



Ambulatory surgery centers (ASCs) have maintained a strong track record of high-quality care and positive patient outcomes since their inception 51 years ago. With this high-quality care also comes savings to patients and healthcare payers, providing a value to patients and the healthcare delivery system that is unmatched.

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 ensure Medicare beneficiaries' continued access to high-quality outpatient surgery.

Align the Reimbursement Update Factor for Identical Outpatient Procedures

Issue: Medicare and beneficiaries generally pay twice as much for procedures performed in hospital outpatient departments (HOPD) instead of ASCs. This disparity exists, in part, because ASC payment rates were updated annually using the Consumer Price Index for All Urban Consumers (CPI-U), while HOPD payments were updated with the hospital market basket. In 2019, the Centers for Medicare & Medicaid Services (CMS) agreed to align the update factors and use the hospital market basket to update payments in ASCs for a five-year trial period.

Solution: This provision of the bill makes permanent the alignment of update factors, helping to move to a more complete alignment of the ASC and HOPD payment systems.

Provide Beneficiaries with Outpatient Surgery Quality Information

Issue: While price comparisons for ASCs and HOPDs are readily available to the public,² quality data is not available in a consumer-friendly format.

Solution: This provision of 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

Issue: The Advisory Panel on Hospital Outpatient Payment makes recommendations to the HHS Secretary on issues impacting the HOPD and ASC payment systems, but membership is comprised solely of hospital and health system representatives.

Solution: This provision of the bill would designate one seat on the panel for a representative from the ASC community.

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

² "Procedure Price Lookup for Outpatient Services." *Procedure Price Lookup for Outpatient Services* | [Medicare.gov](http://www.medicare.gov/procedure-price-lookup/), www.medicare.gov/procedure-price-lookup/.

Create a Review Process for Potential Outpatient Procedures

Issue: There is no formal process for stakeholders to use to request codes be added to the ASC Covered Procedures List (ASC-CPL), and CMS is not required to be transparent as to its rationale for keeping a procedure off the ASC-CPL.

Solution: This provision of the bill directs CMS to publish its rationale for declining to add any codes to the ASC-CPL that were formally requested by industry stakeholders.

Eliminate the Copay Penalty for Part B Services

Issue: 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 \$ 1,484 for 2021, and the hospital is made whole by the Medicare program. This copay penalty limits patients' access to care in ASCs and ultimately increases costs to Medicare, its beneficiaries and taxpayers.

This issue primarily impacts 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.³

Solution: This provision of the bill applies the same framework that applies to HOPD services, capping a beneficiary's copay and making the facility whole for the difference.

Allow ASC Services to Grow Naturally

Issue: The HOPD relative payment weights are scaled for budget neutrality. Then, CMS applies a second, ASC-specific weight scalar to maintain budget neutrality within the ASC payment system.⁴ While the legislation directing HHS to implement a revised ASC payment system required CMS to use this second weight scalar *in the first year of implementation*,⁵ the agency has continued to apply this calculation to ASC payment weights annually. The secondary weight scalar penalizes ASCs for shifting Medicare services from higher-cost settings, and in doing so, artificially limits what otherwise would be the natural migration to the lower-cost ASC setting.

Solution: This provision of the legislation would prohibit the agency from conducting the secondary scaling calculation. Instead, the legislation directs the agency to combine ASC and HOPD volume and calculate one outpatient weight scalar, making this provision budget neutral.

³ 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/.

⁴ CY 2021, 85 F.R. 48982, <https://www.govinfo.gov/content/pkg/FR-2020-08-12/pdf/2020-17086.pdf#page=211>

⁵ See Social Security Act 1833(i)(D)(ii): ***In the year the system described in clause (i) is implemented***, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.