTIOLs
  furnished with cataract surgery in an ASC, including incorporating the process into
  the annual update for outpatient payments.

*The proposed rule was scheduled to appear in the Aug 23 Federal Register. Comments on
the ASC payment plan are due by Nov 6.*