

SECTION

7

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## **Ambulatory care**

**Physicians and other  
health professionals**

**Hospital outpatient services**

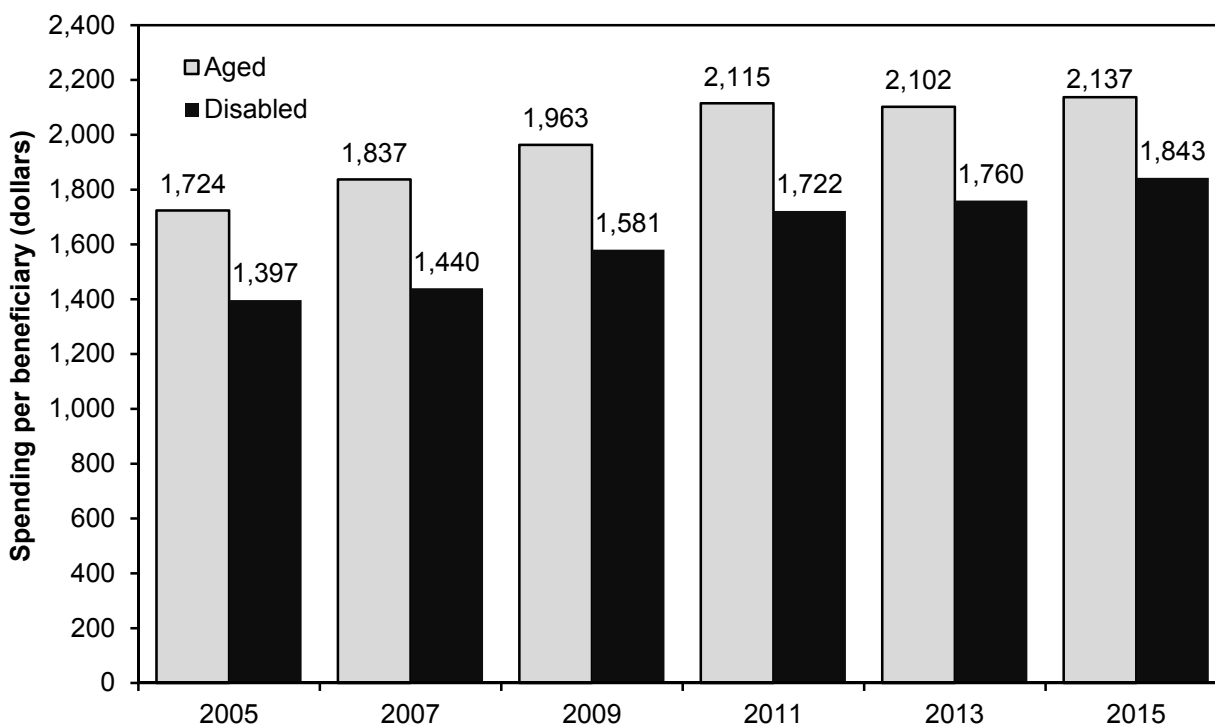
**Ambulatory surgical centers**

**Imaging services**

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**Chart 7-1. Medicare spending per fee-for-service beneficiary on services in the fee schedule for physicians and other health professionals, 2005–2015**

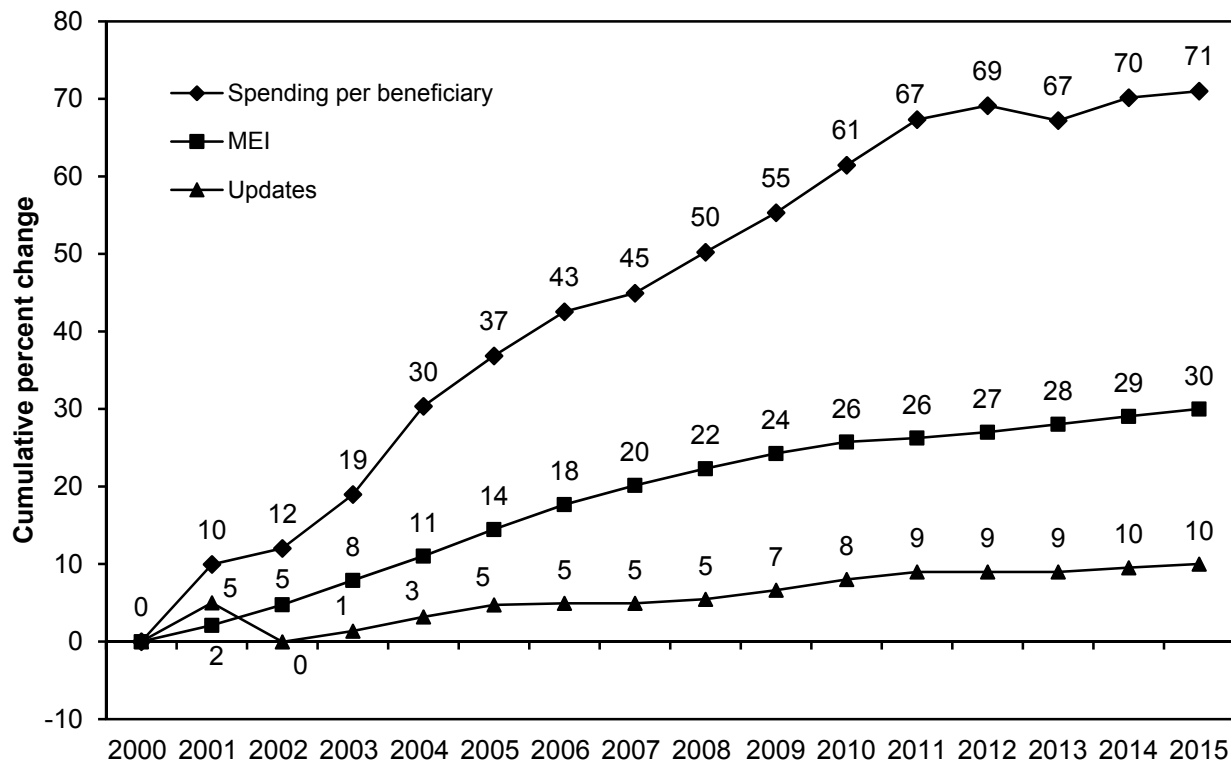


Note: Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The category “disabled” excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the “aged” category.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2016.

- The fee schedule for physicians and other health professionals includes a broad range of services such as office visits, surgical procedures, and diagnostic and therapeutic services furnished in all health care settings. “Other health professionals” refers to nurse practitioners, physician assistants, chiropractors, physical therapists, and other clinicians. Fee schedule spending was \$70.3 billion in 2015.
- Except for a small decrease in spending between 2012 and 2013 (data not shown), spending per fee-for-service beneficiary for fee schedule services has increased annually. From 2005 to 2015, spending per beneficiary grew at a cumulative rate of 25 percent.
- Growth in spending on fee schedule services is one of several factors contributing to Part B premium increases over this period.
- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries (ages 65 and over). In 2015, for example, per capita spending for disabled beneficiaries was \$1,843 compared with \$2,137 for aged beneficiaries.

**Chart 7-2. Growth in the volume of clinician services has caused fee schedule spending to increase faster than input prices and payment updates, 2000–2015**

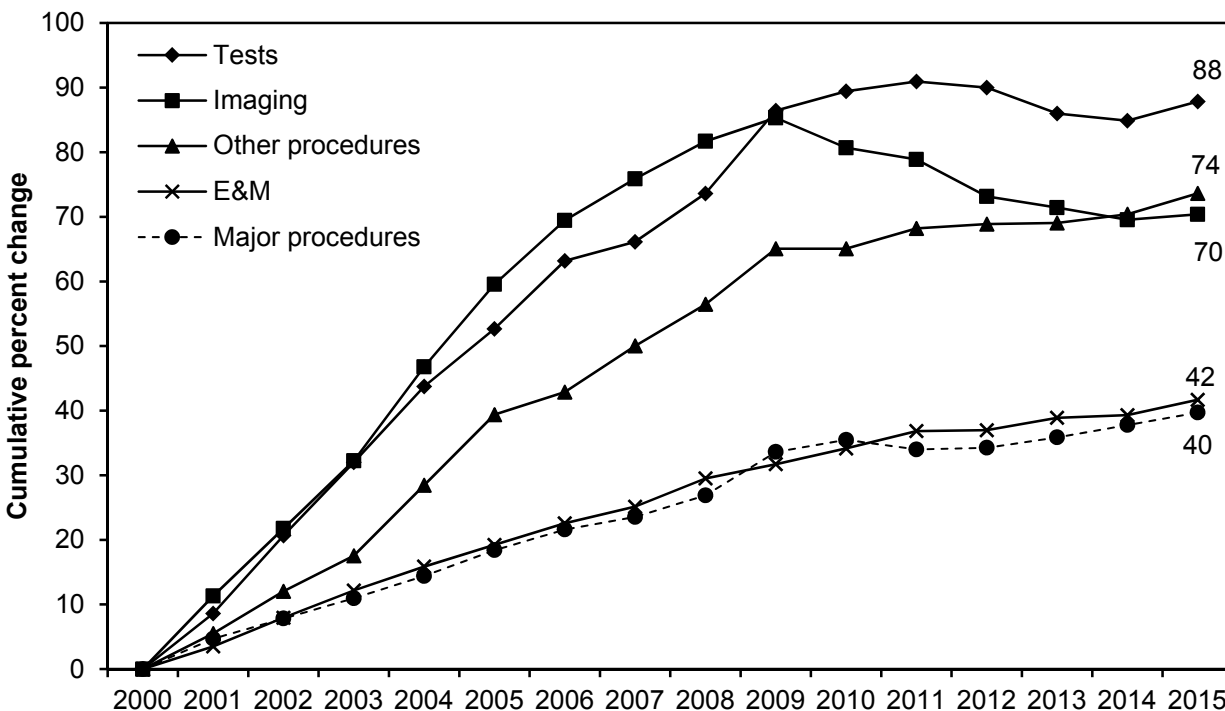


Note: MEI (Medicare Economic Index).

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2016. Centers for Medicare & Medicaid Services. 2014. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2015. Fact sheet. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/sustainablegratesconfact/downloads/sgr2015p.pdf>.

- From 2000 to 2015, Medicare spending per fee-for-service beneficiary for services paid under the fee schedule for physicians and other health professionals increased by a cumulative 71 percent.
- Spending per beneficiary grew much more rapidly over the period than both the fee schedule payment rate updates and the MEI, which measures changes in input prices. Payment updates grew cumulatively by 10 percent, and the MEI increased 30 percent.
- Growth in the volume of services contributed much more to the increase in Medicare spending than payment rate updates. Both factors—volume growth and updates—combined to increase Medicare revenue for physicians and other health professionals.

**Chart 7-3. Growth in the volume of clinician services per fee-for-service beneficiary, 2000–2015**



Note: E&M (evaluation and management). “Volume” refers to the units of service multiplied by relative value units from the fee schedule for physicians and other health professionals. Volume for all years is measured on a common scale, using relative value units for 2015. Volume growth for E&M from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2015, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

- From 2000 to 2015, the volume of some services furnished by physicians and other health professionals grew much more than others.
- The volume of tests grew by 88 percent, the volume of “other procedures” (i.e., other than major procedures) grew by 74 percent, and the volume of imaging grew by 70 percent. The comparable growth rates for evaluation and management services and major procedures were only 42 percent and 40 percent, respectively.
- Volume growth increases Medicare spending, limiting funds available for other priorities in the federal budget and requiring taxpayers and beneficiaries to contribute more to the Medicare program. Rapid volume growth may be a sign that some services in the fee schedule for physicians and other health professionals are mispriced.

**Chart 7-4. Medicare beneficiaries reported comparable ability to get timely appointments with physicians compared with privately insured individuals, 2013–2016**

Survey question	Medicare (ages 65 and older)				Private insurance (ages 50–64)			
	2013	2014	2015	2016	2013	2014	2015	2016
<b>Unwanted delay in getting an appointment:</b> Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”								
<b>For routine care</b>								
Never	73% <sup>b</sup>	72% <sup>a</sup>	72% <sup>a</sup>	68%	69%	69% <sup>a</sup>	69% <sup>a</sup>	67%
Sometimes	20 <sup>b</sup>	20 <sup>ab</sup>	19 <sup>ab</sup>	22	23	23 <sup>a</sup>	23 <sup>a</sup>	23
Usually	3 <sup>b</sup>	3	4	4	4	4	4	5
Always	3	3	3	3	3	3 <sup>b</sup>	3	4
<b>For illness or injury</b>								
Never	82 <sup>b</sup>	83 <sup>ab</sup>	82 <sup>ab</sup>	79 <sup>a</sup>	77 <sup>b</sup>	79 <sup>ab</sup>	77 <sup>ab</sup>	75 <sup>a</sup>
Sometimes	14 <sup>b</sup>	12 <sup>ab</sup>	13 <sup>ab</sup>	16 <sup>a</sup>	17	16 <sup>ab</sup>	17 <sup>a</sup>	19 <sup>a</sup>
Usually	2	2	3 <sup>b</sup>	2 <sup>a</sup>	3	2 <sup>b</sup>	3	3 <sup>a</sup>
Always	1	1 <sup>a</sup>	2	2 <sup>a</sup>	2 <sup>b</sup>	2 <sup>a</sup>	2	3 <sup>a</sup>

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in all years. Sample sizes for individual questions varied.

<sup>a</sup> Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.

<sup>b</sup> Statistically significant difference (at a 95 percent confidence level) from 2016 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys conducted 2013–2016.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Their ability to schedule timely appointments is one indicator of access that we examine.
- Medicare beneficiaries (ages 65 and older) report similar access to physicians for appointments as compared with privately insured individuals ages 50 to 64. For example, in 2016, 68 percent of Medicare beneficiaries compared with 67 percent of privately insured individuals reported “never” having to wait longer than they wanted to get an appointment for routine care.
- Medicare beneficiaries reported slightly more timely appointments for injury and illness as compared with their privately insured counterparts.
- Appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

**Chart 7-5. Medicare and privately insured patients who were looking for a new physician reported more difficulty finding one in primary care, 2013–2016**

Survey question	Medicare (ages 65 and older)				Private insurance (ages 50–64)			
	2013	2014	2015	2016	2013	2014	2015	2016
<b>Looking for a new physician:</b> “In the past 12 months, have you tried to get a new ...?” (Percent answering “Yes”)								
Primary care physician	7%	8%	7% <sup>a</sup>	8% <sup>a</sup>	8%	8%	9% <sup>a</sup>	10% <sup>a</sup>
Specialist	14	17	16	18	16 <sup>b</sup>	17	18	18
<b>Getting a new physician:</b> Among those who tried to get an appointment with a new physician, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it ...”								
<b>Primary care physician</b>								
No problem	70	67	67	64	67	63	63	63
Small problem	11	16	18	15	15	16	18	16
Big problem	17	15	14	20	18	19	17	20
<b>Specialist</b>								
No problem	86	85	87 <sup>ab</sup>	82	87 <sup>b</sup>	85	82 <sup>a</sup>	79
Small problem	8	7	7	10	6	9	8	9
Big problem	5	7	6	8 <sup>a</sup>	7	6 <sup>b</sup>	9	11 <sup>a</sup>

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in all years. Sample sizes for individual questions varied.

<sup>a</sup> Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.

<sup>b</sup> Statistically significant difference (at a 95 percent confidence level) from 2016 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys, conducted 2013–2016.

- In 2016, only 8 percent of Medicare beneficiaries and 10 percent of privately insured individuals reported looking for a new primary care physician. This finding suggests that most people were either satisfied with their current physician or did not need to look for one.
- Of the 8 percent of Medicare beneficiaries who looked for a new primary care physician in 2016, 35 percent reported problems finding one: 20 percent reported their problem as “big,” and 15 percent reported their problem as “small.” Although this number indicates that only about 3 percent of the total Medicare population reported problems finding a primary care physician, the Commission is concerned about the continuing trend of greater problems accessing primary care.
- Of the 10 percent of privately insured individuals who looked for a new primary care physician in 2016, 36 percent reported problems finding one: 20 percent reported their problem as “big,” and 16 percent reported their problem as “small.”
- In 2016, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing a new primary care physician than a new specialist.

## Chart 7-6. Medicare beneficiaries' access to physician care was comparable to privately insured individuals, and minorities in both groups reported unwanted delays more frequently, 2016

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
	All	White	Minority	All	White	Minority
<b>Unwanted delay in getting an appointment:</b> Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”						
<b>For routine care</b>						
Never	68%	70% <sup>b</sup>	64% <sup>b</sup>	67%	67%	68%
Sometimes	22	22	23	23	24	22
Usually	4	4	4	5	5	5
Always	3	3 <sup>ab</sup>	5 <sup>b</sup>	4	4 <sup>a</sup>	4
<b>For illness or injury</b>						
Never	79 <sup>a</sup>	80 <sup>ab</sup>	76 <sup>b</sup>	75 <sup>a</sup>	76 <sup>a</sup>	72
Sometimes	16 <sup>a</sup>	16 <sup>a</sup>	16	19 <sup>a</sup>	19 <sup>a</sup>	20
Usually	2 <sup>a</sup>	1 <sup>a</sup>	2	3 <sup>a</sup>	3 <sup>a</sup>	3
Always	2 <sup>a</sup>	1 <sup>ab</sup>	3 <sup>b</sup>	3 <sup>a</sup>	2 <sup>ab</sup>	4 <sup>b</sup>

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2016. Sample size for individual questions varied.

<sup>a</sup> Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.

<sup>b</sup> Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2016.

- In 2016, Medicare beneficiaries (ages 65 and older) reported access to physicians for appointments comparable with privately insured individuals ages 50 to 64.
- Access varied by race, with minorities more likely than Whites to report access problems in both insurance categories. For example, in 2016, 80 percent of White Medicare beneficiaries reported “never” having to wait longer than they wanted to get an appointment for an illness or injury compared with 76 percent of minority beneficiaries.



## Chart 7-7. Minorities in Medicare are more likely to report problems finding a new specialist than White beneficiaries, 2016

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
	All	White	Minority	All	White	Minority
<b>Looking for a new physician: “In the past 12 months, have you tried to get a new ...?”</b>						
Primary care physician	8% <sup>a</sup>	8% <sup>a</sup>	9%	10% <sup>a</sup>	10% <sup>a</sup>	9%
Specialist	18	19 <sup>b</sup>	14 <sup>b</sup>	18	20 <sup>b</sup>	13 <sup>b</sup>
<b>Getting a new physician: Among those who tried to get an appointment with a new physician, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it ...”</b>						
<b>Primary care physician</b>						
No problem	64	64	64	63	62	66
Small problem	15	15	16	16	17	13
Big problem	20	20	21	20	20	20
<b>Specialist</b>						
No problem	82 <sup>a</sup>	83 <sup>b</sup>	74 <sup>b</sup>	79	81	75
Small problem	10	9	15	9	9	10
Big problem	8 <sup>a</sup>	7	11	11 <sup>a</sup>	10	12

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2016. Sample size for individual questions varied.

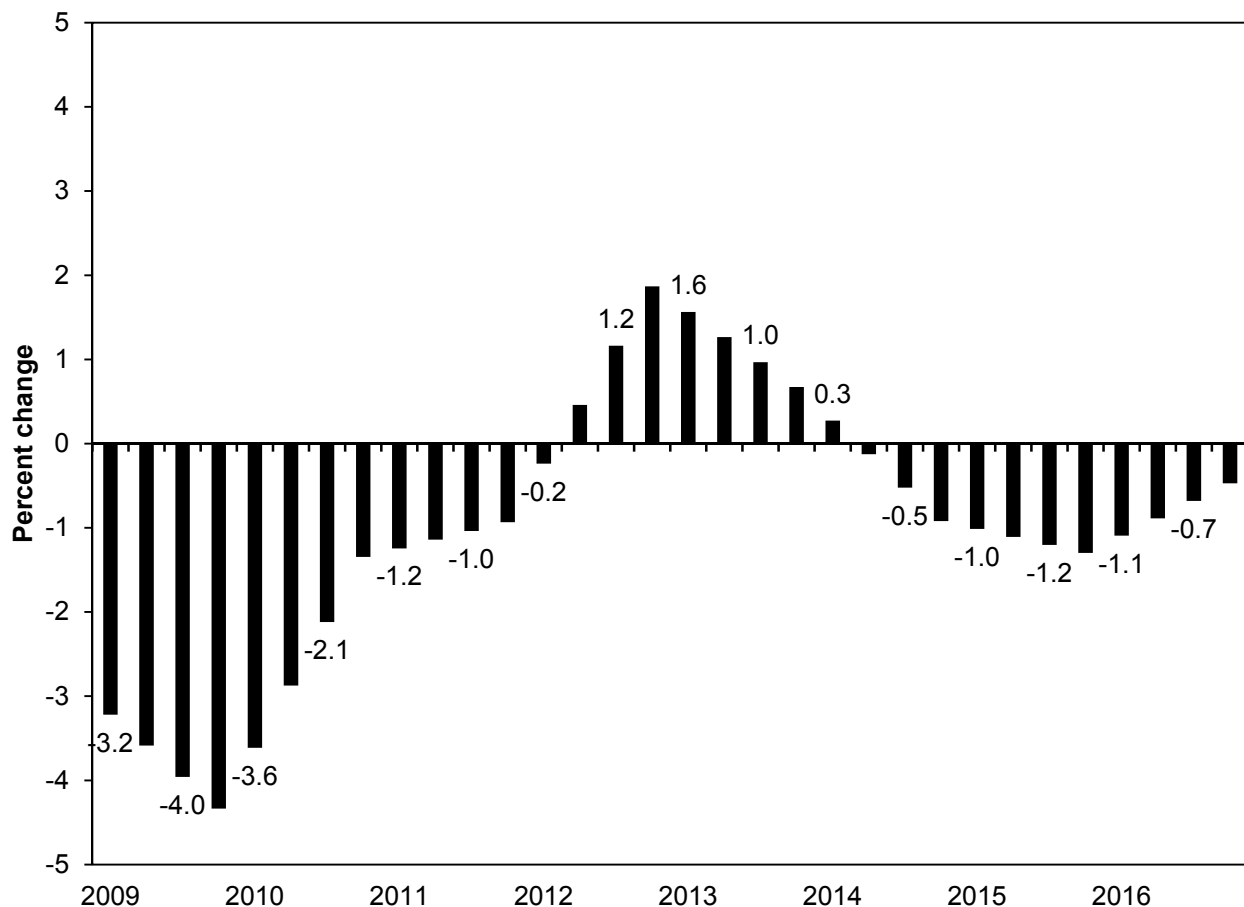
<sup>a</sup> Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.

<sup>b</sup> Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2016.

- Among the small percentage of Medicare beneficiaries looking for a specialist, minorities were more likely than Whites to report problems finding one.

**Chart 7-8. Changes in physicians' professional liability insurance premiums, 2009–2016**



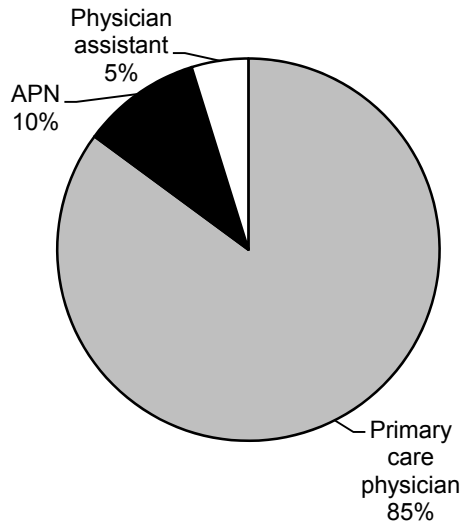
Note: Bars represent a four-quarter moving average percent change.

Source: CMS, Office of the Actuary. Data are from CMS's Professional Liability Physician Premium Survey.

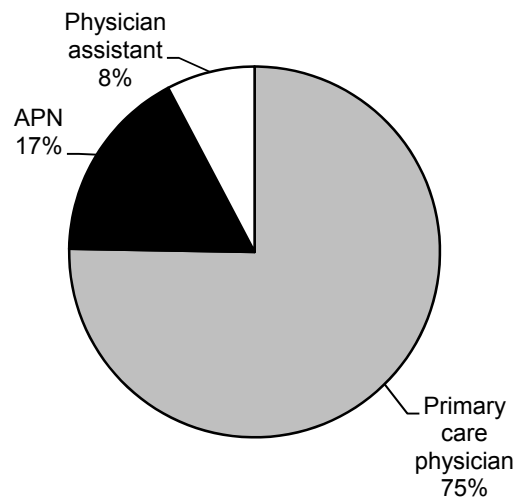
- Professional liability insurance (PLI) accounts for 4.3 percent of total payments under the fee schedule for physicians and other health professionals.
- The change in PLI premiums over the last 16 years reflects a cyclical pattern, alternating between periods of low premiums (characterized by high investment returns for insurers and vigorous competition) and high premiums (characterized by declining investment returns and market exit).
- Premiums increased from 2002 through 2006 (data not shown) and then declined from the second quarter of 2007 through the first quarter of 2012. Premiums grew slowly from the second quarter of 2012 through the first quarter of 2014 and began falling again during the second quarter of 2014.

## Chart 7-9. The shares of primary care services billed by APNs and physician assistants have grown, 2011 and 2015

Total units of service 2011 = 133.4 million



Total units of service 2015 = 143.8 million

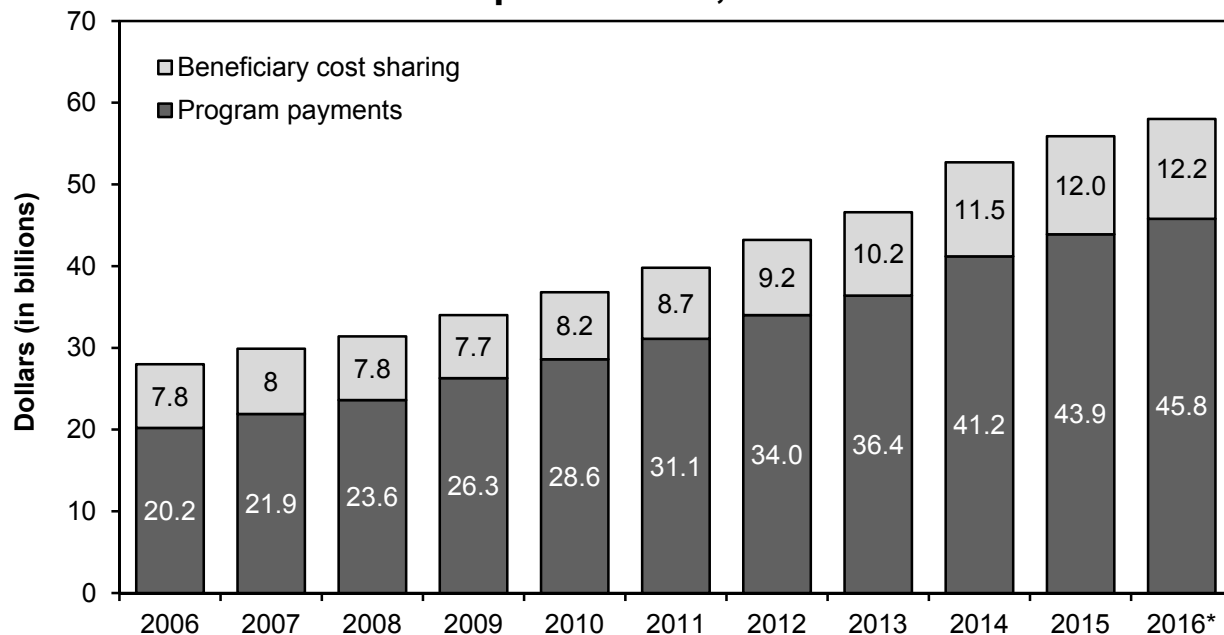


Note: APN (advanced practice nurse). Primary care services are specified services—office visits, home visits, visits to patients in extended care facilities, transitional care management, chronic care management, annual wellness visits, and “welcome to Medicare” visits—when billed by nurse practitioners; clinical nurse specialists; physician assistants; or physicians with a specialty designation of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

- The distribution of primary care services among the clinicians who bill Medicare for these services—primary care physicians (PCPs), APNs, and physician assistants—has changed over time.
- In 2011, primary care services totaled 133.4 million units of service. PCPs billed for most of the services (113.5 million, or 85 percent), followed by APNs (13.4 million, or 10 percent), and physician assistants (6.5 million, or 5 percent).
- By 2015, total primary care services had grown to 143.8 million units of service, an increase of 8 percent compared with 2011. PCPs continued to account for most of these services, but their billed services decreased to 108.2 million, or 75 percent of the total. Primary care services billed by APNs grew to 24.5 million, or 17 percent. Primary care services billed by physician assistants increased to 11.1 million, or 8 percent.
- Units of service billed by primary care physicians include some services—not identifiable as such in claims data—provided by APNs and physician assistants but billed as “incident to” or under the direct supervision of physicians. Medicare pays for such services as if physicians had personally furnished them.

**Chart 7-10. Spending on hospital outpatient services covered under the outpatient PPS, 2006–2016**



Note: PPS (prospective payment system). Spending amounts are for services covered by the Medicare outpatient PPS. They do not include services paid on separate fee schedules (e.g., ambulance services and durable medical equipment) or those paid on a cost basis (e.g., corneal tissue acquisition and flu vaccines) or payments for clinical laboratory services.  
\*Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS from calendar year 2006 to 2016 increased by 107 percent, reaching an estimated \$58.0 billion. The Office of the Actuary projects continued growth in total spending, averaging 9.3 percent per year from 2016 to 2018.
- In 2001, the first full year of the outpatient PPS, spending under the PPS was \$20.1 billion, including \$12.1 billion by the program and \$8.0 billion in beneficiary cost sharing (data not shown). The Office of the Actuary estimates that spending under the outpatient PPS was \$58 billion in 2016 (\$45.8 billion in program spending, \$12.2 billion in beneficiary copayments). We estimate that the outpatient PPS accounted for about 7 percent of total Medicare program spending in 2016.
- Beneficiary cost sharing under the outpatient PPS includes the Part B deductible and coinsurance for each service. Under the outpatient PPS, beneficiary cost sharing is generally higher than for other sectors; in 2015, it was about 21 percent.

## Chart 7-11. Most hospitals provide outpatient services

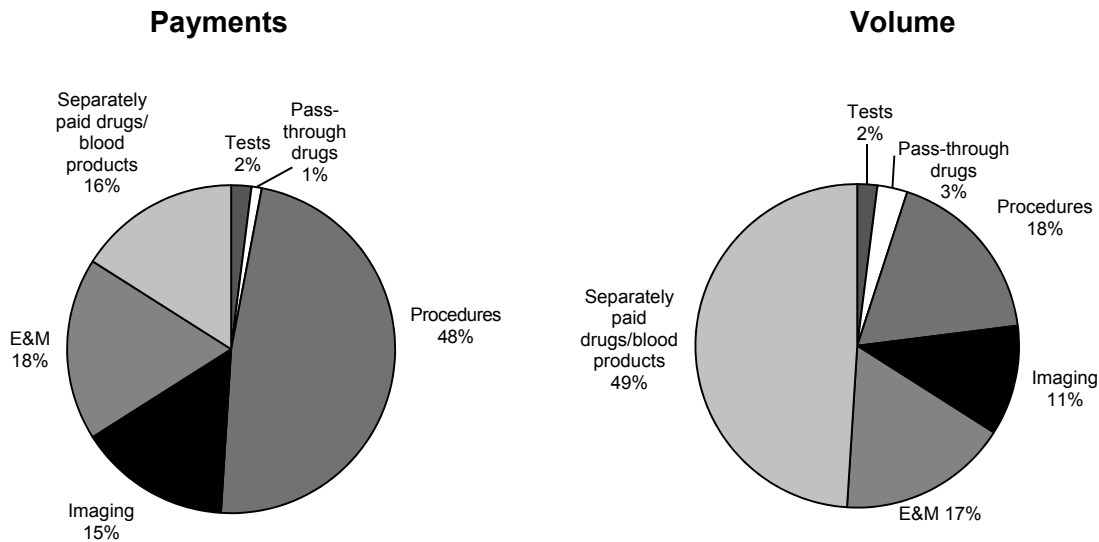
Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
2006	3,651	94%	86%	N/A
2008	3,607	94	87	N/A
2010	3,518	95	90	N/A
2012	3,483	95	91	93%
2013	3,456	96	92	93
2014	3,429	96	92	93
2016	3,370	96	93	93

Note: N/A (not applicable). We list emergency services from 2006 through 2010 as “N/A” because the data source we used in this chart changed the variable for identifying hospitals’ provision of emergency services. We believe this change in variable definition makes it appear that the percentage of hospitals providing emergency services increased sharply from 2010 to 2012, but we question whether such a large increase actually occurred. This chart includes services provided or arranged by short-term hospitals and excludes long-term, Christian Science, psychiatric, rehabilitation, children’s, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare’s outpatient prospective payment system has declined slowly since 2006.
- The share of hospitals providing outpatient services remained stable, and the share offering outpatient surgery steadily increased from 2006 through 2013 and has remained stable since then. The share offering emergency services has remained stable over the period we are able to measure accurately.

**Chart 7-12. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2015**



Note: PPS (prospective payment system), E&M (evaluation and management). Payments include both program spending and beneficiary cost sharing but do not include hold-harmless payments. Services are grouped into the following categories, according to the Berenson–Eggers Type of Service classification developed by CMS: evaluation and management, procedures, imaging, and tests. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2015.

- Hospitals provide many types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently from volume. For example, in 2015, procedures accounted for 48 percent of payments but only 18 percent of volume.
- Procedures (e.g., endoscopies, surgeries, and skin and musculoskeletal procedures) accounted for the greatest share of payments for services (48 percent) in 2015, followed by evaluation and management services (18 percent), separately paid drugs and blood products (16 percent), and imaging services (15 percent).
- Relative to previous years, tests accounted for a much smaller share of volume in 2015. In 2015, CMS began to package many tests as part of a larger payment bundle rather than pay for them separately as had been done in previous years. We include only separately paid items in this analysis, so increased packaging of tests creates an apparent decrease in the volume of tests.

**Chart 7-13. Hospital outpatient services with the highest Medicare expenditures, 2015**

APC title	Share of payments	Volume (thousands)	Payment rate
Total	48%		
All emergency visits	7	13,324	\$297
Clinic visits	5	28,770	96
Level II endovascular procedures	3	191	9,628
Extended assessment & management composite	3	1,549	1,235
Level II implantation of cardioverter-defibrillators	3	48	30,818
Diagnostic cardiac catheterization	2	381	2,576
Level II cardiac imaging	2	861	1,141
Level II intraocular procedures	2	514	1,753
Level III pacemaker and similar procedures	2	90	9,493
Lower gastrointestinal endoscopy	1	1,108	790
Level II echocardiogram without contrast	1	1,860	423
Level III radiation therapy	1	1,499	508
Level III electrophysiologic procedures	1	49	14,362
Level III endovascular procedures	1	41	14,846
Level II laparoscopy	1	156	3,779
Level III nerve injections	1	814	672
Level I plain film including bone density measurement	1	9,459	59
Level III drug administration	1	4,947	108
Level III cystourethroscopy and other genitourinary procedures	1	266	2,085
Level V drug administration	1	1,679	285
Level I upper gastrointestinal procedures	1	820	746
Combined abdomen and pelvis CT with contrast	1	1,280	376
Level I endovascular procedures	1	109	4,539
Level IV drug administration	1	2,730	173
Level II drug administration	1	8,698	53
Level IV cystourethroscopy and other genitourinary procedures	1	150	3,114
PET imaging	1	357	1,286
Average APC		449	167

Note: APC (ambulatory payment classification), CT (computed tomography), PET (positron emission tomography). The payment rate for “all emergency visits” is a weighted average of payment rates from 10 APCs. The shares of payments for the 27 APC categories do not add to the total share of payments (48 percent) because of rounding. The average APC figures in the last line represent averages for all APCs.

Source: MedPAC analysis of 100 percent analytic files of outpatient claims for calendar year 2015.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a few categories that have high volume, high payment rates, or both.

**Chart 7-14. Effects of SCH transfer payments on hospitals' outpatient revenue, 2013–2015**

Hospital group	2013		2014		2015	
	Number of hospitals	Share of payments from hold-harmless and SCH transfer	Number of hospitals	Share of payments from SCH transfer	Number of hospitals	Share of payments from SCH transfer
All hospitals	2,997	0.1%	2,950	0.0%	2,894	0.0%
Urban	2,137	-0.4	2,111	-0.4	2,147	-0.4
Rural SCHs	368	6.2	373	5.6	353	5.6
Rural ≤100 beds	366	0.7	346	-0.4	294	-0.4
Other rural	126	-0.4	120	-0.4	100	-0.4
Major teaching	260	-0.3	273	-0.3	284	-0.3
Other teaching	708	-0.2	700	-0.2	693	-0.2
Nonteaching	2,029	0.5	1,977	0.4	1,917	0.3

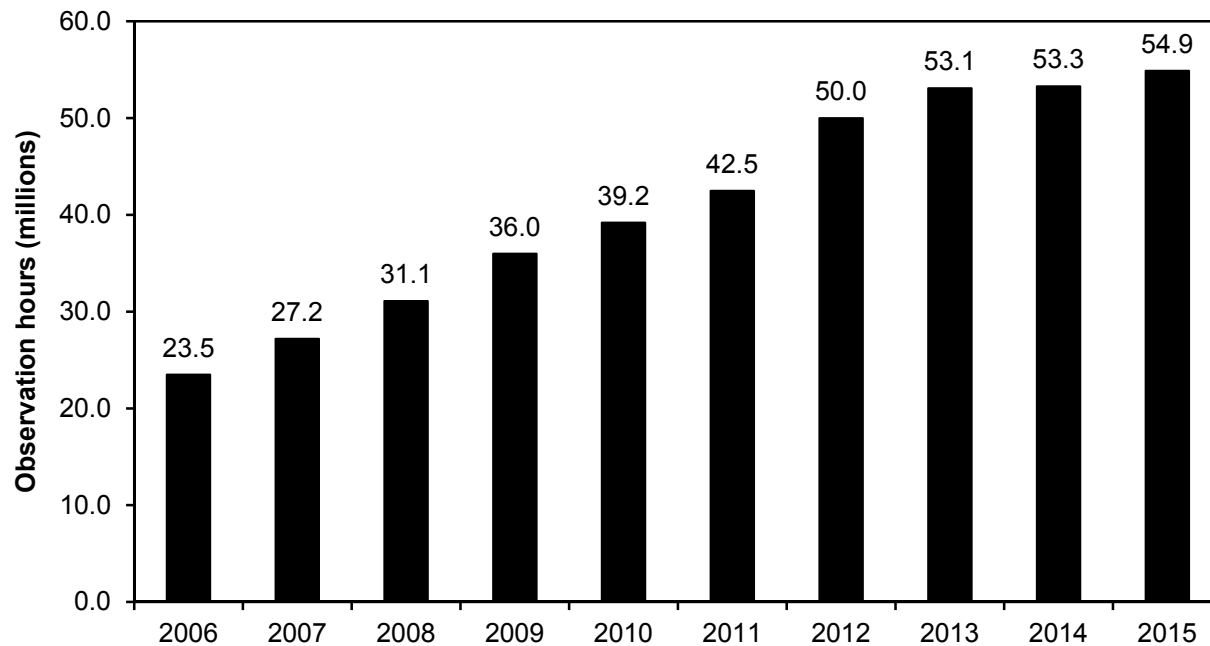
Note: SCH (sole community hospital).

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- In 2006, CMS implemented a policy (the “SCH transfer”) that increased outpatient prospective payment (PPS) rates to rural SCHs by 7.1 percent above the standard PPS rates. This policy is made budget neutral by reducing payments to all other hospitals.
- SCHs and rural hospitals that had 100 or fewer beds received hold-harmless (HH) payments through the end of calendar year 2012. The HH payments sunset on January 1, 2013.
- This table reflects the effects of the HH and SCH transfer policies for hospital categories in 2013, 2014, and 2015. We obtained the data for this table from the hospitals' 2013, 2014, and 2015 cost reports. Many hospitals have 2013 cost reports that cover fiscal year 2013, which means that their cost reports covered part of 2012 and 2013. For those hospitals, payments through the HH policy affected their 2013 cost reports even though that policy expired at the end of calendar year 2012.
- HH payments and the SCH transfer represented 0.1 percent of total outpatient PPS payments for all hospitals in 2013. However, the percentage of total outpatient payments from these policies was 6.2 percent for rural SCHs and 0.7 percent for small rural hospitals. The SCH transfer payments to rural SCHs represented 5.6 percent of their outpatient revenue in 2014 and 2015. Also, the SCH transfer policy reduced outpatient payments to small rural hospitals by 0.4 percent in both 2014 and 2015.



**Chart 7-15. Number of observation hours increased, 2006–2015**



Source: MedPAC analysis of Limited Data Set claims for the outpatient prospective payment system 2006–2015.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.
- Medicare began providing separate payments to hospitals for some observation services on April 1, 2002. Previously, the observation services were packaged into the payments for the emergency department or clinic visits that occurred with observation care.
- The number of observation hours (both packaged and separately paid) has increased substantially, from about 23 million in 2006 to nearly 55 million in 2015. Before 2006, it was difficult to count the total number of observation hours because hospitals were not required to report packaged observation hours on Medicare claims.

## Chart 7-16. Number of Medicare-certified ASCs increased by 11 percent, 2008–2015

	2008	2009	2010	2011	2012	2013	2014	2015
Medicare payments (billions of dollars)	\$3.1	\$3.2	\$3.3	\$3.4	\$3.6	\$3.7	\$3.8	\$4.1
New centers (during year)	282	220	192	195	173	170	180	149
Closed or merged centers (during year)	81	112	110	118	108	107	94	76
Net total number of centers (end of year)	4,921	5,029	5,111	5,188	5,253	5,316	5,402	5,475
Net percent growth in number of centers from previous year	—	2.2%	1.6%	1.5%	1.3%	1.2%	1.6%	1.4%
Percent of all centers that are:								
For profit	95%	95	95	95	95	95	95	96
Nonprofit	4	3	3	3	3	3	3	2
Government	1	2	1	1	1	2	2	2
Urban	92	92	92	92	93	93	93	93
Rural	8	8	8	8	7	7	7	7

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS 2015. Payment data are from CMS, Office of the Actuary.

- ASCs are distinct entities that furnish ambulatory surgical services not requiring an overnight stay. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.
- Total Medicare payments for ASC services increased by 4.0 percent per year, on average, from 2008 through 2015. Payments per ASC fee-for-service beneficiary grew by 3.5 percent per year during this period (data not shown). Between 2014 and 2015, total payments rose by 7.9 percent, and payments per beneficiary grew by 5.2 percent.
- The number of Medicare-certified ASCs grew at an average annual rate of greater than 1 percent from 2008 through 2015. Each year from 2008 through 2015, an average of 195 new facilities entered the market, while an average of 101 closed or merged with other facilities.
- The slower growth in the number of ASCs from 2010 through 2015 may reflect the substantially higher rates that Medicare pays for ambulatory surgical services provided in hospital outpatient departments than in ASCs, the very slow growth of national health care spending and Medicare spending, and the significant increase in hospital employment of physicians.