

## ASCA Government Affairs Update



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### **Draft Accountable Care Organization Regulations Released**

#### **ASC Legislation Being Drafted**

#### **States Consider Necessity of CON Processes**

#### **Medicare Drug/Biologic Changes**

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### **Draft Accountable Care Organization Regulations Released**

The much anticipated draft regulations regarding Medicare Accountable Care Organizations (ACO) have been released. These proposed regulations provide details about the ways Medicare ACOs, which are scheduled to begin operation in January 2012, will function. The health reform law created a Medicare ACO program whereby providers can voluntarily form ACOs to manage the care of Medicare patients and share in any savings that the ACO generates. ASCA has begun to analyze the 429 pages of the regulations and will provide more information on the effect they will have on ASCs soon. In addition, ASCA will be submitting comments on the proposed regulations. A copy of the regulations is available [here](#).

For more information, contact Jonathan Beal at [jbeal@ascassociation.org](mailto:jbeal@ascassociation.org).

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### **ASC Legislation Being Drafted**

Representatives of the Ambulatory Surgery Center Association are working on proactive comprehensive legislation to resolve issues facing the ASC community and provide patients with access to ASCs. The bill is being drafted in consultation with representatives from the physician community. The legislation would:

- provide ASCs with an annual update based on the HOPD market basket rather than the CPI-U;
- add a representative from the ASC community to the Advisory Panel on Ambulatory

Payment Classification Groups (APC) (The purpose of the panel is to review the clinical integrity of the APC groups and their associated weights. The panel also makes recommendations to the Centers for Medicare & Medicaid Services [CMS] on whether services can be safely performed outside of the inpatient setting.);

- allow ASCs to provide CMS-required notifications about patient rights and other issues on the same day of a patient's surgery—removing barriers to surgery on the same day as initial contact with the physician created by the revised Medicare Conditions for Coverage;
- establish a quality reporting system based on the quality measures currently endorsed by the National Quality Forum, and modify current law that gives CMS wide latitude to develop measures without industry consensus and establish burdensome reporting processes; and
- establish a value-based purchasing (VBP) program to reward ASCs for providing high quality care.

The legislation adopts elements of the Accountable Care Organization (ACO) model and the hospital VBP program to design a value-based purchasing program rewarding individual facilities based on their quality performance, and creating an incentive for ASCs and the government to focus on moving clinically appropriate services out of the hospital outpatient department (HOPD). The VBP for ASCs, as envisioned in the legislation, would provide a pool of money generated by savings to the Medicare system as surgery migrates from HOPDs to ASCs. Part of the savings would be returned to the Medicare system and the other portion set aside for bonus payments to ASCs that meet certain quality standards. The bonus pool would apply only in years in which there are demonstrable savings generated for the Medicare system and, therefore, no facilities would be penalized.

For more information, contact Steve Miller at [smiller@ascassociation.org](mailto:smiller@ascassociation.org).

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## States Consider Necessity of CON Processes

A number of states have proposed measures to alter the process of obtaining a certificate of need (CON) for an ASC. Two study bills were introduced in the Iowa House of Representatives that would exempt certain ASCs from the state's CON process. Both study bills were introduced by the Chairman of the House Committee on Human Resources', Representative Linda Miller (R). [House Study Bill 97](#) would exempt all ASCs from the CON process in Iowa. On the other hand, [House Study Bill 98](#) would exempt only those ASCs that would be located in counties that had a population greater than 200,000 but less than 300,000 according to the 2009 estimate by the United States Census Bureau. Each measure failed to receive consideration by the committee prior to the passage deadline.

A measure was introduced in the Hawaii state Senate that proposed repealing the entire CON process for the state; however, the measure failed to meet the deadline for passage from the chamber of origin. Recently, Governor Lincoln Chafee (I) of Rhode Island proposed removing the Health Services Council and the CON process it oversees. According to a [Providence](#)

[Journal article](#), the rationale behind the Governor’s proposal is that the council rarely provides recommendations against CON applications and does not have a strategic plan guiding the decision making process.

For more information, contact Shawn Swearingen at [sswearingen@ascassociation.org](mailto:sswearingen@ascassociation.org).

## Medicare Drug/Biologic Changes

The Centers for Medicare and Medicaid Services (CMS) has made the following changes affecting the 2011 reimbursement of drugs/biologics in ASCs.

- Effective April 1, Medicare will pay for four additional codes representing drugs/biologics. The four new codes are

<b>HCPCS</b>	<b>Description</b>	<b>2011 Rate</b>
C9280	Injection, eribulin mesylate, 1 mg	\$901.00
C9281	Injection, pegloticase, 1 mg	\$304.75
C9282	Injection, ceftaroline fosamil, 10 mg	\$0.72
Q2040*	Injection, incobotulinumtoxin A, 1 unit	\$5.57

\* Q2040 replaces the discontinued code C9278, which was paid at the same rate (\$5.57).

- The rates of 242 drugs/biologics will change beginning on April 1, 2011, due to Medicare’s established process of updating the rates of certain drugs/biologics quarterly to reflect changes in the average sales prices of these items. While the rates of 43% of these 242 drugs/biologics will change by less than one percent, some changes will be significant ranging from a 67% reduction to a 369% increase. A complete list of the changes is available [here](#).
- CMS has corrected the 2010 fourth quarter rates of the following nine drugs/biologics. ASCs may ask that contractors adjust previously paid claims.

<b>HCPCS</b>	<b>Short Descriptor</b>	<b>Previously published</b>	
		<b>CORRECT</b>	<b>INCORRECT</b>
		<b>4<sup>th</sup> Quarter 2010 Rate</b>	<b>4<sup>th</sup> Quarter 2010 Rate</b>
J0833	Cosyntropin injection NOS	\$51.32	\$69.15
J1451	Fomepizole, 15	\$7.14	\$7.42

J3030	mg Sumatriptan succinate / 6 MG	\$45.71	\$52.88
J7502	Cyclosporine oral 100 mg	\$3.04	\$3.05
J7507	Tacrolimus oral per 1 MG	\$3.18	\$3.22
J9185	Fludarabine phosphate inj	\$162.67	\$136.94
J9206	Irinotecan injection	\$7.45	\$6.01
J9218	Leuprolide acetate injection	\$4.50	\$4.07
J9263	Oxaliplatin	\$4.52	\$4.62

- CMS, erroneously, did not include one drug/biologic (Q4119 -Matristem wound Matrix) on its list payable ancillary services for the first quarter of 2011. ASCs who provided this drug during that time may request that their contractor adjust previously processed claims to include a \$5.62 payment for Q4119.

ASCs can bill for certain drugs and biologics when provided in conjunction with a Medicare covered surgery. A list of Medicare-covered drugs and biologics for 2011 is available [here](#). This file has been updated to incorporate the changes noted above. A copy of the document from CMS announcing these changes is available [here](#).

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