Valuation of Ambulatory Surgery Centers

quickreadbuzz.com/2020/04/29/healthcare-zigrang-bailey-wheaton-valuation-of-ambulatory-surgery-centers-3/

National Association of Certified Valuators and Analysts

April 29, 2020

Reimbursement (Part III of V)

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. The facilities typically provide relatively uncomplicated surgical procedures in a non-hospital, outpatient setting, and most ASC cases are non-emergency, noninfected, and elective. This third installment on the valuation of ASCs will discuss the reimbursement environment of ASCs.

Resources:

- Valuation of Ambulatory Surgery CentersâIntroduction (Part I of V)
- Valuation of Ambulatory Surgery CentersâCompetition (Part II of V)

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 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 industryâs 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 industryâs 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 ASCâs 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 Medicareâs conditions of coverage standards, which specify minimum guidelines for âadministration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, nursing services,â 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]Â

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 âtranslatedâ 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 (CPIâU); 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 is now higher than the OPPS CF, 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 âsite-neutralityâ 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 OPPS payment system, wherein the services are paid separately.[25] However, beginning in 2015, CMS began using comprehensive ambulatory payment classifications (C-APCs) in the OPPS 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 systemâs 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 ânew, office-based procedures.â[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 physicianâs office.[29] Further, beginning in 2008, Medicare began paying ASCs separately for certain ancillary services, including:

- âRadiology services that are integral to a covered surgical procedure if separate payment is made for the radiology service in the OPPS;
- Brachytherapy sources implanted during a surgical procedure;
- All drugs that are paid for separately under the OPPS when provided as part of a covered surgical procedure (pass-through and non-pass-through drugs); and
- Devices with pass-through status under the OPPS.â[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). CMSâs final 2020 OPPS 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 OPPS/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, âASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers,â 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 Commissionâs (MedPAC) Recommendation to Congress, in order to improve ASC quality of care, â[t]he Commission has recommended a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers.â[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 Medicareâs 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.

Todd A. Zigrang, MBA, MHA, ASA, CVA, FACHE, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician-integration and financial analysis experience and has participated in the development of a physician-owned, multispecialty management service organization and networks involving a wide range of specialties, physician owned hospitals as well as several limited liability companies for acquiring acute care and specialty hospitals, ASCs, and other ancillary facilities.

Mr. Zigrang can be contacted at (800) 394-8258 or by e-mail to tzigrang@healthcapital.com.

Jessica Bailey-Wheaton, Esq., is Vice President and General Counsel for Heath Capital Consultants, where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions, and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. She is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law.

Ms. Bailey-Wheaton can be contacted at (800) 394-8258 or by e-mail to jbailey@healthcapital.com.

Â

Â

[1]Â Â Â Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 127â129.

[2]Â Â Â Â Â Â Â Â Â Â âAmbulatory surgical centers: Development and managementâ By Thomas R. O'Donovan, Aspen Systems Corp, 1976, p. xiv.

[3]Â Â Â Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 130.

[4]Â Â Â Â Â Â Â Â Â Â Ibid.

[5]Â Â Â Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 132.

[6]Â Â Â Â Â Â Â Â Â Â âHow the Government as a Payer Shapes the Health Care Marketplaceâ By Tevi D. Troy, American Health Policy Institute, December 1, 2015, http://www.americanhealthpolicy.org/Content/documents/resources/Government_as_Payer_12012015.pdf (Accessed 11/6/19) p. 1.

[7]Â Â Â Â Â Â Â Â Â Â âNational Health Expenditure Fact Sheetâ Centers for Medicare and Medicaid Services, April 26, 2019, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (Accessed 11/6/19).

[8]Â Â Â Â Â Â Â Â Â Â âMedicareâs Role in Determining Prices throughout the Health Care System: Mercatus Working Paperâ By Roger Feldman, Bryan Dowd, and Robert Coulam, Mercatus Center, George Mason University, October 2015,Â https://www.mercatus.org/system/files/Feldman-Medicare-Role-Prices-oct.pdf (Accessed 11/6/19) p. 3â5.

[9]Â Â Â Â Â Â Â Â Â Â âVMG Health's 2018 Multi-Specialty ASC Benchmarking Studyâ VMG Health, LLC, 2019, https://intellimarker.com/content/intellimarker/Payor_Mix_-_Charges/ (Accessed 10/16/19).

[10]Â Â Â Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 129.

[11]Â Â Â Â Â Â Â Â Â Â Ibid.

[12]Â Â Â Â Â Â Â Â Â Â âAmbulatory Surgical Center Payment Systemâ Centers for Medicare and Medicaid Services, January 2017, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf (Accessed 11/6/19), p. 3â4.

[13]Â Â Â Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 129.

[14]Â Â Â Â Â Â Â Â Â Â Ibid.

[15]Â Â Â Â Â Â Â Â Â Â Ibid.

[16]Â Â Â Â Â Â Â Â Â Â Ibid.

[17]Â Â Â Â Â Â Â Â Â Â Ibid; âAmbulatory Surgical Center Services Payment Systemâ MedPAC, PaymentBasics, October 2016, http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_asc_final.pdf (Accessed 11/20/19).

[18]Â Â Â Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 129.

[19]Â Â Â Â Â Â Â Â Â Â Ibid.

[20]Â Â Â Â Â Â Â Ibid.

[21]Â Â Â Â Â Â Â Ibid.

[22]Â Â Â Â Â Â Â âCY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)â Centers for Medicare & Medicaid Services, November 1, 2019, https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 11/13/19).

[23]Â Â Â Â Â Â Â Ibid.

[24]Â Â Â Â Â Â Â Ibid.

[25]Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 130.

[26]Â Â Â Â Â Â Â Ibid.

[27]Â Â Â Â Â Â Â Ibid.

[28]Â Â Â Â Â Â Â âAmbulatory Surgical Center Payment Systemâ Centers for Medicare and Medicaid Services, January 2017, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf (Accessed 11/13/19), p. 4â5.

[29]Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 130.

[30]Â Â Â Â Â Â Â âChapter 5 Ambulatory Surgical Center Servicesâ In âReport to the Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2016, http://www.medpac.gov/docs/default-source/reports/chapter-5-ambulatory-surgical-center-services-march-2016-report-.pdf?sfvrsn=0 (Accessed 11/13/19), p. 126.

[31]Â Â Â Â Â Â Â âFederal Issue Brief: CMS Releases Final Updates to the CY 2020 Hospital Outpatient and ASC Prospective Payment Systemsâ Missouri Hospital Association, November 5, 2019, p. 4.

[32]Â Â Â Â Â Â Â âMedicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programsâ Federal Register, Vol. 82, No. 217 (November 13, 2017), p. 52362.

[33]Â Â Â Â Â Â Â âMedicare and Medicaid Programs: Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital Value-Based Purchasing Program; Physician Self-Referral; and Patient Notification Requirements in Provider Agreements; Final Rule with Comment Periodâ Federal Register, Vol. 76, No. 230 (November 30, 2011).

[34]Â Â Â Â Â Â Â âASC Quality Reportingâ Centers for Medicare & Medicaid Services, August 16, 2012, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting/ (Accessed 11/13/19).

[35]Â Â Â Â Â Â Â âASC Quality Reportingâ Centers for Medicare & Medicaid Services, January 11, 2018, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting/index.html (Accessed 11/13/19).

[36]Â Â Â Â Â Â Â Â âFederal Issue Brief: CMS Releases Final Updates to the CY 2020 Hospital Outpatient and ASC Prospective Payment Systemsâ Missouri Hospital Association, November 5, 2019, p. 4.

[37]Â Â Â Â Â Â Â Â âChapter 5: Ambulatory Surgical Center Servicesâ in âReport to Congress: Medicare Payment Policyâ Medicare Payment Advisory Commission, March 2019, p. 140.

[38]Â Â Â Â Â Â Â Â Ibid.

[39]Â Â Â Â Â Â Â Â Ibid.

[40]Â Â Â Â Â Â Â Â Ibid.

[41]Â Â Â Â Â Â Â Â âCY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)â Centers for Medicare & Medicaid Services, November 1, 2019, https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 11/15/19).