

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Room 303-D

200 Independence Avenue, SW

Washington, DC 20201



MEDICARE NEWS

FOR IMMEDIATE RELEASE

July 16, 2007

CONTACT: CMS Public Affairs

(202) 690-6145

CMS REVISES PAYMENT STRUCTURE FOR AMBULATORY SURGICAL CENTERS AND PROPOSES POLICY AND PAYMENT CHANGES FOR HOSPITAL OUTPATIENT AND ASC SERVICES

NEW STEPS TO ENCOURAGE HOSPITAL EFFICIENCIES AND QUALITY

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule revising the payment system for services furnished to people with Medicare in ambulatory surgical centers (ASCs) to better align payments for similar services furnished in a hospital outpatient department (HOPD) or a physician's office. CMS also issued a proposed rule that would update Medicare payment for services in HOPDs under the Outpatient Prospective Payment System (OPPS) and would set new payment rates for ASCs under the revised system effective for services in calendar year (CY) 2008.

The ASC final rule expands beneficiary access to surgical procedures in ASCs and implements steps to make ASC payments more accurate, while aligning payments across Medicare's payment systems to encourage efficient and appropriate choices of outpatient settings for ambulatory surgical procedures. CMS expects to make payments of almost \$3 billion in CY 2008 to the approximately 4,600 ASCs that participate in Medicare.

"The system we are announcing today will promote the goals of quality and efficiency in care furnished to people with Medicare in ambulatory surgical centers," said CMS Acting Administrator, Leslie V. Norwalk, Esq. "In addition, this revised system will take a major step toward eliminating financial incentives for choosing one care setting over another, thus assuring that patients' needs come first."

The proposed OPPS/ASC rule, published concurrently with the ASC final rule, would implement new steps to encourage more efficient care in hospital outpatient departments by providing hospitals with greater flexibility to manage their resources. The proposal also would ensure appropriate payment for high quality hospital outpatient services under

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the hospital Outpatient Prospective Payment System (OPPS). The reforms included in this proposed rule are intended to encourage quality and constrain rapid and accelerating growth in Medicare volume and expenditures for hospital outpatient services.

“As the number of services provided in hospital outpatient setting continues to increase annually,” said Ms. Norwalk, “we are committed to working with hospitals to ensure the care provided to beneficiaries is appropriate, cost-effective and high quality. Today’s proposed rule includes proposed hospital quality measures specific to hospital outpatient care, following the quality measures that have been successfully implemented in the hospital inpatient setting. In addition, this rule’s proposal to increase the size of the OPPS payment bundles will give hospitals the flexibility to manage their resources in the most efficient way possible.”

Revised Payment Methodology For ASCs

The final rule allows ASCs to be paid for any surgical procedure that CMS determines does not pose a significant safety risk to Medicare beneficiaries when performed in an ASC and that is not expected to require an overnight stay. As a result, the final rule adds about 790 procedures for ASC payment beginning in CY 2008. The proposed OPPS/ASC rule would add several additional procedures, which would result in approximately 3,300 covered surgical procedures under the revised ASC payment system. CMS expects that as a result of the significant expansion of surgical procedures paid in ASCs, beneficiaries will experience greater access to surgical services in appropriate settings.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to revise the ASC payment system no later than January 1, 2008. Consistent with the recommendations of the November 2006 Government Accountability Office Report (GAO Report) on ASC costs and payment, CMS is implementing the revised ASC payment system using hospital OPPS relative payment weights as a guide.

The revised ASC payment rates are based on the ambulatory payment classifications (APCs) used to group procedures under the OPPS. As required by the MMA, the revised ASC payment system is budget neutral; that is, it is estimated to have no net effect on Medicare expenditures in CY 2008 compared to the level of expenditures that would have occurred in the absence of the revised payment system. Consistent with the GAO Report, which found that procedures performed in ASCs are generally less costly than those performed in the HOPD, the proposed ASC payment rates for CY 2008 are estimated to be set at 65 percent of the OPPS rates for the corresponding procedures.

Many of the surgical procedures that are included as covered surgical procedures eligible for payment in ASCs under the revised system are procedures that have been performed predominantly in physicians' offices. To avoid creating payment incentives to perform those services in ASCs when they could be safely performed at less cost to Medicare and the beneficiary in a physician's office, payment for surgical procedures identified as 'office-based' is capped at the nonfacility practice expense component of Medicare's Physician Fee Schedule (MPFS) payment rate in the physician office setting. A separate payment to the physician performing these surgical procedures would be made for their professional services provided in the ASC facility.

Under the revised system, Medicare will make separate payment for covered ancillary services, such as radiology services and some drugs and biologicals that are provided integral to covered surgical procedures. Medicare will also provide separate payment to ASCs for the brachytherapy sources that are implanted through surgically placed needles in the treatment of prostate cancer. In addition, Medicare will make payment adjustments for those ASC procedures with high device costs which ensure that the ASC payment includes the same payment for an implantable device as when the procedure is performed in a hospital outpatient department. Procedures with high device costs are those in the OPPS for which the cost of the device equals or exceeds 50 percent of the median cost of the APC.

The ASC payment system will be updated annually through proposed and final rulemaking in close association with updates to the OPPS and the MPFS. The ASC payment rates in the CY 2008 OPPS/ASC proposed rule are based upon the policies of final ASC rule, updated to comport with the proposed OPPS APC recalibration and proposed OPPS payment policies for CY 2008.

The final CY 2008 ASC payment rates will be published in the OPPS/ASC final rule in November 2007, some of which will be incrementally phased in over a four year transition period, with their full implementation in CY 2011. In addition, CMS will account for geographic wage variation in individual ASC payments by applying the wage index to 50 percent of the ASC payment.

Proposed 2008 Policy And Payment Changes For HOPDs And ASCs

Prior to the implementation of the OPPS, beneficiary coinsurance for hospital outpatient services often resulted in beneficiary responsibility for more than half of the actual payment for the HOPD services. In the CY 2008 proposed rule, beneficiary liability under the OPPS would continue to be reduced under a formula that is designed to provide

a gradual transition to 20 percent coinsurance. Based on the proposed rule, the aggregate beneficiary liability is estimated to be 26 percent of the total payment, and almost 3100 services (or 23 percent of all types of services billed under the OPSS) would meet the target coinsurance of 20 percent, increased from about 2600 (or 19 percent of all types of services) in CY 2007.

The proposed rule includes a 3.3 percent inflation update in Medicare payment rates for services paid under the OPSS for CY 2008. CMS projects that hospitals would receive \$34.9 billion in CY 2008 for outpatient services furnished to Medicare beneficiaries under the proposed rule. The proposed changes would affect outpatient services furnished by general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals.

These statutory payment increases are projected to continue a trend of rapid growth in hospital outpatient expenditures. CMS projects that the expenditures under the OPSS in CY 2008 will be approximately 10.5 percent higher than the estimated CY 2007 expenditures. The current rate of growth in expenditures is of great concern to CMS because of its impact not only on taxpayers, but also on beneficiaries whose monthly premiums must pay for 25 percent of Part B expenditures.

While payments to hospitals under the OPSS have increased over the years, these payment increases have not been specifically tied to quality improvements. The statute now requires that the annual payment update factor in CY 2009 and subsequent years be reduced by 2.0 percentage points for hospitals that do not report quality measures. This proposed rule proposes 10 hospital outpatient quality measures for purposes of the quality reporting requirement.

The proposed quality measures include five emergency department acute myocardial infarction transfer measures, two surgical care improvement measures, and one measure each for the treatment of heart failure, community-acquired pneumonia, and diabetes. CMS is also seeking public comment on 30 additional measures that are under consideration for reporting in future years.

CMS is also proposing to increase the size of the OPSS payment bundles as recommended by the Medicare Payment Advisory Commission (MedPAC). This proposal would provide greater flexibility to hospitals in implementing efficient care. Currently, certain items and services, including low cost drugs, anesthesia services, operating and recovery room use, implantable devices, and medical supplies are

packaged in the payment for the associated APCs. CMS is proposing to package payment for seven additional categories of supportive and ancillary services in order to encourage hospital efficiencies in selecting the most clinically appropriate diagnostic and treatment approaches.

In addition, CMS is proposing to establish a new type of APC, called a composite APC, through which a single payment would be made for multiple major procedures performed in a single hospital encounter. CMS is proposing to establish two composite APCs for 2008, one for low dose rate prostate brachytherapy and one for cardiac electrophysiological evaluation and ablation. These composite APCs allow CMS to use the most complete data for rate setting when procedures are commonly provided in combination with one another.

In conjunction with the quality measures and the expanded bundle proposals, CMS is also soliciting public comments on other effective approaches to value-based purchasing that would promote high quality care and encourage hospital efficiencies in light of the continued growth in hospital outpatient expenditures.

CMS is proposing to pay separately for drugs, biologicals, and therapeutic radiopharmaceuticals costing more than \$60 or more per day in CY 2008, consistent with the historical \$50 threshold but updated for inflation. Payments for other drugs would continue to be bundled into payments for their associated procedures. However, as in past years, CMS is proposing to make an exception to the bundling policy for certain anti-nausea drugs often used by cancer patients to counteract side effects of treatment.

Comments on the proposed rule will be accepted until September 14, and a final OPPS/ASC payment rule will be published later this fall.

For the text of the ASC final revised payment system rule see

www.cms.hhs.gov/ASCPayment/

For the text of the combined OPPS/ASC proposed rule, see:

www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage

For Fact Sheets on the final ASC rule and the combined OPPS/ASC proposed rule, see:

www.cms.hhs.gov/apps/media/fact_sheets.asp .

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