

SECTION

7

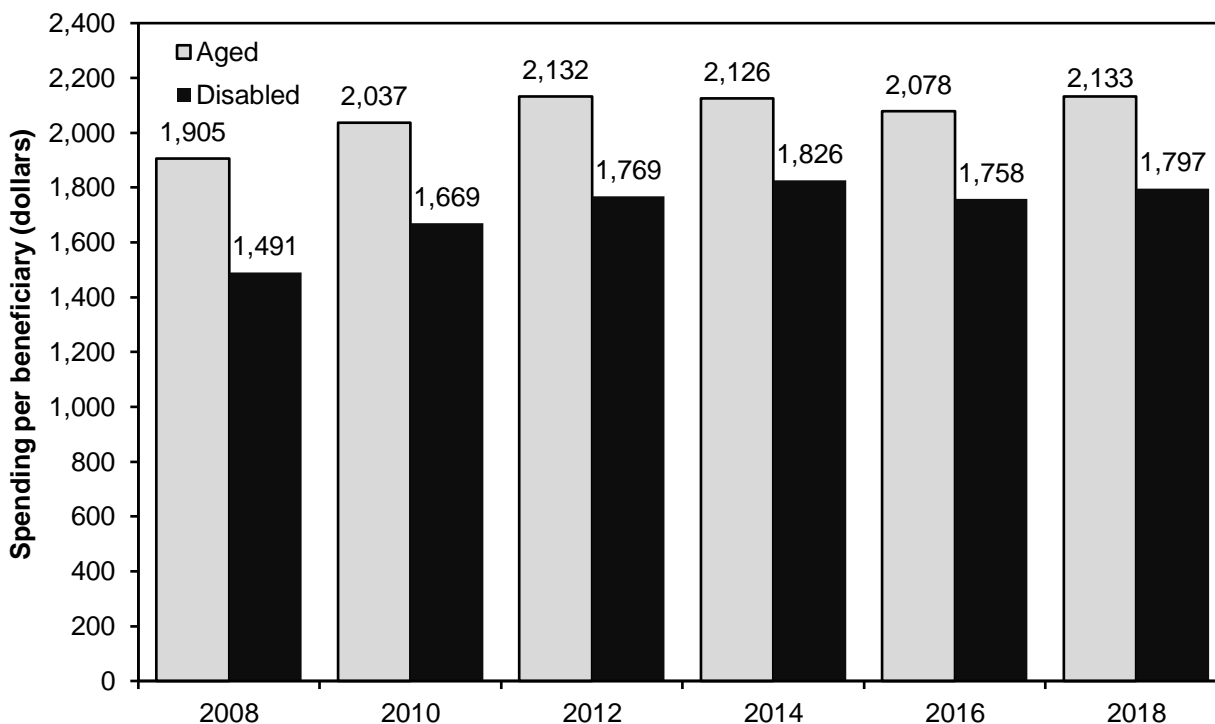
Ambulatory care

**Physicians and other
health professionals**

Hospital outpatient services

Ambulatory surgical centers

Chart 7-1. Medicare spending per fee-for-service beneficiary on services in the fee schedule for physicians and other health professionals, 2008–2018

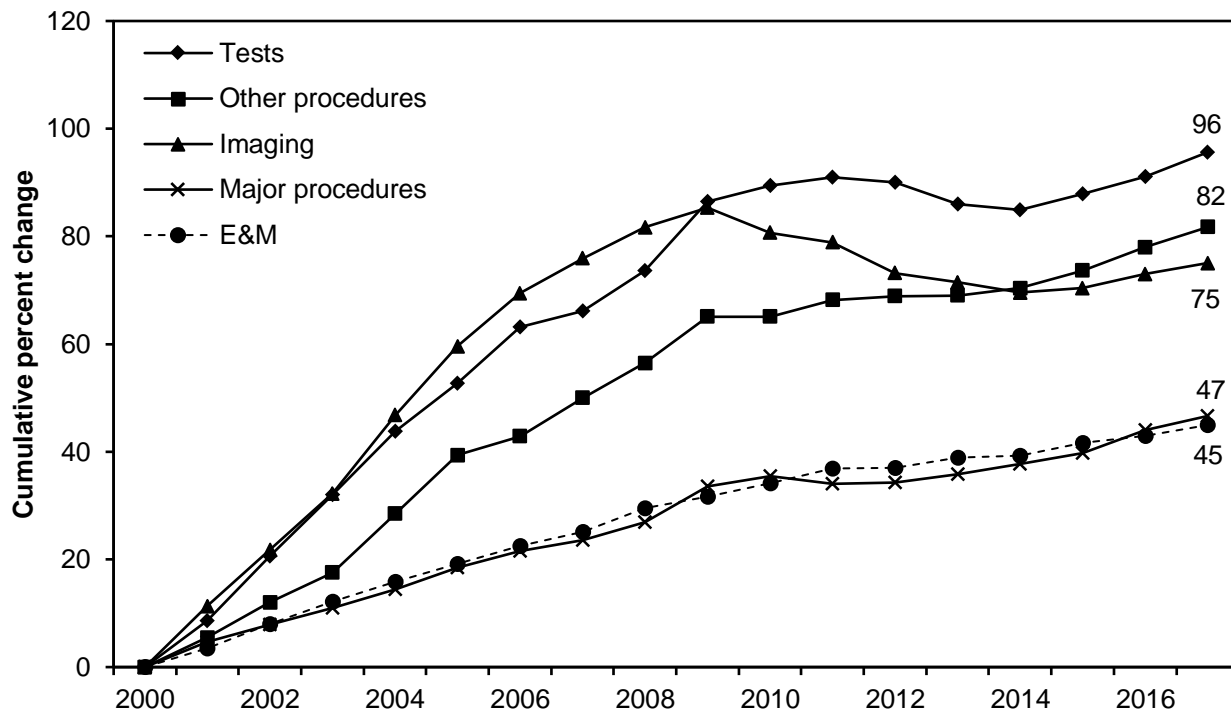


Note: Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The category “disabled” excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the “aged” category.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2019.

- 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. “Other health professionals” refers to nurse practitioners, physician assistants, physical therapists, and other clinicians. Total fee schedule spending was \$70.5 billion in 2018.
- Spending per fee-for-service beneficiary for fee schedule services increased between 2008 and 2012, declined between 2012 and 2016, and began growing again after 2016. From 2008 to 2018, spending per beneficiary (across aged and disabled beneficiaries) grew at a cumulative rate of 13 percent.
- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries (ages 65 and over). In 2018, for example, per capita spending for disabled beneficiaries was \$1,797 compared with \$2,133 for aged beneficiaries. However, spending per capita grew much faster for disabled beneficiaries than aged beneficiaries between 2008 and 2018.

Chart 7-2. Growth in the volume of clinician services per fee-for-service beneficiary, 2000–2017



Note: E&M (evaluation and management). “Volume” refers to the units of service multiplied by relative value units (RVUs) from the fee schedule for physicians and other health professionals. RVUs account for the relative costliness of the inputs used to provide clinician services. Volume for all years is measured on a common scale, using RVUs for 2017. 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 2017, 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.

- Volume growth reflects changes in both the number of services and the complexity (or intensity) of services. From 2000 to 2017, the volume of some services furnished by physicians and other health professionals grew much faster than others.
- The volume of tests grew by 96 percent, the volume of “other procedures” (i.e., other than major procedures) grew by 82 percent, and the volume of imaging grew by 75 percent. The comparable growth rates for major procedures and for evaluation and management services were only 47 percent and 45 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 7-3. Medicare beneficiaries' ability to get timely appointments with physicians was comparable with privately insured individuals, 2015–2018

| Survey question | Medicare (ages 65 and older) | | | | Private insurance (ages 50–64) | | | |
|--|------------------------------|-----------------|-------------------|-------------------|--------------------------------|------------------|-------------------|------------------|
| | 2015 | 2016 | 2017 | 2018 | 2015 | 2016 | 2017 | 2018 |
| Unwanted delay in getting an appointment: Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?” | | | | | | | | |
| For routine care | | | | | | | | |
| Never | 72% ^a | 68% | 73% ^{ab} | 70% ^{ab} | 69% ^{ab} | 67% ^b | 69% ^{ab} | 64% ^a |
| Sometimes | 19 ^a | 22 ^b | 20 | 20 ^a | 23 ^{ab} | 23 ^b | 22 ^b | 26 ^a |
| Usually | 4 | 4 | 3 ^b | 5 | 4 | 5 | 4 | 5 |
| Always | 3 | 3 | 3 | 3 ^a | 3 | 4 | 3 | 4 ^a |
| For illness or injury | | | | | | | | |
| Never | 82 ^{ab} | 79 ^a | 80 ^a | 79 ^a | 77 ^{ab} | 75 ^a | 76 ^a | 74 ^a |
| Sometimes | 13 ^{ab} | 16 ^a | 15 | 15 ^a | 17 ^a | 19 ^a | 18 | 19 ^a |
| Usually | 3 ^b | 2 ^{ab} | 2 | 2 | 3 | 3 ^a | 2 ^b | 3 |
| Always | 2 | 2 ^{ab} | 1 ^b | 2 | 2 | 3 ^a | 2 | 2 |

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

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

^b Statistically significant difference (at a 95 percent confidence level) from 2018 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys conducted 2015–2018.

- 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 (or better) access to physicians for appointments as compared with privately insured individuals ages 50 to 64. For example, in 2018, 70 percent of Medicare beneficiaries compared with 64 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 7-4. Medicare and privately insured patients who were looking for a new physician reported more difficulty finding one in primary care, 2015–2018

| Survey question | Medicare (ages 65 and older) | | | | Private insurance (ages 50–64) | | | |
|---|------------------------------|------------------|-----------------|-----------------|--------------------------------|------------------|------------------|-----------------|
| | 2015 | 2016 | 2017 | 2018 | 2015 | 2016 | 2017 | 2018 |
| Looking for a new physician: “In the past 12 months, have you tried to get a new ...?” (Percent answering “Yes”) | | | | | | | | |
| Primary care physician | 7% ^{ab} | 8% ^{ab} | 9% ^a | 10% | 9% ^a | 10% ^a | 11% ^a | 10% |
| Specialist | 16 ^b | 18 | 17 ^a | 19 ^a | 18 ^b | 18 ^b | 20 ^a | 21 ^a |
| 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 ...” | | | | | | | | |
| Primary care physician | | | | | | | | |
| No problem | 67 | 64 | 69 ^a | 71 | 63 | 63 | 59 ^{ab} | 67 |
| Small problem | 18 | 15 | 13 | 13 | 18 | 16 | 18 | 16 |
| Big problem | 14 | 20 | 14 ^a | 14 | 17 | 20 | 22 ^a | 16 |
| Specialist | | | | | | | | |
| No problem | 87 ^a | 82 | 83 | 84 | 82 ^a | 79 | 81 | 80 |
| Small problem | 7 | 10 | 11 ^b | 7 | 8 | 9 | 11 | 9 |
| Big problem | 6 | 8 ^a | 5 ^a | 8 | 9 | 11 ^a | 8 ^a | 10 |

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

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

^b Statistically significant difference (at a 95 percent confidence level) from 2018 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys, conducted 2015–2018.

- In 2018, only 10 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 10 percent of Medicare beneficiaries who looked for a new primary care physician in 2018, 28 percent reported problems finding one: 14 percent reported their problem as “big,” and 13 percent reported their problem as “small.” Although this finding means that only 3 percent of the total Medicare population reported problems finding a primary care physician, the Commission is concerned about the continuing pattern of greater problems accessing primary care than specialty care.
- Of the 10 percent of privately insured individuals who looked for a new primary care physician in 2018, 32 percent reported problems finding one: 16 percent reported their problem as “big,” and 16 percent reported their problem as “small.”
- In 2018, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing a new primary care physician than a new specialist.

Chart 7-5. Medicare beneficiaries' access to physician care was comparable with privately insured individuals, and minorities in both groups reported unwanted delays more frequently, 2018

| Survey question | Medicare (ages 65 and older) | | | Private insurance (ages 50–64) | | |
|--|------------------------------|-------------------|------------------|--------------------------------|-------------------|------------------|
| | All | White | Minority | All | White | Minority |
| Unwanted delay in getting an appointment: Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?” | | | | | | |
| For routine care | | | | | | |
| Never | 70% ^a | 71% ^{ab} | 65% ^b | 64% ^a | 65% ^{ab} | 61% ^b |
| Sometimes | 20 ^a | 20 ^a | 21 ^a | 26 ^a | 25 ^a | 29 ^a |
| Usually | 5 | 5 | 5 | 5 | 5 | 4 |
| Always | 3 ^a | 2 ^{ab} | 5 ^b | 4 ^a | 4 ^{ab} | 6 ^b |
| For illness or injury | | | | | | |
| Never | 79 ^a | 80 ^{ab} | 75 ^b | 74 ^a | 75 ^{ab} | 71 ^b |
| Sometimes | 15 ^a | 15 ^a | 15 ^a | 19 ^a | 19 ^a | 22 ^a |
| Usually | 2 | 2 | 3 | 3 | 3 | 4 |
| Always | 2 | 2 | 3 | 2 | 2 ^b | 3 ^b |

Note: Numbers may not sum to 100 percent due to rounding and to missing responses (“Don’t Know” or “Refused”) not being presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2018. Sample size for individual questions varied.

^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given category.

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

Source: MedPAC-sponsored telephone surveys conducted in 2018.

- In 2018, Medicare beneficiaries (ages 65 and older) reported better access to physicians for appointments in comparison 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 2018, 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 75 percent of minority beneficiaries.

Chart 7-6. Minorities in Medicare were more likely to report problems finding a new specialist than White beneficiaries, 2018

| Survey question | Medicare (ages 65 and older) | | | Private insurance (ages 50–64) | | |
|---|------------------------------|-----------------|-----------------|--------------------------------|-----------------|-----------------|
| | All | White | Minority | All | White | Minority |
| Looking for a new physician: “In the past 12 months, have you tried to get a new ...?” | | | | | | |
| Primary care physician | 10% | 10% | 9% | 10% | 9% | 11% |
| Specialist | 19 ^a | 20 ^b | 15 ^b | 21 ^a | 23 ^b | 19 ^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 ...” | | | | | | |
| Primary care physician | | | | | | |
| No problem | 71 | 71 | 69 | 67 | 72 ^b | 59 ^b |
| Small problem | 13 | 14 | 14 | 16 | 15 | 17 |
| Big problem | 14 | 15 | 14 | 16 | 14 ^b | 23 ^b |
| Specialist | | | | | | |
| No problem | 84 | 86 ^b | 77 ^b | 80 | 82 ^b | 74 ^b |
| Small problem | 7 | 7 | 10 | 9 | 9 | 11 |
| Big problem | 8 | 7 ^b | 13 ^b | 10 | 8 ^b | 13 ^b |

Note: Numbers may not sum to 100 percent due to rounding and to missing responses (“Don’t Know” or “Refused”) not being presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2018. Sample size for individual questions varied.

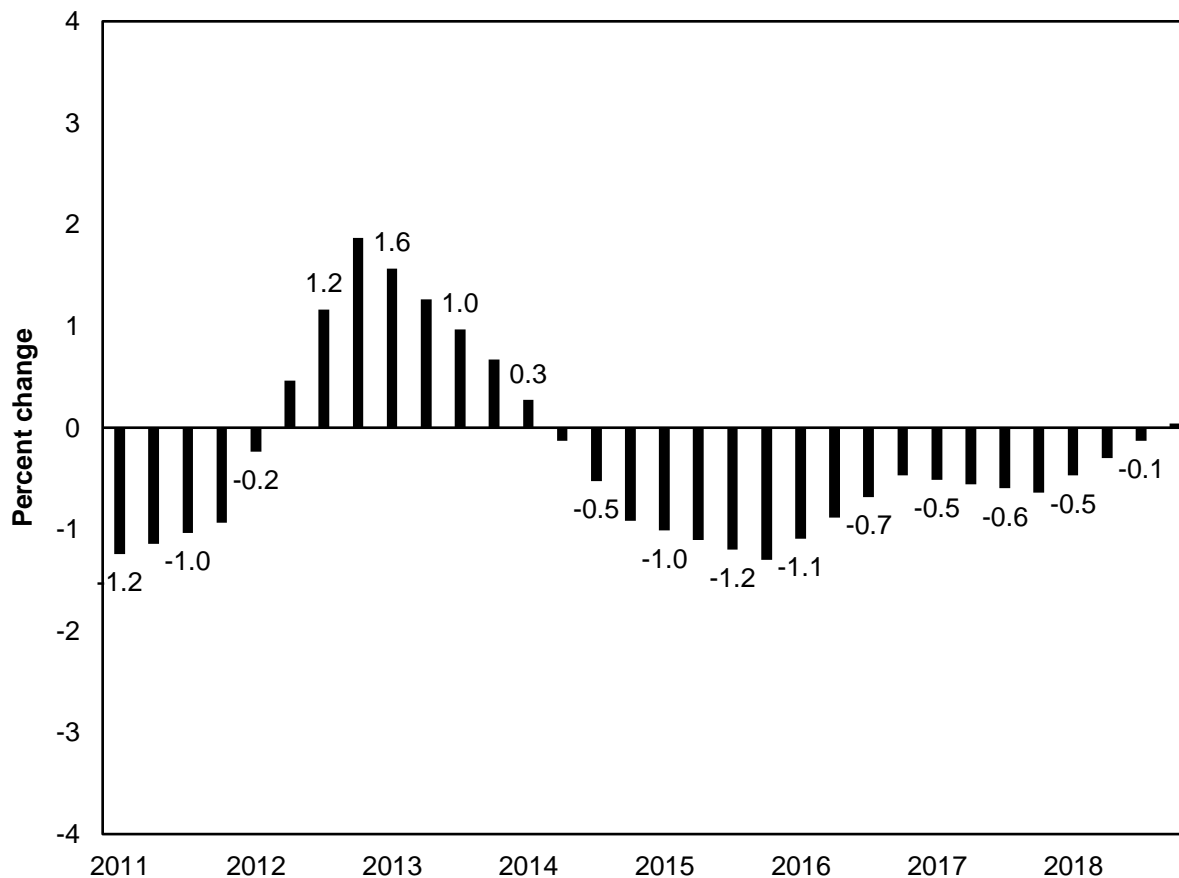
^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given category.

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

Source: MedPAC-sponsored telephone surveys conducted in 2018.

- Among the share of Medicare beneficiaries looking for a specialist, minorities were more likely than Whites to report problems finding one. This pattern also held for privately insured individuals ages 50 to 64.

Chart 7-7. Changes in physicians' professional liability insurance premiums, 2011–2018



Note: Bars represent a four-quarter moving average percentage 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.
- Changes in PLI premiums reflect 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 the first quarter of 2007 (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, after which they declined through the third quarter of 2018.

Chart 7-8. Number of E&M office visits billed by APRNs or PAs grew rapidly from 2010 to 2017

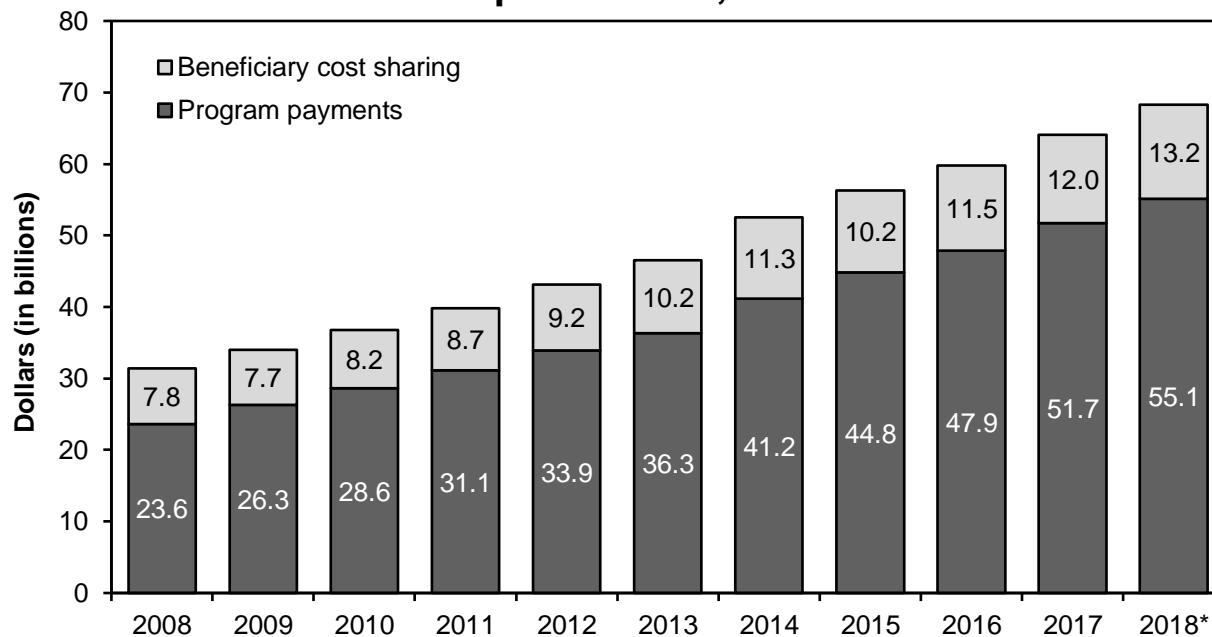
| Practitioner type | Number of visits (in millions) | | | | | | | | Percent change, 2010–2017 |
|------------------------|--------------------------------|------|------|------|------|------|------|------|---------------------------|
| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | |
| APRN or PA | 11 | 13 | 15 | 18 | 20 | 24 | 28 | 31 | 184% |
| Primary care physician | 97 | 95 | 93 | 91 | 88 | 86 | 84 | 81 | –16 |
| Specialist | 133 | 134 | 136 | 142 | 140 | 141 | 143 | 141 | 6 |
| Total | 241 | 242 | 244 | 251 | 249 | 251 | 255 | 253 | 5 |

Note: E&M (evaluation and management), APRN (advanced practice registered nurse), PA (physician assistant). E&M office visits include HCPCS codes 99201–99205 and 99211–99215. The primary care physician category includes internal medicine, family medicine, pediatric medicine, geriatric medicine, and (in 2017) hospitalists. Many physicians who previously billed under the internal medicine specialty began billing as hospitalists when Medicare introduced a hospitalist specialty code in April 2017. The change does not affect these results because hospitalists billed relatively few E&M office visits in 2017. The specialist category is defined as not being a primary care physician, APRN, or PA. Numbers may not sum to total due to rounding. These figures do not account for “incident to” billing.

Source: MedPAC analysis of the Physician/Supplier Procedure Summary file.

- From 2010 to 2017, the number of E&M office visits billed by APRNs and PAs increased from 11 million to 31 million, an increase of 184 percent.
- Over the same period, the number of E&M office visits billed by primary care physicians decreased by 16 percent; the number billed by specialists increased by 6 percent.
- The rapid increase in E&M office visits billed by APRNs and PAs underscores the growing role APRNs and PAs play in providing care to Medicare beneficiaries.

Chart 7-9. Spending on hospital outpatient services covered under the outpatient PPS, 2008–2018



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, except those packaged into payment bundles.
*Estimated figures.

Source: CMS, Office of the Actuary.

- The Office of the Actuary estimates that spending under the outpatient PPS was \$68.3 billion in 2018 (\$55.1 billion in program spending, \$13.2 billion in beneficiary copayments). We estimate that the outpatient PPS accounted for about 7 percent of total Medicare program spending in 2018.
- Overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS from calendar years 2008 to 2018 increased by 117 percent, an average of 8.1 percent per year. The Office of the Actuary projects continued growth in total spending, averaging 10.0 percent per year from 2018 to 2020.
- Beneficiary cost sharing under the outpatient PPS includes the Part B deductible and coinsurance for each service. Under the outpatient PPS, beneficiary cost sharing was about 19 percent in 2018.

Chart 7-10. Most hospitals provide outpatient services

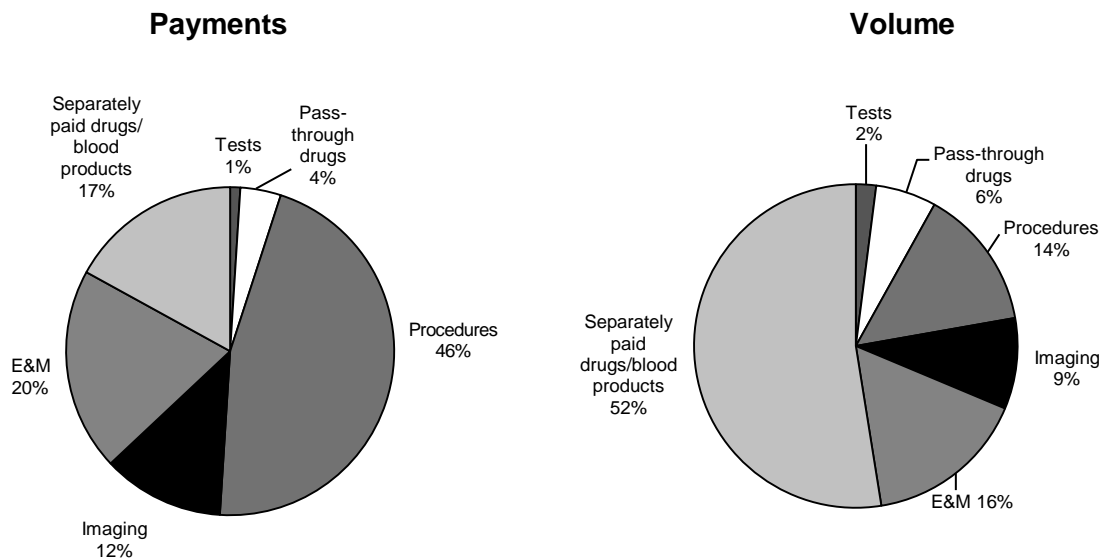
| Year | Acute care hospitals | Share offering | | |
|------|----------------------|---------------------|--------------------|--------------------|
| | | Outpatient services | Outpatient surgery | Emergency services |
| 2008 | 3,607 | 94 | 87 | N/A |
| 2010 | 3,518 | 95 | 90 | N/A |
| 2012 | 3,483 | 95 | 91 | 93% |
| 2014 | 3,429 | 96 | 92 | 93 |
| 2016 | 3,370 | 96 | 93 | 93 |
| 2017 | 3,346 | 96 | 93 | 92 |
| 2018 | 3,301 | 96 | 93 | 90 |

Note: N/A (not applicable). We list emergency services from 2008 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 share 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 acute care 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 2008, from 3,607 in 2008 to 3,301 in 2018.
- The share of hospitals providing outpatient services remained stable, and the share offering outpatient surgery steadily increased from 2008 through 2014 and has remained stable since then. The share offering emergency services declined slightly from 2016 to 2018.

Chart 7-11. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2017



Note: PPS (prospective payment system), E&M (evaluation and management). “Payments” include both program spending and beneficiary cost sharing. We grouped services into the following categories, according to the Berenson-Eggers Type of Service codes developed by CMS: evaluation and management, procedures, imaging, and tests. “Pass-through drugs” and “separately paid drugs/blood products” are classified by their payment status indicator.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2017.

- 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 2017, procedures accounted for 46 percent of payments but only 14 percent of volume.
- Procedures (e.g., endoscopies, surgeries, and skin and musculoskeletal procedures) accounted for the greatest share of payments for services (46 percent) in 2017, followed by evaluation and management services (20 percent), separately paid drugs and blood products (17 percent), and imaging services (12 percent).
- Payments for pass-through drugs increased substantially from 2016 to 2017, from 2 percent of all payments in 2016 (data not shown) to 4 percent of all payments in 2017. Pass-through drugs are new drugs that have been approved by the FDA; were not paid under Medicare’s hospital outpatient payment system before January 1, 1997; and have been determined to have costs that are not insignificant in relation to the outpatient PPS payment rate for the applicable service. Statute allows drugs to have pass-through status for two to three years.

Chart 7-12. Hospital outpatient services with the highest Medicare expenditures, 2017

| APC title | Share of payments | Volume (thousands) | Payment rate |
|---|-------------------|--------------------|--------------|
| Total | 54% | | |
| All emergency visits | 7 | 13,470 | \$309 |
| Clinic visits | 6 | 31,737 | 107 |
| Comprehensive observation services | 6 | 1,456 | 2,223 |
| Level 3 endovascular procedures | 3 | 203 | 9,752 |
| Level 2 ICD and similar procedures | 2 | 44 | 30,527 |
| Level 3 drug administration | 2 | 6,638 | 180 |
| Level 4 musculoskeletal procedures | 2 | 218 | 5,222 |
| Level 1 endovascular procedures | 2 | 387 | 2,834 |
| Level 3 electrophysiologic procedures | 2 | 61 | 16,785 |
| Level 2 imaging without contrast | 2 | 8,404 | 113 |
| Level 3 radiation therapy | 1 | 1,755 | 495 |
| Level 1 intraocular lens procedures | 1 | 476 | 1,824 |
| Level 4 imaging without contrast | 1 | 1,855 | 450 |
| Level 3 nuclear medicine and related services | 1 | 725 | 1,139 |
| Level 3 imaging without contrast | 1 | 3,557 | 226 |
| Level 1 laparoscopy and related procedures | 1 | 192 | 4,119 |
| Level 2 lower GI procedures | 1 | 973 | 878 |
| Level 3 pacemaker and similar procedures | 1 | 79 | 9,414 |
| Level 4 endovascular procedures | 1 | 53 | 14,782 |
| Level 5 urology and related services | 1 | 193 | 3,484 |
| Level 4 drug administration | 1 | 2,193 | 279 |
| Level 1 imaging with contrast | 1 | 2,325 | 265 |
| Level 1 upper GI procedures | 1 | 955 | 700 |
| Level 2 vascular procedures | 1 | 247 | 2,361 |
| Level 1 imaging without contrast | 1 | 9,427,678 | 60 |
| Level 2 excision/biopsy/incision and drainage | 1 | 442,335 | 1,237 |
| Level 4 nuclear medicine and related services | 1 | 396 | 1,322 |
| Average APC | | 579 | 166 |

Note: APC (ambulatory payment classification), ICD (implantable cardioverter-defibrillator), GI (gastrointestinal). The payment rate for “all emergency visits” is a weighted average of payment rates for 10 emergency visit APCs (not listed on this chart). The shares of payments for the 27 APC categories do not add to the total share of payments (54 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 2017.

- 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 7-13. Off-campus provider-based departments provided a mix of services different from on-campus outpatient departments, 2017

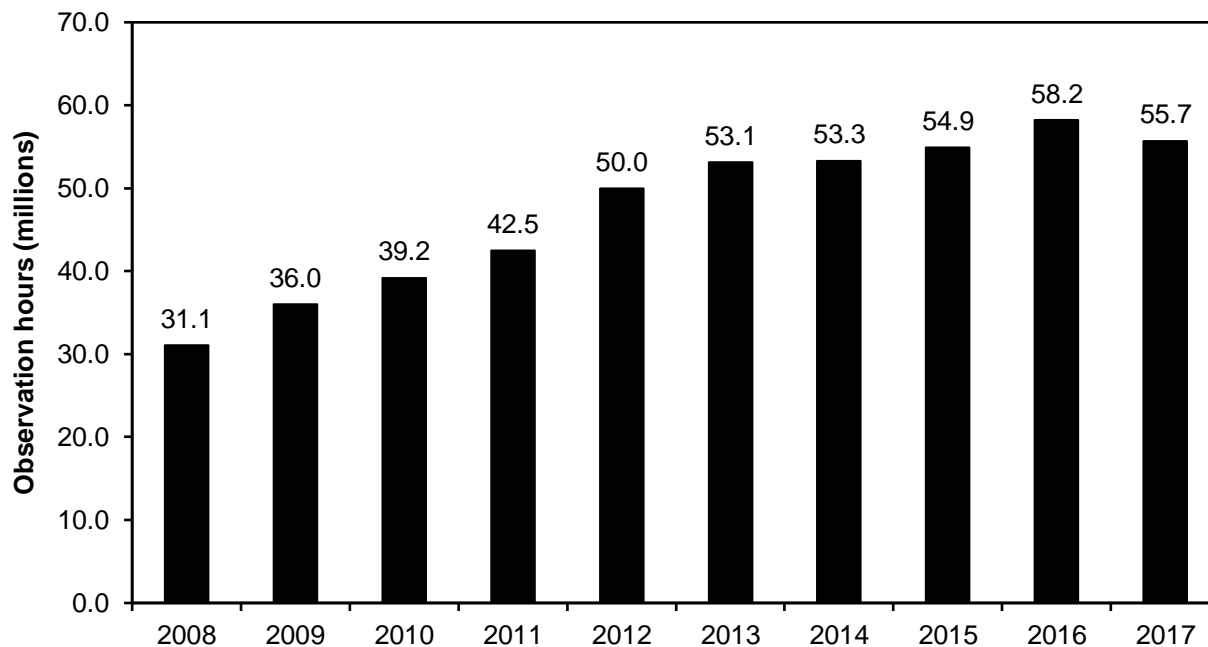
| Off-campus PBDs | | On-campus outpatient departments | |
|----------------------------------|-----------------------|---------------------------------------|-----------------------|
| APC | Share of OPPS revenue | APC | Share of OPPS revenue |
| Clinic visits | 18.0% | Observation services | 6.0% |
| Level 4 drug administration | 2.5 | Clinic visits | 4.4 |
| Level 4 imaging without contrast | 2.2 | Level 3 endovascular procedures | 3.6 |
| Level 3 radiation therapy | 2.2 | Level 4 ED visits | 3.1 |
| Level 3 nuclear medicine | 2.1 | Level 5 ED visits | 2.9 |
| Level 2 imaging without contrast | 2.0 | Level 2 ICD procedures | 2.5 |
| Level 3 imaging without contrast | 1.6 | Level 3 drug administration | 2.1 |
| Level 1 intraocular procedures | 1.3 | Level 4 musculoskeletal procedures | 2.0 |
| Level 4 nuclear medicine | 1.2 | Level 1 endovascular procedures | 2.0 |
| Level 2 skin procedures | 1.2 | Level 3 electrophysiologic procedures | 1.9 |

Note: PBD (provider-based department), APC (ambulatory payment classification), OPPS (outpatient prospective payment system), ED (emergency department), ICD (implantable cardioverter-defibrillator), GI (gastrointestinal).

Source: MedPAC analysis of hospital outpatient standard analytic claims files from 2017.

- PBDs of hospitals provide a mix of services that is different from the mix provided in on-campus outpatient departments. In 2017, only 1 of the 10 APCs that had the highest Medicare revenue in off-campus PBDs was also 1 of the 10 highest Medicare revenue APCs in on-campus outpatient departments (clinic visits).
- The services that have the highest Medicare revenue in off-campus PBDs are clinic visits, imaging without contrast, and drug administration. The services that have the highest Medicare revenue in on-campus outpatient departments, however, are observation care, clinic visits, ED visits, and relatively complex procedures such as endovascular procedures and implanting cardioverter-defibrillators. On average, services provided in off-campus PBDs are much less complex than services provided in on-campus outpatient departments. In 2017, the average relative weight was 2.18 for services provided in off-campus PBDs and 5.00 for services provided in on-campus outpatient departments (data not shown).
- Cancer treatment is a predominant source of Medicare revenue in off-campus PBDs, as Level 4 drug administration—which includes chemotherapy administration—and Level 3 radiation therapy are among the largest sources of Medicare revenue in that setting. Additionally, 32.6 percent of the Medicare revenue in off-campus PBDs is from drugs used in cancer treatment, primarily chemotherapy drugs.

Chart 7-14. Number of hospital outpatient observation hours declined in 2017 after nearly a decade of steady increases



Source: MedPAC analysis of Limited Data Set claims for the outpatient prospective payment system 2008–2017.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.
- On April 1, 2002, Medicare began providing separate payments to hospitals for some observation services. Previously, the observation services were packaged into the payments for the emergency department or clinic visits that occurred with observation care.
- The number of hospital outpatient observation hours (both packaged and separately paid) has increased substantially, from about 31 million in 2008 to more than 58 million in 2016, but decreased to about 56 million in 2017. The decrease from 2016 to 2017 is reflective of a decrease in the number of observation stays of long duration (more than 48 hours), which is consistent with an increase over the same period in the number of short inpatient stays.

Chart 7-15. Number of Medicare-certified ASCs increased by 9 percent, 2011–2017

| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|-------|-------|-------|-------|-------|-------|-------|
| Medicare payments (billions of dollars) | \$3.4 | \$3.6 | \$3.7 | \$3.8 | \$4.1 | \$4.3 | \$4.6 |
| New centers (during year) | 195 | 176 | 177 | 187 | 167 | 159 | 189 |
| Closed or merged centers (during year) | 127 | 114 | 117 | 119 | 106 | 90 | 60 |
| Net total number of centers (end of year) | 5,154 | 5,216 | 5,276 | 5,344 | 5,405 | 5,474 | 5,603 |
| Net percent growth in number of centers | 1.5% | 1.2% | 1.2% | 1.3% | 1.1% | 1.3% | 2.4% |
| Share of all centers that are: | | | | | | | |
| For profit | 94 | 94 | 94 | 94 | 94 | 94 | 94 |
| Nonprofit | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Government | 3 | 3 | 3 | 3 | 3 | 2 | 2 |
| Urban | 92 | 93 | 93 | 93 | 93 | 93 | 93 |
| Rural | 8 | 7 | 7 | 7 | 7 | 7 | 7 |

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Some figures do not match to Chart 7-16 in our 2018 Databook because CMS updated our source file, the Provider of Services file. Some totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS 2017. Payment data are from CMS, Office of the Actuary.

- ASCs are distinct entities that furnish ambulatory surgical services not requiring an overnight stay in a hospital. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.
- Total Medicare payments per fee-for-service (FFS) Medicare beneficiary for ASC services increased by approximately 4 percent per year, on average, from 2011 through 2017 (data not shown). Payments per FFS beneficiary that was served in an ASC grew by 5.3 percent per year during this period. From 2016 to 2017, total payments rose by 7.4 percent, and payments per beneficiary grew by 7.7 percent (per beneficiary data not shown).
- The number of Medicare-certified ASCs grew at an average annual rate of 1.4 percent from 2011 through 2017. From 2011 through 2017, an average of 179 new facilities entered the market, while an average of 105 closed or merged with other facilities.
- Compared with earlier years (not shown), the number of ASCs grew slowly from 2011 through 2017. The slower growth 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.

