Ambulatory Surgery Centers and Health Care Reform: Opportunities and Challenges for the Progressive Retina Surgeon

BY MICHAEL A. ROMANSKY, JD

"No good deed goes unpunished." I remember I heard this for the first time on the first day of my internship at Los Angeles County University of Southern California. I have heard it many times since. How does it apply to Ambulatory Surgery Centers (ASCs)? Look at the lessons of cataract surgery. As surgeons switched to a phacoemulsification, a more efficient and more technically demanding surgery, the Government took this opportunity to punish cataract surgeons by reducing their reimbursement. The parallel with microincisional vitrectomy surgery and the migration to ASCs is obvious.

What lessons have we learned? We have learned that to serve our patients, we must protect the integrity of our profession. In this environment, political lobbying groups, such as the Outpatient Ophthalmic Surgery Society, are not only the source for advocacy but also the source for the education of our lawmakers. This is the lesson we have learned from our cataract colleagues: we must support lobbying groups and educate lawmakers, as Michael Romansky describes in this column. This is a necessity to ensure that our patients get the best possible care.

-Pravin U. Dugel, MD

In Part 1 of this series that appeared in the January/February issue of *Retina Today*, I discussed the prospects for the ophthalmic ASC within the context of the inevitable enactment of comprehensive health care reform. Of course, as likely Republican Presidential candidate Mitt Romney recently reflected on the election of Scott Brown to the Senate: "For that victory that stopped Obama-care and turned back the Reid-Pelose liberal tide, we have something to say that you'd never think you'd hear at the Conservative Political Action Committee, 'Thank you, Massachusetts.'" Yet, as I put pen to paper this morning, President Obama has released his new proposal in anticipation of this week's supposed bipartisan summit on health care reform. Should we sound the death knell on reform? For purposes of this article, I am not sure it matters.

I should not be so glib. As a consumer of medical services and as a taxpayer, I do care about what transpires

with respect to health care reform. However, I stand by what I preached a month ago. *At a time when public policymakers are searching for meaningful health care reform, improving quality and access, while reducing costs, it should be clear that ambulatory surgery centers (ASCs) are a part of the solution.* This country's 5,100 surgery centers are doing an exemplary job of expanding their role in meeting the surgical needs of the Medicare population while saving hundreds of millions of dollars annually. Nowhere is this phenomenon more evident than in the ophthalmic ASC, where 60% of patients elect to have their cataract surgery. Comparable savings will be realized now that payment rates for retinal services have been significantly increased in the ASC.

ASC ISSUES ON THE HORIZON

Whether comprehensive health care reform is enacted, with a trillion and a half dollar deficit this year and for the foreseeable future, we can expect federal policymakers to search for savings in the Medicare program. As such, all providers will be targeted for budget savings, including ASCs. Let's take a moment to identify the legislative and regulatory issues facing the ophthalmic ASC community in the year or two ahead:

ASC Payment Rates. ASCs have not enjoyed a cost of living adjustment since 2004 and should receive a modest 1.2% update in 2010, based on the Consumer Price Index – Urban (CPI-U}. OOSS and the ASC community will be urging CMS in the 2011 payment update to adopt the higher Hospital Market Basket index that hospital outpatient departments receive.

ASC Legislation. The Outpatient Ophthalmic Surgery Society, the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery, and the American Association of ASCs have rallied in support of The ASC Access Act of 2009, which would mandate that CMS implement the higher hospital market basket update index for ASCs, apply a more favorable budget neutrality index to surgery centers, and enable ASCs to enjoy the same treatment that hospitals receive with respect to innovative and expensive medical devices.

ASC Quality and Cost Reporting. Some legislators would like to impose quality and cost reporting responsibilities on ASCs. With respect to the latter, the ASC community is unalterably opposed: ASC rates are based on a discount off of hospital outpatient reimbursement; as such, there is no reason to collect ASC cost data. We are proud of our outcomes, but have been woefully unimpressed with CMS' ability to design viable health outcomes measures; to date, the ASC community has supported CMS' decision to defer imposition of quality reporting on ASCs.

Medicare Conditions for Coverage. As reported lin the last issue of *Retina Today*, federal and state regulators are aggressively surveying hundreds of ASCs throughout the country to "validate" compliance with the new Medicare ASC certification requirements, with a special emphasis on infection control and sterilization practices.

Physician Ownership of ASCs. The ASC industry will need to expend some effort to thwart hospital industry endeavors to curtail physicians' ability to invest in, and refer their patients to, surgery centers. Hospital campaigns are generally focused at the state level.

WHAT CAN THE RETINA SURGEON DO?

The threshold decision for the retinal surgeon is whether he or she is interested in controlling his surgical environment and improving his or her profitability. You have read this far, so I will assume that your interest is at least somewhat piqued. We know a few things to be true. The Medicare reimbursement and regulatory climate continues to favor consideration of vitreoretinal surgery in the ASC. Under the new ASC payment system launched in 2008, the major vitreoretinal codes double in payment over the four-year transitional period; as reported last month, from 2009 to 2010, CPT 67036 (remove inner eye fluid) increases from $1,077 to $1,351 and CPT 67108 (repair detached retina) from $1,255 to $1,438. As noted above, commencing in 2010, all ASC facility fees will receive annual cost of living adjustments.

In all, the prospects for the ophthalmic ASC, and for the retinal specialist moving into the surgery center, are excellent. As always, however, there are always threats and challenges emanating from the White House, Congress, CMS, and the State Capitals; it is incumbent upon every ASC owner, operator, and user to do his part to protect the industry, his patients, and his investment. How do we accomplish this ambitious agenda? First, we recognize that your lobbyists alone cannot accomplish the tasks at hand. The retinal community can simply joins forces with those who have been successful for almost thirty years in building the ophthalmic ASC industry and in securing government payment for cataract and other ophthalmic services. My suggestions for actions follow:

Join the Outpatient Ophthalmic Surgery Society (OOSS). There are a multitude of national medical specialty organizations competing for your trade association dollar. In fact, there are several within ophthalmology alone; however, only OOSS is dedicated to ensuring that your patients have access to the high-quality and cost-effective care provided in the ophthalmic ASC

(www.OOSS.org). For 30 years, OOSS has an enjoyed an unparalleled record of success in promoting the interests of ASCs before Congress and CMS. OOSS is dedicated to serving the retinal surgeon.

Educate Your Elected Officials. Whether we suggest that you write your Congressman or Senator or submit comments to CMS on a proposed rule, our goal is for the policymaker to hear from an informed constituent, ie, the retinal surgeon. It requires only a few phone calls or emails to establish a relationship with your Representative and Senators. OOSS makes the task very easy. In about 5 minutes' time and a few clicks on the keyboard, you can send an e-mail to your legislator asking him to assist in any number of OOSS legislative activities. We will provide you with all the necessary tools.

Political Action. Political action is not a four-letter word. The Outpatient Ophthalmic Surgery Political Action Committee (OOSPAC) is the only PAC whose sole purpose is to advance the interests of surgeons who own and practice in ophthalmic ASCs. Our PAC is a small one, and if we are to effectuate our legislative and regulatory objectives, we will need to support our allies in Congress. Please consider making a contribution.

Thirty years ago, when OOSS was founded, the pioneers in the outpatient ophthalmic surgery movement were labeled as charlatans and buccaneers. There was no facility reimbursement from the Medicare program; facility costs were cross-subsidized with practice incomes because, in most surgeons' minds, their patients would be best served by receiving their surgical care in the ASC. We have come a long way. The government now recognizes the ASC as the standard of care in ophthalmic surgery. There are new opportunities for the vitreoretinal surgeon to follow in the footsteps of anterior segment surgeons and achieve exceptional patient outcomes, with an increase in productivity and profitability. By joining an organization like OOSS and devoting a few hours a year to a government relations effort, the retina community can make a difference. ■

Michael A. Romansky, JD, is Washington Counsel and Vice President of Corporate Development for OOSS. He has practiced exclusively in the area of health law for 30 years, representing healthcare providers, companies, and organizations before Congress and all federal agencies with jurisdiction over health programs.

Pravin U. Dugel, MD, is Managing Partner of Retinal Consultants of Arizona and Founding Member of the Spectra Eye Institute in Sun City, AZ. He is a Retina Today *Editorial Board member. He can be reached at pdugel@gmail.com.*

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health effects through midlife—that there is something serious being set in motion by obesity at early ages." Dr. Looker said in a news release. "We all expect to get beyond 55 these days."

1. Franks PW, Hanson RL, Knowler WC, Sievers ML, Bennett PH, Looker HC. Childhood obesity, other cardiovascular risk factors, and premature death. *N Engl J Med.* 2010;362(6):485–493.

Reducing Salt Intake May Save Lives, Money

Modest reductions in salt consumption could substantially reduce the incidence of heart disease, stroke, and heart attacks and significantly reduce medical costs in the United States, according to a study published in the *New England Journal of Medicine*.[1]

Investigators used the Coronary Heart Disease (CHD) Policy Model to quantify the benefits of potentially achievable, population-wide reductions in dietary salt of up to 3 g per day (1200 mg of sodium per day) in US residents 35 years of age and older.

"Reducing dietary salt by 3 g per day is projected to reduce the annual number of new cases of CHD by 60,000 to 120,000, stroke by 32,000 to 66,000, and myocardial infarction by 54,000 to 99,000, and to reduce the annual number of deaths from any cause by 44,000 to 92,000," the study authors said. "A regulatory intervention designed to achieve a reduction in salt intake of 3 g per day would save $10 billion to $24 billion in health care costs annually."

The researchers estimated that lowering daily salt intake by 3 grams would have health benefits as significant as reducing smoking by 50% or using statin drugs to treat people with low or intermediate risk for heart disease. ■

1. Bibbins-Domingo K, Chertow GM, Coxson PG, et al. Projected effect of dietary salt reductions on future cardiovascular disease. *N Engl J Med.* 2010;362(7):590–599.

David S. Boyer, MD, is a Clinical Professor of Ophthalmology at the University of Southern California Keck School of Medicine, Department of Ophthalmology, in Los Angeles. He is a member of the Retina Today *Editorial Board. Dr. Boyer may be reached at +1 310 854 6201; fax +1 310 652 7250; or via e-mail: vitdoc@aol.com.*

CONTACT US

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