

AMBULATORY SURGICAL CENTER ACCESS ACT OF 2009 (H.R. 2049) SUMMARY

IMPORTANCE OF ASCS TO PATIENTS

Ambulatory surgical centers (ASCs) provide patients with a high-quality, convenient and less expensive option for their surgery. When Medicare beneficiaries choose ASCs for their surgery, both the beneficiary and the Medicare program save significant money. Last year, about 5,300 ASCs provided five million outpatient surgeries.

ASCs are a critical point of access for important screening benefits and other nondiscretionary services such as diagnostic colonoscopies and cataract removal surgery. Colonoscopies are the method to detect and treat colon cancer and are still widely underutilized according to the Centers for Disease Control and Prevention. As the dominant provider of these and other benefits in many markets, establishing a fair and reasonable payment system is critical to ensuring access to these critical services.

Patients save considerable money when they choose ASCs for their surgery. For example, Medicare beneficiaries save 61 percent when they have cataract surgery at an ASC and 57 percent when they have a diagnostic colonoscopy at an ASC. It is critical that ASCs remain a viable and alternative for all patients, including Medicare beneficiaries.

SAVINGS TO BENEFICIARIES: FIVE HIGHEST VOLUME ASC PROCEDURES

| Procedure | HOPD Copay | ASC Copay | % Savings at ASCs |
|------------------------------|-------------------|------------------|--------------------------|
| Cataract Surg w/iol, 1 Stage | \$495.96 | \$192.94 | 61% |
| Upper GI Endoscopy, Biopsy | \$143.38 | \$78.41 | 45% |
| Diagnostic Colonoscopy | \$186.06 | \$79.77 | 57% |
| Colonoscopy and Biopsy | \$186.06 | \$79.77 | 57% |
| After Cataract Laser Surgery | \$104.31 | \$51.72 | 50% |

ASC ACCESS ACT MAINTAINS PATIENT ACCESS

As recently as six years ago, ASCs were paid 86.5 percent of hospital outpatient department (HOPD) rates, on average. But a multiple year payment freeze and additional cuts have reduced ASC payments to 59 percent in 2009 of HOPD rates for the *same* procedures.

Discretionary actions by CMS threaten to lower ASC payments to just 52 percent within the next five years, making many procedures unviable at an ASC and forcing patients to delay necessary outpatient surgery and pay substantially more in the hospital setting. Specifically, CMS is pursuing two actions, not required by statute, that threaten patient access to ASCs:

- CMS is adopting a “secondary rescaling” calculation, which reduces ASC payments when volume increases at ASCs, notwithstanding these procedures are paid at a substantial discount from hospitals where they would otherwise be performed.
- CMS proposes updating ASC payments by CPI-U, which represents inflation in the cost of items purchased by consumers, not by hospital market basket, which every other provider in Medicare receives and is based on health care input costs.

The ASC Access Act would stop projected payment cuts by fixing ASC payments at the current 59 percent of the HOPD payment rate. ASCs face inflationary pressures similar to those confronted by hospitals. Intense competition for nurses, rapidly rising medical device costs, and a growing need to adapt new health information technology contribute to inflation across a variety of health care settings. There is no policy basis for providing increasingly divergent payment rates from the already discounted payments to ASCs.

The bill requires MedPAC to conduct a study to evaluate how to encourage more clinically appropriate outpatient surgical services to be provided at the most cost-effective site of care. The bill also clarifies that ASCs may provide surgery to patients on the same day it is scheduled.

Quality Improvements

The bill would require more useful information to be provided to patients, including requiring ASCs and outpatient hospitals to report the same quality and cost-sharing information for outpatient surgery procedures. Currently, CMS can require different quality information to be reported by ASCs and HOPDs for the same procedures and patients are not meaningfully informed of their cost-sharing obligations for these procedures.