On July 13, the Centers for Medicare and Medicaid Services released its proposed fee schedule updates for 2018 for ambulatory surgery centers and hospital outpatient departments. The proposal included a modest 1.9 percent increase to ASC rates for 2018; however, the more interesting piece of the proposal related to the potential of CMS reimbursement for total joint replacements in ASCs.

CMS is soliciting comments from interested parties on whether to remove three joint replacement procedures from the inpatient-only list: total knee arthroplasty, partial hip arthroplasty, and total hip arthroplasty. This revives a CMS advisory panel recommendation from August 2016 to remove total knee arthroplasty from the inpatient-only list. However, CMS took it a step further this time by also proposing to remove partial and total hip replacements as well. The removal from the inpatient-only list would pave the way for CMS reimbursement of these procedures in an ASC setting.

In the past, the hospital industry has opposed the removal of these procedures from the inpatient-only list, as they can be lucrative procedures for hospitals. However, CMS appears intent on pressing forward with this proposal and may do so even in the face of hospital opposition. The fact that CMS is again raising the issue demonstrates its seriousness in moving these procedures to the outpatient setting.

Many ASCs are already performing these procedures on non-Medicare patients. The Ambulatory Surgery Center Association estimates more than 200 ASCs across the country are currently performing joint replacement procedures.¹ SurgCenter Development, an ASC developer and operator, has been performing joint replacement procedures since 2013, and announced in June 2017 that it had performed 20,000 joint replacement procedures in its centers across the nation. And the success rate of these procedures has been quite high — approximately 94 percent of hip replacement and 99 percent of knee replacement patients were discharged on the same day of surgery.²

In a tangentially related move, on August 15, CMS proposed a reduction in the number of mandatory geographic areas participating in the Comprehensive Care for Joint Replacement model. While the CJR model predominately impacts hospitals, this reduction in the CJR model may further signal CMS’s intention to shift certain joint replacement procedures to the outpatient setting.
HOW COULD THIS IMPACT ASC VALUES?

This proposal continues the trend of surgical procedures migrating to the outpatient and ASC settings. With advancements in medical technologies, surgical techniques, and anesthesia procedures, more complex surgical cases can now be performed safely in an ASC setting. As a result, inpatient surgeries have declined over the past couple of decades while outpatient procedures have dramatically increased. This trend is expected to further accelerate as technology continues to advance and patients seek lower-cost procedures.

If finalized, the addition of total knee and hip replacements to the Medicare ASC-approved list could be a financial boon for ASCs providing orthopedic surgeries. However, the reimbursement rates that CMS sets for these procedures will be a large indicator as to how much Medicare total joint volume will migrate to ASCs. If the reimbursement rates are set too low, ASCs may not be able to perform these procedures profitably, and therefore, may refrain from doing so. But this would most likely be just a speed bump on the road of progress, as these procedures — and more complex procedures — will inevitably move to the outpatient setting.