

## **Ambulatory Surgery Centers Are Strengthening a Critical Funding Source for Safety-Net Hospitals**

By Craig Jeffries

The article by Gabel et al. attempts to conclude that the safety-net hospitals suffer because physician-owners route low-paying/higher-cost Medicaid patients to hospital outpatient departments (HOPDs). However, their data clearly demonstrate that 55% of these Medicaid patient referrals go to the physician-owned ASC and 61% of these Medicaid referrals go to a for-profit ASC. Physician-owned and for-profit ASCs are treating a high majority of their Medicaid referrals!

Moreover, the premise of Gabel et al. is that the higher-paying/lower-cost "well-insured" patients treated at ASC will "siphon off profit centers that have traditionally cross-subsidized care for hospitals." Yet the employers that fund commercial insurance (and their "well-insured" patients) and taxpayers that fund Medicare are able to realize substantial savings for every patient that is treated at the ASC rather than the hospital outpatient department.

Medicare reimbursement translates into a 35% savings for every beneficiary that ends up in the ASC rather than HOPD. A 2004 analysis showed that the Medicare program would pay approximately \$464 million more per year if all procedures performed in an ASC were instead furnished at a hospital. That's \$464 million that can help safety-net hospitals.

One might better conclude that physician-owned ASCs have allowed patients, employers, and taxpayers to achieve substantial savings and thus continue the ability of employers and taxpayers to help fund cross-subsidized care at safety-net hospitals. ASCs are strengthening a critical funding source for safety net hospitals -- employers -- and thus Gabel et al. needs a Time Out because they are operating on the wrong [provider] site!

**Medicare ASC Growth:** Let's be clear that the 13.3% per year growth in total Medicare ASC payments was during a time when Medicare ASC reimbursement was frozen, proving again that ASCs have been effective at controlling their cost growth during the same period that hospitals were receiving significant annual increases.

**Type of Facility:** For research that attempts to illuminate experience with procedures performed in ASCs, the data from 80 hospital outpatient departments involving 802,959 discharges is at best misleading. These hospital outpatient procedures, and the referral patterns attributed to them, reflect a wide range of services that ASCs simply cannot provide because of state or federal laws and regulations. A far better comparison should have been made by Gabel et al. between just the procedures that can be performed in both the ASC and hospital outpatient department.

**Patient Characteristics:** While patient selection based on severity of illness and mortality was not a specific focus of this research, the discharge status in Exhibit 1 certainly underscores that good decisions appear to have been made by physician-owned and for-profit ASCs, since 99+% of their patients were discharged home. By comparison, the HOPD discharged over 15% of their patients to another type of institution, hospital, or skilled nursing facility. While the authors suggest that doctors may refer "sicker patients to hospital outpatient departments," they do not offer any analysis that these may also be an appropriate clinical decision. Instead, they follow the rhetoric that this may be a cost-shifting decision related to low-paying Medicaid patients by physicians who put profits ahead of patients.

**Medicare Impact:** While the authors note that the ASC and the HOPD account for "roughly equal shares of total [Medicare] patients," they fail to highlight that most hospitals account for Medicare patients as a loss -- just as they do for Medicaid patients. Thus, if you combine the data from

Exhibit 1 for Medicare and Medicaid, the contributions to the safety net of the physician-owned (33.9%) and for-profit (46.9%) ASCs are about the same as or better than the experience of the HOPD (39.3%).

**Impact on Other States:** While the Pennsylvania data is a rich resource for analysis and should continue to be a source to understand the valuable role of ASCs, caution is needed in transferring this experience to other states. In certain states (e.g., Massachusetts, Utah), despite the efforts of licensed ASCs to make changes, state regulations prohibit the physician-owned ASC from providing services to Medicaid recipients.

**Conclusion:** Gabel et al. argue that the profits hospitals reap from services that could be performed less expensively in an ASC cross-subsidize important safety-net services of the hospital. We do not disagree that hospitals need money to operate important community services; however, funding these services through an amorphous overpayment for certain services to certain types of patients smacks of bad public policy. Most hospitals receive subsidies for their uncompensated care costs through Medicare and Medicaid's disproportionate-share payments, payments above the empirical costs for medical education (the IME adjustment), and the enormous savings they achieve as tax-exempt entities that allow them to avoid the taxes paid by all physician-owners of for-profit ASCs. None of these subsidies are available to physician-owned and for-profit ASCs to offset losses on their charity-care services. This is further illustrated by calculating that if ASCs did 8% Medicaid, like the hospitals, they would only be doing 588 additional Medicaid cases. Surely, ASCs absorbing less than 600 cases from the HOPD is insufficient to preserve the hospital "safety net," particularly in comparison to the savings ASCs achieve for safety-net funding sources such as employers and taxpayers.