



Update

Journal of the Federated Ambulatory Surgery Association
Volume XXI, Number 1 • January/February 2004



**Medicare: What Can We
Expect in 2004?**

**State Legislative Action:
What to Expect in 2004?**

**Medical Equipment—
If It Sounds Too Good to
Be True, It Probably Is**

**BRIGHT LIGHTS,
BIG
CITY**

and an Orthopedic ASC
that's a Shining Example
in Patient Care

What To Expect



What will the hottest political and regulatory issues for ASCs be at the state level in 2004? FASA predicts

- physician ownership
- workers' compensation fee schedules
- certificate of need (CON)
- provider taxes
- tort reform

Physician Ownership

With the national hospital associations focusing major attention on the issue of physician ownership of health care facilities, ASCs can expect this issue to be raised in several states in 2004. Over the last two years, the American Hospital Association (AHA) has conducted a campaign against "specialty care

providers," which include ASCs and surgical hospitals, among other facilities. As part of this campaign, AHA has focused on the need to limit the ability of physicians to refer patients to facilities in which they have an interest. They are joined in this battle by the Federation of American Hospitals, which made enacting federal limits on specialty hospitals its number one priority, even ahead of fighting cuts in Medicare inpatient reimbursement. Although hospitals have been successful in enacting some federal limitations, they are continuing to press for state action.

Fueled by the rapid expansion of specialty hospitals in their states, hospital associations in **California, Indiana, Louisiana** and **Ohio**

sought restrictions on physician ownership in 2003. Only **California** actually enacted new restrictions, however, and the final legislation represented a partial victory for ASCs in the state. As enacted, the legislation does not ban physician ownership, as had been specified in earlier versions of the workers' compensation legislation that had been passed by one branch of the legislature. Instead, the law adopted prohibits a physician from referring workers' compensation patients to ASCs in which the physician has a financial interest unless the procedure to be performed has been pre-approved by the workers' compensation carrier and the patient is informed of the physician's financial interest in the

2003 Physician Ownership Restrictions				
	Status	Covers ASCs	Covers Hospitals	Notes
California	Effective 1/01/04	Yes	No	Workers' compensation only
Indiana	Not enacted	Yes	Specialty	
Louisiana	Not enacted	No	All hospitals	
Ohio	Not enacted	No	All inpatient	

ASC. This was a major issue in **California**, and the California Ambulatory Surgery Association (CASA) led ASCs throughout the state in fighting the ban. Although the new law allows physicians to refer to ASCs in which they have a financial interest, providing that the notification conditions are met, some insurers are using the new law as an excuse to deny authorizations based upon physician ownership in an ASC. According to CASA Past President Tom Wilson, "CASA is aggressively working with the legislature leadership and Governor Schwarzenegger's administration to clarify the intent."

In some states, physician ownership legislation proposed in 2003 applied only to specialty hospitals. The federal 18-month prohibition on physician investors in specialty hospitals (who do not qualify for grandfathering) billing Medicare or Medicaid that passed Congress in 2003 may slow pressure for state bans in the coming year. In **Ohio**, for example, state legislation was withdrawn after this federal legislation was enacted. This was the sec-

ond year that similar legislation was introduced in **Ohio**. Even though the legislation may be temporarily on hold, the issue remains a hot topic in that state.

In 2004, ASCs will find it increasingly important to monitor their state legislatures for the introduction of legislation that affects physician ownership. There are rumors of the impending introduction of legislation in **Colorado** and **Texas**. Hints of impending legislation may be included in politicized editorial

and opinion pieces in local newspapers or through conversations with insurers and suppliers that work with a number of different health care providers and are active in a range of areas. Additional places to monitor the climate for potential changes include the web sites of local hospital associations or major hospital systems. For example, in **Ohio**, the particularly contentious battle regarding physician investment in surgical hospitals occurred after two of the area's major hospital systems acted to deny and/or revoke the privileges of physician investors in surgical hospitals. The Ohio State Medical Association will be pursuing legislation that bars hospitals from removing or denying medical staff credentials to physicians on grounds such as these. A similar provision was included in the legislative proposal recently withdrawn in the state.

continued on page 38

Even Cities Are Getting into the Action!

Actions that may affect ASCs may crop up anywhere. For example, in 2003, a city governing body in Newton, **Kansas**, passed a moratorium on the issuance of operating licenses for ASCs and hospitals. According to the moratorium issued by the Newton City Commission, until licensure application and review procedures are formulated for the city, no ASCs or hospitals can be developed. During this time, a task force will be studying ASCs and specialty hospitals and the "potential adverse effects to the general public interest, health and welfare and to the City taxpayers in relation to excessive competition in hospital and ambulatory surgical care facilities and services." Exceptions will be granted for facilities that can prove that they will not engage in activities that are competitive in any manner with existing hospitals and ASCs.



Tom Wilson

Past President of the California Ambulatory Surgery Association

“ASCs would serve themselves well by proactively lobbying for a reasonable workers’ compensation fee schedule. A wise man once said, ‘the best time to arrange a line of credit from the bank was when you did not need it.’”



Mike Cusick

Florida Society of Ambulatory Surgical Centers

“In the case of surgery centers, [the proposed legislation] would have resulted in a 50% reduction in fees. At those levels, most if not all surgery centers would have been forced to drop out of the market. Ironically, this would have forced more patients into higher-cost hospital care, resulting in substantial increases in workers’ compensation health care costs.”

Workers’ Compensation Fee Schedules

ASCs in states that have not yet developed a fee schedule for workers’ compensation should be prepared for activity in that area. Following in the footsteps of **Washington** in 2001 and **Oregon** in 2002, **California**, **Florida**, **North Dakota** and **Texas** all evaluated fee schedules based on the Medicare program in 2003. Only **Florida** actually removed language from its comprehensive workers’ compensation reforms that would have tied ASC payments to Medicare fees. This success was the result of aggressive lobbying by the Florida Society of Ambulatory Surgical Centers.

Although all of the proposals for revamping workers’ compensation that were considered in 2003

would have tied reimbursement systems to Medicare, the states varied greatly in how they approached the conversion factor, carve-outs and the system upon which the fee schedules are based. **California** and **North Dakota** adopted systems that are tied to Medicare payments to hospital outpatient departments (HOPD). Payments to ASCs in **California** were reduced significantly. However, due to the leadership of CASA and the support provided by ASCs throughout the state, the damage was limited in comparison to previous versions of the legislation considered by the state legislature during the past several years. In **North Dakota**, FASA, a few other groups and ASCs urged the state to improve its proposal by addressing new technology, outlier payments, reimbursements for implants and differences in bundled services between ASC and HOPD services. As a result, the state’s Workforce

Workers’ Compensation Fee Schedules				
	Status	Medicare Payment System Used	Conversion Factor	Notes
California	Effective 1/01/04	HOPD* APCs	125%	
North Dakota	Effective 1/01/04	HOPD* APCs	124%	Pass-through payments made
Oregon	Effective 4/01/02	ASCs	250%	No automatic rate update; arthroscopies paid higher
Texas	Proposed rule	ASCs	230%	No retroactive application
Washington	Effective 1/01/02	ASCs		Some additional procedures covered

*Hospital Outpatient Department

Safety and Insurance Board will be making some modifications and publishing more complete instructions and definitions for ASCs regarding these issues.

Also during 2003, the **Texas** Workers' Compensation Commission (TWCC) issued a proposed rule that would implement an ASC workers' compensation fee schedule set at 230% of the Medicare ASC rate. In contrast, in April 2002, TWCC adopted a medical fee schedule of 125% of the Medicare fee schedule for physicians. FASA cosponsored a session with the Texas Medical Association (TMA) that was designed to brief



John Harries, MD

President, Massachusetts Association of Ambulatory Surgery Centers (MAASC)

“The overall cost of health care in Massachusetts is the most expensive in the world. It also has the second lowest ASC penetration per capita in the nation. MAASC believes that these two facts are intimately linked, and our mission is to educate employers, legislators and policy makers of this relationship.”

and prepare ASC representatives for testifying at a recent state hearing on this issue. TMA staff and counsel shared physicians' perspectives, experiences and advice that they had gained by aggressively battling a comparable proposal

affecting physicians adopted in 2002.

As states look at ways of controlling escalating health care costs, they are likely to rely on fee schedules to curb costs and provide consistent and uniform payments to providers

continued on page 40

for similar services. Increasingly, states have turned for answers toward the Medicare program, despite its flaws, seeing it as a system that is easy to implement, can be maintained with limited effort and imposes only a minimal state regulatory burden. Additional states are expected to move forward with a fee schedule, possibly in 2004. Furthermore, if a state is addressing fee schedules for other health care providers, ASCs are likely to be next on its list. ASCs should be sure to monitor what their states' workers' compensation commissions are doing. Now is the time to prepare to evaluate proposals and advocate for those policies that are in the best interests of ASCs and their patients. As advised by CASA Past President Tom Wilson, "ASCs would serve themselves well by proactively lobbying for a reasonable workers' compensation fee schedule. A wise man once said, 'the best time to arrange a line of credit from the bank was when you did not need it.'" ASCs should organize their data so that they can quickly and easily calculate how potential changes may impact their abilities to serve workers' compensation patients. ASCs may find it helpful to contact the department responsible for ASC reimbursement in their state, ask to be placed on its mailing or e-mail list and routinely volunteer to assist it if the department ever needs help on ASC issues. If committees or task forces are created to review ASC or other workers' compensation issues, ASCs should make certain they are represented!

Certificate of Need

Certificate of need (CON) activity may be on the horizon in many states in 2004. As state governors and legislatures battle rising health care costs and hospitals continue to advocate aggressively for legislation that modifies existing CON requirements for ASCs, more changes in CON regulations are likely to be introduced. ASCs can expect these changes to place further obstacles in the way of new ASC development or effectively close ASCs that previously fell outside a state's CON requirements.

Some actions will likely affect all health care facilities, as is the case in **Maine**. As a part of Maine Governor John Elias Baldacci's strategy to address the state's rising health care costs, a moratorium has been imposed on the building and expansion of ASCs and other health care facilities in the state that require a CON.

Other CON actions in 2004 are likely to be directed solely at ASCs or surgical hospitals or both. These moves are likely to be led by hospital associations. ASCs across the

nation, including facilities in **Connecticut**, **Massachusetts** and **Pennsylvania**, were hit by such attempts in 2003. For example, hospitals in **Connecticut** argued that changes in CON requirements were necessary to level the playing field among all providers of surgical services. This led to the enactment of legislation in 2003 requiring **Connecticut** ASCs and other facilities in the state that use moderate or deep sedation, moderate or deep analgesia or general anesthesia to obtain a CON and a license.

Similar arguments in **Massachusetts** led to the introduction of legislation expanding CON requirements for ASCs in that state. That bill, which is currently pending in the legislature, does not include a grandfathering provision for facilities currently operating as extensions of physician's offices, thus placing in jeopardy most ASCs in Massachusetts. Currently, a determination of need (DON), Massachusetts's version of a CON, is not required for ASCs that are an extension of a physician's office, which is how the majority of ASCs in the state are currently designat-

Wallace N. McLeod, Jr, MD



**Chair, Legislative Committee
Georgia Society of Ambulatory Surgery
Centers**

"If it walks like a duck, quacks like a duck, and looks like a duck, it's probably a duck! The language in the bill calls the 6% tax a 'provider fee,' but it is clearly a tax. Our governor is on record as supporting no new taxes, and this is a big plus for us. Passing this bill would compromise cost effectiveness by passing on costs to the citizens of Georgia and would quite likely restrict access to care by forcing marginally profitable centers to close."

ed. The legislation would alter the definition of *clinic*, requiring any ASC in the state to be licensed as a clinic. This change would automatically require a DON review for all ASCs currently operating as extensions of physicians' offices.

In May 2003, FASA and the Massachusetts Association of Ambulatory Surgery Centers (MAASC) co-hosted a meeting in Boston for all interested parties. During a meeting with the state senator sponsoring the DON legislation, MAASC was able to explain the "unintended consequences" of his proposed legislation. According to MAASC President John Harries, MD, "The bill was redrafted to reflect our sug-

gestions and it is currently under consideration by the legislative Joint Committee on Health Care. The challenge facing MAASC in the months ahead is to prevent further changes to the bill by the hospital lobby."

Nonetheless, not all CON legislation holds negative prospects for ASCs. Some CON legislation may be beneficial. For example, ASCs in **Georgia** continue to push for a resolution that would urge the Georgia Department of Health to include general surgery ASCs among the types of physician-owned single-specialty ASCs that can be built without obtaining a CON. That resolution is now pending in the **Georgia** legislature.

Georgia exempts certain physician-owned single-specialty ASCs from the state's CON requirements, but general surgery ASCs are classified as multi-specialty ASCs and thus require a CON. In 2003, **Michigan** and **Vermont** also revised their CON laws in a way that could benefit ASCs in those states. Both states expanded situations in which an ASC can be built without obtaining a CON.

Provider Taxes

Access to health care and their state's budget crisis remain foremost in the minds of governors and legislators across the nation. States may look to provider taxes as

continued on page 42

What's better than knowing you're among the best in ambulatory health care?

Having proof that you are.

For over 20 years, AAAHC has defined the best in high-quality health care by setting standards and conducting peer-based reviews appropriate to the ambulatory environment. Accreditation not only gives you proof of quality services, but also provides the recognition you deserve, and the marketing advantage that is essential in today's competitive health care environment.

AAAHC ACCREDITATION:

- ▲ Provides proof of quality services;
- ▲ Helps you identify ways to improve performance and increase efficiency; and
- ▲ Offers the benefit of national recognition.

AMONG THE TYPES OF ORGANIZATIONS THE AAAHC HAS ACCREDITED NATIONWIDE ARE:

- ▲ Office-based surgery centers and practices;
- ▲ Ambulatory surgery centers;
- ▲ Single- and multi-specialty group practices; and
- ▲ Other ambulatory health care organizations.

To learn more about AAAHC accreditation and what it can mean to your organization, call 847-853-6060 or visit us at www.aaahc.org.



Accreditation Association
for Ambulatory Health Care, Inc.

A Measure of Leadership in Health Care Quality

AAAHC

Tom Pliura, MD, JD

Decatur HealthCare, LLC

Advice from an Advocate



Do:

- Speak with patients about the problem of tort reform.
- Try to personalize the problem by using specific names of physicians who have left the community or stopped offering certain services.
- Always remain professional.
- Convey a message that the problem is crippling all segments of our society, not just the medical profession.

Don't:

- Make tort reform simply a money issue.
- Become adversarial when advocating on the issue.
- Pass up a chance to inform patients about the problem.

a method of reducing budget deficits in 2004. As a result, ASCs need to be vigilant about working to prevent the introduction or enactment of proposals that are detrimental to ASCs and their patients and work diligently to mitigate or remove onerous requirements in those proposals that are enacted.

In 2004, for the second consecutive year, ASCs in **Georgia** will be fighting provider tax legislation in their state. The Georgia Society of Ambulatory Surgery Centers (GSASC) is aggressively opposing this legislation. Under a bill introduced in 2003, ASCs, laboratories, X-ray facilities and other diagnostic or imaging service providers would have had to pay a provider tax of 6% of their gross receipts. Physicians' offices and hospitals would not have been subject to the provider tax. According to GSASC Legislative Committee Chair Wallace N. McLeod, Jr, MD, "Fortu-

nately, we had a physician-friendly legislator who was able to kill the bill before it could be voted on in committee, and the session ended without any action being taken on the bill. We fear, however, that this bill or a similar one will be re-introduced this session and we have made contingency plans to fight it."

ASCs elsewhere were not untouched by provider tax legislation in 2003. In **Oklahoma**, legislation was enacted making ASCs and hospitals subject to a provider tax of up to 30% of net revenues—the highest in the nation. The tax will be calculated on the difference between 30% and the sum of the facility's net revenues from Medicare and Medicaid plus its state corporate tax contribution.

On the positive side, **Florida** ASCs found provider tax relief during 2003 as the result of a settlement of a class action lawsuit filed more than seven years ago in that state.

The lawsuit was supported by FASA and the Florida Society of Ambulatory Surgical Centers. Based on the final court decision in this case, Florida ASCs will no longer be required to pay a provider tax. The suit challenged the constitutionality of a 1½% tax on gross revenues of ASCs and selected other outpatient facilities. The amount paid during the term of the lawsuit was placed in an escrow account and is being reimbursed to ASCs, after attorney fees are taken out.

Tort Reform

Medical liability reform will remain one of the biggest issues for health care providers in 2004. As they continue to focus on escalating insurance rates and potentially reduced access to health care services, state legislators, governors, insurance commissioners and numerous regulatory bodies will be introducing a variety of reforms designed to curb the crisis. According to a recent survey conducted by the National Conference of State Legislators, 30 state legislatures are considering medical liability tort reform. Of these 30 state legislatures, 27 indicated that quality assurance programs may be used as a way to reduce medical errors and improve patient safety. Twenty-six state legislatures indicated that they may address reporting requirements.

Tort reforms introduced in 2004 will be similar to those seen in 2003 and will likely center around a few key changes in rules and regulations, including caps on noneconomic damages, oversight and management of insurance policies, frivo-

lous lawsuits and arbitration. Liability reform legislation pending in **North Carolina** does not contain caps on noneconomic damages for ASCs or other health care providers. Passed within a day after the state Senate reconvened to “address the crisis in medical liability insurance costs,” the bill adds quality assurance committees to the list of review committees whose findings and analyses are not subject to discovery or use in a civil action against ASCs or hospitals. Several other protections included in the bill would not apply to ASCs. The legislation has passed the North Carolina Senate and now moves to the House to be considered once it reopens. In **Connecticut**, Governor John G. Row-

land has called a special session of the state legislature to take action to control the costs of medical liability insurance in that state. He explained, “In other states this issue has reached crisis level. People have lost access to doctors who can’t afford premiums. . . . In Connecticut we can do better. We need to address this problem before the crisis worsens.”

Another tort reform strategy involves the use of the state constitution. In a September 2003 election, **Texas** showed how it’s done when its voters passed a constitutional amendment preventing caps on malpractice awards in that state from being struck down as uncon-

Topping the States’ Action List

- Health Workforce Shortages—38 States
- Medical Errors and Patient Safety—32 States
- Medical Liability Tort Reform—30 States

Source: National Conference of State Legislatures

stitutional by the Texas Supreme Court under a 1998 law in that state. The Texas voters approved a constitutional amendment that allows the legislature to set limits on noneconomic damages in all cases. A cap on noneconomic damages in

continued on page 44

Pre-owned Equipment from Mobile Instrument

Why Pay More?

Mobile Instrument now offers a full range of Pre-owned Equipment at a fraction of the cost of new equipment.

Quality & Value.

Mobile Instrument will help you get the most out of your limited capital equipment budget.



Call Today.

Let Mobile present the affordable options available to you from our extensive pre-owned equipment inventory.



MOBILE INSTRUMENT
SERVICE & REPAIR INC.

1-800-722-3675

www.mobileinstrument.com

Action You Can Take in 2004!

Use these key strategies:

1. Develop a relationship with the public officials responsible for changes that affect ASCs in your state. For example, meet with the individuals working on regulatory changes and with staff or legislators on committees that review legislation affecting your ASC. Make sure that they know you want to help them develop and review legislation, rules or regulations that would affect your ASC. When they call, make time to follow through on your offer of help! If you don't like their proposals, succinctly explain your concerns and provide them with data and research to ensure that ASC interests are heard.
2. Invite state legislators and regulatory officials to visit your ASC and show them the quality and much-needed health care services your ASC provides to the members of their communities. Tout the specific

merits of your individual ASC that may interest them. For example, for women legislators, it may be helpful to explain the leadership roles that women play in your ASC.

3. Above all, get involved in your state ASC association. If your state does not have a formal organization, make sure you are part of local networking groups so that you can work together to monitor and address issues while they are under development. Formal state organizations are not a prerequisite for action. For example, **Arkansas** was successful in passing recovery care prior to the formal formation of its state organization. Recently, **Arizona** ASC administrators successfully postponed the implementation of labor-intensive requirements for retroactive data collection and today they are working with key state officials on the development of a more appropriate data collection instrument.

medical liability and other major reforms for ASCs and other health care providers were enacted earlier in the year in the Lone Star State, limiting claims on noneconomic damages to \$250,000 per claim or \$500,000 when more than one facility is involved. Another state where such constitutional changes are being pursued is **Florida**. There, the Florida Medical Association is circulating a petition to obtain enough signatures to add a constitutional amendment to the ballot for the November 2004 election that would allow the Florida legislature to set limits on attorneys' fees in medical liability cases.

While proposals will vary across the nation, ones that include patient safety or reporting requirements are likely to impose additional administrative and possibly monetary burdens on ASCs. ASCs

need to remain aware of any new legislation that is introduced on these matters and advocate for meaningful reforms that are appropriate for the ASC setting. It is also important that ASCs work with legislators and allies such as state medical societies and other physician organizations that are advocating for reform. FASA member Tom Pliura, MD, JD, of Decatur HealthCare, LLC, is one such advocate. Pliura has organized rallies in **Illinois** and advises that "the medical liability insurance/tort crisis has major ramifications for all health care providers. When speaking to your patients, the media and your elected representatives about this issue, try to convey a message that the public is suffering the most from this crisis."

In 2003, few of the reforms had specific provisions for ASCs.

While ASCs and their employees can benefit from general tort reform, it is important that they continue to monitor and review legislation to ensure that ASCs and the patients that they serve are included in such reforms.

Preparing for Advocacy

How can an ASC be ready if legislation that threatens the quality of care it can provide or compromises the services it can provide for its patients is introduced or pursued in its state? While the issues may be daunting, an ASC's voice of experience can make a difference. With an incredible range of legislative and regulatory action on the horizon in states across the country, ASCs must remain on

the forefront of activity and be aware of what is happening. As 2004 dawns, ASC staff should make sure to add the following item to their list of New Year's resolutions: Become more involved in advocacy activities. Whether you work with a formal state association or lobby informally through an independent group, ASCs need to be heard. Heed the advice and the experience of those who battled and won in 2003 and begin now to prepare strategies. Align yourself with potential allies, including legislators and their

staff, regulatory officials, and groups and individuals with similar goals. In **Ohio**, for instance, aggressive lobbying against the physician ownership legislation is being led by the Ohio State Medical Association. Whether physicians have an ownership interest in your ASC or simply perform procedures at the facility, encourage them to get involved in their state medical and specialty societies and voice their concerns about potential legislative or regulatory action. The box on page 44 outlines a few key steps that will

help ASCs prepare for action in 2004.

FASA wishes the best of luck to all ASCs with their 2004 legislative and regulatory activities! Make sure to keep FASA abreast of changes and to turn to us for resources that can help your advocacy efforts succeed. If you need help developing networking groups or formalizing a state association, do not hesitate to contact FASA at FASA@fasa.org. A list of state associations is available in the FASA membership directory or by e-mailing FASA@fasa.org. ♦

 <p>Pulse Oximeters</p>	 <p>Defibrillators</p>	 <p>CO₂ Monitors</p>	 <p>Surgical Tables</p>	 <p>Operating Room Lights</p>
 <p>Portable Anesthesia</p>	<h1 style="margin: 0;">We operate within your budget.</h1> <p style="margin: 10px 0;">We understand the needs of today's surgery center, and will provide you with equipment you and your patients can rely upon.</p>  <p style="font-size: small;">New and Refurbished Medical Equipment</p> <p style="font-size: large; font-weight: bold;">1-800-462-8956 • www.dremed.com</p> <p style="font-size: large; font-weight: bold;">(502) 244-4444</p>			 <p>Patient Monitors</p>
 <p>AEDs (Defibrillators)</p>				 <p>Anesthesia Systems</p>