MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Friday, December 5, 2003**
**9:05 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM:**

**Ambulatory surgical center services: assessing payment adequacy and updating payments -- Ariel Winter**

MR. WINTER: Good morning.

I'll be discussing our assessments of payment adequacy for ASC services and our draft recommendation for updating payment rates for 2005.

I'll also be discussing ways to revise the ASC payment system AND how CMS decides what procedures to pay for in an ASC.

We'll start with the question of whether Medicare payments for ASC services are adequate in 2004. In assessing payment adequacy, one of the factors we generally look it is the relationship of payments to costs. As we've discussed before, however, we lack recent data on the cost of ASC services. CMS was required by statute to perform a survey of ASC costs and charges every five years but it's last survey of ASC costs was in 1994. The Medicare conference agreement eliminated the survey requirement.

We'll come back to this issue later on, when we discuss how to revise the ASC payment system.

So to assessment payment adequacy ASCs, we examined the four factors listed here. For the first factor, it appears the beneficiaries have good access to ambulatory surgical services. The number of ASCs has significantly expanded over the last several years. In addition, the number of beneficiaries receiving ASC services grew by 14.5 percent per year on average between 1998 and 2002.

Although ASCs are still not available in all parts of the country, beneficiaries who are unable to access ASCs may obtain surgical services in other settings such as hospital outpatient departments and, in some cases, physician offices.

At the October meeting we looked at data on growth in the supply of ASCs. To quickly review, there has been rapid growth in the number of Medicare certified ASCs between 1997 and 2002, which has continued for the first half of 2003.

We've also recently examined changes in the average number of operating rooms per ASC, which is one indicator of surgical capacity. This number stayed constant at 2.5 between 1997 and 2002.

Industry sources tell us that the majority of ASCs are Medicare certified, however we don't know the specific proportion. An industry survey of ASCs finds that Medicare accounts for about 25 to 30 percent of revenues for a typical ASC.

As you requested last time, we are trying to identify ASCs

by the types of services in which they specialize, particularly new ones entering the market. However, we've been encountering some problems with the data and don't have this information for today's meeting.

The next factor we looked at is changes in the volume of ASC services. Between 1998 and 2002 the volume of services provided by ASCs to beneficiaries increased by over 60 percent as the chart shows here. The average annual growth rate during this period was 15 percent. During these years, ASC payment rates increased by less than 1 percent per year, which suggests that the level of payments in 1998 was adequate to sustain high-volume growth. Almost all of the increase in ASC volume was due to more beneficiaries receiving services rather than an increase in the number of services per patient.

Between 2001 and 2002 the following types of procedures grew fastest: colonoscopy, upper GI endoscopy, and minor musculoskeletal procedures which includes interventional pain management services.

There are various factors that could be influencing the growth of ASC services received by beneficiaries but it's difficult to isolate the impact of each factor. First, Medicare payment rates might be more than adequate, particularly given that the current rates are based on 1986 cost data and may reflect productivity gains since then that have reduced costs.

Second, there has been a general shift of surgical services from inpatient hospital to ambulatory settings over the last several years. This shift is related to changes in clinical practice and technology which have expanded the use of ambulatory surgical procedures such as colonoscopy and cataract removal.

We find that this trend is much more pronounced in ASCs than outpatient departments. Between 1998 and 2002, the volume of ambulatory surgical services provided to Medicare beneficiaries in ASCs grew much faster than the volume of these services in outpatient departments. The average annual growth rate was 15 percent in ASCs as compared to almost 2 percent in outpatient departments.

These differences in growth rates may be related to the profitability of Medicare payments or to other factors. For example, ASCs may offer patients more convenient locations than outpatient departments. Medicare coinsurance is often lower in ASCs. ASCs may offer physicians more control over staffing, the surgical environment and scheduling. In addition, physicians can increase their practice revenues by investing in ASCs.

Our analysis suggests that ASC's have good access to capital. First, there has been rapid growth in the number of ASCs over the last five years, which suggests that new ASCs are

able to obtain capital to begin operations.

Most ASCs are independently owned by local investors while some ASCs partner with larger for-profit corporations. Two of the largest ASC chains experienced substantial revenue and earnings growth in 2002 and are expected to continue growing in 2003.

In summary, the factors we've examined show that there's rapid market entry by new ASCs, high volume growth in the volume of ASC services provided to Medicare beneficiaries, and sufficient access to capital for providers. This suggests that Medicare payments to ASC are more than adequate to cover current costs.

The next part of the update framework is to ask how Medicare payments to ASCs should change for 2005. Several factors could affect the change in the unit cost of ASC services. The first factor is inflation and input prices. The ASC payment system uses the consumer price index for urban consumers to approximate changes in input prices. The CPIU is currently projected to increased by 2.1 percent for fiscal year 2005. ASC costs may also increase due to scientific and technological advances that enhance the quality of care but also raise costs. There are certain mechanisms in the ASC payment system that separately account for the cost of some new technologies such as additional payments for new types of intraocular lenses used for cataract surgeries.

In addition, high growth in the volume of procedures likely to use new technologies suggest that current payments are adequate to cover their costs. Thus, we do not make an allowance for cost increases due to scientific and technological advances.

The final factor that affects ASC costs is productivity growth. As with other sectors, MedPAC's policy standard for expected productivity growth is 0.9 percent. By subtracting productivity growth from input price inflation, it appears that the cost of ASC services will increase by 1.2 percent in the coming year. We believe that current base payments are at least adequate to cover this increase in costs.

Thus, our draft update recommendation is that there should be no update to payment rates for ASC services for fiscal year 2005. It is based on our conclusion that current Medicare payments to ASCs are more than adequate to cover current costs and are at least adequate to cover the expected 1.2 percent increase in next year's costs. Because this would reflect current law, there would be no spending implications. We do not believe that this would affect ASC's ability to provide services to beneficiaries.

The Medicare conference agreement requires the Secretary to

implement a revised ASC payment system, taking into account a GAO study of whether it would be appropriate to use outpatient procedure categories and relative weights for the ASC payment system. The GAO study is supposed to consider data submitted by ASCs.

Here we take a closer look at the issues involved in revising the ASC payment system based on the outpatient payment system. ASC procedures are currently placed in one of nine broad payment groups, which makes it difficult to pay accurately for individual services. By contrast, the outpatient payment has over 500 payment groups. The use of a greater number of groups could enhance the accuracy of ASC payments.

In addition there is currently significant variation among rates by setting for some high volume surgical services which could create financial incentives to shift service between settings. Using the same grouping of services and relative weights in each setting would likely make the rates more comparable, thus minimizing these incentives.

Finally, linking the two systems would allow CMS to update ASC procedure groups and weights each year, along with its annual revisions to the outpatient payment system.

This approach does present some concerns, however. The outpatient rates may not reflect the relative costs of individual services which could have a large impact on ASCs that specialize in a narrow range of procedures. If the relative costs of procedures are different in each setting, the outpatient weights may not reflect the relative costs of ASC services.

Finally, outpatient departments are eligible to receive certain payments in addition to the base rate such as pass-through payments for new devices, which ASCs do not receive. Outpatient departments, unlike ASCs, are also allowed to bill separately for radiology or imaging services that are ancillary to surgical procedures. On the other hand, ASCs can bill separately for prosthetic devices such as joint implants used in surgical procedures unlike outpatient departments.

We propose addressing these issues by recommending that the Secretary revise the ASC payment system based on the outpatient weights and procedure groups but periodically use recent ASC cost data to monitor the adequacy of ASC rates, calibrate the relative weights, and develop a conversion factor that recognizes the lower cost of ASC services compared to outpatient services.

We propose not specifying how the Secretary should collect cost data. The main options appear to be through surveys, cost reports, or perhaps by asking groups of experts to estimate the relative levels of resources used for different services. Each

of these approaches would have its pros and cons.

We expect that a conversion factor based on more recent ASC cost data would result in ASC rates that are lower than outpatient rates for the same service, taking into account additional payments received in either setting. This is based on our finding from the March 2003 report that outpatient departments are probably the higher cost setting for two reasons: they have additional regulatory requirements and they treat patients who are more medically complex.

We are currently unable to project the spending implications of this recommendation. Under current law total payments in a revised ASC payment system must be budget neutral to payments under the old system. Our proposal may not result in budget neutrality because we're recommending that the conversion factor should ensure that ASC rates are lower than outpatient department rates. ASC rates that are higher than outpatient rates would decline, while ASC rates that are significantly lower than outpatient rates would probably increase. And it's unclear how these changes would offset each other.

In terms of provider implications, ASCs that focus on services that currently receive higher rates in ASCs than outpatient departments, such as some endoscopy procedures, would experience payment reductions. However, ASCs that provide services currently reimbursed at much lower levels in ASCs than outpatient departments, such as some orthopedic procedures, might receive higher payments.

We don't expect this recommendation to reduce beneficiaries access to ambulatory surgical services. If some ASCs provide fewer services, beneficiaries could still receive care in outpatient departments.

The next issue relates to the list of procedures paid by Medicare in ASCs. CMS is required by statute to maintain a list of procedures eligible for payment by Medicare when performed in an ASC. Procedures must meet several criteria to be placed on the list. They must be performed in inpatient settings at least 20 percent of the time, but cannot be performed in physician offices more than 50 percent of the time. A procedure must not exceed 90 minutes of surgery or four hours of recovery time and anesthesia must last no longer than 90 minutes.

There are also clinical safety criteria. For example, a procedure is excluded if it results in extensive blood loss or involves major invasion of body cavities.

CMS is required to update this list every two years. However, the list was not updated between 1995 and March 2003, when it was last expanded. Long gaps between updates make it difficult for the list to keep up with technological changes.

They make it possible to perform more services in ASCs.

In addition, the volume in other settings may no longer be a relative criterion for determining what services are clinically appropriate to provided in an ASC. In 1998 CMS proposed eliminating the time limits criteria and reducing the importance of the site of service volume criteria, but retaining the clinical standards. This proposal has not been implemented.

Instead of maintaining a list of services that are eligible for payment, it might make sense for CMS to create a list of services that are specifically excluded from payments. Unless included in such a list, a service could be paid when performed in an ASC. For example, CMS maintains a list of inpatient only services that are excluded from payments in hospital outpatient departments.

When considering what services to exclude from ASC payment, CMS should probably continue to apply clinical safety standards and exclude services that are likely to require an overnight hospital say. To avoid creating financial incentives for services to shift from physician offices to ASCs, CMS might consider excluding procedures that are routinely performed in physician offices and would be paid significantly more in an ASC.

We propose recommending that after the ASC payment system is revised, the Congress should authorize CMS to replace the current list of approved ASC procedures with a list of procedures that are specifically excluded from payment based on clinical standards and payment differences between ASCs and physician offices.

We propose that this change occur only after CMS has revised the ASC payment system and reduced payment disparities between ASCs and outpatient departments. Otherwise, opening up the ASC list could drive services from outpatient departments to ASCs because of payment differences.

This recommendation could increase Medicare spending if more surgical services overall are performed over and above the shifted services from other settings to ASCs. On the other hand, if ASCs are paid less than outpatient departments under a revised payment system, Medicare spending could decline if services shift from outpatient settings to ASCs. ASCs would likely to be able to provide a broader range of services, thus improving beneficiaries access to care. Beneficiaries who could obtain services in an ASC instead of an outpatient department would also likely have lower cost sharing.

This concludes my presentation and I look forward to your feedback.

MS. DePARLE: I like recommendation three, I think, if I understand it. So what you're proposing is that rather than

have the agency try to figure out what is clinically appropriate, allow clinicians to figure that out. And with the exception of some things that are specifically excluded, then things can get more quickly diffused into the ambulatory surgical center setting?

MR. WINTER: That's right. That's the idea. The Agency should still continue to look at whether procedures that are being done in outpatient departments are clinically appropriate and safe to perform in an ASC based on the different abilities of each setting.

MS. DePARLE: But it makes it a little easier to get things moving. I think that would save them a lot of time, actually.

On the second recommendation, I don't quite understand -- well, first you said something about you were having trouble with the data on one of the questions we had asked you to look at. What exactly -- data is the issue here. We haven't had any data. So what are you looking at and what are the problems with the data?

MR. WINTER: You and Jack asked me last time to look at what kinds of services ASCs are specializing in, try to identify, try to come up with some kind of matrix for identifying ASCs by what they provide.

We've been trying to do that linking ASCs to claims data but we've had a lot of problems matching up ASC providers to ASC claims. So that's been the hang up there. We're going to try to work with one of the industry associations and see if they can help us out doing a survey of their own membership, and we're going to continue pushing this Medicare claims data question.

But that's what I was referring to.

MS. DePARLE: That would only be for Medicare. Part of the question here and I think that what Jack was getting at, if I recall. is that if 75 percent or 70 percent of their revenues, of a typical ASCs revenues, are non-Medicare, the business model is different. What I remember him saying is something different is going on, something different is driving this.

You're having a hard time even looking at Medicare claims data. I understand that's hard. But if we're only going to know then about Medicare, that really still doesn't tell us as much as I think I'd like to know about this industry as we're trying to make these recommendations.

MR. WINTER: There is an industry survey that does classify ASCs by whether they provide a certain service or not. So they find that about half of ASCs provide ophthalmology, 45 percent plastic surgery, 40 percent GI. What they don't say is what percent of their volume these services account for, so it's hard to say what they specialize in. But we are going to try to work

with the industry some more and figure out if there's a way we can develop a typology.

MS. DePARLE: On the second recommendation, how does it relate to the GAO study that is being required? Would we be recommending that the Secretary move ahead without that study? Or how do the two relate to each other?

MR. WINTER: That's a good point. The intention here is that subject to the GAO's recommendations, the Secretary should go ahead and do this. But it's an opportunity right now for the Commission to lay down its market in terms of what it thinks a new ASC system should look like, whether it should be designed along the lines of the current outpatient payment system or something different.

Because the GAO report is due January 2005, which would be before the March report after this one. So the March 2004 report would be the next opportunity.

MS. DePARLE: You're concerned that might be too late.

MR. WINTER: If we wait until March 2005, it might be too late. We could do something in June 2004 as well, if you want to spend more time thinking about it and studying it.

MS. DePARLE: The GAO, are they just looking at the feasibility of doing a payment system that's based on the outpatient payment system?

MR. WINTER: My understanding is that they're supposed to use data submitted by ASCs and other factors, as well, to look at whether it's appropriate to apply the outpatient weights and procedure groups to the ASC system and then make recommendations as to whether that should be implemented or not.

MS. DePARLE: So we would be answering that question. We would be saying, in this recommendation, that it is appropriate.

MR. HACKBARTH: Is GAO looking at the relative cost issue, both the conversion factor and the relative weights, as opposed to analyzing whether it's appropriate to have a similar system for ASCs versus outpatient departments?

MR. WINTER: The legislation does not specifically say they're supposed to look at the relative costs of an ASC procedure versus an outpatient procedure but only the relatives within each setting. Of course, they may decide to go ahead and do that once they have --

MS. DePARLE: Somebody has to look at that because we're never going to get anywhere. That's part of the problem.

MR. HACKBARTH: My question didn't come out clearly. Let me try again.

Is the mandate to GAO, does it assume that we're talking about a system that links payment for ASCs and hospital outpatient departments? So we're looking at that sort of architecture.

Now the questions that we need to answer are questions about costs and we need data, GAO please go collect that data. So the premise is that the architecture is some sort of a linked system, a synchronization of payment for ASCs and hospital outpatient departments is the premise, I think, isn't it?

MR. WINTER: The question GAO is supposed to answer is whether that process is appropriate. They're supposed to take a look at whether that's appropriate. But you're correct, what we'd be saying here is that we think, in general terms, this framework is appropriate. We do think that the Secretary should periodically collect ASC cost data and make sure that it's appropriate and make some minor adjustments if necessary.

MS. DePARLE: I guess, just to be clear, is GAO in collecting the data from the ASCs going to get some data about cost? Because the problem I have with our recommendation -- and Glenn knows I have this problem -- I don't have a problem with assuming that the architecture should be similar. That's what we proposed in '98 originally. We did not have the data to do the work necessary to set up those two systems, so we didn't move forward. And we haven't moved forward now in six years.

So I object to our presuming lower costs without any data.

MR. HACKBARTH: I don't think that's what this recommendation does, at least as I read it. It assumes the same architecture is the way to go, and I do believe that.

MS. DePARLE: [off microphone.] And I don't disagree with that.

MR. HACKBARTH: But it says that there ought to be data collected to look at the issue of how to set the conversion factor and whether the relative weights ought to be adjusted.

MS. DePARLE: But our recommendation says develop a conversion factor that recognizes the lower cost. And I don't think I have the data to say that.

DR. MILLER: I think your comment is fair and I'll take responsibility for this. I think in our recommendation the point that we wanted to recognize if that our analysis had generally driven us in this direction. And I think the marker we were trying to lay down in talking about the recognition is an expectation that we will find that. And if that's not the case, then the cost data will show that and then we would recognize it on the basis of the cost data.

But our data to this point suggests that it is, in fact, lower. And what we wanted to be clear about is that we're not accepting a budget neutral or higher, because if the payment system right now is driving payments through that results in them being paid more than OPDs, we didn't want to particularly err on that side of saying well, then that's just the way it needs to be.

So we're trying to set a marker that our expectation is based on our analysis to this point, that is likely to be lower. It may not have done that well in this language, but that's what the intention was.

MS. DePARLE: But isn't our analysis a little speculative? They don't have certain regulatory requirements.

DR. MILLER: Absolutely.

MS. DePARLE: So it's not qualitatively the kind of analysis that we've done on other things. That's the point I've made.

DR. MILLER: That's why, in this recommendation, we are adamant on this point that the data on the cost needs to be collected. So ultimately you can calibrate on the weights and answer definitively the question on the conversion factor.

DR. REISCHAUER: Let me see if I have this right. We're willing to recognize lower costs where they're lower but not higher costs where they're higher, based on the recommendation we made last year.

MS. DePARLE: Whatever the costs are, they are. Some of them are higher, some of them are lower. If we're going to align it, it should be fair and they should be aligned. So in some cases they should go up. In some cases they should go down.

That's another issue, is this budget neutral or not?

DR. REISCHAUER: That's a question because I thought we were saying it's good to encourage this sector to the extent that it can provide the service at the same cost or lower. But because there are social externalities that we think are negative in the movement of services from OPDs to surgical centers, we're a little leery about paying them whatever their costs in instances where their costs are higher.

Now maybe I'm wrong, but I think that was the tendency.

MS. DePARLE: That's what the Commission said last year.

DR. REISCHAUER: That's what we said last year. But if that's the case, than the sentence here in this recommendation should say factors that recognize the relative cost of ASC services where lower rather than lower cost, which is what you were objecting to, which sounds like a presumption that always their costs are lower.

DR. MILLER: I think, if we're all talking to each other, we're agreeing at this point because I want to be clear that when you attach it to the OPD system, if that on a relative basis moves services around, it would move services around. The question is sort of the overall conclusion about why would their costs, in general, be higher.

MS. DePARLE: I would have been in favor of parity, not only saying only where lower.

DR. REISCHAUER: I wanted to ask Ariel a couple of things. One is do we know why the requirement for collecting cost data was taken out in this latest legislation?

MR. WINTER: My guess is because Congress might have been a little frustrated that -- either frustrated with the Agency for not redoing the survey since '94 or understanding that the Agency had limited resources and didn't have the ability to redo the survey.

And also reflecting the notion that if you move towards linking the two payment systems, then you may not need cost data because you just update the weights and the procedure groups based on how you do it on the outpatient side. So that you no longer need to worry about -- my guess is this is the thinking -- you no longer need to worry about what the relative costs are for ASC services, because you collect data on relative costs for outpatient services. You just calibrate the relative weights at the same time.

DR. REISCHAUER: The first couple of those reasons you gave strike me as, in a way, outrageous. You haven't done what we've asked you do. Therefore, I'll punish you by not asking you to do it. The limited capability of the Agency, I would have thought, although I'm terribly naive on these kinds of things, that a chunk of money transferred to Price Waterhouse or something could get you an answer here. This is the kind of thing that accounting firms do all the time.

MR. HACKBARTH: They shifted it over to GAO. They said CMS has not done it and so we're going to ask GAO to do it. Presumably, they think GAO will be more responsive.

DR. REISCHAUER: I do, too.

One of the things that interests me about this whole sector is the question of whether the services being provided are primarily substitutes for outpatient services or supplements to. I was wondering if -- this is not for this particular chapter, but over the long run we might want to try and answer that question by looking at the four or five states that have concentrations of these entities and looking at for the Medicare heavy procedures the incidence of those procedures within those states as opposed to the states that don't have many ASCs is significantly higher.

And then to ask the question, does this result in improved outcomes, I mean better health? Or do we think that this is another sign of overutilization? Because in the long run that's the kind of question we should be asking it strikes me.

MR. WINTER: We have an analysis like that underway. We're going to be looking at ASC penetration in various markets and whether that's associated with an overall higher level of use of surgical services. And I like your idea of trying to relate it

to outcomes. We'll think some more about how to do that.

MR. MULLER: I want to support the general sense here that having a payment system that has more than nine categories and more like 500 makes a lot of sense and move in that direction, which I think we were moving towards last year and you're recommending here is good.

I feel like Bob, that we need a conversion factor and obviously getting that after many years of trying to get it, and just reflecting Glenn's conversation, we really need that.

I also think, similar to the conversation we had yesterday on dialysis centers. These ASCs, being more focused, do allow the notions of whether productivity can be achieved in this sector. We had some extended conversation about this yesterday, to really be tested because they see a far more narrow set of patients and conditions and so forth.

So a sense in which what the productivity factor in health care might be, as opposed to the kind of general multifactor productivity factor we use, I think could be tested quite well in a couple of settings like ASCs, dialysis, and so forth, where you don't have all the range of the hundreds of type of DRGs and APCs coming in that you see in the outpatient setting of hospitals. And also you have a different regulatory environment. They're not 24/7, and so forth.

So I think testing the productivity assumption in this arena would be a good way for us to look, in addition to Bob's question of substitution versus supplement. Which obviously, if it happens in five states -- I mean, in some ways if it's happening in five states more than in 50, you start asking yourself is it medicine or something else that's driving this kind of movement, because if it was happening everywhere to the same extent, understanding at the same time that there are regulatory restrictions in many of the Northeast states that keep this from occurring to the same extent that it happens in the states were, in fact, it did happen.

But if we could really focus on the productivity analysis over the course of the next X years, I think that would be very helpful in this setting.

DR. STOWERS: I wanted to shift gears just a little bit. I appreciated your mentioning the lower coinsurance. Even if a physician is not involved in the ambulatory surgery center and they're getting ready to refer a patient, and especially if the patient has limited resources, it can make a big difference, at least in my experience, on the financial possibility of the patient that they're facing with an upcoming procedure as to whether I refer them to a physician that's going to do this procedure in an ambulatory surgery center as opposed to the hospital.

So I really appreciated you putting that in here. I'm just wondering if we couldn't quantify that for some of the more common procedures, as to what the difference is and financial responsibility to the patient of whether they go to the hospital or whether they go to an ambulatory surgery center. I think that wouldn't be that difficult to do.

And I know one comes out of one pot of money and one comes out of the other, but I wonder just how complicated it would be to say we're going to apply this set of copay rules -- could we get the copay rules the same for both somehow? And I know that might be a regulatory impossibility, but it may very well be worth looking into. Because no matter how we level this playing field on this end of the deal, if we don't level the playing field on the incentive of where the patients are being sent, We've only accomplished half of our goal there.

So I'd like to see that expanded, so I appreciated you bringing that up.

MR. HACKBARTH: Any others?

MS. DePARLE: Bob raises, and I'm still not clear, so our draft recommendation to, the Congress has in the Medicare bill said that the Secretary should develop a new payment systems that is budget neutral relative to what the projected spending for ASCs were. Our recommendation is not budget neutral? Or is it? I can't tell for sure.

MR. WINTER: It may not be. It depends on -- what they're saying is the conversion factor is based on what would equate payments under the old system to payments under the new system. We're saying the conversion factor should be linked to actual cost data and reflect lower cost of ASCs services where that's shown to be true, based on our discussion today.

So that may end up leading to higher overall ASC payments or lower overall ASC payments. It's hard to tell because about one-third of the payments right now are for services in which the ASC rate is the higher than the outpatient rate, and two-thirds are the reverse. So it's just hard to say how that's going to end up coming out once you implement outpatient weights.

MS. DePARLE: So like the cataract, I remember on that chart you showed us last year, the cataract procedure where it was paid more in the outpatient setting, for example, right?

MR. WINTER: That's right.

MS. DePARLE: So two-thirds of the procedures are paid more, then this recommendation could lead to higher spending?

MR. WINTER: It could if you end up -- it depends on how much you raise those rates versus how much you lower the ones that are currently higher than the outpatient setting.

MR. SMITH: Which raises the question of whether or not we

want to or have an obligation to reiterate our earlier recommendation, which is that ASC rates ought to be lower when they're lower and not exist when they're higher. Bob said it more elegantly than I did.

But partly because we've got some budgetary consent here and partly because we have some institutional concerns, that migrating services to higher cost settings is not in our interest, not in the program's interest. We said that before.

It would seem to me that if we're going to go down the road of the wording in recommendation two, once we clear up what we mean by lower costs, it seems to me we have an obligation to reiterate the earlier recommendation that ASC costs be recognized when they are lower but not when they're higher, or the ASC rates be recalibrated when they're lower but not when they're higher.

MR. HACKBARTH: I'd personally be happy to see that happen. But even if that is the case, you could still have an increase in spending because some of the cases where the ASC rates are lower, they could move up based on the cost data. But you'd still have that upward limit for any given procedure we're not going to pay more for an ASC.

MR. SMITH: [off microphone.] And we would presume budget neutrality.

MR. HACKBARTH: Right. So when we come back with a recommendation in January, it will include that element in it.

Anybody else on ASCs? Okay, thanks, Ariel.

The last item is SNFs.