CMS Proposal Ties Outpatient Pay to Quality

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The Centers for Medicare and Medicaid Services has proposed an overall 3% increase in payments for outpatient hospital care in 2009, almost a full percent below the update for 2008. As expected, reporting on quality of care is being tied to the amount of increase hospitals and other outpatient providers will receive.

For the first time, hospitals and other recipients of payments under the outpatient system that do not report data on seven quality measures on emergency department and perioperative care will see only a 1% increase.

The proposed rule, issued in July, also outlines changes for ambulatory surgery centers (ASCs) that are part of a 4-year transition to a new payment system that began this year. In 2009, as was the case this year, ASCs would be paid 65% of the rate paid for the same service in an outpatient hospital department.

The agency estimates it will spend $29 billion in 2009 on payments to acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute-care hospitals, community mental health centers, children's hospitals, and cancer hospitals. That's $2 billion more than the estimated $27 billion CMS will spend on such services this year, said the agency.

"The changes proposed for 2009 are intended to give hospitals greater flexibility to manage their resources and give them incentives to improve efficiency so that both beneficiaries and taxpayers get the most value for their health care dollar," said CMS Acting Administrator Kerry Weems in a statement.

CMS is proposing to more aggressively penalize hospitals and other outpatient providers that do not report quality data. Providers must report on 7 measures in 2008 and on 11 in 2009, including 4 imaging efficiency measures. In addition, the agency is seeking to reduce copayments for beneficiaries who are treated at hospitals that do not report quality data.

By law, Medicare is gradually changing the payment system so that beneficiaries will be liable for only 20% of a covered service. The coinsurance rate has varied widely over the last 8-10 years. In 2009, about 25% of services will be subject to the 20% coinsurance, up from 23% in 2008, said CMS.

Inpatient psychiatric facilities and community mental health centers that do not report data on seven quality measures will see only a 1% increase.

For imaging—a huge and growing portion of Medicare expenditures—CMS would make a single payment for multiple imaging procedures performed in a single hospital session, including ultrasound, computed tomography, and magnetic resonance imaging.

CMS also proposes reducing pay for some of the higher-cost device-oriented procedures: a 48% reduction in pay for the placing of left ventricular pacing add-on leads; a 3% decrease for replacing pacemakers, electrodes, or pulse generators; and 4% for stent placement.

A small increase is proposed for most neurology devices, but placement of neurostimulator electrodes would be slashed by 52%.

For ASCs, reimbursement would decrease for 92 procedures, but increase for 2,475 procedures, according to the Ambulatory Surgery Center Association. Gastrointestinal procedures as a whole are slated for a 6% reduction, and nervous system procedures and pain management would be reduced by 3%, according to Washington Analysis, a firm that advises investors on health policy developments.

Finally, the agency said that it is proposing to create four new ambulatory payment classifications for type B emergency departments (those that offer emergency-level services but are not open 24 hours a day, 7 days a week). According to data collected by CMS, most type B emergency visits are more expensive than a clinic visit, but less expensive than a visit to a traditional emergency department. The goal is to make payment for the type B centers more reflective of actual costs.

CMS is accepting public comments on the proposals until Sept. 2 and expects to issue the final rule Nov. 1. ■