Medicare Proposal Targets ASC, Outpatient Payments

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In a sweeping, 1,000-page proposal, the Centers for Medicare and Medicaid Services is seeking to change how it pays for procedures performed in outpatient departments and at ambulatory surgery centers. Two goals are to rein in rising outpatient expenses and to level the payment differential between ASCs and outpatient departments.

In a statement, CMS Administrator Mark McClellan said that it was time to look more closely at outpatient payments: "Doing nothing is not sustainable from the standpoint of Medicare costs and beneficiary premiums, and we want public input on the best approaches to promoting high-quality, affordable care."

With 12% growth in 2006 and projected growth of 10% for 2007, outpatient costs are putting a squeeze on beneficiaries, who must make 25% copayments, Dr. McClellan said during a press conference sponsored by the agency.

CMS is proposing that hospitals receive an average 3% increase in outpatient payments if they submit quality data on the inpatient side. Hospitals would be required to report on patient satisfaction to receive the full inpatient and outpatient update. They would also report risk-adjusted outcome measures, including 30-day mortality for acute myocardial infarction, heart failure, and pneumonia, and three measures from the Surgical Care Improvement Project. The agency said it anticipates asking for outpatient quality data as outpatient-specific measures are developed.

Hospitals that do not submit quality data will be penalized. Instead of the full outpatient rate, they'll receive the outpatient update minus 2%. Overall, outpatient spending—which covers general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals—will hit $32.5 billion in 2007 under the proposed rule.

The agency is also proposing to increase from three to five the number of payment levels for visits to an outpatient clinic or emergency department. The maximum payment for clinic visits would be $133, up from $92, and emergency department visits would rise from $244 in 2006 to $345 in 2007. CMS also would create a new set of Healthcare Common Procedure Coding System (HCPCS) codes for visits to dedicated emergency departments (DEDs) subject to the Emergency Medical Treatment and Labor Act. The new codes would help CMS determine the relative cost of services provided at DEDs compared with emergent care furnished at a 24-hour-a-day, 7-day-a-week facility.

Most individual outpatient procedures will receive a small increase in reimbursement, but some are also slated for a reduction. Insertion, replacement, or repair of an implantable cardioverter defibrillator lead would be covered at $22,800 in 2007, up from $22,300 in 2006, and insertion or replacement of a pacemaker pulse generator would be paid at $16,400, up from $10,000, according to Washington Analysis, LLC, which follows Medicare developments for Wall Street.

Drug infusion devices would receive relatively large increases of 23%-56% but neurostimulator implantation would decrease from $11,600 in 2006 to $10,800, according to the report by Washington Analysis.

The rule would also change how hospitals are paid for drug infusions. Currently, hospitals are paid the same for each type of infusion, whether it takes an hour or several hours. Under the new rule, hospitals would be paid for the initial hour plus additional fees for more hours. They also would receive a larger payment for complex drug administration.

On the ASC side, the goal "is to help our beneficiaries get the outpatient care they need in the most appropriate setting, by eliminating payment differences that inappropriately favor one outpatient setting over another and that may add to Medicare costs," said Dr. McClellan in the statement.

In 2007, CMS is proposing to cap the amount paid to ASCs at no more than the reimbursement for outpatient departments, to produce at least $150 million in savings. The agency also proposed to add 14 more procedures to the list of what it will cover at ASCs in 2007—including wound repair, percutaneous vertebroplasty, repair of venous blockage, ligation of hemorrhoids, and percutaneous transcatheter stent placement—and another 763 procedures in 2008. Any procedure that is considered safe and does not require an overnight stay would be considered eligible for Medicare reimbursement in 2008.

ASCs said they had no objection to bringing payments in line with those received by outpatient departments. But the industry was upset over CMS's proposal for a 2-year phase-in of a new payment system, beginning in 2008. By 2009, ASCs would be reimbursed at 62% of the outpatient rate. The industry—which includes about 4,500 centers—had been hoping to receive 75% of the outpatient rate.

"The proposed payment rate will result in Medicare beneficiaries and the Medicare program paying more for outpatient surgery because patients' only choice for many surgical procedures will be the more costly hospital setting," said Kathy Bryant, president of the Federation of Ambulatory Surgery Centers, in a statement. The proposed rate will discourage many ASCs from offering certain procedures, said Ms. Bryant.

In a statement, the American Association of Ambulatory Surgery Centers called on members to submit comments to CMS objecting to the new proposal and to do the same with their congressional representatives.

CMS is receiving comments on the outpatient and ASC-payment proposal until October 10. A final rule will be published later in the fall, said the agency. ■