MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, October 10, 2003
9:02 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Work plan for ambulatory surgical center issues
-- Ariel Winter

MR. WINTER: Good morning. I'll be providing a brief update on the ambulatory surgical center payment system, discussing the factors we use to assess payment adequacy, and presenting preliminary data on growth in the number of ASCs.

Medicare uses a fee schedule to pay for facility services provided in an ASC. The fee schedule divides procedures into nine payment groups and the rates for these groups are based on cost data from the 1986 survey of ASCs.

CMS conducted a new survey in 1994 but rates based on the survey were never implemented due to congressional action. The agency recently said that it has developed a new survey instrument, however it has not yet been fielded. CMS also said that it is exploring ways to revise the ASC payment system so that ASC rates are better aligned with hospital outpatient and physician office rates. This does not necessarily mean paying the same rate in each setting. It could mean using similar relative weights for services in each setting.

The annual update for ASC rates is based on the increase in the consumer price index for urban consumers. In March, the Commission recommended that the update for FY 2004 be eliminated. The House Medicare bill would reduce the update by two percentage points from 2004 through 2008. The Senate bill has no such provision.

A full update of 2 percent recently went into effect for FY 2004. Medicare payments to ASCs totaled almost $2 billion in 2002, the second consecutive year in which payments increased by 17 percent. This amount is less than 1 percent of total Medicare spending.

In March CMS published a final rule that updated the list of procedures eligible for Medicare payment when performed in an ASC. The rule added 300 new codes and deleted 144 for a new total of 2,400. The list had last been updated in 1995. CMS expects that these changes will expand the volume of ASC services and increase Medicare spending by $5 million a year.

CMS assigned new procedures to one of the nine ASC payment groups by matching new codes to codes that are currently on the list based on their clinical similarity and use of resources. As I mentioned earlier, the current rates for these groups are based on fairly old cost data.

It is worth noting that CMS thought about ways to minimize disparities between ASC and outpatient rates for the same services when developing this rule. For example, they considered assigning new codes to the ASC payment groups that were most similar to the outpatient payment rates for these codes. However, they decided not to use this approach because it could have resulted in new ASC procedures being paid different rates than similar procedures currently on the list.

In addition, CMS found that certain procedures met the

criteria for inclusion on the list but would have been paid much more in an ASC than other ambulatory settings, even if placed in the lowest ASC payment group of $340. Because adding these procedures to the ASC list could have created financial incentives to shift these services to ASCs, CMS excluded them from the list.

As we did last year, we will again assess the adequacy of Medicare payments for ASC services. Although we lack recent date on the cost of ASC procedures, there are several other factors we can use to judge the adequacy of payments which are listed here. We will look at the recent entry and exit of ASCs from the Medicare market on the next slide.

But before we get there, I want to mention that we have a research project underway with RAND that we hope will shed light on the quality of care provided in ASCs. One of the project's goals is to development measures that will allow us to compare outcomes for services provided in ASCs, outpatient departments, and physician offices. These outcome indicators could eventually be used to assess changes in the quality of care provided in ASCs. Although this project will not be completed in time for the March report next year, we hope to be able to use the findings in the update process for FY 2006.

Our preliminary analysis of new data from the provider of services file shows that there is continued strong growth in the number of Medicare-certified ASCs. At the end of 2001, there were almost 3,400 centers. As of June 2003, there were over 3,700. The number grew by 6.7 percent in 2002 and at an annual rate of 7.7 percent in the first half of 2003.

During 2002 over 300 ASCs entered the Medicare program while 83 closed or merged with other centers. Most of the new centers are freestanding for-profit entities located in urban areas. This is also true of existing ASCs. ASCs tend to be geographically concentrated. Over 40 percent of centers are located in five states that account for 26 percent of beneficiaries.

As part of our study of specialty providers which we discussed at last month's meeting, we will analyze the market factors that are associated with ASC location. The factors we plan to look include the presence of certificate of need rules, population growth, household income, and the supply of hospital beds and physicians.

This concludes my presentation and I welcome any questions or comments.

MR. HACKBARTH: Ariel, remind me where we stand on getting cost data? Is anything in progress or imminent on that?

MR. WINTER: In the rule this past March, in which CMS updated the list of procedures on the list, they said that they've completed a survey instrument but there's no information about when they plan to field that instrument. They do say that, based on prior experience, it takes about two years to field the survey, collect the data, audit it, and analyze the.

DR. REISCHAUER: This is a general comment about the way we structure these analyses, so this is to Mark as much as to you, Ariel. That is, I think we should preface always our discussion

of entrance and exit into the importance of Medicare to that type of provider's business. And if 5 percent of ASCs' business is Medicare, it's clearly not the Medicare tail that's wagging this dog, it's something else. And lots of people coming in and going out isn't really relevant, and access to capital is another thing that you should do the same way.

MR. WINTER: That's a good point and we estimated last year that Medicare accounts for about 20 to 30 percent of ASC revenue, but that's going to vary by the kind of ASCs. So ASCs that specialize in cataract procedures are going to much be higher, endoscopy could be lower.

MR. FEEZOR: Ariel, the factors again you're going to be analyzing in the market, CON, bed supply, physician supply, and there were a couple of others.

MR. WINTER: We talked about household income, median household income, population growth which could be a factor in where they decide to locate. Faster growing areas might be more attractive. We would also look at demographic factors, percent of non-white residents.

We're also going to look at the presence of other kinds of specialty providers like specialty hospitals and freestanding imaging centers.

DR. ROWE: [Off microphone.] Ariel, I think the time has come to look at this differently. In the beginning, when there weren't that many of these it was fair to lump them. But now we're up over 3,000 and this is not one of these you've seen one redwood you've seen all the redwoods. They are very different kinds of facilities, some of them specialize, as you say, in cataracts, others in other kinds of procedures. They vary in their size. They vary in their ownership.

I think it would be helpful maybe even working with the professional organizations that represent these facilities, maybe they have a classification of them. Maybe the literature includes -- I don't follow this literature. But rather than just show us the volume blame changes in the 3000, let's see if we can develop some subcategories that tell us something about what's really happening here from a policy point of view if we're going to try to make some suggestions.

I don't know what that categorization would look like, but I think it would be worth trying to develop one.

MR. WINTER: We did publish a table in last year's report on the breakdown of ASCs by their specialty based on industry data. What we're planning to do now is actually look at what the distribution is based on their provision of Medicare services. So using Medicare data, what are those that specialize in ophthalmology procedures, endoscopy, et cetera. We also want to look at them by the number of ORs, which is provided in the provider services data and other characteristics.

MS. DePARLE: I feel like a broken record on this because I've said many times that I'm very uncomfortable with basing our assessment of the adequacy of Medicare payments to ambulatory surgical centers on 20-year-old data. I think it's really bad that CMS hasn't done the survey and that we don't have better data.

But that sad, if we are going to use other things as proxies, which we did last year, and it appears we're headed in that direction this year, I agree with Bob that we should try to be a little more precise about exactly what we're looking at. And to the extent that it's possible -- I don't know if it is possible Ariel -- but among the new entrants to the market, you've described several things that you're going to look at. I might suggest -- I don't know if you said physician supply as one of the things. Did you say hospital beds, too, in patient hospital beds?

MR. WINTER: Yes.

MS. DePARLE: So I might suggest that if there's any way to look at not just the importance of Medicare to ASCs in general, which you seem to indicate we have some data on, or on average what the ASC revenue is and how much of it is attributable to Medicare. But is it possible to look at that based on the new entrants, whether they are in fact following that same trend?

Because I've seen information at least anecdotally that would seem to indicate that they're not.

MR. WINTER: I'll look into that, whether we can address that.

MR. HACKBARTH: I share your concern, Nancy-Ann, about the lack of data. We really do not have much here on which to base a recommendation. The fact of rapid growth, in and of itself, is not necessarily a bad thing. It reflects changes in medical practice and may be good for patients, physicians. I'm not biased in anyway against doing more in ambulatory surgical centers. What makes it suspect is the fact that these rates are based on such old data. And then there was the added fact of the disparity in payment between what we pay for the hospital outpatient department in an ASC. That's what sort of raised the potential flags about this.

MS. DePARLE: But it's not all in the same direction. Remember, we had that discussion before. Some of the rates are higher in an outpatient setting. Not all of them, but we did have that discussion before.

MR. HACKBARTH: And so it's frustrating to hear that we're going to be in essentially the same position in terms of hard information for at least the next couple of years. I wish there was something we could do about that.

DR. REISCHAUER: Do we have any information about how many of these ASCs, either new ones or existing ones, are not Medicare-certified? Because they don't have to be to serve Medicare folks. And a test of whether payments are adequate is whether they choose to serve them, particularly the new ones. And if they do, it would suggest that Medicare payments are at least covering marginal costs.

MS. DePARLE: [Off microphone.] For some procedures.

DR. REISCHAUER: Yes. But you either do or you don't, I would gather. So it's sort of on average.

MS. DePARLE: By an ASC doesn't have to do every procedure. So it could be that you'd make the decision that for some things it's adequate, so you want Medicare certification. But I agree with you.

MR. WINTER: If I could just address that, the list we have is only for Medicare-certified ASCs. I don't have a list of those that are Medicare-certified and those that are not. I've heard from the industry that many of them, even if they're not serving any or many Medicare beneficiaries, do get certified because private payers require that or give some incentive for doing so.

Our numbers track pretty closely to numbers that have been published by an industry survey, so they not -- they track very closely to that. So that would suggest that most, if not all, ASCs that are serving private payers exclusively are also Medicare-certified.

MR. HACKBARTH: Any others?

Thanks Ariel.