Outpatient Surgery Quality and Access Act

H.R. 5818 / S. 3132

Ambulatory surgery centers (ASCs) have provided high-quality care and cost savings to patients and healthcare payers since their inception 51 years ago. From 2011 to 2018, ASCs saved Medicare $28.7 billion, and ASCs 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 outpatient surgical care.

By enacting the *Outpatient Surgery Quality and Access Act,* Congress will:

Align the Reimbursement Update Factor for Identical Outpatient Procedures

The bill makes permanent the 2019 decision by the Secretary of the US Department of Health and Human Services (HHS) to use the same update factor for hospital outpatient departments (HOPDs) and ASCs, better aligning the ASC and HOPD payment systems.

Provide Beneficiaries with Quality Information

The bill directs the US Department of Health and Human Services (HHS) to publish a comparison of quality measures that apply to both ASCs and HOPDs.

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

The bill designates one seat on the panel, currently comprised solely of hospital and health system representatives, for a representative from the ASC community.

Create a Review Process for Potential Outpatient Procedures

The bill directs the Centers for Medicare & Medicaid Services (CMS) to publish its rationale for declining to add any codes to the ASC Covered Procedures List that were formally requested by industry stakeholders, providing transparency in a currently opaque system.

Eliminate the Copay Penalty for Part B Services

The bill applies the same framework to ASCs that applies to HOPDs, capping a beneficiary's copay and making the facility whole for the difference. Ending the penalty will increase access to care and ultimately decrease costs to Medicare and its beneficiaries. The penalty most penalizes those without supplemental coverage—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]

Allow ASC Services to Grow Naturally

CMS scales HOPD relative payment weights for budget neutrality and then applies a second, ASC-specific weight scalar to maintain budget neutrality within the ASC payment system.[3] This secondary weight scalar penalizes ASCs for shifting Medicare services from higher-cost settings, artificially limiting what otherwise would be the natural migration to the lower-cost ASC setting. This bill would prohibit the agency from conducting the secondary scaling calculation and instead directs CMS to combine ASC and HOPD volume and calculate one outpatient weight scalar, making this provision budget neutral.

---

[1] "Study: Reducing Medicare Costs by Migrating Volume from HOPDs to ASCs," *Advancing Surgical Care*, www.advancingsurgicalcare.com/reducinghealthcarecosts/costsavings/reducing-medicare-costs.

[2] Brunt, Christopher S. "Supplemental Insurance and Racial Health Disparities under Medicare Part B." *Health Services Research*, John Wiley and Sons Inc., Dec. 2017, www.ncbi.nlm.nih.gov/pmc/articles/PMC5682138/.

[3] *Federal Register* 85, No. 156 (August 12, 2020): 48982. https://www.govinfo.gov/content/pkg/FR-2020-08-12/pdf/2020-17086.pdf#page=211