

Ambulatory Surgery Centers And Health Care Reform: Opportunities And Challenges For 2010

BY MICHAEL A. ROMANSKY, JD



There is not a week that passes that someone does not ask me whether ambulatory surgery centers (ASCs) are as attractive for vitreoretinal surgery now as they were 2 years ago. The answer is a resounding, "Yes." The reasons are twofold: advances in surgical instrumentation and advances in legislative lobbying efforts. The former is beyond the focus of this column, but the latter will be discussed in a two-part series by the person most responsible for the lobbying efforts of ASCs in Washington. Michael A. Romansky, JD, Washington Counsel and Vice President of Corporate Development for the Outpatient Ophthalmic Surgery Society (OOSS), is one of the most dedicated and tireless individuals I have ever met. Despite all the reimbursement cuts in the health care reform legislation, despite constant challenges from the powerful hospital lobbies, and despite the relative apathy of ASC owners who benefit from the efforts of OOSS but do not belong to the organization, Mike has not only championed the rights of ASCs, but has positioned ASCs as a solution to our current health care crisis. As you read his two-part series in Retina Today, consider all the effort put forth and the challenges overcome to make ASCs still attractive for vitreoretinal surgery. Thanks to Mike and OOSS, ASCs are indeed a solution to our current health care crisis.

-Pravin U. Dugel, MD

In my role as an advocate for the Outpatient Ophthalmic Surgery Society (OOSS) and the ambulatory surgery center (ASC) industry over the past 26 years, I have been ridiculed for my tongue-in-cheek characterization of the ASC as the "hub of the health care delivery system." Retina surgeons, however, need only to consider the work that has been done by Pravin Dugel, MD, on the socioeconomics of retina practice in the ASC to understand that an ASC may be a qualitatively better surgical experience for you and your patients, as well as a potentially more profitable one. In this article, I discuss several key legislative and regulatory developments affecting ASCs, highlighting their impact on the retinal surgeon. In next issue's Retina in the ASC article, I

will address the role of OOSS in fostering a climate in which ophthalmic ASCs have flourished and how the retinal surgeon can effectuate positive results at the Centers for Medicare & Medicaid Services (CMS) and on Capitol Hill.

HEALTH CARE REFORM AND THE ASC

Reader, pay close attention: This will be the first article you have read within an ophthalmology journal that will discuss health care reform and *not* focus on physician update/sustainable growth rate (SGR), the establishment of an independent payment advisory board, a mandatory physician quality reporting initiative (PQRI), or a physician-compare Web site. This is not to suggest

2010 ASC FACILITY RATES FOR OPHTHALMIC SURGICAL PROCEDURES

CODE	PROCEDURE	REIMBURSEMENT		
		2008	2009	2010*
15821	Blepharoplasty	\$591	\$673	\$841
15823	Blepharoplasty	\$591	\$774	\$881
65855	Laser Surgery of Eye	\$132	\$136	\$115
65160	Glaucoma Surgery	\$574	\$649	\$840
66180	Implant Eye Shunt	\$940	\$1176	\$1,430
66821	Nd:YAG Laser	\$288	\$258	\$234
66984	Cataract	\$976	\$964	\$962
67036	Vitrectomy, Pars Plana	\$857	\$1,077	\$1,351,41
67108	Repair Detach Retina	\$1,136	\$1,255	\$1,439
67228	Treat Retinal Lesion	\$215	\$212	\$212
67904	Repair Eyelid Defect	\$666	\$696	\$697
67921	Repair Eyelid Defect	\$576	\$638	\$668
*rounded to nearest dollar				

that these are not extremely important issues, just that all of organized medicine, the American Academy of Ophthalmology (AAO), and the American Society of Cataract and Refractive Surgery (ASCRS) have covered these issues well.

My goal in this *Retina Today* article is to provide a sharp focus on a handful of issue that are not as well addressed, but that will have an indelible impact on the surgical care delivered to patients in the ophthalmic surgical setting.

In the morass of health care reform, where does the ASC fit? At a time when public policymakers are searching for meaningful health care reform that improves quality and access while reducing costs, it should be clear that ASCs are a part of the solution. In my opinion, the country's 5,100 ASCs are doing an exemplary job of expanding their role in meeting the surgical

needs of the Medicare population while saving hundreds of millions of dollars annually. Nowhere is this phenomenon more evident than in the ophthalmic ASC, where 60% of patients elect to have their cataract surgeries.

Are ophthalmic surgeons and ophthalmic ASCs doing their parts to reduce Medicare expenditures? Yes: A recent study by the KNG Consulting Group concluded that 94% of the growth in cataract cases in ASCs was attributable to migration from more costly hospital outpatient departments to ASCs. When the ASC payment system is fully implemented in 2011 and payment for many retina procedures has doubled from their pre-2008 rates to over \$1,500, the government will realize tremendous savings as these services migrate from the hospital outpatient department to the ASC.

Earlier this year, Reps. Kendrick Meek (D-FL) and

Wally Herger (R-CA) introduced HR 2049, The Ambulatory Surgical Center Access Act of 2009. Among other things, this bill would promote ASCs' ability to continue to serve Medicare patients by improving facility payments to our centers. This would be accomplished by eliminating onerous budget neutrality adjustments applied by CMS to ASC rates and by providing ASCs with an annual inflation update at the hospital market basket rate (used to pay hospitals), rather than the lower consumer price index-urban (CPI-U). The ASC community's hope was to have this legislation included in health care legislation being considered by Congress.

Like many providers, however, we have been placed on the legislative defensive by Congress' need to garner budget savings to pay for reform. The health care reform bill approved by the House of Representatives would reduce the 2010 rates of all providers by a "productivity adjustment" of 1.3%. Because CMS has proposed a CPI-U update of 1.2% in 2010, ASCs could emerge with essentially no update at all. The Senate health care reform bill also includes a productivity adjustment; however, it would not kick in until 2011, meaning that ASCs would enjoy a cost-of-living adjustment in 2010. As such, our efforts now are directed at supporting the Senate provision when and if a conference is convened to iron out a final health care reform bill. We are also opposing provisions that would require ASCs to submit cost reports, arguing that it is unnecessary and burdensome because our rates are and should be tied to those paid to hospitals.

CMS SETS 2010 ASC RATES

It is true: Physicians who devote a few hours per year to the task of lobbying policymakers can make a difference. A case in point is the 2010 ASC payment rule-making. ASCs have not enjoyed a cost-of-living adjustment for 6 years and were finally scheduled for one to be effective in 2010. CMS proposed to utilize the CPI-U as the measure of ASC cost inflation, which under CMS' proposal would have yielded a 2010 update of 0.6%. OOSS and the ASC community recommended that CMS adopt the Hospital Market Basket as the measure of ASC cost inflation, arguing strenuously that the CPI-U does not reflect medical cost inflation and is highly volatile, particularly in response to economic factors unrelated to the delivery of surgical services. Although CMS did not agree to switch the update factor to the Hospital Market Basket, the agency utilized a different CPI-U calculation, which had the effect of increasing the proposed ASC rates by an additional 1.1%. Even with these modest annual updates, pay-

ments for retina procedures are increasing substantially each year (Table 1).

THE NEW MEDICARE CONDITIONS FOR COVERAGE

No development in Washington has generated more mail in my inbox than the new Medicare ASC Conditions for Coverage. For the first time in 25 years since Medicare started certifying ASCs, CMS issued new Medicare regulations governing a multitude of issues, including ASCs' physical structure, quality assurance, and governing body and management, to name a few. Very controversial, however, were new requirements that have the effect of limiting the ability of ASCs to schedule and perform surgery on the same day. The new rules essentially mandate that the ASC must provide the patient with verbal and written notice of his or her rights (including disclosure of physician financial interests or ownership in the ASC; advance directives; rights of property and person; privacy; confidentiality of records) "prior to the date of the procedure, ie, the patient's registration or admission to the ASC." There is an exception permitting surgery on the same day when the referring physician indicates in writing that it is "medically necessary" for surgery to be conducted that day; however, CMS makes it clear that same-day cases are expected to be rare and that frequent occurrences may represent noncompliance with advance notice requirements.

Surveyors, however, have bigger things on their minds, and it is causing some consternation within the ASC community. Forty million dollars in economic stimulus recovery funds have been made available to state health agency surveyors, under contract with CMS, to conduct unannounced "validation" surveys of literally hundreds of ASCs across the country to assess compliance with Medicare conditions for coverage, with a special emphasis on infection control and sterilization practice. OOSS is providing guidance to ASCs across the country regarding compliance with these new and complex regulations.

PHYSICIAN OWNERSHIP OF ASCS

For years, policymakers such as Rep. Pete Stark (D-CA) and the hospital industry have taken aim at physician ownership of health care facilities. If health care reform legislation is enacted this year, it will likely sound the death knell for new surgical and specialty hospitals. I do not expect that Congress will legislate federal limits on physician ownership of ASCs. Why am I so certain of this? There are currently almost as many ASCs in the nation as there are hospitals; as such, surgery centers are an indelible part of the deliv-

ery system. We have an impeccable record with respect to quality and patient satisfaction. Under the new ASC payment system, in which a percentage of the rates paid to hospital outpatient departments is paid to surgery centers, the government and the patient save money literally every time a case is performed in the ASC rather than the hospital. The Office of the Inspector General has even established an ASC investment safe harbor, under which a facility is deemed to be per se legal if certain conditions are met. I am more sanguine, however, about our prospects battling the hospital community at state and local levels. Over the past several years, we have seen state hospital associations succeed in persuading legislators and regulators at state and local levels to impede the development of ASCs through myriad approaches, including bans on self-referral, ASC provider taxes, and more rigorous certificate-of-need and licensure laws. We must remain mindful of these activities and be prepared: These battles are truly about survival of the ASC.

WHAT CAN A FACILITY DO?

Ophthalmologists and ASCs will continue to face challenges. Yes, we may wish that health care reform were not so prominent on the immediate horizon. Yes, we are irritated that CMS continues to try to nickel-and-dime ASCs despite the ASC being the best example of value health care in the entire delivery system. Over the past decade, however, the policies OOSS and the ASC community (with assistance from the AAO and the ASCRS) have adopted, the government relations program in Washington, and the targeted grassroots lobbying physicians have performed from their homes—states have allowed ASCs to survive and indeed thrive in an increasingly competitive, highly regulated, budget-conscious environment. In the next issue, I will focus on what the retina community and individual retina surgeons can do to make a difference in Washington. ■

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