ambulatory surgery centers (ASC) have been getting more attention from regulators and health policymakers over the past year, and not all of it has been welcome.

From quality reporting legislation to Medicare payment issues, ASCs have been under review. That is due in part to efforts by hospitals to curtail what they see as unfair competition from physician groups with access to the most profitable patients and procedures, without the added strains of emergency and uninsured care.

It is time to address these issues, speakers and attendees agreed during the April annual conference of the Ambulatory Surgery Center Association in Nashville, Tennessee.

The association’s president, Kathy Bryant, urged members to communicate with legislators, regulators, and their own communities about the contributions they make and the hardships some of the new regulations will cause.

“We have to stay on message,” she warned. “It’s important that we’re all saying the same thing.”

Payment disparities

Changes in Medicare reimbursement levels for 2009 show ASCs are losing ground on payment for high-volume procedures. Payments will decline up to 22% (for paravertebral procedures for pain management). Other declines include:

- cataract surgery: -1%
- upper GI endoscopy: -7%
- diagnostic colonoscopy: -6%
- lesion removal during colonoscopy: -6%.

Because of differences in the way adjustments are calculated, hospital outpatient departments do not face such serious cuts. For example, the Medicare Payment Advisory Commission (MedPAC), the advisory panel for Medicare, recommended an inflation update factor of 3.6% for hospitals but only 0.6% for ASCs. Bryant noted MedPAC’s original recommendation was a factor of 0% for ASCs until intensive industry lobbying succeeded in raising it to a positive level.

The reason, she said, is that MedPAC and other federal agencies have been listening to hospitals. A MedPAC report to Congress in March defends the lower reimbursement rate by claiming advantages that ASCs have.

It states, “Physicians have greater control and may be able to perform more surgeries per day in ASCs because they often have customized surgical environments and specialized staffing.” The panel also appeared to conclude that because volumes and revenues had risen in preceding years, ASCs were thriving.
Until 2003, according to ASC Association figures, Medicare payments to ASCs were about 80% of the amounts paid to hospital outpatient departments. The rate is now 59%, and the association says if nothing is done, the rate is on track to drop to 50% within 5 years.

MedPAC’s argument, according to its January meeting transcript, is that lower rates for ASCs are appropriate because ASCs have lower costs than hospitals, which may be because they have less complex patients and fewer regulatory requirements than hospitals. MedPAC also expressed concern that as the number of ASCs increases, the volume of outpatient surgery will grow and increase Medicare spending.

The ASC Association has argued to MedPAC that one goal should be to get 60% to 70% of services now performed at hospitals at a higher cost into the “most cost-effective, clinically apt place” where they can be performed.

**Regulatory hardships**

The changes that took effect this year in Medicare Conditions for Coverage also cause concern, despite some modifications. “Over-night stay,” for example, now means “24 hours,” rather than “continuing past 11:59 pm,” a change that permits more procedures beginning later in the day. Still, Bryant noted, an ASC cannot schedule a procedure that would include, as a matter of treatment protocol, subsequent transfer to a hospital. “If you do,” she says, “you are risking your certification, not just the payment.”

Another sore point is the 24-hour notice requirement for advising patients of their rights and the ownership status of the surgery center because it forces some patients to wait longer than necessary for treatment, just to wait out the notification period (sidebar).

In response to quality reporting requirements that penalize nonparticipants with decreased reimbursement, the association has sponsored a collaboration that generated 11 quality measures for surgery centers, of which 6 have been approved by the National Quality Forum.

As with other requirements, Bryant says of performance measures, “We want to share our data. But we want to share our data in a fair way.”

**‘Playing the charity card’**

One of the main reasons regulators have tended to sympathize with hospital protests is that hospitals play the charity card in what ASCs believe is a misleading way, Bryant says. ASCs, especially those affiliated with hospitals, often provide charity care as a public service or to comply with hospital policy. Hospitals, which are required by law to treat all emergency patients, act as if that were a sacrifice, Bryant noted.

She maintained that the physicians who provide uncompensated care in their own surgery centers really do make a personal sacrifice of time and money.

Hospitals that say they are losing needed revenues to ASC competition also are misrepresenting the case, Bryant said.

Between 2003 and 2006, hospital outpatient volume nationwide grew by 2.1%. However, revenues from outpatient procedures increased by 9.3%, meaning those procedures brought in a higher proportion of income to hospitals.

As an industry organization, the ASC Association said it will step up lobbying efforts this year but is also trying to involve individual ASC owners and staff members, beginning with a legislative and compliance seminar in June. Letter-writing campaigns are continuing, and the association’s staff
distributed sample letters and talking points to attendees with the admonition that personal messages from constituents count with policymakers.

The ASC Association also is planning a national open house day August 11, when ASCs around the country will invite community residents to visit and learn about the benefits of receiving diagnosis and treatment at local facilities.

It is also rounding up support for the Ambulatory Surgical Center Access Act of 2009 (HR 2049). The bill would tie ASC payments to hospital outpatient payments and maintain the 59% rate.

“ASCs are a critical point of access for important screening benefits and other nondiscretionary services such as diagnostic colonoscopies and cataract removal surgery,” a sample letter to legislators notes. The bill would also modify the patient rights and ownership notification rule to allow surgery the same day it is scheduled.

Stay informed and speak up

While making their voices heard, ASCs also need to keep their ears open as broader health care issues emerge, ASC Association lobbyist Sarah Walters told a conference audience. “We’re seeing a lot of traction” on health care reform, she said, with the White House letting Congress take the lead in drafting specific legislation.

She predicted it would address delivery systems, such as insurance and Medicare, along with types of coverage. Expect more emphasis on prevention and wellness, she advised.

ASCs can be a part of the national discussion of health care reform, she said, as offering cost savings and patient choice. But first, she added, “there’s the problem with payments that we need to address.”

Both listen and speak up, she urged. “It is critically important for ASCs to be informed, and don’t hesitate to write your members of Congress. I think the challenge is to make sure our voice is heard.”

Time to speak up

The association’s chair, Alsie Sydness-Fitzgerald, CASC, agreed that ASCs need to speak up more.

“Speaking as a nurse, I don’t understand, if we perform, say, an arthroscopy, why we get paid less for it than a hospital.”

She noted that when the first ASCs emerged during the 1970s, they were seen as a source of more personalized care but faced little controversy. It has been their success in recent years that led to greater regulatory scrutiny, and she said it now is time to confront the misconceptions that have arisen.

“We’ve been around a long time,” Sydness-Fitzgerald said. “The reason people don’t know about us is we’ve been very quiet.”

—Paula DeJohn

CMS allows exception on advanced notice

In late May, ASCs celebrated news that Medicare will allow an exception in its new ASC Conditions for Coverage (CfCs) that reflects one of their concerns about the patient notification rule. The CfCs took effect May 18, 2009.
The exception came in interpretive guidelines for state survey agencies issued May 15 by the Centers for Medicare and Medicaid Services (CMS). The guidelines allow an exception in certain cases to the rule that a patient must receive written notice of patient rights and ASC ownership at least a day in advance of surgery.

The exception applies to situations in which the patient is referred for surgery on the same day the procedure is scheduled, and the referring physician states in writing that the procedure is medically necessary that day and is appropriate for an ASC.

The ASC Association lobbied CMS for relaxation of the advance notice rule, which they say presents a hardship in many cases. Association president Kathy Bryant said of the change, “We appreciate CMS’s willingness to reconsider its decision. This is a great example of the impact ASCs can have when we work together on issues like these.”

She noted the exception is unlikely to occur often because ASCs normally perform elective procedures and rarely schedule them on the same day.

More information is at http://ascassociation.org/coverage/