AMBULATORY SURGICAL CENTER SERVICES PAYMENT SYSTEM

paymentbasics

Revised: October 2024

The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.

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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. Medicare covers surgical procedures in ASCs 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. The most common ASC procedures in 2022 were cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures. Medicare payments to ASCs were $6.1 billion in 2022, including both program spending and beneficiary cost sharing.

Medicare pays for facility services provided in ASCs—such as nursing, recovery care, anesthetics, drugs, and other supplies—using a 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. However, the conversion factor used in the ASC payment system is less than that used in the OPPS. Beneficiaries are responsible for paying the Part B deductible ($240 in 2024) and 20 percent of the ASC payment rate.

Defining the care 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 that are integral to surgical procedures. For example, CMS pays separately for:

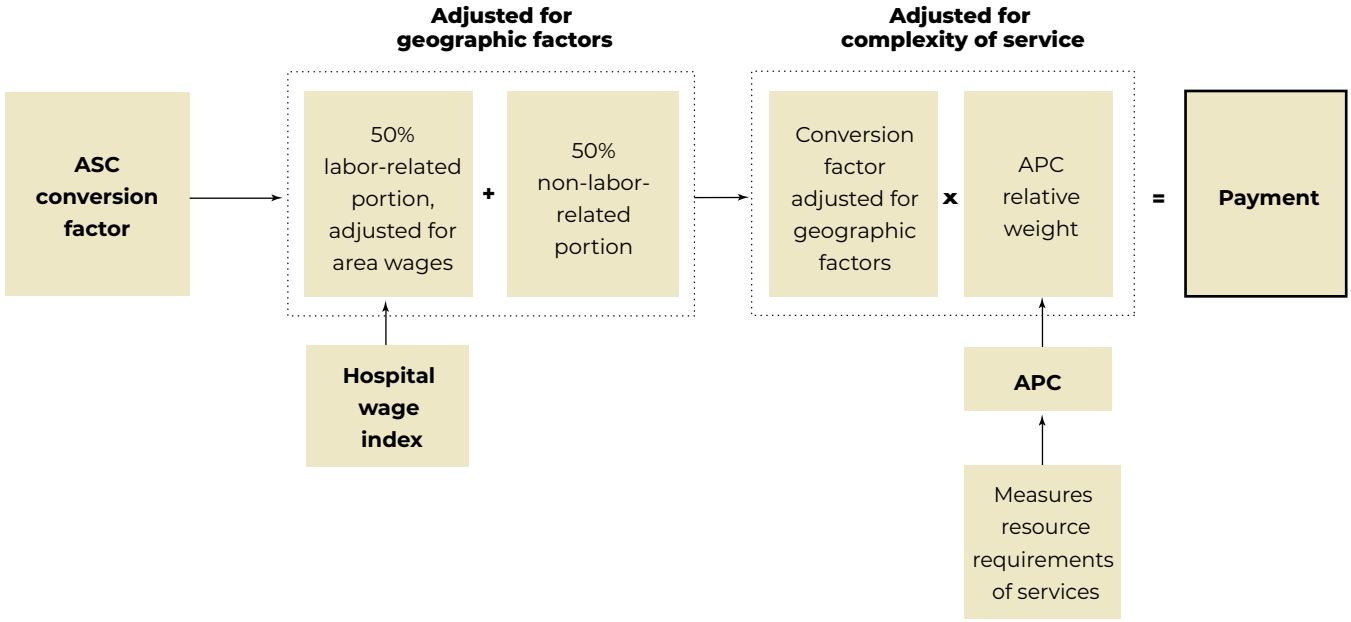
- corneal tissue acquisition,
- brachytherapy sources,
- certain radiology services, and
- drugs that have pass-through status under the OPPS or that have costs per day that exceed $135 in 2024.

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.

Setting the payment rates

The relative weights for most procedures in the ASC payment system are based on the relative weights in the OPPS. CMS uses the geometric mean of the costs from hospital outpatient claims to develop the OPPS weights. The ASC system uses a conversion factor—lower than that used in the OPPS—to translate the relative weights into dollar amounts. The 2024 ASC conversion factor is $53.51, which is 61 percent of the OPPS conversion factor. 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. To account for geographic differences in input prices, CMS adjusts the labor portion of the ASC

Figure 1 Ambulatory surgical center services payment system, 2024



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 30 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.

conversion factor by the hospital wage index (Figure 1). Based on research conducted by the Government Accountability Office, which concluded that labor accounts for 50 percent of ASC costs, the labor portion and the nonlabor portion of the ASC rate are each equal to 50 percent.

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 mitigate 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 30 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 nondevice 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 nondevice portion of the service.

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.

Payment updates

Both the relative weights and the conversion factor are updated annually. CMS updates the ASC relative weights 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 aggregate 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 2024, this factor reduced the ASC relative weights by 11.2 percent below the OPPS weights. This scaling factor does not apply to separately payable drugs or pass-through devices.

For 2019 through 2024, CMS updates the conversion factor annually by the hospital market basket, minus an adjustment for multifactor productivity growth, as required by the Affordable Care Act of 2010. (Previously, CMS had based these updates on the Consumer Price Index for Urban Consumers.) ■