

Valuation of Ambulatory Surgery Centers (ASCs): Reimbursement

As noted in the first installment of this five-part series, an *ambulatory surgery center* (ASC) is a distinct entity that primarily provides outpatient surgical procedures to patients who do not require an overnight stay after the procedure.¹ The facilities typically provide relatively uncomplicated surgical procedures in a non-hospital, outpatient setting, and most ASC cases are non-emergency, noninfected, and elective.² This third installment in this five-part series on the valuation of ASCs will discuss the reimbursement environment of ASCs.

ASCs are presumably a lower cost setting than *hospital outpatient departments* (HOPDs); however, due to the ASC industry's reluctance to offer cost data, there is no empirical data to support this belief.³ Instead, this presumption is supported by the fact that the average time for surgical visits at ASCs are 25% to 39% lower compared to HOPDs, which may contribute to lower costs for ASCs.⁴ This lower cost assumption has led to lower reimbursement for ASCs by payors such as Medicare. For example, in 2019, the Medicare payment rates to HOPDs for outpatient surgical services were 94% higher than the amount paid to ASCs for providing the same outpatient surgical services.⁵ The ASCs industry's reluctance to report cost data may be hindering the equality of payment in ambulatory services and may contribute to problems with quality reporting.

The U.S. government is the largest payer of medical costs, primarily through the Medicare and Medicaid programs; this significant market share allows the U.S. government to exert a strong influence on the healthcare reimbursement environment.⁶ In 2017, Medicare and Medicaid accounted for an estimated \$705.9 billion and \$581.9 billion in healthcare spending, respectively, combining for approximately 37% of all healthcare expenditures.⁷ The spending proportionality of these public payors in the healthcare marketplace results in their reimbursement rates being used as a benchmark for private reimbursement rates.⁸ However, ASCs may face less price pressure from public payors, as commercial payors typically comprise 54% of an ASC's gross charges.⁹

Medicare Reimbursement for Freestanding ASCs

Medicare has covered procedures performed in ASCs since 1982.¹⁰ To be eligible to receive Medicare payments, a freestanding ASC must meet Medicare's conditions of coverage standards, which specify

minimum guidelines for "*administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, nursing services,*" and other areas.¹¹ Medicare pays for a bundle of surgical and facility services provided by ASCs, and also allows ASCs to bill separately for certain ancillary and physician services.¹²

The Medicare ASC payment rate for a given procedure is largely based upon the relative weight of a procedure and a conversion factor (CF).¹³ First, the ASC relative weight, which indicates the resource intensity of a procedure compared to other procedures, is connected to the relative weight in the *Outpatient Prospective Payment System* (OPPS) and updated annually.¹⁴ The OPPS relative weight for the procedure is then proportionally adjusted, in order to maintain budget neutrality, to arrive at the ASC relative weight.¹⁵ For example, the 2019 adjustments resulted in ASC relative weights that were 12% less than OPPS relative weights.¹⁶ Second, the ASC relative weight is "translated" into the payment amount through the CF.¹⁷ The ASC CF, which (similar to the ASC relative weight) is purposefully lower than the OPPS CF, was historically based on the *consumer price index for all urban consumers* (CPI-U); part of the reason for that discrepancy was because the OPPS CF was updated by the hospital market basket (MB) index.¹⁸ However, in 2019, CMS changed the ASC CF update basis, from the CPI-U to the hospital MB index; consequently, for the next five years (through 2023), the ASC payment system is being updated by the hospital MB index minus a multifactor productivity (MFP) adjustment.¹⁹ As a result of connecting the ASC CF to the hospital MB index, the ASC CF growth rate is now expected to be higher than the OPPS CF growth rate, because the OPPS CF includes an additional reduction from the hospital MB index (hospital MB index minus a MFP adjustment minus a statutory adjustment).²⁰ However, beginning in 2020, both ASC and OPPS CFs will be tied to the hospital MB index minus an MFP adjustment (i.e., there will be no additional statutory adjustment).²¹

In addition, CMS updated ASC payment rates in 2018 by 2.1%, based on the hospital MB increase of 2.9% minus a 0.8% adjustment for MFP, marking the first time CMS has tied the ACS CF to the hospital MB index.²² The ASC CF being tied to hospital MB rate promotes "*site-neutrality*" between hospitals and ASCs because reimbursement rates between the two settings are

equalized, thus encouraging migration of services from the hospital setting to the lower cost ASC setting.²³ CMS has chosen to continue this site-neutrality practice in 2020, finalizing an update to ASC rates for 2020 equal to 2.6% based on the hospital MB increase of 3.0% minus a 0.4% MFP adjustment.²⁴

Regarding ancillary services, the ASC payment system largely parallels the OPSS payment system, wherein the services are paid separately.²⁵ However, beginning in 2015, CMS began using *comprehensive ambulatory payment classifications* (C-APCs) in the OPSS payment system, but did not implement the same for the ASC payment system.²⁶ CMS declined to implement C-APCs in the ASC payment model due to the ASC claim system's inability to bundle ancillary items.²⁷

Certain procedures performed in ASCs are not reimbursed pursuant to the ASC CF. For example, those services performed in ASCs that are generally performed in physician offices at least 50% of the time constitute "new, office-based procedures."²⁸ In an effort to prevent physicians from migrating their practices out of their offices and into ASCs, CMS determined that it would reimburse for these services performed in an ASC at a rate that is the lower of: (1) the ASC rates; or, (2) the practice expense portion of the *Medicare Physician Fee Schedule* (MPFS) payment rate that would apply to the procedure if performed in a physician's office.²⁹ Further, beginning in 2008, Medicare began paying ASCs separately for certain ancillary services, including:

- (1) "Radiology services that are integral to a covered surgical procedure if separate payment is made for the radiology service in the OPSS;
- (2) Brachytherapy sources implanted during a surgical procedure;
- (3) All drugs that are paid for separately under the OPSS when provided as part of a covered surgical procedure (pass-through and non-pass-through drugs); and,
- (4) Devices with pass-through status under the OPSS."³⁰

ASC Quality Reporting

ASC quality reporting is an essential element to ASC reimbursement because compliance may result in higher Medicare reimbursement from CMS (and noncompliance may result in lower reimbursement). CMS's final 2020

OPSS rule language increased payment rates under ASC payment system by 2.6% for ASCs that meet the quality reporting requirements under the *ASC Quality Reporting (ASCQR) Program*.³¹ Alternatively, ASCs that do not meet their reporting requirements may incur a two percentage point reduction in the ASC facility fee reimbursement (meaning their payment rate update would be 0.6%).³²

The ASCQR Program was set forth by CMS in the 2012 OPSS/ASC Final Rule with Comment Period.³³ Eight quality measures were originally established by CMS;³⁴ that number has now increased to 12 measures.³⁵ In addition, CMS recently adopted a new measure, "ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers," which will begin in 2024.³⁶

Value-Based Purchasing Program

The *Patient Protection and Affordable Care Act* (ACA) mandates that the Secretary of the *Department of Health and Human Services* (HHS) develop a plan to implement a *value-based purchasing* (VBP) program for Medicare payments to ASCs.³⁷ As stated in the 2017 *Medicare Payment Advisory Commission's* (MedPAC) Recommendation to Congress, in order to improve ASC quality of care, "[t]he Commission has recommended a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers."³⁸ The VBP program would establish reimbursement adjustments based on quality measures linked to performance.³⁹ However, the ASC VBP program has yet to be implemented.⁴⁰

Future Trends

As the pressure for price transparency in healthcare continues to increase, ASC providers will likely be forced to comply with cost data reporting in the foreseeable future. The cost reporting may prove to be burdensome, but may help ASCs to further increase quality of care. Moreover, it seems that Medicare's equalization of payment (i.e., *site-neutrality*) for ambulatory services will be a permanent fixture of the ASC payment system going forward. *Site-neutrality* should provide the ASC industry with a competitive advantage. Medicare is actively encouraging the migration of services away from the hospital setting toward the ASC setting.⁴¹ This push from Medicare will likely lead to a significant increase in ASC volumes, which may result in increased revenue.

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