ASCA Comments on Energy and Commerce Health Subcommittee Legislative Hearing on “Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Healthcare”

April 26, 2023

Chairman Guthrie and Ranking Member Eshoo:

The Ambulatory Surgery Center Association (ASCA), representing more than 6,000 Medicare-certified surgery centers in the United States, is pleased to provide comments on the Energy & Commerce Subcommittee on Health legislative hearing on specific legislation to increase transparency and competition in healthcare. Ambulatory surgery centers (ASCs) provide high-quality care and cost savings to patients and healthcare payers. As Medicare pays ASCs about half as much as hospital outpatient departments (HOPDs) for performing identical procedures, surgery centers save the program considerable sums. From 2011 to 2018, ASCs saved Medicare $28.7 billion as a lower-cost site of care and are projected to save an additional $73 billion between 2019 and 2028.\(^1\) Forecasted savings, however, are threatened by problematic Medicare policies that result in continually declining reimbursement and other factors that limit Medicare beneficiaries’ access to efficient outpatient surgical and procedural care in the surgery center setting.

Our community welcomes the opportunity for a discussion on the important topics of cost, transparency and competition and the important role that our centers can play as an increasing number of patients seek outpatient services for a myriad of surgical specialties such as gastroenterology, ophthalmology, orthopedics and urology, all performed in a convenient setting for the beneficiary and at a lower price than competitors.

On its face, the phrase “site neutrality” has been construed as a catch-all to include a number of policy proposals that our community of healthcare providers and patients would support. However, we are particularly concerned with draft legislation before the committee -- : “H.R.____, To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings”, which would slash ASC payments to the physician office rate if just a plurality – not majority – of care is offered in the physician office. A foundational element of the surgery center model is that ASCs are the proper setting for appropriate patients—that subset of the Medicare population without the comorbidities that would dictate they receive care in a hospital. Similarly, there are beneficiaries who benefit from receiving care in the highly-regulated ASC environment over that of a physician’s office. Using payment policy to drive patient care to a lower-cost, unregulated environment will present risks to patients that are not addressed in this legislation.

As an example, ASCs would see their reimbursement cut from $3,600 to $1,500 for urologic procedure Cystourethro w/implant because physician offices volume was 35.8 percent, barely beating out HOPD volume at 35.5 percent and ASC volume at 28.6 percent. The Committee should modify this policy to require at least a majority (i.e. 50.1 percent) of care to be provided in the site-of-service for that site’s payment policy to apply. Even with that, a policy to ensure that

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\(^1\) “Study: Reducing Medicare Costs by Migrating Volume from HOPDs to ASCs,” Advancing Surgical Care, www.advancingsurgicalcare.com/reducinghealthcarecosts/costsavings/reducing-medicare-costs.
patients with higher risk profiles can be seen in the appropriate setting, with additional reimbursement for that setting to defray costs, should be considered. In that vein, the bill appears to limit downside payment cuts to hospitals but not ASCs. Those rules should apply equally to both sites of care and not just limit impact of reimbursement cuts to hospitals but not ASCs.

More fundamentally, the Committee should consider policies that encourage migration from the more expensive setting to the ASC setting rather than simply cutting provider payment rates. As such, we recommend your consideration of the Outpatient Surgery Quality and Access Act (H.R. 972), which more fundamentally ties ASC reimbursement to the HOPD payment system by codifying the current identical market basket update for both settings and includes ASC volume with hospital outpatient volume for purposes of applying a single scalar to ASC payments. The bill also provides important transparency for patients by requiring HHS to publish a comparison of quality measures across both sites of care. Most importantly, it would provide the same beneficiary copayment cap in the ASC setting that now only applies to the HOPD setting so that patients are not dissuaded from getting care in the more efficient setting.

We share your goals to create more access for patients to affordable health care while saving money on procedures that can be done more efficiently in lower-cost settings. As Congress contemplates advancing site-neutral policies, ASCA suggests several essential design features:

**Focus on the patient’s perspective on services that can be done in a less costly setting than the hospital.**

Access to more sites of care will increase competition between providers, drive costs down, and create better outcomes for patients. This will save Medicare more dollars in the short and long term. Surgery centers have an increasing role in this space considering the growing number of outpatient surgeries every year.

**Include the Co-Pay Cap Provision of Outpatient Surgery Quality and Access Act.**

A beneficiary access problem arises because Congress enacted a beneficiary copayment cap in the HOPD setting equal to the inpatient deductible when it enacted the Hospital Outpatient Prospective Payment System on the theory that beneficiaries should never be penalized for getting care in the more efficient setting. But, there is no similar copayment cap in the ASC setting.

A beneficiary typically has a coinsurance responsibility of 20 percent of the procedure’s cost when that procedure is performed in an ASC. When a beneficiary receives the same procedure in an HOPD, the copay is capped at the inpatient deductible amount, which is $1,600 for 2023, and the hospital is made whole by the Medicare program.

Without a similar co-pay cap in the ASC setting, a perverse result is that many patients choose the higher cost setting for certain procedures because their beneficiary copayments are capped even though the cost to Medicare is substantially higher than if the beneficiary received care in the ASC.

The co-pay cap provision of the Outpatient Surgery Quality and Access Act of 2023 (H.R. 972) applies the same framework to ASCs that exists in HOPDs, providing the same cap on a
beneficiary’s ASC copay that exists in the HOPD setting. We believe patients will naturally opt for lower cost settings if their out-of-pocket liability is similarly capped in the surgery center. If even a small percentage of patients migrate to the ASC setting, the cost of the cap more than pays for itself and just a 5-10 percent migration for these procedures would produce hundreds of millions in net savings to the Medicare program.

Establishing the same co-pay cap in the ASC setting will increase patient access to care and ultimately decrease costs to Medicare and its beneficiaries. Notably, the current lack of a co-pay cap in the ASC setting penalizes part B Medicare patients lacking supplemental coverage. This is an area where a racial disparity in access has been observed, with only 40 percent of black beneficiaries being covered by supplemental insurance in contrast to 72 percent of white beneficiaries.²

Numbers at a Glance:

Total knee arthroplasty (27447) and total hip arthroplasty (27130) are two prominent procedures that would benefit from the copay cap policy fix. Additionally, a spine code with significant ASC commercial volume but low Medicare volume (22551), and a dialysis circuit code (36906) are provided below for comparison. For reference, the difference in patient responsibility for each of the codes is listed below³:

- 27447: $2,054 (+ $236 over HOPD)
- 27130: $2,067 (+ $248 over HOPD)
- 22551: $2,097 (+ $192 over HOPD)
- 36906: $2,281 (+ $623 over HOPD)

ASC Covered Procedures List

To further increase cost savings, we must increase the list of procedures that can be performed in an outpatient setting. While one draft bill before the committee would reform the inpatient only list for certain musculoskeletal hospital procedures, that reform is not meaningful unless the corollary reform is made to establish an HOPD and ASC payment for those procedures and allow ASCs to provide those procedures by significantly expanding or reforming the ASC-payable list.

Total shoulder (23472) is a prime example of a procedure is not currently payable in ASCs but is ready for migration considering the high success rates of other total joint replacements in the ASC setting generally. There are currently 370 total codes that are payable in HOPDs but not ASCs by Medicare. Congress should allow ASCs to provide any surgical procedures permitted in the HOPD.

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³ https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates