AMBULATORY SURGICAL CENTER SERVICES PAYMENT SYSTEM

*payment***basics**

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Medicare covers surgical procedures provided in freestanding or hospital-operated ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish ambulatory surgery; the most common procedures in 2016 were cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures. According to preliminary estimates from the Centers for Medicare & Medicaid Services (CMS), Medicare payments to ASCs were $4.4 billion in 2017, including both program spending and beneficiary cost sharing.

In January 2008, Medicare began paying for facility services provided in ASCs—such as nursing, recovery care, anesthetics, drugs, and other supplies—using a new payment system that is primarily linked to the hospital outpatient prospective payment system (OPPS). (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) Like the OPPS, the ASC payment system sets payments for procedures using a set of relative weights, a conversion factor (or base payment amount), and adjustments for geographic differences in input prices. Beneficiaries are responsible for paying the Part B deductible and 20 percent of the ASC payment rate.

Defining the products that Medicare buys

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the approximately 3,600 procedures approved for payment in an ASC is classified into an ambulatory payment classification (APC) group on the basis of clinical and cost similarity. There are several hundred APCs. All services within an APC have the same payment rate. The ASC system largely uses the same APCs as the OPPS.

Within each APC, CMS packages most ancillary items and services with the primary service. CMS pays separately for certain ancillary items and services when they are integral to surgical procedures. For example, CMS pays separately for:

- corneal tissue acquisition,
- brachytherapy sources,
- certain radiology services, and
- many drugs.

In addition, ASCs can receive separate payments for implantable devices that are eligible for pass-through payments under the OPPS. Pass-through payments are for specific, new technology items that are used in the delivery of services. The purpose of these payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS rates.

In 2008, CMS substantially expanded the list of services that qualify for facility payment in ASCs. Medicare began paying for all procedures that do not pose a significant safety risk when performed in an ASC *and* do not require an overnight stay. CMS updates the list of approved procedures annually.

Setting the payment rates

The relative weights for most procedures in the ASC payment system are based on the relative weights in the OPPS. These weights are based on the geometric mean cost of the services in that payment group according to hospital outpatient cost data. The ASC system uses a conversion factor to translate the relative weights into dollar amounts. The ASC conversion factor is less than the OPPS conversion factor for two reasons. First, CMS set the initial ASC conversion factor for 2008 so that total ASC payments under the

This document does not reflect proposed legislation or regulatory actions.

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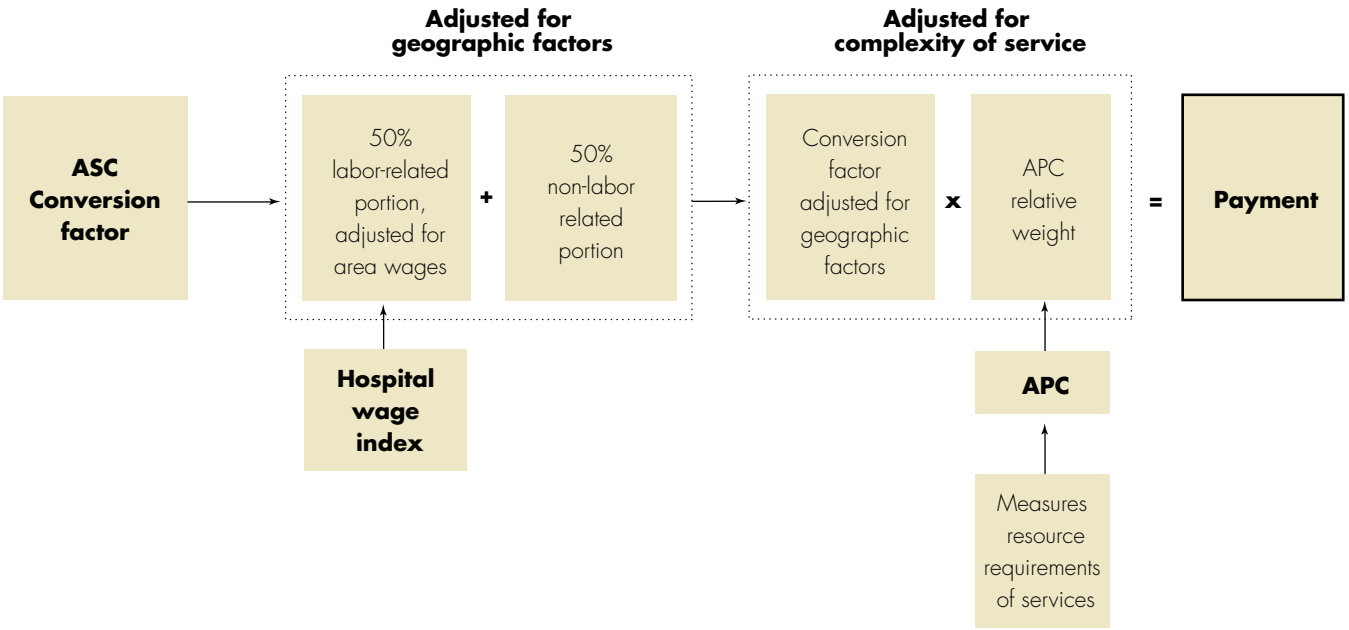
Figure 1 Ambulatory surgical center services payment system



Note: ASC (ambulatory surgical center), APC (ambulatory payment classification). The APC is the service classification system for the outpatient prospective payment system and ASC payment system. CMS uses methods different from the one shown here to set payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures (where the cost of the device accounts for more than 40 percent of the total procedure payment). For example, payment for new, office-based procedures and separately payable radiology services equals the lower of the ASC rate (as determined by the method shown above) or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office.

new payment system would equal what they would have been under the previous payment system. By comparison, the initial OPPS conversion factor was based on total payments for hospital outpatient services in 2000. Second, CMS uses different update factors to account for changes in input prices for ASCs and hospitals. The 2018 ASC conversion factor is $45.58, which is 58 percent of the OPPS conversion factor. Consequently, the ASC rates are less than the OPPS rates. Also, ASCs that do not submit their data on a set of standardized quality measures face a 2.0 percent reduction in their conversion factor and, consequently, their payment rates.

CMS uses methods different from the one described above to set ASC payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures. New, office-based procedures are services that CMS began paying for in ASCs in 2008 or later that are performed in physicians' offices at least 50 percent of the time. Payment is the lower of the standard ASC rate (based on the method described above) or the practice expense portion of the physician fee schedule rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and overhead costs of a service). CMS set this limit on the ASC rate for new, office-based services to minimize financial incentives to shift services from physicians' offices to ASCs. CMS applies the same policy to separately payable radiology services. When separately payable drugs are provided in ASCs, CMS pays ASCs the same amount it pays under the OPPS.

Device-intensive procedures are defined as OPPS services for which the device cost

is packaged into the procedure payment *and* the cost of the device (such as a spine infusion pump) accounts for more than 40 percent of the total payment. When these procedures are provided in ASCs, CMS divides the payment for these services into a device portion (which includes the cost of the device) and a non-device portion. CMS pays the ASC the same amount it would pay under the OPPS for the device portion of the service but pays the standard ASC rate for the non-device portion of the service.

To account for geographic differences in input prices, CMS adjusts the labor portion of the ASC rate by the hospital wage index. CMS does not adjust the non-labor portion of the ASC rate. Based on research conducted by the Government Accountability Office, which concluded that labor accounts for 50 percent of ASC costs, both the labor portion and the non-labor portion of the ASC rate are equal to 50 percent.

As in the OPPS, ASC payment rates are adjusted when multiple surgical procedures are performed during the same encounter. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

CMS updates the ASC relative weights annually based on changes to the OPPS relative weights and the physician fee schedule practice expense amounts. Because the OPPS relative weights usually change each year by a small amount, CMS adjusts the new OPPS weights so that projected program spending based on the current mix of services does not change. However, the mix of services in ASCs differs from that of hospital outpatient departments. Therefore, using the new OPPS relative weights could increase or decrease total ASC spending. To ensure that ASC spending does not change as a result of the new weights, CMS adjusts each ASC relative weight by the same scaling factor. In 2018, this factor reduced the ASC relative weights by 10 percent below the OPPS weights. This scaling factor does not apply to separately payable drugs or pass-through devices.

In 2018, CMS increased the ASC conversion factor by 1.2 percent, based on a 1.7 percent increase in the consumer price index for all urban consumers, which CMS uses to update ASC rates, minus a 0.5 percent deduction for multifactor productivity growth, as required by the Patient Protection and Affordable Care Act of 2010. ■