THE REAL NUMBERS: How CMS Has Missed the Forest for the Trees
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CMS's proposed rule to reimburse Ambulatory Surgery Centers (ASC's) at 62% of Hospital Outpatient Departments (HOPD's) is preposterous. Although comparing the two environments as they treat the same patient types makes perfect sense, the way they arrived at the 38% reduction is down right idiotic. The intent of creating an equitable, not equal, transparent playing field for both entities to compete on is a brilliant idea; to do so by overpaying HOPD's and underpaying ASC's is just downright lazy. How can CMS think that just because HOPD rates are set, in the name of "budget neutrality", ASC's should get the raw end of the deal? Although it might sound crazy to CMS, maybe the whole rate structure should be readjusted based on some sense of reality - not an unfair "budget neutral" approach. Lets look at the facts.

Over our 30+ year history Marasco & Associates, a healthcare architectural firm, has helped develop 300+ ASC's & 20+ hospitals. We have therefore helped prepare hundreds of feasibility analyses projecting actual overhead costs. Many of our clients have asked us to look at their proposed facility as both an ASC as well as a HOPD. They want to know the increase in costs to an ASC now, in order to convert it into a HOPD later. Their long term goal is obviously to turn their ASC into a surgical hospital - we have had several clients that have successfully done exactly that. Surgical hospitals are fully accredited, certified & licensed hospitals that specialize in handling surgical cases.

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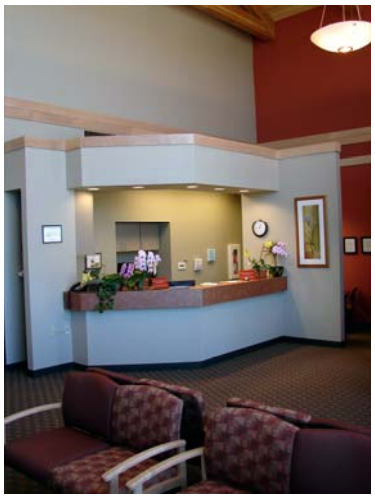
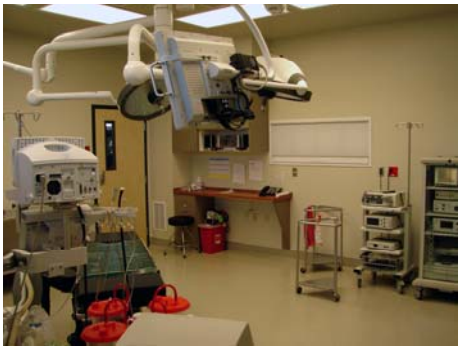
In order to find a fair and equitable reimbursement percentage reduction of HOPD payment rates for ASC's one needs to look carefully at a facilities total overhead. This overhead is broken into four major cost categories - staff, supplies, real estate and equipment. As real-estate development is my expertise as well as being one of the largest cost differentials between a HOPD and an ASC, that is where I will begin.



REAL-ESTATE

One must keep in mind that each state has its own rules & regulations for the development of an ASC or a hospital and we simply don't have time to cover every situation. Most states however have at least partially adopted the American Institute of Architects, Guidelines for Design & Construction of Hospital & Health Care Facilities as a basis for the physical environment requirements of both an ASC as well as a HOPD. Of course other codes, like the International Building Code (IBC), National Fire Protection Agency (NFPA), American National Standards Institute (ANSI)…, are applied locally to ASC's and hospitals alike. This is therefore a general comparison, and as with most comparisons may not apply to every situation.

For this article I have compared a 4 operating & 2 procedure room ASC to a like HOPD within a hospital. Although this article does not permit me the space to show you the actual comparison, we have posted it on our website at www.marasco-associates.com for your review. In a nutshell our findings indicate that it takes ~10% more square footage to build a HOPD than a comparable ASC. Most of this increase comes from the required larger corridor widths, "circulation", as well as larger distances between gurneys and obstructions throughout a HOPD. There are also some minor requirement differences for scrub facilities as well as specimen and blood storage areas. The other large difference comes in the form of non-usable square footage like mechanical & electrical rooms. Typically the capabilities of an integrated HOPD's heating, ventilation and air conditioning system as well as its electrical and medical gas systems are required to be higher than those of an ASC.



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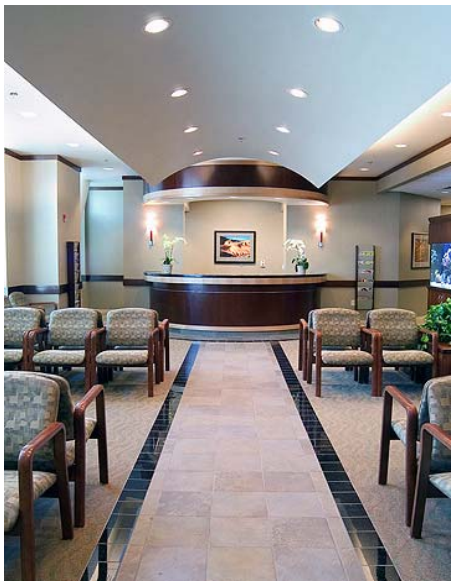
This doesn't mean that an ASC's environment is unsafe; it simply means that as part of a globally more complex facility, i.e. a hospital, an integrated HOPD is typically required to meet higher standards. In fact many states allow free standing HOPD's to meet ASC standards. However for arguments sake lets assume a worse case scenario of an integrated HOPD. In addition to the higher capability level of these systems, by being part of a hospital a HOPD is considered an Institutional or "I" occupancy under the IBC & NFPA…, while an ASC can often be classified as a Business or "B" occupancy. An "I" occupancy requires a fire rated building type while a "B" occupancy typically does not. In addition an "I" occupancy has stricter fire partition standards, shorter exit corridor lengths…. Because of these reasons the construction cost of a HOPD is ~25% more than an ASC. We get this cost figure from RSMeans "CostWorks" program, which is the construction industries most used, quoted, and respected construction and facility management cost guide. We have used these figures to accurately estimate costs on over 500 projects and can assure you they are accurate.



When you compound the 10% increase in size with the 25% increase in construction costs you get a net 38% increase in total real-estate costs. Although this 38% increase sounds right in line with CMS's proposed 38% decrease to HOPD payment rates for ASC's, it actually couldn't be farther from the truth. When you take this 38% increase and apply it to real-estate costs, which account for no more than 15% of the total facility overhead, the total facility overhead is increased by only 6%. Of course there are an infinite number of smaller items one can nit pick about, but in a best case scenario the increased real-estate costs of providing a HOPD environment over an ASC environment will net a maximum **10% total facility overhead cost gain for the HOPD**.

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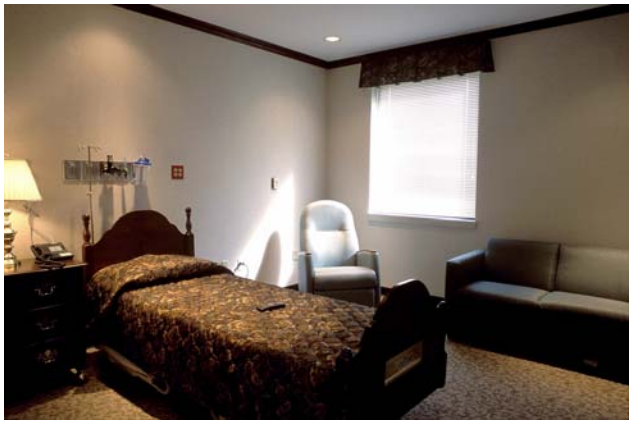
Given an ASC's ability to offer more consistent hours to their non-union staff than a hospital typically can, one can argue that the ASC has the advantage on this overhead cost component. Due to market conditions we typically do not see this competitive edge exceeding 15%. When you take this 15% increase and apply it to staffing costs, which account for no more than 45% of the total facility overhead, the total facility overhead is increased by only 7%. Once again there are of course an infinite number of smaller items one can nit pick about, but in a best case scenario the increased staffing costs of providing a HOPD environment over an ASC environment will net a maximum **10% total facility overhead cost gain for the HOPD**.

SUPPLIES, EQUIPMENT & MISCELANEOUS

As each facility is treating a like patient, the supplies, equipment & miscellaneous (insurance, management, marketing…) costs for either an ASC or a HOPD to service that patients' needs should be the same. In fact a hospital, with its globally larger purchasing budget, should actually have a competitive advantage over an ASC and should be paying less for these overhead costs. However for arguments sake let's say that these overhead costs are a push and will net a **0% total facility overhead cost gain for the HOPD**.

Of course there are numerous other costs that can be nit picked. The hospitals tout that ASC's don't need to be accredited or collect & submit annual financial & quality data like they do and that this costs them additional money. Most of the nations ~5,000 Medicare certified ASC's are also accredited by AAAASF, AAAHC and/or JCAHO even though they are not required to be and although currently not a requirement for ASC's, CMS is already talking about making data collection & submittal one. Many ASC's already provide AAASC, FASA and/or OOSS with similar data in order to better serve their industry and patients.



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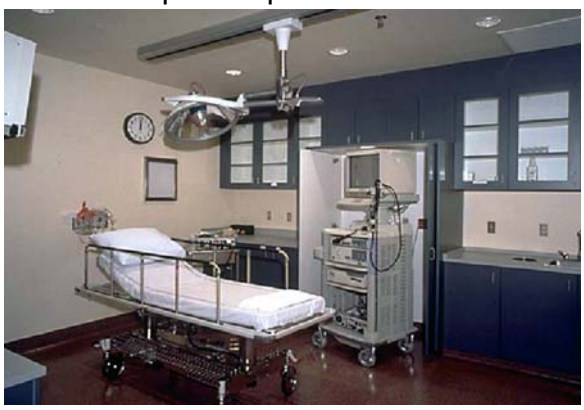
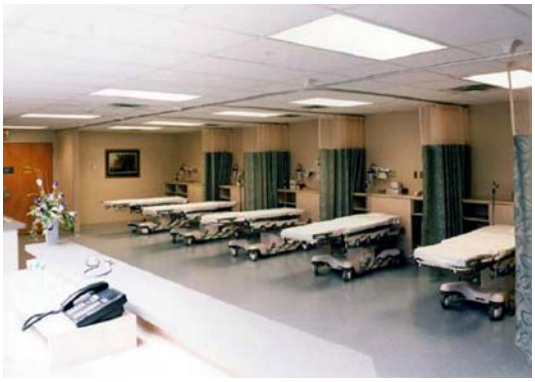
This just goes to show how dedicated the ASC industry is to quality patient care. Making ongoing accreditation and data collection & submittal a requirement in order to compete equitably with HOPD's will not pose a problem to the vast majority of the nations ASC's. However for arguments sake let's say that these requirements are not applied to ASC's. As this overhead cost component accounts for no more than 10% of the total facility overhead, a best case scenario for providing a HOPD environment over an ASC environment will net a maximum **5% total facility overhead cost gain for the HOPD**.



Ultimately when you add it all up even in a very conservative setting, providing a HOPD environment over an ASC environment to provide services on a like patient should cost no more than 20-25% of the facilities total overhead. Therefore for CMS to pay ASC's anything less than 75-80% of HOPD payment rates is simply unfair . Again to maintain this "budget neutrality" by overpaying HOPD's and underpaying ASC's is just wrong. All the ASC industry is asking for is the chance to compete on an equitable transparent playing field, just like the FTC, GAO & OIG would want. CMS has the opportunity to create this field once and for all; I just hope they can find a way to pull it off.

Strangely enough the biggest looser of this whole situation would be CMS themselves. If passed at the proposed 62% rate this ruling will at a minimum discourage the development of new ASC's and at a maximum cause at least some existing ones to stop taking Medicare patients or go out of business altogether. Even at a more equitable 75-80% of HOPD payment rates for ASC's, CMS is getting equal if not better care for their patients at a 20-25% discount over HOPD's – why would they want to mess with that kind of success? ASC's already save CMS over a billion dollars a year by using them over hospitals, eliminating that savings does not sound like a "budget neutral" situation to me. Another response to the proposed rate would be the very reason I know so much about these cost differences in the first place – surgical hospitals!



The 62% rate will force surgeons to upgrade their ASC's to surgical hospitals in order to survive by taking advantage of CMS's infinite, "budget neutral" wisdom. By taking this approach to setting the percentage reduction rate, CMS will ultimately do more harm than good to themselves as well as us, the taxpayers. We need to convince the powers that be, your Representatives & Senators, that they shouldn't cut off their nose to spite their face. They need to help create an equitable payment differential between ASC's and HOPD's, keep that differential tied to the same inflation factor and move forward.

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