

*(H.R. 4350) : to amend title XVIII of the Social Security Act to modernize payment for ambulatory surgical centers under the Medicare program, and for other purposes.*



Enacting H.R. 4350 to amend title XVIII of the Social Security Act to modernize payment for ambulatory surgical centers under the Medicare program, sponsored by Representatives Devin Nunes (R-CA) and John Larson (D-CT), is necessary to ensure that the Medicare program and its beneficiaries continue to enjoy the high level of care and cost savings that the more than 5,700 ambulatory surgery centers (ASC) across the nation provide.

ASCs have transformed the outpatient experience for millions of Americans by offering a convenient, personalized, lower-cost setting of care—and have done so with a strong track record of top-quality care and positive patient outcomes. According to analysis by the University of California-Berkeley Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, during the four-year period from 2008 to 2011, ASCs saved the Medicare program **\$7.5 billion—\$2.3 billion** in 2011 alone. The Berkeley researchers also found that ASCs have the potential to save Medicare up to **\$57.6 billion more** over the next decade. The value ASCs provide extends beyond the Medicare program, with Healthcare Bluebook and HealthSmart reporting that ASCs reduce costs in the private insurance market by more than **\$38 billion** per year.

Although these savings occur because taxpayers pay significantly less—and patients' coinsurance is less—for the same procedures when performed in ASCs instead of hospital outpatient departments (HOPDs), the difference in payment has ballooned to the point that Medicare is paying HOPDs nearly **twice** as much as it pays ASCs for the same services. Over the past decade, ASCs have been subjected to a six-year payment rate freeze and hamstrung by payment updates determined using an inflation measure that is unrelated to the true costs of providing healthcare services. The difference in payments between ASCs and HOPDs, however, jeopardizes Medicare beneficiaries' access to care.

To ensure Medicare patients continue to have access to the high-quality, cost-effective services ASCs provide, the H.R. 4350 would enact the following reforms:

### **Update Reimbursement for ASC Services Using the Same Update Factor as HOPDs—The Hospital Market Basket.**

In 2019, Medicare's reimbursement rates are 94 percent higher in HOPDs compared to ASCs. This disparity exists, in part, because ASC payment rates were updated using the Consumer Price Index for All Urban Consumers (CPI-U), while HOPD payment increases were based on the hospital market basket. The CPI-U is not an appropriate measure for a healthcare facility's costs, and the hospital market basket is based on factors directly related to the increasing costs of providing medical care—inflationary pressures shared by both hospitals and ASCs. The Centers for Medicare & Medicaid Services (CMS) recognized this in its 2019 payment rule and determined that the hospital market basket should be used to update payments to both sites of service for the next five years.

Since there are no significant differences in the cost of goods and services provided by ASCs and HOPDs, the same update mechanism should apply. H.R. 4350 would require CMS to update ASC payments according to the more appropriate hospital market basket.



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## **Create Transparency of Quality Reporting & Medicare Beneficiary Information.**

Both ASCs and HOPDs that treat Medicare patients are required to submit quality data based on measures established by CMS. In the event that a measure is applicable to both the ASC and HOPD settings, CMS would be required to post the results online in a “side-by-side comparison.” The publicly available data would include quality measures for both sites of service in the same geographic area.

## **Add an ASC Representative to the Advisory Panel on Hospital Outpatient Payment.**

Since decisions made by the panel impact ASC facility fees and the list of procedures that Medicare will reimburse ASCs for providing, ASCs—like hospitals—should have an industry representative on the panel.

## **Disclose Criteria Used to Determine ASC Procedure List.**

Currently, CMS can exclude a procedure from the ASC procedure list because of a general concern for six specific criteria. CMS, however, is not required to disclose which of the criteria triggers the exclusion for a given procedure. This makes it difficult for ASCs to marshal the data needed to challenge these decisions.

H.R. 4350 would add transparency to the CMS review process by requiring CMS to disclose which of the criteria trigger the exclusion and prohibit CMS from excluding procedures reported with unlisted codes from the ASC setting. Adding procedures that can be performed safely in an ASC setting to this list saves Medicare and its beneficiaries money.