

Ambulatory Surgery: National and State Environments and Key Policy Considerations

Presentation to the State Hospital Review and Planning Council
New York State Department of Health
October 2, 2008



Presentation Overview

- Market share, geographic and specialty distribution nationwide
- Literature review - Quality
- Ambulatory surgery in New York
 - Ambulatory surgery settings in New York State
 - Procedures
 - Medicare and Medicaid reimbursement
 - Payor mix
- Policy considerations



Background:

Ambulatory Surgery Market Share

- 60-70% of all surgeries performed take place in an ambulatory setting (MedPac report to Congress 2004)
- Between 2000-2007 the number of Medicare-certified ASCs nationwide grew by over 60% (MedPac Data Book, June 2008)
- Approximately 5,300 ASCs in all 50 states, provide more than 22 million procedures annually. (Ambulatory Surgery Center Association, 2008)

Penetration:

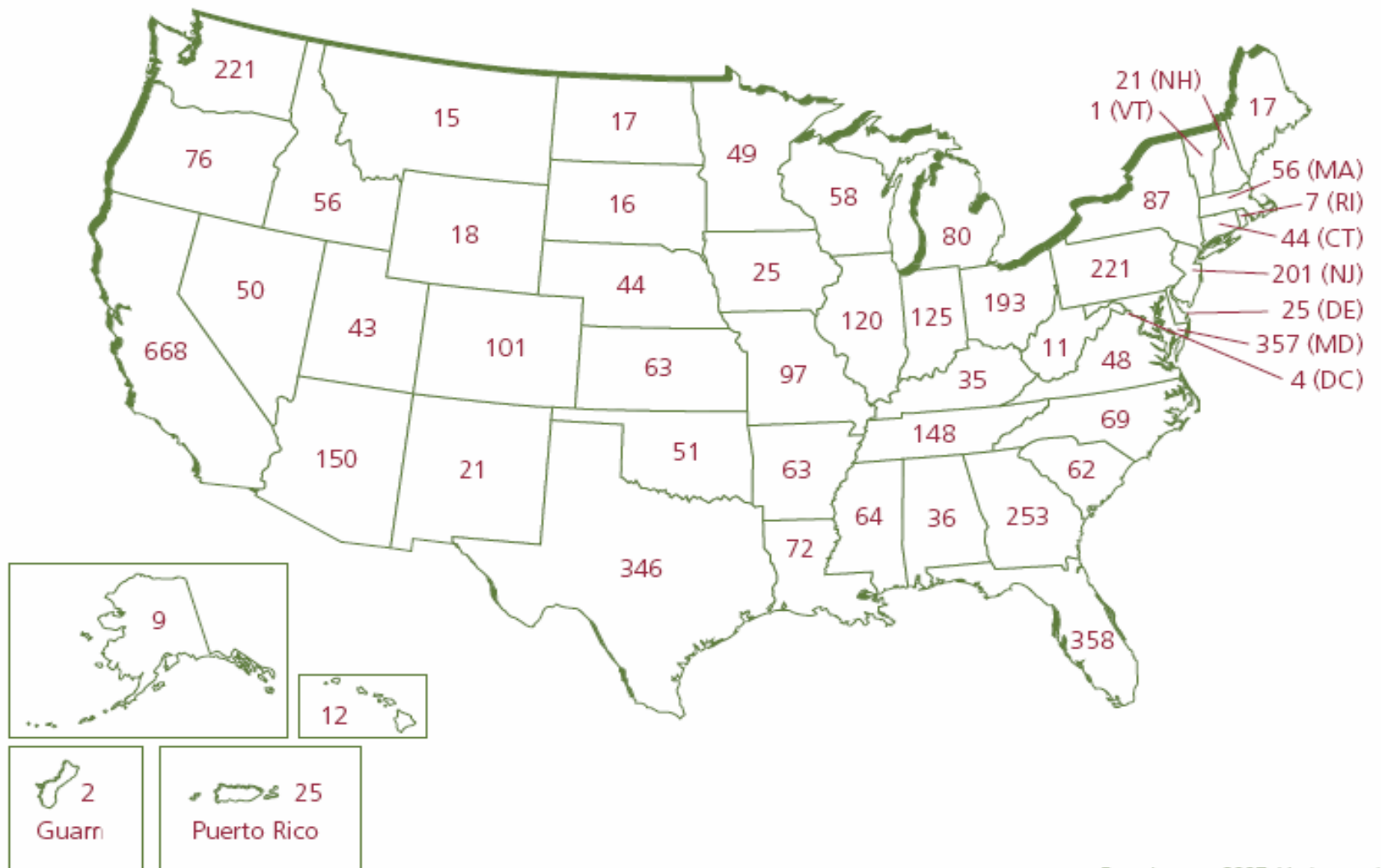
*ASCs per 100,000 population March 2008

Selected neighboring states	Top 5 states	Bottom 5 states
Massachusetts 0.87	Maryland 6.35	Rhode Island 0.66
New Jersey 2.31	Idaho 3.73	Virginia 0.62
Pennsylvania 1.78	Wyoming 3.44	West Virginia 0.61
Connecticut 1.26	Washington 3.42	New York 0.45
New York 0.45	Delaware 2.89	Vermont 0.00

Source: Ambulatory Surgery Center Association

*Licensure requirements for ASCs vary by State

ASCs by State



Based upon 2007 Medicare data

Literature Review: Quality

- Fleisher, L.A. et al., 2007: Compared quality outcomes for ambulatory surgery in ASCs and HOPDS in New York:
 - Higher comorbidity scores in HOPD patients in comparison with ASC;
 - Absence of deaths in freestanding ASCs consistent with a smaller number of procedures and lower comorbidity in ASC patients;
 - Developed a risk index to identify most appropriate setting for ambulatory surgery patients.

Quality (cont.)

- Chukmaitov, et al., 2007: Compared quality outcomes in ASCs and HOPDs in Florida:
 - Confirms importance of risk-adjustment for comorbidities
 - Neither ASCs or HOPDs performed better overall;
 - Appear to be some differences for unexpected hospitalization for specific procedures when risk adjusted for both primary and secondary diagnosis;
 - For certain procedures HOPD may have an advantage (e.g. colonoscopies).
 - More specialized diagnostic procedures (e.g. spinal injection for myelography) ASCs may have an advantage.



Literature Review: Quality

- Vila, H. et al, 2003: Found ten-fold increase in death rates in office settings in Florida as compared to ASCs.
- Venkat, A.P., et al., 2004: Analyzed Florida data from the same time period as Vila's 2003 study and concluded that office-based surgery is safe and cost-effective as compared to ASCs.

Quality (cont'd.)

- Fleisher, L.A., et al., 2004: Compared inpatient hospitalization and death after outpatient surgery in elderly patients and found:
 - ASCs had the lowest adverse events even after controlling for patients with high risk;
 - Increased risk of hospital admission or death within 7 days of an ambulatory surgery procedure is associated with: more advanced age (85+), prior inpatient admission within the last 6 months, ambulatory surgery procedure at a physician's office or hospital outpatient department, and invasiveness of surgery;
 - Concluded physicians are properly screening patients and performing outpatient surgery in most appropriate setting given the condition of the patient and the complexity of the procedure.

Ambulatory Surgery Settings in NYS

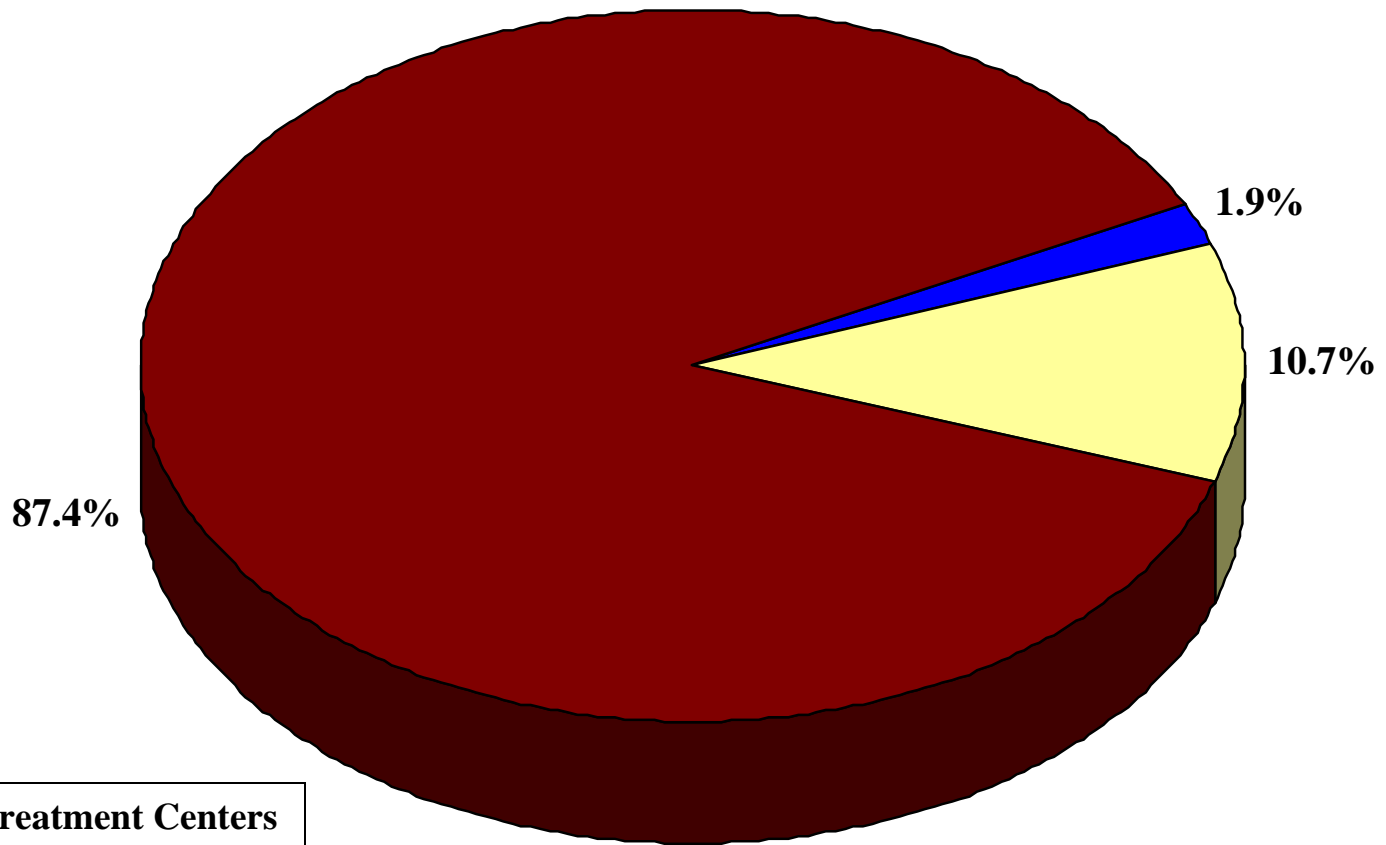
Ambulatory Surgery Settings	Licensed and Regulated under PHL Art. 28	National Accreditation Required	SPARCS Reporting	HCRA Pool Payments	Specified Adverse Event Reports
Hospitals	X		X	X	X
Hospital X-Clinics	X	X	X	X	X
ASCs	X	X	X	X	X
Physician Offices		X By 7/14/09			X




Top 10 Ambulatory Surgery Procedures by Facility Setting in New York State

Source: New York State Department of Health SPARCS Data, 2007

Hospitals and Hospital Extension Clinics	Diagnostic Treatment Centers
Colonoscopy and Biopsy	Lens and Cataract Procedures
Diagnostic Cardiac Catheterization: Coronary Arteriography	Colonoscopy and Biopsy
Suture of Skin and Subcutaneous Tissue	Insertion of Catheter or Spinal Stimulator and Injection into Spinal Canal
Traction; Splints; and Other Wound Care	Upper Gastrointestinal Endoscopy; Biopsy
Upper Gastrointestinal Endoscopy; Biopsy	Other OR Therapeutic Procedures on Joints
Other Vascular Catheterization: Not Heart	Abortion (Termination of Pregnancy)
Lens and Cataract Procedures	Other Therapeutic Procedures on Muscles and Tendons
Insertion of Catheter or Spinal Stimulator and Injection into Spinal Canal	Excision of Semilunar Cartilage of Knee
Excision of Skin Lesion	Other Therapeutic Procedures on Eyelids; Conjunctiva; Cornea
Other OR Therapeutic Procedures on Joints	Bunionectomy or Repair of Toe Deformities

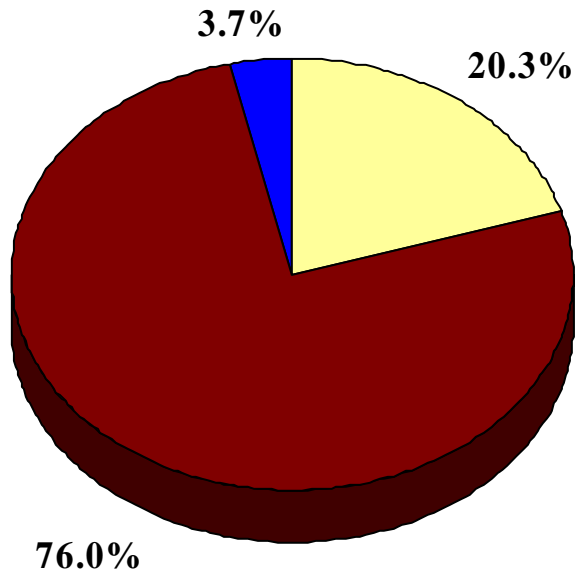
Distribution of Ambulatory Surgery Procedures by Setting



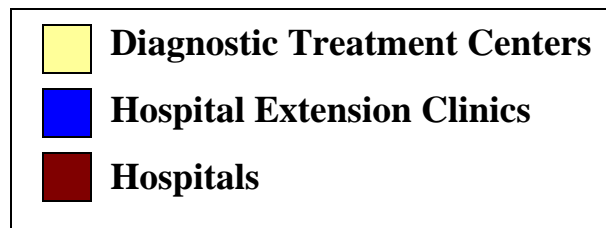
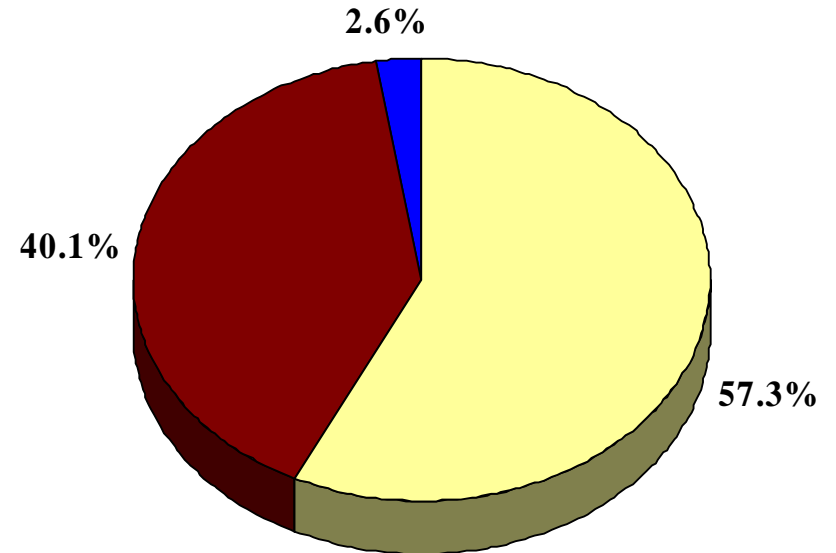
-  Diagnostic Treatment Centers
-  Hospital Extension Clinics
-  Hospitals

Distribution of Most Common Procedures by Facility Type

Colonoscopy & Biopsy



Lens & Cataract Procedures



Medicare Reimbursement

- 4-year phase-in beginning 1/1/08 to align ASC rates with the ambulatory payment classification (APC) groups used for hospital outpatient departments (HOPDs).
 - 2008: 75% based on 2007 rate and 25% on new methodology.
 - 2011: ASC reimbursement is expected to be approximately 65% of hospital outpatient department rate.

- Procedures predominantly performed in a physician's office: ASC rate is capped at the non-facility practice expense payment under the Physician Fee Schedule.

Medicaid Reimbursement – Hospital-Based Ambulatory Surgery and ASCs

□ ASCs

- New APG Methodology for Hospital-Based Ambulatory Surgery and ASCs:
 - Hospital-based ambulatory surgery: Beginning 12/1/08 with full APG reimbursement.
 - Free-standing ASCs: Effective 3/1/09. Four year phase-in using a blend of existing avg. reimbursement and APG pricing.
 - Each procedure assigned to an APG group, which is weighted based on average cost.
- Final weight for each procedure on the claim is summed and multiplied by the base rate, capital is added.
- Physician services paid separately. Eff. 1/1/09 will be 50% of Medicare approved amount.

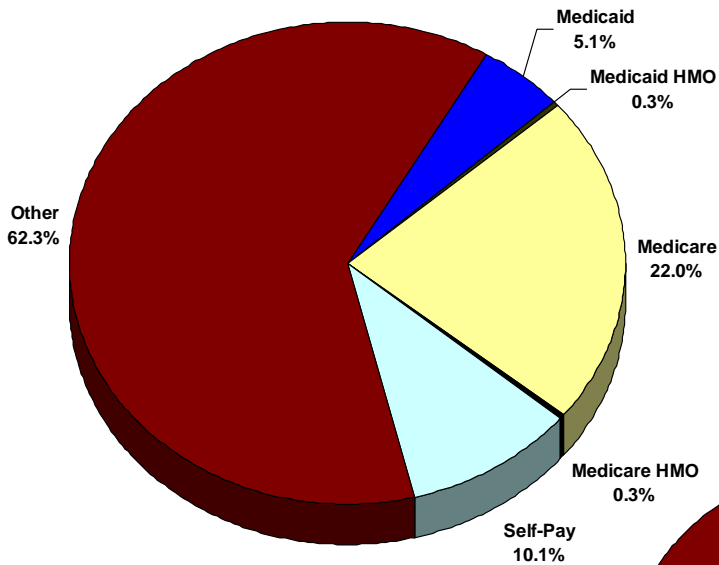


Medicaid Reimbursement - OBS

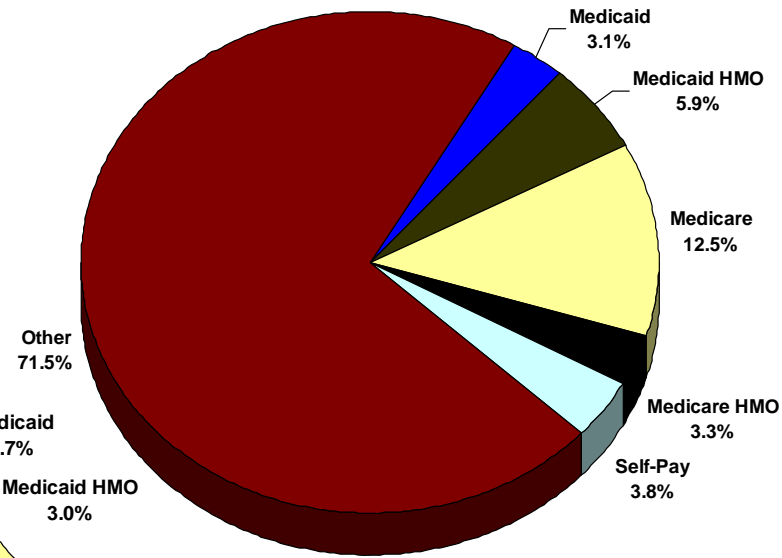
- Physician fee schedule based on CPT code.
- Eff. 1/1/09, surgery fees will be raised on average to 60% of the Medicare-approved amount.

Payer Mix by Setting (Expected Principal Reimbursement)

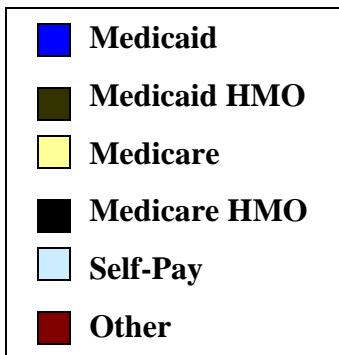
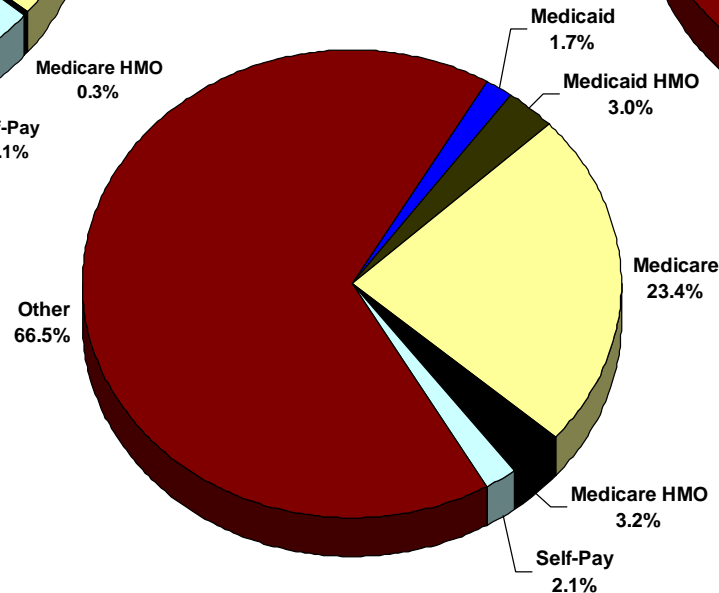
Diagnostic & Treatment Centers



Hospitals

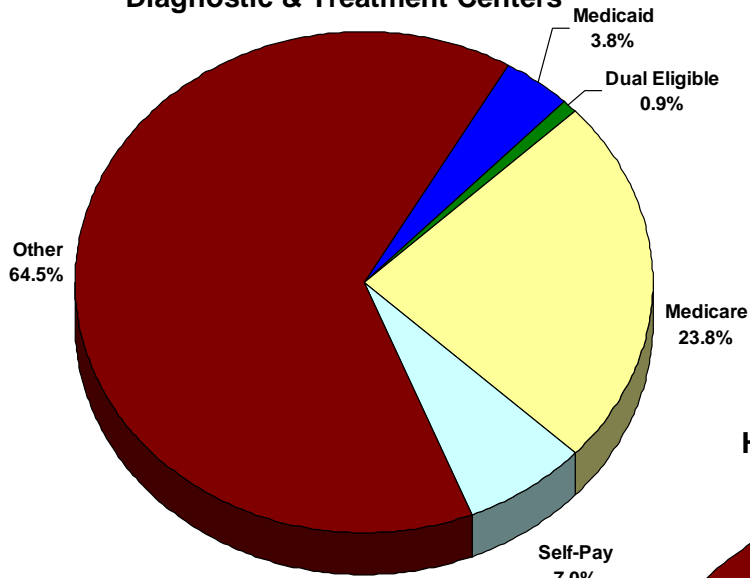


Hospital Extension Clinics

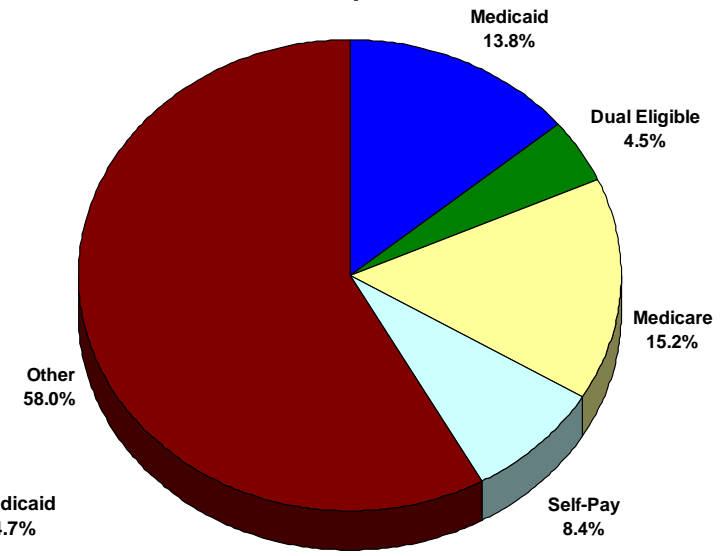


Payer Mix by Setting (Source of Payment)

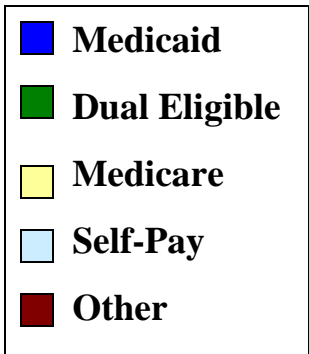
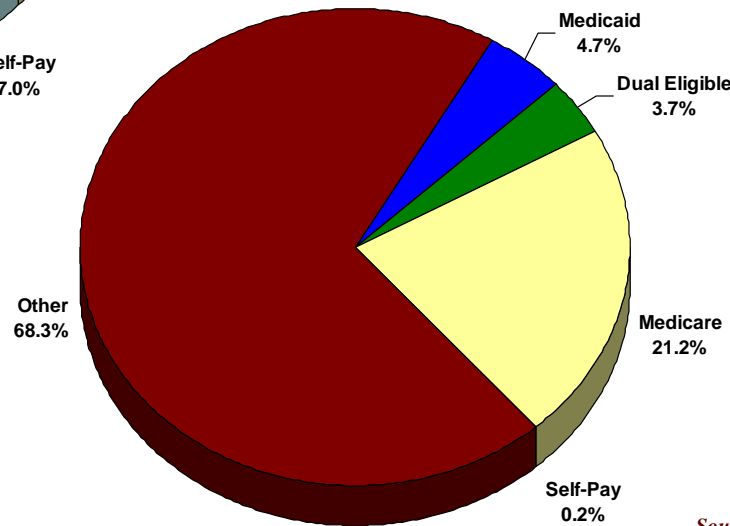
Diagnostic & Treatment Centers



Hospitals

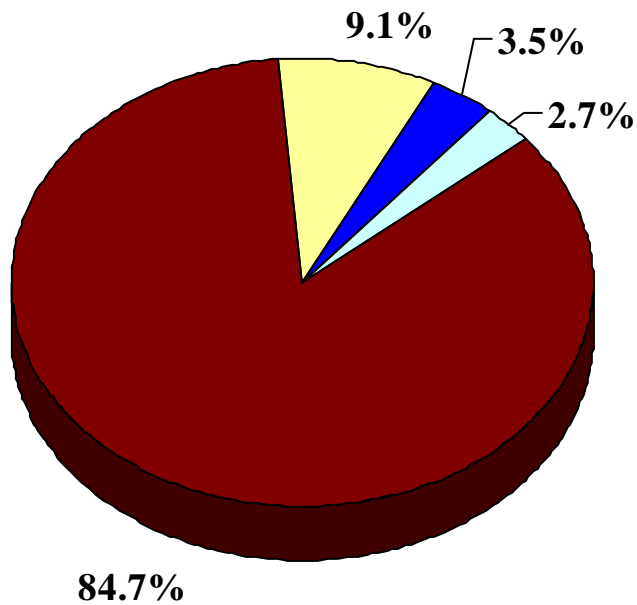


Hospital Extension Clinics

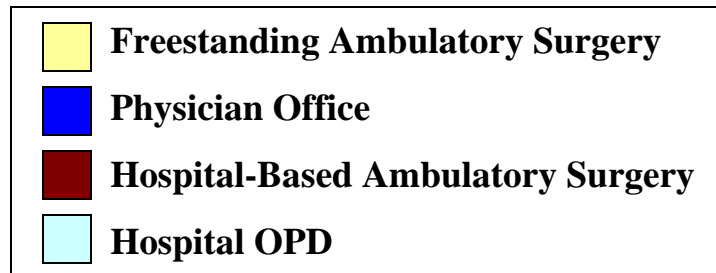
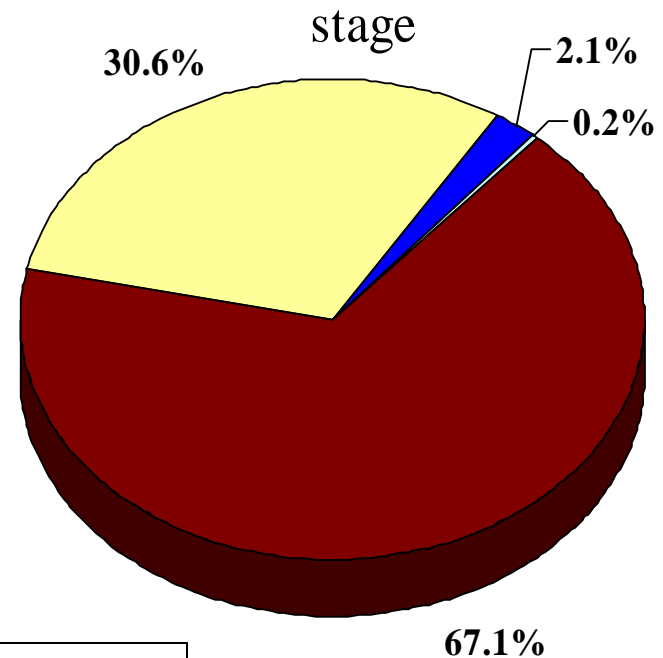


Distribution of Selected Medicaid Fee-For-Service Claims by Setting

Colonoscopy & Biopsy



Cataract Surgery w/iol, 1 stage





Policy Considerations

- Access
 - Economic
 - Geographic
 - Capacity
- Cost
- Quality
- Consumer preference
- Impact on essential services and safety net providers