



New York State Association of Ambulatory Surgery Centers

February 16, 2017

**To Members of the Senate Finance, Assembly Ways and Means,
Senate Health, and Assembly Health Committees:**

My name is Tom Faith and I am the President of the NYS Association of Ambulatory Surgery Centers (NYSAAASC). Ambulatory Surgery Centers (ASCs) have been a major player in the elective surgical and diagnostic arena for approximately 20 years. In fact, a full 87% of surgical procedures are considered safe to perform outside of a hospital. Ambulatory Surgery Centers are licensed, Article 28 facilities which deliver high-quality care in a regulated and cost effective setting. There are 134 of facilities in NYS and we performed over 900,000 surgical and diagnostic procedures in 2017 alone. Furthermore, New York's ASCs have contributed approximately \$2B (or over 9% of their revenue) to the HCRA fund for distribution to fund NY's Hospital's Charity Care responsibility since 2007.

For the first 15 years, NYSAAASC focused on educating members on regulatory matters associated with the Certificate of Need (CON) process, the safe delivery of care, the assessment of quality measures, and patient satisfaction. Today, I find us in an equally demanding role, as advocates for and against certain legislative and regulatory changes. Today, my testimony centers on the importance of the setting in which care is delivered. While this topic is often overlooked, the setting in which care is delivered impacts both the quality and cost of that care.

The Governor's budget is rightfully focused on reducing the cost of healthcare delivery for third party payers, New York State, employers, and private citizens. In reading through the Executive's Budget Proposal, we were heartened to see mention of a task force to reform healthcare regulations. I am here to suggest that any such task force give serious consideration to the setting of elective of healthcare delivery.

New York's healthcare system is best served by matching patients to the appropriate level of care, be that in a licensed Article 28 facility or in the less regulated setting of an office-based practice. This combined healthcare model will improve outcomes and reduce costs. As you consider the creation of a task force focusing on improving outcomes and reducing costs, please keep in mind that where a patient receives treatment is important. For instance an endoscopy at an ASC will cost \$650 dollars while that same procedure in a hospital may cost \$1,500 dollars or more. This represents a significant savings for a patient who is receiving high-quality care in a comfortable, and safe, setting.

Ambulatory Surgery Centers are subject to the same rules and regulations as hospitals including CON, health/safety codes, charity care requirements and many others. ASCs perform a wide range of procedures including colonoscopy screenings, cataract surgery, reconstructive surgery, and orthopedic surgery for injured workers. When I opened my first Ambulatory Surgery Center in 1979, I would have never predicted that we would be talking about spine surgery or total joint replacement. Now, with advances in surgical care, ASCs perform many procedures that were once only available in hospital operating rooms.

Once again, both the Senate and Assembly have introduced bills mandating the exact same reimbursement structure for procedures performed at an office-based practice and those performed at an ASC or Hospital. This is relevant to this budget conversation because it suggests a fundamental misunderstanding of the proper scope of services, and regulatory costs, for Article 28 *facilities* and office-based *practices*. Given how important the site of service is for overall costs and outcomes it is important to understand the differences between licensed Article 28 facilities and accredited office-based practices.

Unlike hospitals and ASCs, office-based practices are not licensed by the DOH and they are not subject to the same level of oversight and inspection. This is an extremely important distinction. As such, office based practices are neither facilities nor centers. Again, this is an important but often overlooked distinction, which has implications for the type of care that can be safely performed. Medicare, Medicaid, and most commercial payers have identified those procedures which they believe can be safely performed at a physician's office. These procedures are already reimbursed with something called a site of service differential to recognize the physician's commitment to safety.

Let me be as clear as possible: NYSAASC is not opposed to office-based surgery (OBS). We are opposed to an open ended scope of practice that is potentially unsafe, duplicative, and more expensive. Reimbursing OBS practices at the same level as a licensed hospital or ASC will increase the cost of healthcare delivery and, possibly, undermine patient safety. It is simply not in line with the State's objectives for healthcare, as outlined in the Executive Budget Proposal, and numerous other documents and policies.

It is significantly more expensive to license, operate, and maintain a hospital or ambulatory surgery center (ASC) than it is to run an OBS practice; this is precisely the reason why Article 28 institutions are eligible for a facility fee. As I have already stated, OBS practices are eligible for a site of service differential. One important difference in overhead is the New York Public Goods Pool (or HCRA), a fund created to finance service for indigent individuals; OBS practices are not under the same obligation. Shifts in performing surgical procedures away from Article 28 facilities would mean fewer resources for charity care, and budgetary action would be required to off-set billions of dollars in HCRA losses, which is contrary to the spirit of the Executive Budget proposal.

Ambulatory Surgery Centers will play a critical role in the future of healthcare in NYS as they relieve pressure on overburdened, underfunded hospitals and offer patients the peace of mind that comes with having procedures performed in a highly-regulated setting. In summary, matching a procedure and a patient to the appropriate level of care is one of the most important conversations that can take place when discussing efficiencies in the healthcare system. This should be a central discussion point for any task force that is established to examine modernizing the healthcare system. We urge the Senate and Assembly to consider the setting in which care is delivered as you evaluate legislation and this budget proposal.

Respectfully submitted,

Thomas J. Faith
President
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