Medicare’s proposed new payment system for ambulatory surgery centers (ASCs), slated to take effect Jan 1, 2008, for the first time would link ASC payments to hospital outpatient payments.

The ASC industry generally has supported that approach. But the proposal has important differences that could affect ASC payments, industry leaders are saying.

The proposal was published Aug 23 by the Centers for Medicare and Medicaid Services (CMS). Comments are due by Nov 6.

At first blush, it looks like ASCs would get 62% of what hospital outpatient departments (HOPDs) receive in the first year of the new system.

But there’s concern about the details, Kathy Bryant, president of FASA Inc, a trade group for ASCs, said in an Aug 30 audioconference. But she cautioned ASCs to wait to comment until FASA Inc has completed its analysis. She also noted that changes are likely before CMS publishes the final rule.

New concepts

The proposal introduces some new concepts for ASCs. Bryant outlined basics of how the new system is likely to work. Congress ordered the plan to be budget neutral, meaning it is not supposed to cost Medicare more than the current system. That doesn’t give CMS much leeway, she explained.

The hospital outpatient department (HOPD) payment system, on which the new ASC system would be based, groups CPT codes into ambulatory patient classifications, or APCs. HOPD payments are determined using 2 basic steps:

• Each APC has a relative weight, which reflects how procedures in that group relate to other APCs for cost and resource use. For example, a cataract procedure might belong to an APC with a relative weight of 24, while a colonoscopy is in an APC with a relative weight of 8. That means the payment for cataracts would be about 3 times that of a colonoscopy.
• To arrive at the actual payment, the relative weight is multiplied by a conversion factor, which is set each year. Right now, the conversion factor is about $60.

The graph shows how payments for specialties would be affected in 2008 if the proposal is unchanged.
It would be hard for ASCs to predict how their payments would change from year to year. Instead of the 9 current Medicare payment groups, there would be 221 APC rates that could be adjusted up or down.

**Big differences for ASCs**

There are important differences between the HOPD system and proposed ASC system that could have a big effect on ASCs. Major differences include:

- Relative weights would be adjusted every year. In 2008, the relative weights would be the same for HOPDs and ASCs, but after that relative weights would be adjusted a second time for ASCs.
- Payment rates would be updated annually. But starting in 2010, CMS would use 2 different methods: ASC payments would be updated using the consumer price index for urban consumers (CPI-U), while HOPD rates would be adjusting using the hospital market basket, an inflation factor reflecting resources hospitals use. In recent years, the hospital market basket has gone up faster than the CPI-U, probably in part because of increases in nurses’ salaries.
- Bundles of services covered by the APCs would be different for ASCs and HOPDs.
- Local wage adjustments would be made differently. For HOPDs, about 60% of the payment would be adjusted for local wages, while 34% of the ASC payment would be.

**Payment limit for office procedures**

Another proposal, which Bryant said could be “incredibly significant,” applies to about 500 of the 750 procedures CMS plans to add to the Medicare-approved list of procedures in ASCs. These are procedures performed 50% or more of the time in a physicians’ office. Essentially, CMS proposes to pay ASCs no more than a physician’s practice would get for performing these procedures in the office. (This would not affect how much physicians are paid.)

“This limitation only applies to ASCs—not hospitals,” Bryan said. “This is yet another reason why ASCs are not being proposed to be paid 62% of the HOPD rate.”

**ASC list would expand**

In a move long-awaited by ASCs, CMS plans to take a new approach to the Medicare ASC list. Starting in 2008, all surgical procedures would be on the list unless there is a reason to exclude them for safety reasons. But the ASC community might take issue with CMS’s criteria for defining safety, Bryant said. CMS proposes to exclude only procedures it says “pose a significant safety risk” or require an overnight stay. Procedures excluded would be those involving major blood vessels, major or prolonged invasion of body cavities, significant blood loss, or defined as inpatient only by CMS.

But Bryant said this approach is not flexible enough to allow for the future as technology changes. A procedure that CMS defines as unsafe for an ASC today might not be considered unsafe in 10 or 20 years. But once the CMS criteria are set, it is difficult to get them changed.