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ASC and OBA Medical Directors' Meeting
Friday, October 18th, 2024 • Philadelphia, PA

ASCA Federal Update

1

Learning Objectives

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- Explore the history of ASCs and projected trends for the future.
- Analyze the ASC Medicare payment system, including the ASC Quality Reporting Program, highlighting 2025 proposed rule developments.
- Discuss federal legislation being considered that would impact ASCs.

2

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History of ASCs

3

1970s & 1980s

- First ASC - February 12, 1970
- 1974 - Society of Freestanding Ambulatory Surgical Care incorporated
- 1976 - Omnibus Budget Reconciliation Act of 1980 officially provides Medicare reimbursement
- 1982 - Medicare approves payment for ~200 ASC procedures
- 1988 - ASC industry passes milestone of 1000 facilities

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1990s & 2000s

- 1995 - Founding of International Association for Ambulatory Surgery (IAAS)
- 1995 - Medicare expands ASC list to 2000 procedures
- 2000 – 3000 ASCs
- 2004 – 4000 ASCs
- 2008 – Medicare implements new payment system linking ASC rates to hospital outpatient prospective payment system (OPPS)
- 2008 – Conditions for Coverage overhauled

5

Today

- 2024 – 6,377 Medicare certified ASCs
- More than 4,000 surgical codes on Medicare's ASC list
- 2022
  - 6.2 million FFS Medicare procedures
  - $6.1 billion in FFS Medicare reimbursement

6

Site of Care Projections 2024-2034

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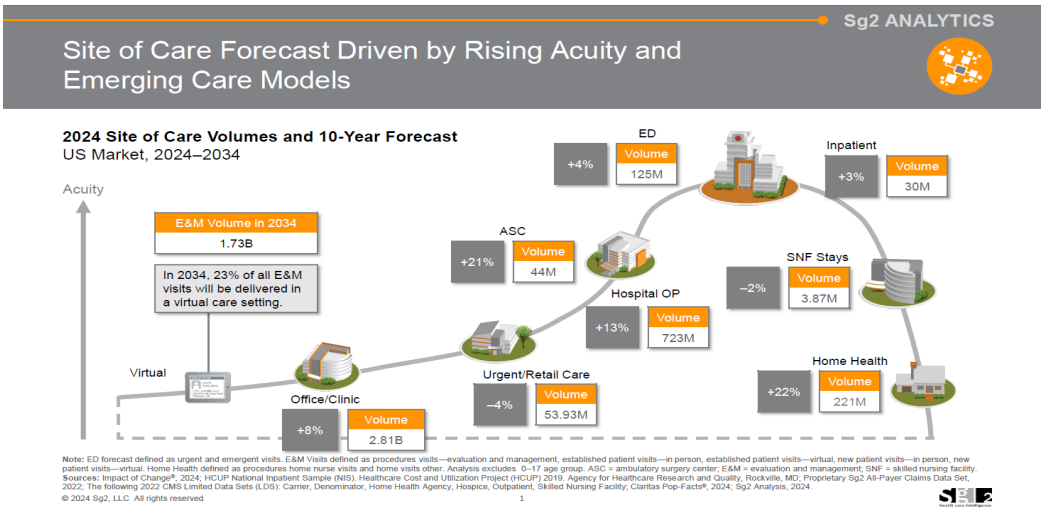

7

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Medicare Payment Policy

8

Medicare Reimbursement

§ 416.61 Scope of facility services.

(a) ***Included services.*** Facility services include, but are not limited to -

(1) Nursing, technician, and related services;

(2) Use of the facilities where the surgical procedures are performed;

(3) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures;

(4) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

(5) Administrative, recordkeeping and housekeeping items and services; and

(6) Materials for anesthesia.

(7) Intra-ocular lenses (IOLs).

(8) Supervision of the services of an anesthetist by the operating surgeon.

9

Hospital Outpatient Prospective Payment System (OPPS) / ASC Payment Rule Timeline

- **Proposed rule**: Usually early July
- Comments due 60 days after proposed rule
- **Final rule**: Typically issued 60 days prior to January 1 effective date
- Payment Rates Effective January 1
  - Correction Notices
  - Quarterly Updates

10

2025 Proposed Payment Update

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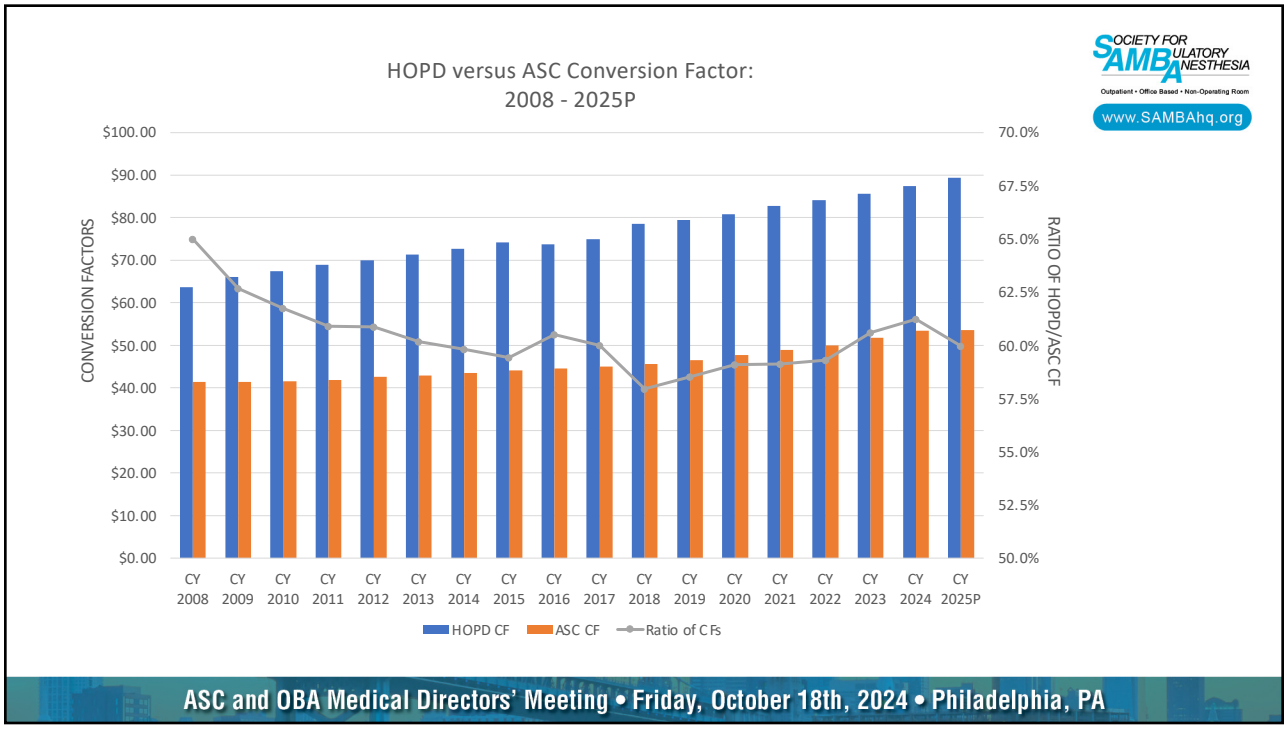
- **ASC Effective Inflation Update: 2.6%**
  - CMS to use hospital market basket index through 2025
  - Hospital Market Basket: 3.0%
  - Multi-factor productivity (MFP) adjustment: 0.4%
- **HOPD Effective Inflation Update: 2.6%**
  - Hospital Market Basket: 3.0%
  - Multi-factor productivity (MFP) adjustment: 0.4%
- **Secondary Rescaling Factor: 0.876**
- **Rate change varies by procedure**

11



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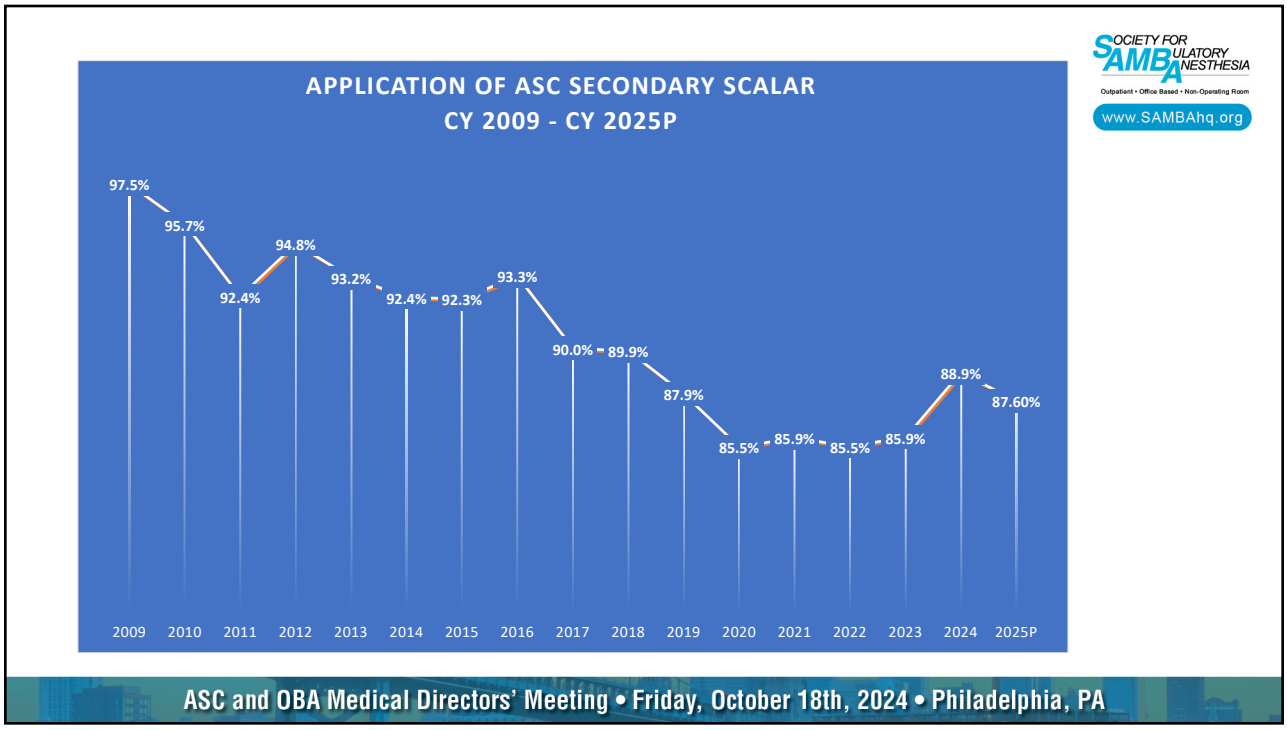

13

Top 100 Procedures by Volume

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Specialty	Total Codes in Top 100	2022 ASC Volume for Top 100 Codes	Δ 2024F – 2025P
Dermatology	6	50,869	3.15%
Gastrointestinal	15	1,903,049	3.05%
General	1	5,818	3.45%
Ophthalmology	22	1,803,124	2.35%
Orthopedics	21	358,553	2.18%
Otolaryngology	4	58,229	4.10%
Pain Management	15	969,018	1.74%
Spine	3	50,005	3.02%
Urology	10	169,557	2.78%
Vascular/Cardio Surgery	3	42,180	-0.55%
Grand Total	100	**5,410,402**	**2.43%**

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14

Top 10 Procedures by Volume

HCPCS	Descriptor	Specialty	2022 Volume	July 2024 Rate	2025 Proposed Rate	Δ 2024 – 2025 P
66984	Cataract surg w/iol 1 stage	Ophthalmology	1,165,208	$1,183.57	$1,205.23	1.8%
43239	Egd biopsy single/multiple	Gastroenterology	474,978	$470.17	$497.46	5.49%
45385	Colonoscopy w/ lesion removal	Gastroenterology	465,629	$612.08	$626.82	2.35%
45380	Colonoscopy and biopsy	Gastroenterology	432,508	$612.08	$626.82	2.35%
64483	Inj foramen epidural l/s	Pain Management	257,601	$472.76	$478.78	1.26%
66821	After cataract laser surgery	Ophthalmology	235,975	$301.49	$305.57	1.34%
64493	Inj paravert f jnt l/s 1 lev	Pain Management	189,565	$472.76	$478.78	1.26%
G0105	Colorectal scrn; hi risk ind	Gastroenterology	152,106	$474.05	$485.67	2.39%
62323	Njx interlaminar lmbr/sac	Pain Management	125,844	$358.69	$372.04	3.59%
64635	Destroy lumb/sac facet jnt	Pain Management	106,989	$897.67	$920.62	2.49%
			3,606,403			**2.43%**

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15

Medicare ASC Covered Procedures List (ASC-CPL)

- Historically includes surgical procedures CPT 10000-69999 (unless excluded)
- Ancillary services (when provided in conjunction with surgical code)
- List updated annually (mid-year coding changes)
- Evaluates excluded procedures to determine if any codes currently excluded should be added to the ASC-CPL

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General Exclusions

c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical procedures that—

(1) Generally result in extensive blood loss;
(2) Require major or prolonged invasion of body cavities;
(3) Directly involve major blood vessels;
(4) Are generally emergent or life-threatening in nature;
(5) Commonly require systemic thrombolytic therapy;
(6) Are designated as requiring inpatient care under §419.22(n) of this subchapter;
(7) Can only be reported using an unlisted surgical procedure code
(8) Otherwise excluded under §411.15 of this subchapter

17

ASC-CPL Nomination Process Changes for 2024

- Name Change in 2023 – "Pre-Proposed Rule CPL Recommendation Process"
- Stakeholders submit codes for consideration by March 1
- CMS will review whether codes meet exclusionary criteria

18

ASC-CPL Nomination Process

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- ASCA submitted the following codes:

- ***Cardiovascular Codes***
  - Electrophysiology Studies and Ablations: 93613, 93619, 93620, 93623, 93650, 93653, 93654, 93655, 93656 and 93657
  - Cardioversion and TransEsophageal Echocardiogram: 92960 and 93355

- ***Spine Codes***
  - Posterior Lumbar Inter-body Fusion: 22630
  - Combined Posterior Lumbar and Posterior Lumbar Inter-body Fusion: 22633

NONE were proposed for addition to ASC-CPL.

19

Proposed ASC-CPL Additions for 2025

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- CMS proposed the following codes:
  - ***ADRC Therapy***
    - 0717T, 0718T
  - ***Cardiovascular Codes***
    - Pacemakers: 0795T, 0801T
  - ***Dental Codes***
    - D7251, D7280, D7410, D7411, D7412, D7413, D7414, D7415, D7450, D7451, D7460, D7461, D7485, D7521, D7530, D7540

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ASC Quality Reporting Program

21

Quality Reporting in 2025 OPPS/ASC Proposed Payment Rule

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CMS is proposing to add the following measures cross-program measures:

(1) the Facility Commitment to Health Equity (FCHE) measure beginning with the CY 2025 reporting period/CY 2027 payment determination;

(2) the Screening for Social Drivers of Health (SDOH) measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and

(3) the Screen Positive Rate for Social Drivers of Health (SDOH) measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

CMS also requested public comment on the "potential development of frameworks for specialty focused reporting and minimum case number for required reporting under the ASCQR Program."

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22

ASC 15: Outpatient/Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)

- The five survey-based measures (ASC-15a-e) are collected via one survey {OAS CAHPS}:
- ASC-15a: About Facilities and Staff;
- ASC-15b: Communication About Procedure;
- ASC-15c: Preparation for Discharge and Recovery
- ASC-15d: Overall Rating of Facility; and
- ASC-15e: Recommendation of Facility

Voluntary reporting in CY 2024; mandatory reporting beginning in CY 2025

23

OAS CAHPS Survey

- Survey has 34 questions:
  - 22 questions related to the patient, the facility, communication, and patient reported outcomes
  - 12 demographic questions
  - ASCs may add up to 15 supplemental questions
- Survey must be conducted via telephone, mail or mixed-mode (mail with telephone follow-up); electronic with phone and electronic with mail (these two modes added in 2022)
- CMS requires 200 completed surveys
- Must contract with CMS-certified vendor (currently 16)
- https://www.ascassociation.org/asca/asc-operations/quality/oas-cahps

24

ASC-21: THA/TKA PRO-PM

- Pre-operative data collected from 0-90 days before the procedure and post-operative data collected between 300-425 days after the procedure.
- Must submit 44 to 47 data elements for each THA patient and a total of 46 to 49 data elements for each TKA patient when complete PRO data is provided by the patient.
- Has not been tested in the ASC setting
- Voluntary reporting begins with CY 2025-2027 reporting periods followed by mandatory reporting beginning with the CY 2028 reporting period.

25

Public Reporting of Facility Specific Quality Reporting Data

- CMS publicly reports ASC data here: https://data.cms.gov/provider-data/

- A facility comparison dashboard is available here: https://www.qualityreportingcenter.com/en/facility-compare-dashboard/

26

Legislative Update

27

Outpatient Surgery Quality and Access Act (H.R. 5818 and S. 3132)

- CPI-U to HMB
- ASC representation on payment panel
- Comparable quality data (ASCs and HOPDs)
- Transparency re: ASC-approved procedures list
- Co-pay cap
- ASC weight scalar

28

Medicare Cost Transparency Tool for Certain Surgical Procedures

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- Mandated by the 21st Century Cures Act (signed into law December 13, 2016)
  - **https://www.medicare.gov/procedure-price-lookup/**
- Outpatient facility checklist: Which facility is best for my outpatient procedure? **https://www.medicare.gov/what-medicare-covers/outpatient-facility-checklist**
  - Also a hospital and ASC look up tool

29

ASC to HOPD Beneficiary Comparison

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Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
Code: 66984

Ambulatory surgical centers		Hospital outpatient departments	
Patient pays (average)	$341	Patient pays (average)	$549
This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.		This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.	
More cost information		More cost information	
All costs are national averages		*All costs are national averages*	
Total Cost	$1,711	Total Cost	$2,748
Doctor Fee	$528	Doctor Fee	$528
Facility Fee	$1,183	Facility Fee	$2,220
Medicare Pays	$1,368	Medicare Pays	$2,198
Patient pays	$341	Patient pays	$549

Next Steps: Use this checklist to talk to your doctor about your costs and options, find hospitals in your area, or get data on ambulatory surgical centers.

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Co-Pay Cap Issue

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Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
Code: 63655

Ambulatory surgical centers		Hospital outpatient departments	
Patient pays (average)	$3,762	Patient pays (average)	$1,799
This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.		This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.	
More cost information		More cost information	
All costs are national averages		*All costs are national averages*	
Total Cost	$18,815	Total Cost	$21,680
Doctor Fee	$838	Doctor Fee	$838
Facility Fee	$17,977	Facility Fee	$20,842
Medicare Pays	$15,052	Medicare Pays	$19,880
Patient pays	$3,762	Patient pays	$1,799

In hospital outpatient departments, Original Medicare caps your copayments at $1,632. This likely applies to this procedure.

31

Lower Costs, More Transparency Act (H.R. 5378) Health Care PRICE Transparency Act 2.0 (S. 3548)

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Beginning January 1, 2026, ASCs would publish:

- Standard charges for each item or service furnished in the ASC;
- Information on the ASC's prices for as many of the CMS-specified shoppable services (or up to 300 shoppable services provided by facility;
- Indication of which of CMS shoppable services are not provided at the ASC;

There are penalties for non-compliance in the bill.

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32

Draft Site Neutral Legislation

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- Evaluates HOPD, ASC and physician office volume over four-year period
  - HOPD volume highest: status quo
  - ASC volume highest: HOPDs drop to ASC rate; physician office remains on MPFS
  - physician office volume highest: all drop to MPFS

33

Site of Service Facility Fee Restrictions

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By: Frank H.B. No. 1692

A BILL TO BE ENTITLED

AN ACT

relating to facility fees charged by certain health care providers;
providing an administrative penalty.

Sec. 328.002. PROHIBITED FACILITY FEES. (a) Except as provided by Subsection (b), a health care provider may not charge a facility fee, including a facility fee for:

(1) outpatient health care services; or

(2) health care services identified by the executive).

First Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO
INTRODUCED

LLS NO. 23-0436.01 Jerin Darling x2241 HOUSE BILL 23-1215

HOUSE SPONSORSHIP

Sirota and Boesenecker,

SENATE SPONSORSHIP

Mullica and Cutter,

(2) **Site-specific limits.** (a) ON AND AFTER JANUARY 1, 2024, A HEALTH-CARE PROVIDER AFFILIATED WITH OR OWNED BY A HOSPITAL OR

-4- HB23-1215

HEALTH SYSTEM SHALL NOT CHARGE, BILL, OR COLLECT A FACILITY FEE FOR HEALTH-CARE SERVICES PROVIDED AT AN OFF-CAMPUS LOCATION OR PROVIDED THROUGH TELEHEALTH, REGARDLESS OF PAYER TYPE.

General Assembly *Governor's Bill No. 6669*
January Session, 2022 LCO No. 3865

Referred to Committee on PUBLIC HEALTH

Introduced by:
Request of the Governor Pursuant to Joint Rule 9

AN ACT PROTECTING PATIENTS AND PROHIBITING UNNECESSARY HEALTH CARE COSTS.

(l) (1) A health care provider may only charge, bill for or collect a facility fee for services provided (A) on a hospital's campus, (B) at a facility that includes a hospital emergency department, or (C) at a freestanding emergency department.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2023

S 3

SENATE BILL 321
Health Care Committee Substitute Adopted 4/20/23
Third Edition Engrossed 5/1/23

Short Title: Medical Debt De-Weaponization Act. (Public)

Sponsors:

Referred to:

March 20, 2023

A BILL TO BE ENTITLED

AN ACT TO ADOPT THE PRO-FAMILY, PRO-CONSUMER MEDICAL DEBT PROTECTION ACT TO LIMIT THE ABILITY OF LARGE MEDICAL FACILITIES TO CHARGE UNREASONABLE INTEREST RATES AND EMPLOY UNFAIR TACTICS IN DEBT COLLECTION AND TO LIMIT THE ABILITY OF NON-HOSPITAL HEALTH CARE FACILITIES TO CHARGE FACILITY FEES.

(b) Limits on Facility Fees. – The following limitations are applicable to facility fees:

Page 10 Senate Bill 321-Third Edition

General Assembly Of North Carolina Session 2023

(1) No health care provider shall charge, bill, or collect a facility fee unless the services are provided on a hospital's main campus or at a facility that includes an emergency department.

(2) Regardless of where the services are provided, no health care provider shall charge, bill, or collect a facility fee to outpatient evaluation and management services, or any other outpatient, diagnostic, or imaging services identified by the Department.

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34

Site of Service Facility Fee Restrictions

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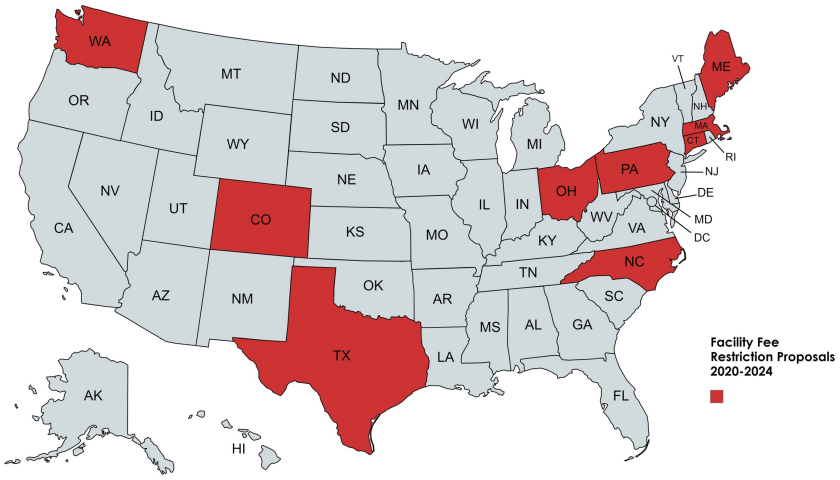

35

References

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- **2025 OPPS/ASC Proposed Payment Rule:**
- https://public-inspection.federalregister.gov/2024-15087.pdf

- **2025 Proposed Rule ASC Addenda:**
- https://www.cms.gov/license/ama?file=/files/zip/2025-nprm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip

- **ASCA Payment Resources:**
- http://www.ascassociation.org/federalregulations/medicarepayments

- **ASC Quality Reporting Program:**
- https://qualitynet.cms.gov/asc
- https://www.ascassociation.org/medicare/quality-reporting
- https://www.ascassociation.org/asca/asc-operations/quality/oas-cahps

- **Legislation Links:**
- https://www.congress.gov/bill/118th-congress/house-bill/972
- https://www.congress.gov/bill/118th-congress/senate-bill/312
- https://www.congress.gov/bill/118th-congress/house-bill/5378
- https://www.congress.gov/bill/118th-congress/senate-bill/3548

36

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Questions?

knewbury@ascassociation.org

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37