The ambulatory surgery center (ASC) industry is participating vigorously in the process to revise the Medicare reimbursement system for procedures performed at ASCs.

The 2 trade organizations that represent ASCs, the Federated Ambulatory Surgery Association (FASA) and the American Association of Ambulatory Surgery Centers (AAASC), have been talking and meeting with government rule makers to promote their policy recommendations related to Medicare payments.

“We have a lot of support in Congress and a lot of interest from members in the direction CMS (Centers for Medicare and Medicaid Services) is going,” says Craig Jeffries, executive director of AAASC (www.aaasc.org).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS by Jan 1, 2008 to implement a revised payment system for surgical services provided at ASCs.

CMS hosted a 1-hour “listening session” on Aug 2 for ASC professionals to voice their concerns and recommendations regarding the revised Medicare payment system. About 530 callers listened in to the session, and 21 people spoke, including surgeons, nurses, and business managers.

“The listening session was the beginning of an aggressive dialogue in the next couple of years,” says Kathy Bryant, FASA (www.fasa.org) executive director.

Many participants were disappointed in the 1-way listening-session format, Bryant says. CMS officials invited comments but did not provide feedback or ask questions about callers’ comments. Joan Sanow, deputy director of CMS’s Division of Outpatient Care, moderated the session.

“I was impressed by the number of ASCs that participated around the country,” Jeffries says. “I think it was helpful for CMS to hear from the ASCs themselves, but I think the agency missed an opportunity to understand the issues of concern for ASCs by not probing more deeply into some of the comments that were made or engaging in a dialogue.”

Jeffries notes that this is the first listening session CMS has held on a surgery center topic since 1996.

“It may be quite some time before individual ASCs have the opportunity to talk with regulators again,” he says.

Bryant believes the listening session might have been more useful if ASCs could have commented on a proposal already on the table. “I’m not a big fan of the listening-session approach when people are just asked to comment in the abstract,” Bryant says. “It’s like Dad asking the kids, ‘Hey, what should we get Mom for Christmas?’ rather than ‘Hey, should we get Mom slippers for Christmas?’”

Industry recommendations
The ASC industry has a wish list for CMS Administrator Mark McClellan, MD, PhD. The industry advocates the following revisions to Medicare payments:

A common payment method
The ASC industry wants Medicare to reimburse ASCs based on a uniform percentage of rates paid to hospital outpatient departments (HOPDs) for the same services. This percentage would take into account that hospitals are largely not-for-profit, must take all patients, and that teaching hospitals bear costs of medical education.

To achieve relative uniformity between HOPD and ASC rates, AAASC recommends that:
ASCs and HOPDs should use the same set of payment groups, known as ambulatory patient classifications (APCs).

ASC rates should incorporate payments for all items, goods, and services for which HOPDs are compensated, including separate add-on payments for medical devices, outliers, implants, and laboratory services.

ASCs and HOPDs should receive the same annual payment updates.

HOPD and ASC payment rates should be adjusted by the same wage indices.

“Clearly they should be basing our payment system on the payments made to hospital outpatient departments,” says Jerry Henderson, RN, MBA, CNOR, CASC, executive director of the Surgi-Center of Baltimore, Owings Mills, Md, and a caller into the listening session.

“We should get annual increases when they get annual increases. ASCs have a freeze on Medicare payment increases until the end of the decade; hospitals don’t. And if they tie our system into their system, they need to calculate the total payment for supplies, implants, and outliers, not just the facility fee and procedure fees.”

An exclusionary procedures list

The Medicare Payment Advisory Commission (MedPAC), an independent federal body that advises the US Congress on Medicare issues, recommended in March 2004 that Congress should authorize CMS to create a list of services specifically excluded from payment at ASCs. In other words, CMS would pay for any ambulatory surgical service not on the exclusionary list, as long as it is medically necessary.

Historically, the opposite has occurred. The only procedures for which Medicare will pay a facility fee when performed in an ASC are those on a list of approved procedures. CMS is required to update the list every 2 years but hasn’t kept to that schedule.

“The agency hasn’t meaningfully updated the list in over 23 years,” Jeffries says. “This means Medicare beneficiaries have been deprived of hundreds of safe and effective surgical services offered at ASCs to the non-Medicare population.”

In fact, CMS proposed deleting 100 procedures from the approved list late last year, but in May, after extensive lobbying and public input, CMS deleted only five procedures from the list and added 65.

“The comments we received provided clear, clinical evidence that deleting the procedures, as we had proposed, could have led to reduced access or riskier care for patients with more complicated conditions if performed in a physician’s office rather than an ASC,” says CMS Administrator McClellan.

“The list needs to go away,” Henderson says. “It was made based on criteria designed for outpatient surgery centers 20 years ago. Technology has changed, procedures have changed, and what we’re able to do is a lot different. The only list we need is a list of excluded procedures that cannot be performed safely in an ASC.”

Bryant concurs. “An ASC list limits the ability of physicians to select the site of service they believe is most clinically appropriate for their patients,” she says. “The list also limits Medicare beneficiaries’ access to procedures that many other patients routinely receive in ASCs.”

In addition, FASA recommended to CMS in July that certain procedures should be added to the existing list immediately, well before the ASC payment system is implemented by 2008. These include:

- knee arthroscopies for osteochondral autografts and meniscal transplantation
- diagnostic flexible sigmoidoscopy
- ligation of internal hemorrhoids
- laparoscopic cholecystectomy
- stereotactic computer-assisted navigational procedures
- injection procedures for lumbar, cervical, or thoracic discography.

Update conditions of participation

To become Medicare certified and eligible to receive facility fees, ASCs must meet Medicare’s conditions of participation. According to Jeffries, these conditions have not been modified since the inception of the ASC benefit almost 25 years ago.
AAASC wants the updated conditions of participation to include that:

- Appropriately equipped ASCs can offer overnight recovery care.
- ASCs may have an “effective procedure” for immediate transfer of a patient to a Medicare participating hospital rather than a “formal transfer agreement” with a hospital.
- ASCs may affiliate with hospitals, physician offices, and other providers as long as the ASC is physically, administratively, and financially distinct from the other entities.

**Adequate payment for implants and medical devices**

The industry wants ASCs to receive the same payment for all items and services, including implants and medical devices, that HOPDs receive. In addition, ASCs advocate that any policy regarding payments to HOPDs and ASCs for implants and other items and services not incorporated into the composite rates be clear and uniformly applied by Medicare carriers.

“Without adequate payment for implants, which sometimes cost thousands of dollars, ASCs will not be able to offer Medicare beneficiaries these procedures,” Bryant says.

Kelly Shirer, manager of finance at the Wildwood Surgical Center in Toledo, and a caller into the CMS listening session, says CMS must clarify the definition of an implant.

“We believe an implant is anything you leave in the body to restore function, whether it’s an artificial joint or screws, anchors, tissue expanders, or scleral tissue used to anchor glaucoma valves,” Shirer says. “Different intermediaries vary greatly in how they pay for implants, and they look to Medicare policy for guidance, but it’s been nonexistent or confusing.”

**Beneficiary co-payment**

The ASC industry prefers that the Medicare beneficiary’s co-payment remains at 20%, even though the co-payment at HOPDs can be up to 45%.

“It’s an incentive for patients to come to ASCs,” Bryant says. “We want them to be able to have a low-cost, high-quality choice.”

**Phase in for single-speciality ASCs**

To protect single-speciality ASCs, which represent 40% of the industry, the trade organizations are lobbying for phased-in implementation of the new payment system, Bryant says. Certain specialties, such as urology, gastrointestinal endoscopy, and laser eye procedures, are usually reimbursed at a higher rate by Medicare at ASCs.

“It will be a real financial hardship for certain single-specialty ASCs unless there is a gradual phase in of a new reimbursement system,” Henderson says.

**Until 2008**

CMS officials say they await a survey of ASC costs conducted by the Government Accountability Office (GAO) to continue the rulemaking process. GAO distributed the survey to 50 Medicare-certified ASCs in July as a pilot and then disseminated the survey to another 550 randomly selected centers. From this data, GAO hopes to capture a center’s total facility costs and costs for ASC operations—information that will be used to compare the relative costs of procedures performed in ASCs versus HOPDs.

Jeffries predicts CMS will make proposed rules available for public comment at the end of 2006 or beginning of 2007.

“In the meantime, we’re going to keep our members informed and writing their government officials, and keep meeting with CMS to maintain a constant dialogue on these issues,” Jeffries says.

—Leslie Flowers

Leslie Flowers is a freelance writer in Indianapolis.