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Ambulatory surgery and the government: an evolving partnership

As ambulatory surgery evolves, so does the interests of the federal government. Ambulatory surgery is not a recent phenomenon of modern surgery. The true phenomenon is the significant attention it has received from federal policymakers in the past decade.

Times have changed since 1909, when the *British Medical Journal* reported that James Nicoll MD performed more than 7000 operations on an ambulatory basis. The number of operations performed in hospital outpatient settings increased over threefold between 1980 and 1990. According to the unpublished data from the American Hospital Association Annual Survey Files, in 1982 there were 4.2 million operations conducted in outpatient hospital settings, while in 1990 the number increased to over 11.6 million. In contrast, the number of inpatient operations decreased from 16.1 to 11.4 million over the same period of time.

In 1990, nearly three-quarters of all ambulatory surgical procedures were performed in hospital outpatient departments. That year, 72.1% of all ambulatory surgical procedures were conducted in hospital outpatient facilities, 16.3% were performed in ambulatory surgical centres (ASCs) and 11.6% were performed in doctor's offices. Even with the smaller percentage, the number of freestanding ASCs has increased 651%, from 239 centres in 1983, to 1555 centres in 1991. The number of procedures performed in ASCs has increased accordingly.

As surgical care is shifting its venue, the government is working to keep pace with the changes. From the legislative perspective, United States Representative Ron Wyden, a Democrat from the state of Oregon, introduced the bill, HR 6096, the Ambulatory Care Quality Improvement Act of 1992. The purpose of the bill was to establish a programme under which certain ambulatory health care facilities would be regulated to ensure that the health care services they provide are rendered safely and effectively. The bill did not pass. Prior to introducing this bill, he had developed many draft proposals on the topic. Rep. Wyden often consulted with the American College of Surgeons as he reviewed and revised those drafts.

Two years ago, Rep. Wyden, as Chairman of the US House of Representatives Small Business Subcommittee on Regulation, Business Opportunities and Energy, held a hearing on safety and quality of care problems at unlicensed, non-certified or under-monitored surgical, diagnostic and immediate care facilities. At that hearing, the US General Accounting Office concluded that unless the Department of Health and Human Services or a reputable private accrediting organization is monitoring an unlicensed freestanding facility, patients do not have adequate assurance that quality care can be provided.

On February 4, 1993, the College submitted to Rep. Wyden several suggestions for modifying his bill before it is reintroduced in the 103rd Congress. These recommendations were a compilation of the comments solicited from the Governors' Committee on Ambulatory Surgical Care and from representatives of the College's Advisory Council for Plastic and Maxillofacial Surgery and the Advisory Council for Otorhinolaryngology.

Starting from September 7, 1982, the federal government has paid Medicare benefits for the facility costs of certain operations performed in ASCs. Freestanding ASCs are reimbursed on the basis of a prospective fee schedule for certain operations, whereas hospital outpatient departments are paid rates determined by a blended payment amount of 42% of hospital-specific costs and 58% of the ASC payment rate.

Some ASC proponents have expressed concern that Medicare's policy of paying hospital outpatient departments on the basis of reasonable costs rather than on the basis of a fixed, prospective rate has resulted in hospitals being paid more than Medicare-certified ASCs for performing the same surgical procedure. Others contend that there are justifiable differences in the costs of furnishing services in hospital outpatient settings. In its March 1992 report to Congress, the Prospective Payment Assessment Commission (ProPAC) recommended that payments for ambulatory surgery performed in the hospital outpatient setting be fully prospective based on national rates adjusted for area wage differences. ProPAC believes that the payment rate should be computed using average hospital costs and freestanding ASC payments in a budget neutral fashion where overall spending would neither increase nor decrease.

On December 31, 1991, payment rates for ASC services were divided into eight payment groups ranging from $285 to $905, an increase of 5.1% from the rates that had been in effect since July 1, 1990. A ninth payment group of $1150 was added to cover the cost of renal extracorporeal shock wave lithotripsy. The inclusion of lithotripsy on the ASC list had been enjoined by federal courts pending review of the Health Care Financing Administration's (HCFA) rate setting procedures. The court has stayed the rate and HCFA is in the process of implementing it.

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As mandated by the Omnibus Budget Reconciliation Act of 1986, HCFA publishes a list of surgical procedures for which facility services are covered when performed in an ASC. HCFA is required to update this list every two years. A new updated list is expected this year.

Although the College has made successful recommendations to HCFA regarding the inclusion and exclusion of certain surgical procedures on the list, it is concerned that the development of such lists may lead to categorizing certain procedures unequivocally as 'ambulatory' without taking into account the patient's unique medical, social, and psychological needs, or giving proper weight to the surgeon's judgement.

HCFA has entered into contracts with groups outside the government for specific projects. The Center for Health Policy Studies (CHIPS) has been retained by HCFA to conduct a study of outpatient resource costs. The primary purpose of the study is to provide data on resource use and costs for a wide variety of surgical procedures, medical visits, and diagnostic tests. These data will be used to test the equity and adequacy of the relative weights and payment levels to be used in HCFA's outpatient prospective payment system.

Also in the area of contracts, HCFA asked the College to work with them on the Medicare Ambulatory Surgical Center Payment Rate Survey. The College will convene a panel of expert consultants to review the payment classifications for nearly 2300 procedures.

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