

Opportunities and Challenges for ASCs in 2009

Ophthalmologists will benefit by getting involved as the Medicare landscape evolves.

BY MICHAEL ROMANSKY



Nothing is simple or straightforward in Washington, DC. In fact, logic does not seem to be a determinate. For example, we are penalized for being efficient. This is true in our clinical practice and apparently is true now for ASCs. The gains ASCs made last year have already been threatened. Michael Romansky is a dedicated ASC advocate representing OOSS. He and OOSS have worked hard to lobby for a new ASC payment plan, implemented in January 2009. They have not, however, rested on their laurels. Michael describes the threats to this plan this year and how OOSS has negotiated a long term solution. Thankfully, we have advocates such as Michael Romansky and OOSS looking out for the interests of good patient care.

The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical association representing more than 1,000 ophthalmologists, nurses, and administrators who specialize in providing high-quality surgical care in ophthalmic ambulatory surgery centers (ASCs). OOSS' mission is to represent outpatient ophthalmic surgeons on federal legislative and regulatory matters and to promote the development and utilization of ophthalmic ASCs.

– Pravin U. Dugel, MD

In the May/June 2008 and July/August 2008 issues of *Retina Today*, I discussed the evolution of the ambulatory surgery center (ASC) industry over the past 25 years, changes in ophthalmic surgical technique and technology, and the implementation of a Medicare ASC payment program in 1983—all in the context of assessing the collective impact on the delivery of surgical eye care to the elderly. In these articles, I noted that the proliferation of ASCs has been more evident in ophthalmology than any other medical specialty. By 2008, at least two-thirds of all cataract cases in the United States were performed in ASCs, and most of these in ophthalmology-specific ASCs. To date, however, few vitreoretinal surgeons have moved their surgeries

to the ASC setting. The historical reason for this is that payment rates for these services have posed significant challenges to even the most efficient of practitioners in recouping ASC facility costs with meager Medicare facility fees.

With the launch of a new ASC payment program in 2008, facility fees for vitreoretinal surgery are substantially improving, suggesting that retinal surgeons may, in increasing numbers, migrate from the hospital to the ASC. In this article, I discuss the current Medicare ASC program and rates, as well as legislative changes being sought by the Outpatient Ophthalmic Surgery Society (OOSS) and others in the ophthalmology and ASC communities that may provide the progressive retinal

ASC Payments for Ophthalmic Services (New Legislation/HR 2049, at 59%)

CPT	Desc	CY 2014 Current Law	CY 2014 Locked at 59%	% Change
66984	Cataract	\$1,015	\$1,144	+12.7
66821	Yag	224	252	+12.5
67904	Repair Eyelid	804	907	+12.8
66170	Glauc. Surg.	1,008	1,136	+12.7
67040	Laser, Retina	1,592	1,795	+12.7
65755	Corn. Trans.	1,592	1,795	+12.7
67036	Vitreectomy	1,592	1,795	+12.7

Figure 1. The impact of the Ambulatory Surgical Center Access Act of 2009 (HR 2049) on ophthalmic ASCs.

specialist with opportunities to provide high quality and lower-cost care to his or her patients in the ASC in the years ahead.

THE NEW ASC PAYMENT SYSTEM: OPPORTUNITIES AND CHALLENGES

The signs from the nation's capital are encouraging.

Covered Procedures. Under the new ASC payment system, virtually all ophthalmic procedures are eligible for Medicare ASC facility reimbursement.

ASC Rates Linked to Hospital Payments. The good news is that, pursuant to the recommendations of the ASC community, our payments are linked to the much higher reimbursement afforded hospital outpatient departments (HOPDs). The percentage of the HOPD provided to ASCs, however, has decreased. Why this

anomaly? When the new payment system was established, Congress mandated that aggregate payments to ASCs remain budget-neutral from year to year. CMS has applied two rather than one budget neutrality adjustment to ASC rates. This rescaling has the effect of reducing ASC payment rates from about 63% of what hospitals receive in 2008 to 59% in the current year to about 50% of HOPD in 5 years.

Annual Updates. Commencing in 2010, ASCs will be afforded an annual payment update to account for inflation, our first since 2004. CMS continues to insist upon using the Consumer Price Index–Urban (CPI-U) as the indicator, rather than the Hospital Market Basket, which is typically about a percentage point higher. Using the higher update makes sense because ASCs are treating the same patients with the same conditions:

inflationary increases in costs of capital, staff, and overhead should be commensurate.

Implantable Devices. Generally, ASCs are now afforded the same additional payments that hospitals receive for new and innovative medical devices and pharmaceuticals. However, the new rates are phased in over a 4-year period and because the new system bundles a procedure's facility fee with sometimes costly implantable devices that were paid for separately, the combined payment rates for facility and device costs for some retina and glaucoma services have actually dropped below 2008 levels. For example, glaucoma patients with a failed trabeculectomy procedure may require an aqueous shunt; however, the ASC's costs for facility overhead and devices exceed the bundled Medicare allowance by \$200 to \$300. Similarly, in retina, the repair of the complicated retinal detachment may require perfluorooctane (PRO) or silicone oil. Neither of these costly items are separately reimbursed under the current regulations. OOSS has argued that this financial disincentive penalizes the more efficient provider, the ASC, where these procedures have been appropriately furnished for years and forces the migration of these services to the more costly hospital outpatient setting.

LEGISLATING A BETTER ASC PAYMENT SYSTEM

The ASC community has developed legislation that would rectify the problems discussed above and otherwise expand Medicare patient access to ASCs and improve facility payments to our centers. Introduced by Representatives Kendrick Meek (D-FL) and Wally Herger (R-CA), The Ambulatory Surgical Center Access Act of 2009 (HR 2049) would make the following meaningful reforms:

- Stop projected payment cuts by permanently fixing ASC payments at 59% of HOPD.
- Preclude CMS from manipulating rates downward by imposing arbitrary budget neutrality adjustments, like secondary rescaling.
- Provide ASCs with the Hospital Market Basket as our inflation index, the same adjustment provided to hospitals.
- Improve ASC payments for implantable devices.
- Assure patient access to same day services at an ASC by prohibiting CMS from requiring that ASCs provide beneficiaries with patient rights information at least a day in advance of surgery.
- Provide guidance to CMS if quality and cost reporting is implemented in the future.

What would be the impact of this legislation on an

ophthalmic ASC? Enactment of HR 2049 would enhance Medicare revenues for ophthalmic surgical services by 12% to 13% (Figure 1). In the case of vitreo-retinal surgery, these increases are above and beyond those encompassed by the existing payment structure.

AS A RETINAL SURGEON, WHAT SHOULD I DO?

Vitreoretinal surgeons will encounter many of the challenges facing the broader Medicare community. The prospect of negative professional fee updates looms and the direction and scope of efforts to enact health care reform is uncertain. The government is substantially augmenting physicians' responsibilities to move to electronic recordkeeping and prescribing. The Medicare ASC program is a shining light on an otherwise grey and ambiguous horizon and is a program that is actually providing the retinal surgeon with financial incentives to provide high quality and lower cost care to Medicare beneficiaries in the ASC. Whether you are operating in an ASC or in a hospital, the choice as to the site of a patient's surgery should rest with the physician. HR 2049 gives you, the vitreoretinal surgeon, and your patients, the flexibility to make that choice.

I hope that you will consider joining the Outpatient Ophthalmic Surgery Society; we are welcoming you to our ranks. Visit OOSS at www.OOSS.org. You should contemplate devoting a couple of hours this year to educating your Senators and Representatives about your concerns in Washington on a plethora of important issues, one of them being enactment of ASC reform legislation. Political action is not a four-letter word. Support of the political action committees of OOSS and the AAO is critical to the success of the ophthalmic community's legislative and regulatory agenda in Washington. Ophthalmology will continue to face new opportunities and challenges as the Medicare landscape evolves; participation in the legislative and regulatory processes by the physician community will have a significant impact on the outcomes. ■

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