

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
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FACT SHEET

FOR IMMEDIATE RELEASE
July 16, 2007

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**A REVISED PAYMENT SYSTEM FOR SERVICES PROVIDED IN
AMBULATORY SURGICAL CENTERS**

Overview

On July 16, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a final rule establishing the policies for the revised payment system for Ambulatory Surgical Centers (ASCs) and a proposed rule combining proposals for the calendar year (CY) 2008 update to the hospital Outpatient Prospective Payment System (OPPS) and to the CY 2008 ASC conversion factor and payment rates. The final and proposed rules are intended to encourage quality and efficient care in the most appropriate outpatient setting given the rapid spending growth for services and the large variations in the use of services. They also are intended to more logically align payment rates across payment systems to eliminate payment incentives favoring one care setting over another. There are currently about 4,600 ASCs enrolled in Medicare. This Fact Sheet summarizes the final policies and proposed update for the revised ASC payment system.

Background

Since 1982, Medicare has paid for certain surgical procedures, such as cataract removal and lens replacement and colonoscopies, when performed in freestanding or hospital-based ASCs. Currently, Medicare pays for more than 2,500 surgical procedures on the ASC approved list, based on a simple fee schedule comprised of nine prospectively determined payment rates. Payment rates range from \$333 to \$1339. The payment rates are adjusted for geographic variation, and a separate payment is made to the physician for surgical and anesthesia services. ASC rates were last rebased in March 1990 using cost, charge, and utilization data from a 1986 survey of ASC costs.

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The ASC payment is for the facility costs only. The physician or other treating professional is paid separately under Medicare's Physician Fee Schedule (MPFS) for the professional services required to perform the surgery.

With the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress required CMS to revise the ASC payment system no later than January 1, 2008. In August 2006, CMS issued a proposed rule proposing changes to OPPS policies and payment rates for CY 2007, which also included the proposed new payment methodology for ASCs. The proposed system recognized that there are overlaps between services performed in hospital outpatient departments, physicians' offices, and ASCs and attempted to avoid creating payment incentives that would favor one setting over another. The proposal based payment rates on a percentage of the OPPS rates, but capped payment to the ASC at the nonfacility practice expense (PE) component of the physician payment under the MPFS for services that are frequently performed in physicians' offices

The OPPS and the ASC provisions for implementation in CY 2007 were finalized in November 2006, and the CY 2008 ASC policies related to the revised payment system are being finalized in this final rule.

Provisions in the Final and Proposed Rules

The final rule adopts the payment policies for the revised ASC payment system to be implemented January 1, 2008. The final weights and payment rates will be published in a combined CY 2008 OPPS/ASC final rule later this fall. As originally proposed in the August 2006 proposed rule and as supported by a November 2006 Government Accountability Office (GAO) Report, *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System*, CMS will implement the revised ASC payment system using OPPS relative payment weights for Ambulatory Payment Classifications (APCs) as a guide. The new ASC payment system will promote quality, efficiency, and rational alignment of payment rates across payment systems.

Expanded List of ASC Procedures:

The final rule expands access to procedures in the ASC setting by providing ASC payment for approximately 790 additional surgical procedures in CY 2008. CMS excludes from Medicare ASC payment only those surgical procedures determined to pose a significant safety risk to beneficiaries or that are expected to require an overnight stay following the procedure in the ASC.

CMS continues to identify surgical procedures as those listed by the American Medical Association (AMA) within the surgical range of Current Procedural Terminology (CPT) codes, and also includes within the scope of surgical procedures those services that are described by Level II Healthcare Common Procedure Coding System (HCPCS) codes or Category III CPT Codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range.

In the combined OPPS/ASC proposed rule, CMS proposes to add several procedures to the list of covered surgical procedures (in addition to the approximately 790 added in the final rule) and to update the list of covered ancillary services in coordination with the proposed OPPS update.

Revised Payment Rates:

Under the final ASC payment methodology rule, the revised ASC payment rates will be based on the APCs used to group procedures under the OPPS. The ASC rates will also be adjusted so that the revised ASC payment system is budget neutral in CY 2008. That is, the estimated expenditures under the revised payment system for ASCs in CY 2008 are intended to result in the same aggregate amount of expenditures that would have occurred in the absence of the revised ASC payment system.

With certain exceptions, the illustrative CY 2008 ASC rates included in the final rule are approximately 67 percent of the corresponding payments rates for the APCs, to take into account the lower costs of furnishing services in the ASC setting. These illustrative rates have been updated in the CY 2008 OPPS/ASC proposed rule and may change when the OPPS/ASC final rule is issued.

For the proposed OPPS/ASC payment rates and policies rule, CMS estimates that the CY 2008 ASC rates will be about 65 percent of the OPPS rates. The proposed rates are based on the final methodology established in the ASC final rule but use more recent data and are affected by the updated OPPS rates and policies proposed for CY 2008. The ASC payment rates for many procedures estimated in the proposed rule change little compared with the illustrative rates in the final ASC payment system rule. This is because the proposed CY 2008 ASC payment rates in the proposed rule reflect the proposed increased payment rates for many OPPS services in CY 2008 compared with CY 2007 that are largely offset by the slightly lower budget neutrality adjustment factor in the proposed OPPS/ASC rule compared with the final ASC payment system rule.

Many of the surgical procedures that are newly payable in ASCs are commonly performed in physicians' offices and, as such, are ineligible for ASC payment under the existing ASC payment system. CMS does not want to create inappropriate payment

incentives for procedures to be performed in ASCs if the physician's office is the most efficient setting for providing high quality care. Therefore, payment to ASCs under the revised ASC payment system for procedures commonly performed in physicians' offices will be made at the lesser of the ASC rate or the MPFS nonfacility PE amount. The final ASC payment system rule sets out the procedures that will be subject to this cap in CY 2008. Based on a review of the most recent utilization data, the OPPS/ASC proposed rule proposes a number of additional procedures for designation as office-based procedures, subject to the payment cap.

ASC payment rates in the proposed OPPS/ASC rule for CY 2008 are proposed according to the final policies adopted in the final rule, and are based on the most recent claims and utilization data available at the time the proposed rule is issued. The final payment rates for ASCs will be published as part of the CY 2008 OPPS/ASC final rule later this year, and will reflect any policy revisions and updated claims and utilization data. Because the revised ASC payment system will have a significant impact on payments for certain procedures, the final rule establishes a four year transition period for implementing the revised rates in order to give ASCs adequate time to adjust.

ASC Payment for Device-Intensive Procedures:

The ASC final rule packages payment for a high cost device, one for which the cost of the device accounts for more than half the median cost of the procedure, into the associated procedure payment, as it is under the OPPS. The final rule modifies the general ASC payment methodology to pay the ASC the same for the device as is paid under the OPPS, and applies the ASC budget neutrality adjustment only to the service portion of the payment. Therefore, the device portion of the proposed ASC payment for the device intensive procedure is 100 percent of the corresponding OPPS payment for the device cost, while the service portion of the proposed ASC payment for the device-intensive procedure would be about 65 percent of the corresponding OPPS service payment, just like the payment for other surgical procedures under the revised ASC payment system. CMS is not proposing any changes to this policy in the OPPS/ASC proposed rule.

The ASC final rule adopts the same policy related to full credit and no cost implantable device replacement that applies to the OPPS. That is, when a replacement device is supplied to the ASC at no cost, the payment to the ASC for the procedure to implant the replacement device will be reduced by the device portion of the ASC payment.

In the proposed rule, CMS proposes to reduce the ASC payment by one half of the device portion of the ASC payment for certain surgical procedures into which the device cost is

packaged, when an ASC receives a partial credit toward replacement of an implantable device. This partial payment reduction would apply to certain covered surgical procedures in which the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. The proposed policy mirrors the proposed policy under the OPSS for CY 2008.

Payment for ASC Covered Ancillary Services:

The final rule provides for Medicare to pay ASCs separately for covered ancillary services that are provided in an ASC to beneficiaries. To be eligible for payment, the services must be integral to covered surgical procedures and must be provided immediately before, during or immediately after a covered procedure. Covered ancillary services that are eligible for separate payment include: radiology services, drugs and biologicals that are separately payable under the OPSS, devices that are eligible for pass-through payments under the OPSS, brachytherapy sources, and corneal tissue acquisition.

CMS is not proposing to change these policies in the OPSS/ASC proposed rule for CY 2008, but is proposing to revise the Stark Law definitions of “radiology and certain other imaging services” and “outpatient prescription drugs” to exclude those radiology services, and imaging services, and drugs that are covered ancillary services. Therefore, physicians would be permitted to refer these services to ASCs in which they had a financial interest, and the ASCs would be permitted to bill Medicare for these services, without violating the self-referral prohibitions.

Under the final rule, payment for a covered ancillary radiology service is made to ASCs at the lesser of the ASC rate or the amount of the nonfacility PE under the MPFS. To ensure that no duplicate payment is made, only ASCs may receive separate payment for the facility resources required for the covered ancillary radiology services provided in ASCs. This policy will ensure that payment for all ancillary radiology services, whether packaged or separate, is made to the ASC, thereby providing appropriate payment to the ASC for those radiology services that are essential to the delivery of safe, high quality surgical care.

Under the final ASC rule, Medicare will pay ASCs separately for all drugs and biologicals that are separately paid under the OPSS, when those drugs and biologicals are provided integral to covered surgical procedures. Payment will be equal to the OPSS payment rates for that year, without application of the ASC budget neutrality adjustment. In addition, as in the OPSS, the ASC payment rates for these items will not be adjusted for geographic wage differences.

The final ASC rule also provides for separate payment at contractor-priced rates for devices that have pass-through status under the OPSS when the devices are an integral part of a covered surgical procedure. The rule also provides separate payment for brachytherapy sources at the OPSS rates or contractor-priced rates if OPSS rates are unavailable. The proposed OPSS/ASC rule proposes to establish prospective payment rates for these brachytherapy sources in CY 2008 under both the OPSS and ASC payment systems. Payment for corneal tissue acquisition will continue to be made at reasonable cost when corneal transplants are performed in ASCs.

Physician Payment for Non-covered ASC Procedures:

ASCs currently receive facility payments under the ASC payment system only for surgical procedures included on the list of ASC covered procedures (the list is updated every two years). A separate payment is made to the physician or other treating professional performing the procedure. If the procedure is on the ASC list, the physician is paid for the practice expense component of the service based on the higher facility PE relative value units (RVUs). If the procedure is not on the list, the physician is paid for practice expenses based on the nonfacility PE or technical component RVUs.

In the proposed OPSS/ASC rule, CMS is proposing to pay physicians who furnish noncovered procedures in ASCs using the facility PE amount, rather than the higher nonfacility PE amount. This proposal is intended to make the payments to physicians who furnish noncovered procedures in ASCs more consistent with the policy under the OPSS and to recognize that under the final ASC payment system rule, only procedures that have been determined to pose a significant safety risk or are expected to require an overnight stay are excluded from the ASC list.

Budget Neutrality, ASC Payment Rate Calculations, and ASC Updates

As required by the MMA, the revised ASC payment system as set out in the final rule is designed to be budget neutral; that is, CMS estimates that the revised payment system will have no net effect on Medicare expenditures in CY 2008 compared to the level of expenditures that would have occurred in CY 2008 in the absence of the revised payment system.

To establish the budget neutrality adjustment for the revised ASC payment system, CMS took into account that the revised ASC payment system might lead to changes in the settings in which procedures would be performed, and that surgical procedures could be expected to migrate among ASCs, physicians' offices, and hospital outpatient departments (HOPDs). CMS assumed that approximately 25 percent of the HOPD

volume of new ASC surgical procedures will migrate from hospitals to ASCs during the first two years of implementation of the revised ASC payment system and that 15 percent of the volume of new ASC surgical procedures currently provided in physicians' offices will migrate to ASCs during the first four years of the revised ASC payment system. CMS makes no proposal to revise this methodology in the OPPS/ASC proposed rule.

The illustrative budget neutrality adjustment for CY 2008 in the ASC final rule is based on those assumptions and estimated CY 2007 OPPS and MPFS rates and full CY 2005 utilization data. The estimated ASC CY 2008 budget neutrality adjustment factor in the final rule is 67 percent. In the proposed OPPS/ASC rule, the budget neutrality adjustment factor is somewhat lower, 65 percent, due to proposed changes in OPPS payment rates as a result of APC recalibration, including the proposal to expand the size of the OPPS payment bundles, as well as use of CY 2006 claims and utilization data.

The standard ASC payment for most ASC covered surgical procedures is calculated as the product of the estimated ASC conversion factor and the ASC relative payment weight (set based on the OPPS relative payment weight) for each separately payable procedure. Payment rates to ASCs for surgical procedures that are commonly performed in physicians' offices and for the technical component of covered ancillary radiology procedures cannot exceed the MPFS nonfacility PE amount. Payments to ASCs for covered surgical procedures and certain covered ancillary services are geographically adjusted using the Inpatient Prospective Payment System (IPPS) wage index values, as recognized under the IPPS and OPPS, with 50 percent as the labor-related factor.

For example, based on the budget neutrality adjustment factor in the proposed rule, the proposed ASC conversion factor for CY 2008 is calculated as 0.65 (proposed budget neutrality adjustment factor) x \$63.693 (proposed CY 2008 OPPS conversion factor) = \$41.400.

The ASC final rule provides for a four year transition period for implementation of the rates calculated according to the standard methodology of the revised ASC payment system. For procedures on the CY 2007 list of ASC covered procedures, CMS will make payment based on a blend of the new ASC payment rates and the current ASC rates. Thus, for CY 2008, the payment rates for procedures subject to the transition are comprised of a 25/75 blend, specifically 25 percent of the CY 2008 revised ASC rate plus 75 percent of the CY 2007 ASC rate; in CY 2009, the ratio will change to 50/50; and for CY 2010 it will be 75/25. Beginning in CY 2011, CMS will fully implement revised ASC payment rates calculated according to the policies of the revised payment system.

In the annual updates to the ASC payment system, CMS will set ASC relative payment weights equal to the OPPS weights and then scale the ASC weights in order to maintain budget neutrality in the ASC payment system. Without scaling, changes in the OPPS relative payment weights for nonsurgical services could cause an increase or decrease in ASC expenditures due to differences in the mix of services provided by hospital outpatient departments and ASCs.

The statute requires a zero percent ASC update through CY 2009. Beginning in 2010, CMS will update the ASC conversion factor by the Consumer Price Index for All Urban Consumers (CPI-U).

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