

Current Issues in Regard to Ambulatory Surgery Centers

WITH TREXLER M. TOPPING, MD

Over the past several years there has been a major transition whereby more retina surgeons are performing their procedures in the ambulatory surgery center (ASC) environment, largely because the reimbursement for the surgical procedures has been ratcheting upward. Previously, reimbursement for retinal procedures was abysmally low and, because the surgeries take so much longer than anterior segment surgeries such as cataract surgery, to do these in the ASC didn't make financial sense.

Now that retina surgeons are more involved in ASCs, the issues that affect these facilities are more pertinent to the subspecialty. Retina Today recently had the opportunity to speak with Trexler M. Topping, MD, from Ophthalmic Consultants of Boston, regarding some issues surrounding policies that affect ASCs.

RT: Please explain the issue of pass-throughs in an ASC.

Dr. Topping: *Pass-through* is a term used for the process of passing the cost of a surgical item through to the payer. The only pass-through that currently exists (for ophthalmic ASCs) is corneal material for corneal transplantation. All other items used in surgery are now borne by the facility.

Previously, one could negotiate with payers reimbursement for certain items, such as silicone oil, perfluorocarbon liquid, or Molteno tube shunts (New World Medical, Inc, Rancho Cucamonga, CA). Currently, however, they are all now bundled into a single facility fee for performing the procedure, regardless of whether these added items are employed. Federal law eliminated the use of pass-throughs in ASCs approximately 7 years ago. Fortunately, this occurred around the same time that reimbursement rates for ASC rates rose, so ASC managers were able to compensate for the loss of payment for these surgical items.

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RT: What role will ASCs play in the formation of accountable care organizations (ACOs)?

Dr. Topping: The answer is that nobody really knows at this point, but let me put this in a slightly different light. The goals of ACO formation include the ability to deliver the highest quality of care at the lowest possible cost. If you perform a procedure at an ASC, the ASC facility fee is only 57% of what it is in a hospital OR. Therefore, your cost of providing the service at the ASC is significantly lower.

Let's suppose a patient in an ACO requires removal of a macular pucker. The physician fee is the same regardless of where the surgery is performed, but the OR cost in an ASC is approximately \$1,550, while the cost in a hospital outpatient surgical facility is in the neighborhood of \$2,700. Thus the cost for performing the same service at the ASC is approximately \$1,100 lower than in the hospital, which should make an ACO think positively about ASCs as sources of cost savings.

RT: Recently, the US Department of Health and Human Services has introduced the concept of value-based purchasing for ASC payments. Please discuss how this will affect ASCs.

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Dr. Topping: Value-based purchasing while maintaining quality outcomes is an idea that would seem to pose significant challenges to some organizations within medicine. ASCs have been on the forefront of outcomes analysis for some time, however, so this should not be an issue. For re-credentialing purposes, ASCs must review their complication rates every 1 to 3 years and must show the ability to perform these analyses in a high-quality manner.

RT: In March, the Medicare Payment Advisory Commission recommended a 0.6% increase in ASC payments but a 2.4% increase for hospitals. Why do ASCs continue to be paid less than hospitals for the same services?

Dr. Topping: A hospital, or a combination of hospitals, is often the largest employer in a county, region, or even a state. Thus hospitals have a huge amount of lobbying power in Congress. Approximately 7 or 8 years ago, ASC payments were supposed to increase to two-thirds of what hospital outpatient centers were receiving, but the actual increase adds up to about 57% of what hospitals receive. What is happening is that we are getting consumer price index increases every year and the hospitals are getting medical market basket increases, which are much more representative of what the actual costs are. Small ASCs simply do not have the lobbying power that hospitals do, so even though the insurance companies and Medicare may save a good amount of money on ASCs because they are more cost effective, when it comes time to give out the money, the organizations with the most lobbyists are going to be the ones to get it.

RT: What retina surgical volume is necessary for an ASC to be profitable?

Dr. Topping: That is a question without an answer. I currently run two ASCs; one has retina capabilities and the other does not. I am a member of a third, which has retina capabilities. At the largest ASC in which I operate,

we began performing retinal procedures roughly 15 years ago at a significant loss. Our anterior segment surgeons, however, were happy to have us around. If, for example, a nucleus was dropped during cataract surgery, the retina surgeon could be called into the OR and easily remove the nucleus with a vitrectomy technique. The patients and their families were happy because they did not have to return for a second surgery, and, overall, it was a positive situation.

Now, with the increasing surgical volumes that we have in our facility and with the increasing reimbursements for the procedures, it is not only cost-neutral, but even slightly cost-positive to perform retina surgeries in an ASC. Part of the decision whether to include retina surgery in your ASC is whether you want have the highest possible profit margin, which would exclude retina, or whether you want to improve the quality of services by including retina and possibly reduce your profit margin.

There is not a magic number. It all depends on regional costs, ASC throughput, and the quality of the management and structure of an organization.

RT: What are some things to watch in Congress in the coming months?

Dr. Topping: Of course we hope that the Ambulatory Surgical Center Quality and Access Act (H.R. 2108/S. 1173) passes through the House and Senate, but it will come down to how much money Congress is trying to save.

Aside from these bills facing Congressional approval, other issues that will be interesting to watch involve drug approvals in the US Food and Drug Administration. It is expected that we will soon have two new therapies available to us: aflibercept (Eylea, Regeneron Pharmaceuticals, Inc.) for age-related macular degeneration and the fluocinolone acetonide intravitreal insert (Iluvien; Alimera Sciences, Alpharetta, GA) for diabetic macular edema. It will be interesting to see how they are priced when/if approved and how much Medicare and insurance companies are willing to pay for them. ■

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