ASC CAMPAIGN FOR
Advancing Surgical Care
Quality for Patients, Value for Healthcare

Good morning Chairman Pallone and Ranking Member Shimkus. I am Chris Holden, President and CEO of AmSurg and Member of the Ambulatory Surgery Center Advocacy Committee (ASCAC) Board. AmSurg operates 200 ASCs in 33 states. I speak today on behalf of the ASC Advocacy Committee, the voice for the ASC industry and comprised of leading ASC operators, state associations and the ASC Association working on behalf of the industry to raise awareness about the important role ASCs play within the health care system and community.

Ambulatory Surgery Centers (ASCs) are health care facilitates that specialize in providing essential surgical and preventative services in an outpatient setting. With approximately 5,300 facilities across all 50 states, ASCs perform more than 25 million surgeries and procedures a year, which constitute about 35-40 percent of all outpatient surgeries. We have become a major component of the health care continuum and an essential point of access for important preventive benefits such as colonoscopies to detect colon cancer and cataract surgeries to repair eye sight. We are dedicated to providing high quality care to our patients at an affordable cost to them as well as private and public payors.

Despite our significant presence in the outpatient surgery sector, there is very little information available to patients about the relative price of services offered by the different types of providers in their community. Medicare and most insurers post information about the price paid by Medicare or the beneficiaries' out-of-pocket liability in the traditional silos of facility type rather than presenting information across settings. As a result, there is very little awareness of the significant savings available when patients to choose to have their surgical service performed in the ASC setting. Under Medicare, there is a 42 percent difference in payment for a service performed in the hospital and the same service performed in the ASC setting. Medicare always saves money when patients choose an ASC for their outpatient surgery.

We believe that patients and their physicians can make the most informed decisions based on their clinical needs. That decision-making can be greatly enhanced if patients and providers can compare their options on the basis of price and quality. For this reason, the Ambulatory Surgery Center Advocacy Committee announced our support for the Barton-Stupak legislation, "The Patients' Right to Know Act" (H.R. 4803). The "Patients' Right to Know Act" is especially timely: the recent health reform legislation instructed the Secretary to report on quality measures and a system for linking payment to quality for the ASC setting by 2011. The program she develops for rewarding high quality and low cost should enable the Medicare program, patients, and physicians to make comparisons among all providers of surgical services--within

settings and across settings. Establishing the goal of transparency now will provide important direction for pay for performance programs in ASCs.

We believe this bill will empower patients with critical information in order to make more informed decisions on where to receive their care. In particular, it will provide consumers with information on the quality and price of services paid by private insurers, Medicaid and Medicare at hospitals and ambulatory surgery centers (ASCs). Providing this information will enable patients and their physicians to choose the highest quality, lowest cost setting appropriate for their care. For example, a patient contemplating cataract removal should be provided information on hospitals and ASCs in their area – health outcomes, patient satisfaction beneficiary cost-sharing and reimbursement to those facilities in an easy to understand manner.

Understanding Differences in Payor Mix

ASCs are licensed to treat patients who can receive care and return home on the same day of their surgery. Presenting information on the payor mix of services across settings requires an understanding of the types of services offered in each setting as well as payment and other policies.

Types of cases performed in ASCs

In 2007, forty-six percent of Medicare payments to ASCs were for eye procedures, primarily cataract removal/lens insertion (40 percent). Colonoscopy and upper GI procedures accounted for 25 percent of Medicare ASC payments in 2007. Cataract removal and colonoscopies, two services essential to the Medicare population, accounted for 57 percent of total Medicare payments to ASCs. Eye procedures are simply less common in the non-Medicare population, making the ASC payor mix more heavily weighted toward Medicare than the hospital setting. On the other hand, colorectal cancer screening guidelines call for testing to begin at age 50, meaning that centers focused on GI procedures will have a lower percentage of Medicare cases and higher percentage of private insurance. Colorectal cancer screenings remain underutilized in the Medicaid and indigent care populations, although we have made huge strides over the past decade to expand access to CRC screening. We are optimistic that a provision in the health reform legislation to waive the coinsurance for CRC screening will improve access to and utilization of recommended services.

Payment policies that affect site of service

In addition to differences in the types of services performed in ASCs and hospitals, payment and tax policy also has a strong influence on the types of patients treated in each setting. In the hospital setting, several important policies expand hospitals ability to care for the un- and under-insured. For example,

- Not-for-profit hospitals are obligated to provide a charitable benefit to maintain their tax-exempt status. Some experts suggest that the value of tax-exempt status is worth $20 billion to the hospital industry.[1]
- Medicare and Medicaid Disproportionate Share Hospital (DSH) Payments were originally intended to compensate hospitals for the higher operating costs they incur in treating a large share of low-income patients. More recently, many policymakers present DSH funds as a mechanism to preserve access to care for Medicare and low-income populations by financially assisting the hospitals they use. The federal Medicaid DSH allotment for 2009 was approximately $11 billion. Medicare DSH Payments are projected to be $9.8 billion.[2]
- Medicare pays hospitals for a portion of their Medicare bad debt. As the only provider receiving bad debt payments, hospitals are partially shielded by federal subsidy when the facility is unable to collect the beneficiaries' coinsurance.

Each of these adjustments has a sound basis in Medicare policy; however, there are no companion policies to encourage other providers to subsidize the uninsured. While the hospital industry is primarily tax-exempt, most ASCs are for profit entities that pay federal, state, and local taxes. In addition, ASC owners pay taxes on their revenue from the facility as well. In some areas, states levy a tax on ASCs to pay for uncompensated care delivered in hospital settings.

Empowering patients with information on the price and quality of services will supplement the expanded coverage of the uninsured and help patients and payors stretch limited financial resources most efficiently.

Providing Meaningful Price Comparisons

Today more than ever, Americans are facing higher coinsurance or are covered under high-deductible health plans that expose them to significant out-of-pocket costs before coverage kicks in. Even in Medicare, out-of-pocket obligations are considerable. As a result, price has

---

[1] NANCY M. KANE, TAKING THE PULSE OF CHARITABLE CARE AND COMMUNITY BENEFIT AT NONPROFIT HOSPITALS, STATEMENT TO THE U.S. SEN. COMM. ON FINANCE 2 (Sept. 13, 2006) (estimating value of exemption from all sources as approaching $20 billion per year)

[2] http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf, accessed 05/03/2010.

been an important determinant to of whether patients seek important preventive services like screenings colonoscopies. We applaud the Congress for acting to eliminate patients' liability for services recommended by the US Preventive Services Task Force. In the outpatient surgery setting, this should be a tremendous benefit to increase the use of screening services for colon cancer that have been proven to be cost-effective measures to prevent colon cancer and reduce mortality. Despite tremendous strides in increasing screenings, there are still millions of Americans who are not receiving recommended screening services.

Providing meaningful information that allows patients to compare the price of services and their out-of-pocket liability should also allow patients to select the least costly setting appropriate to their clinical needs in consultation with their physician. Because many outpatient surgeries can be performed in hospitals and ASCs, it is critical to provide patients with meaningful price comparisons across settings.

Under Medicare, there is a 42 percent difference in payment for a service performed in the hospital and the same service performed in the ASC setting. Medicare always saves money when patients choose an ASC for their outpatient surgery. Beneficiaries can save even more. This year, a patient needing cataract surgery would face an average difference in copayment of 61%. When the service is performed in the ASC, the beneficiary would be liable for $196; however, the patient would owe $496 if the same service were instead provided in the hospital outpatient department. Building an awareness of this among the Medicare population and the physicians who refer patients can help the Medicare program leverage the buying power of its beneficiaries.

Comparison of 2010 ASC and HOPD beneficiary copayments

HCPCS	*Description*	*ASC Copay*	*HOPD Copay*	*Difference*
66984	Cataract surg w/iol, 1 stage	$192.49	$495.96	61%
43239	Upper gi endoscopy, biopsy	$73.89	$143.38	48%
45378	Diagnostic colonoscopy	$76.05	$186.06	59%
45380	Colonoscopy and biopsy	$76.05	$186.06	59%
45385	Lesion removal colonoscopy	$76.05	$186.06	59%
66821	After cataract laser surgery	$46.81	$104.31	55%
64483	Inj foramen epidural l/s	$59.20	$97.09	39%
66982	Cataract surgery, complex	$192.49	$495.96	61%
45384	Lesion remove colonoscopy	$76.05	$186.06	59%
29881	Knee arthroscopy	$209.92	$403.36	48%
63650	Implant neuroelectrodes	$699.19	$885.85	21%
29827	Arthroscop rotator cuff repr	$327.64	$804.74	59%

It is also important to present consumers the payment rates for procedures at the facility level. In Medicare, many components of the payment system adjust hospital and ASC payments

based on their geography (the wage index) or based on hospital-specific characteristics (outpatient hold harmless rates, cost-based payment, and other add-on payments). The wage index alone produces significant differences in the price of services at an ASC and HOPD within the same metropolitan statistical area as shown below.

Payment for arthroscopic procedure in selected markets (29828)

Geographic Area	*Payment*		*Ratio of ASC:HOPD Payment*
	OPPS	*ASC*	
Wheeling WV-OH (OH providers)	**$2,987**	**$1,625**	**54%**
Connecticut	**$3,719**	**$2,041**	**55%**
Wilmington, DE-MD-NJ (NJ providers)	**$3,543**	**$1,891**	**53%**
Pine Co., MN*	**$3,294**	**$1,847**	**56%**

*** Reflects application of out-commuting adjustment of 0.0812 to rural MN index**
Values reflect final FY2010 IPPS wage index and proposed ASC CY 2010 wage index values

If just half of the patients who sought surgical services in the hospital last year had instead gone to an ASC, the Medicare program would save Medicare about $2 billion a year and the beneficiaries hundreds of millions of dollars in lower copayments.[3] The transparency provided in your bill can generate even more savings for patients, Medicare and Medicaid as patients are empowered to select providers on the basis of price and quality.

Providing Meaningful information on Quality

In addition, ASCs welcome greater transparency on quality metrics. More than 20 percent of ASCs are voluntarily reporting results on ASC quality measures endorsed by the national Quality Forum (NQF) while our industry continues to urge the Centers for Medicare and Medicaid Services to implement a system for nationwide quality measurement. In addition, our patient satisfaction rates are better than 90 percent. An apples-to-apples comparison of ASCs to hospitals for similar procedures will provide critical transparency and encourage individual hospitals and ASCs to continue to improve their health outcomes.

CMS has the current authority to require ASC quality reporting but has not utilized it, and our industry has repeatedly encouraged CMS to implement a mechanism for ASC quality reporting. In addition, current law does not require CMS to collect and share comparable quality information from ASCs and HOPDs, diminishing the utility of having data from each setting. The

[3] ASC Association analysis of comparing the ASC and HOPD cost of half of the procedures performed in the HOPD in 2008 which are eligible for payment in the ASC.

ASC industry supports H.R. 2049, the *Ambulatory Surgery Center Access Act,* which includes a provision similar to the requirements of H.R. 4803. The ASC Access Act would require CMS to present side-by-side comparisons of ASC and HOPD quality and beneficiary coinsurance in each geographic area. Like the *ASC Access Act*, the *Patients' Right to Know Act* will help facilitate meaningful comparisons of facility quality by requiring ASCs and hospitals to report similar information where appropriate.

Although CMS has not implemented quality reporting for ASCs, our industry has come together behind an initiative to develop quality measures and collect performance on those measures from centers across the country. Today, approximately 20 percent of the industry voluntarily submits quality data to the ASC Quality Collaboration on the 6 measures endorsed by the National Quality Forum for ASCs.

ASC Quality Measures Endorsed by the National Quality Forum

Measure	***Description***
Patient Fall in the ASC	The frequency of ASC admissions experiencing a fall while in the confines of an ASC
Patient Burn	The frequency of ASC admissions experiencing a burn, regardless of severity, while in the care of an ASC
Hospital Transfer/Admission	The frequency of ASC admissions experiencing a transfer or admission to a hospital upon discharge from an ASC
Wrong Site, Side, Patient, Procedure, Implant	The frequency of ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event while in the care of an ASC
Prophylactic IV Antibiotic Timing	ASC admissions having an order for an antibiotic to help prevent surgical wound infection that received the antibiotic in the appropriate timeframe
Appropriate Surgical Site Hair Removal	The percentage of ASC admissions that had body hair removed with electric clippers or hair removal cream

As you move forward, we want to work with you to ensure that the pricing information disclosed is accurate presents the most meaningful comparison for consumer choice. We look forward to working with you to advance this bipartisan legislation that empowers patients and the providers who care for them.