

CHAPTER

5

**Ambulatory surgical
center services**

R E C O M M E N D A T I O N

- 5** The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Ambulatory surgical center services

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures to patients who do not require an overnight stay after the procedure. In 2013, 5,364 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries, and Medicare program and beneficiary spending on ASC services was \$3.7 billion.

Assessment of payment adequacy

Our analysis indicates that beneficiaries' access to ASC services is adequate: The available indicators of payment adequacy for ASC services, discussed below, are positive. However, our analysis also indicates slower growth in the number of ASCs and volume of services in 2013 than in previous years.

Beneficiaries' access to care—Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC services has generally been adequate.

- **Capacity and supply of providers**—From 2008 through 2012, the number of Medicare-certified ASCs grew by an average annual rate of 1.7 percent; in 2013, the number increased by 1.1 percent (the vast majority of new ASCs were for profit). The relatively slow growth may be related to the higher Medicare payment rates for most ambulatory procedures in hospital outpatient departments (HOPDs) than in ASCs; for 2015, the Medicare rates are 82 percent higher in HOPDs than in

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ASCs. This payment difference may help explain why several hospitals have recently expanded their outpatient surgery capacity. In addition, physicians have increasingly been selling their practices to hospitals, and these physicians are more likely to perform procedures at the hospitals that employ them than at freestanding ASCs.

- **Volume of services**—From 2008 through 2012, the volume of services per FFS beneficiary grew by an average annual rate of 2.1 percent; in 2013, volume increased by 0.5 percent.

Quality of care—ASCs began submitting data on quality measures to CMS in October 2012, and CMS’s contractor released preliminary data for 2013. However, there is not yet sufficient information to assess ASC quality or the change in quality over time.

Providers’ access to capital—Because the number of ASCs has continued to increase, access to capital appears to be adequate.

Medicare payments and providers’ costs—From 2008 through 2012, Medicare payments per FFS beneficiary increased by an average of 3.4 percent per year and by 2.0 percent in 2013. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to assist in assessing payment adequacy.

On the basis of these indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2016. In addition, it is vital that CMS begin collecting cost data from ASCs without further delay. ■

Background

An ambulatory surgical center (ASC) is a distinct entity that primarily provides outpatient procedures to patients who do not require an overnight stay after the procedure. In addition to ASCs, hospital outpatient departments (HOPDs) and, in some cases, physicians' offices perform outpatient surgical procedures.

Since 1982, Medicare has covered and paid for surgical procedures provided in ASCs. Medicare covers about 3,400 procedures under the ASC payment system. Physicians who perform procedures in ASCs or other facilities receive a separate payment for their professional services under the payment system for physicians and other health professionals, also known as the physician fee schedule (PFS). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2008, Medical Group Management Association 2009b).¹ Physicians who perform surgeries in ASCs they own receive a share of the ASC's facility payment in addition to payment for their professional services. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify standards for administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, and nursing services.

Medicare pays for a bundle of facility services provided by ASCs—such as nursing, recovery care, anesthetics, and supplies—through a system that is primarily linked to the outpatient prospective payment system (OPPS), which Medicare uses to set payment rates for most services provided in HOPDs (a more detailed description of the ASC payment system can be found online at <http://medpac.gov/documents/payment-basics/ambulatory-surgical-center-services-payment-system-14.pdf?sfvrsn=0>). The ASC payment system is also partially linked to the PFS. The ASC system underwent substantial revisions in 2008 (see online Appendix A from Chapter 2C of our March 2010 report to the Congress at http://medpac.gov/documents/reports/Mar10_Ch02C_Appendix.pdf?sfvrsn=9). The most significant changes included a substantial increase in the number of surgical procedures covered, allowing ASCs to bill separately for certain ancillary services, and large changes in payment rates for many procedures.

For most covered procedures, the ASC relative weight, which indicates the relative resource intensity of the

procedure, is based on its relative weight under the OPPS, consistent with a previous Commission recommendation (Medicare Payment Advisory Commission 2004). Although the ASC payment system is linked to the OPPS, payment rates for all services covered under both systems are lower in ASCs for two reasons. First, the relative weights have been lower in the ASC system. CMS makes proportional adjustments to the relative weights from the OPPS to maintain budget neutrality in the ASC system. In 2015, this adjustment reduces the ASC relative weights by 7.8 percent below the relative weights in the OPPS (i.e., the ASC relative weights for these services are 7.8 percent lower than the corresponding OPPS relative weights). Second, for most procedures covered under the ASC system, the payment rate is the product of its relative weight and a conversion factor, set at \$44.07 in 2015, which is lower than the OPPS conversion factor (\$74.14 in 2015).

The ASC conversion factor is lower for two reasons. First, CMS set the initial ASC conversion factor for 2008 so that total ASC payments under the revised payment system would equal what they would have been under the previous payment system.² By comparison, the initial OPPS conversion factor was based on total payments for hospital outpatient services in 2000. Second, CMS updates the ASC conversion factor based on the consumer price index for all urban consumers (CPI-U), whereas it uses the hospital market basket as the basis for updating the OPPS conversion factor. We are concerned that the CPI-U may not reflect ASCs' cost structure (see text box discussing the ASC market basket, pp. 128–129). However, CMS does not collect ASC cost data that could be used to examine whether an alternative input price index would be an appropriate proxy for ASC costs. The ASC industry has opposed the collection of cost information for this purpose (Ambulatory Surgery Center Association 2012). Nevertheless, the Commission has recommended that CMS collect cost data from ASCs to identify an alternative price index (Medicare Payment Advisory Commission 2010b).

CMS uses a method different from the method described above to determine payment rates for procedures that are predominantly performed in physicians' offices and were first covered under the ASC payment system in 2008 or later (under the method described above—the standard ASC method—ASC rates are based on OPPS relative weights). Payment for these “office-based” procedures is the lesser of the amount derived from the standard ASC method or the practice expense portion of the PFS rate that applies when the service is provided 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 rate for certain office-based procedures to prevent migration of these services from physicians' offices to ASCs for financial reasons.³ The Commission has been investigating payment rate differences across multiple ambulatory settings, including ASCs, HOPDs, and physicians' offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013a, Medicare Payment Advisory Commission 2012).

The ASC payment system generally parallels the OPPS in terms of which ancillary services are paid separately and which are packaged into the payment of the associated surgical procedure. In 2015, however, CMS has implemented comprehensive ambulatory payment classifications (C-APCs) for the OPPS but not for the ASC system. C-APCs will largely combine into a single payment all hospital services reported on a claim that are covered under Medicare Part B, with a few exceptions. CMS chose not to implement C-APCs in the ASC system because the ASC claims processing system does not allow for the type of packaging of ancillaries necessary for creating C-APCs.

Starting in 2008, Medicare began making separate payments to ASCs for the following ancillary services:

- radiology 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 pass-through and non-pass-through drugs that are paid for separately under the OPPS when provided as part of a covered surgical procedure; and
- devices with pass-through status under the OPPS.⁴

The Medicare program and beneficiaries pay less for services provided in ASCs than in HOPDs, and evidence suggests that ASCs' internal costs are, on average, lower than HOPDs'. However, we do not have recent ASC cost data that would allow us to quantify cost differences between settings. The Government Accountability Office (GAO) compared ASC cost data from 2004 with HOPD costs and found that provider costs were, on average, lower in ASCs than in HOPDs (Government Accountability Office 2006).⁵ In addition, a study that used data from the

National Survey of Ambulatory Surgery found that the average time for ambulatory surgical visits for Medicare patients was 39 percent lower in ASCs than HOPDs (83 minutes vs. 135 minutes), which could contribute to lower costs in ASCs (Hair et al. 2012).⁶ Average times were also lower in ASCs than HOPDs for specific procedures, such as those involving the digestive system and nervous system. The authors of the study were unable to estimate the extent to which shorter average times in the ASC were due to a healthier mix of patients in ASCs or greater efficiency relative to HOPDs (Hair et al. 2012).

Are Medicare payments adequate in 2015?

To address whether payments for the current year (2015) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2016), we examine several measures of payment adequacy. We assess beneficiaries' access to care by examining the supply of ASC facilities and changes over time in the volume of services provided, providers' access to capital, and changes in ASC revenue from the Medicare program. ASCs began submitting quality data to CMS in October 2012, and CMS's contractor released preliminary data for 2013. However, there is not yet sufficient information to assess ASC quality or the change in quality over time. Moreover, we cannot examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.⁷ Finally, we caution that the effect of Medicare payments on the financial health of ASCs is limited because Medicare accounts for a minority of ASC revenue. According to the Medical Group Management Association's most recent national survey of ASCs, Medicare's share of overall ASC revenue was about 17 percent in 2008 (Medical Group Management Association 2009b).⁸ This share may vary regionally; for example, Medicare accounted for 24 percent of revenue for ASCs in Pennsylvania in 2013 (Pennsylvania Health Care Cost Containment Council 2014).

Our available indicators of payment adequacy are positive. Beneficiaries have adequate access to care in ASCs, although some groups of beneficiaries—such as dual eligibles, African Americans, and beneficiaries under age 65—are less likely to receive care in ASCs than in HOPDs (see text box). In addition, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow.

Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments

There is evidence that patients treated in ambulatory surgical centers (ASCs) are different in several ways from those treated in hospital outpatient departments (HOPDs). Our analysis of Medicare claims from 2013 found that the following groups are less likely to receive care in ASCs than in HOPDs: Medicare beneficiaries who also have Medicaid coverage (dual eligibles), African Americans (who are more likely to be dually eligible), beneficiaries who are eligible for Medicare because of disability (under age 65), and beneficiaries who are age 85 or older (Table 5-1).⁹ The smaller share of disabled and older beneficiaries treated in ASCs may reflect the healthier average profile of ASC patients relative to HOPD patients. In addition, the smaller share of African American patients in ASCs relative to HOPDs may be linked to differences in the geographic locations of ASCs and hospitals, the lower rate of supplemental coverage among African Americans, the higher proportion of African Americans who are dual eligibles, and the relatively high percentage of African Americans who use HOPDs or emergency departments (EDs) as their usual source of care (Centers for Medicare & Medicaid Services 2014a).

(continued next page)

TABLE 5-1

Medicare patients treated in ASCs differ from patients treated in HOPDs, 2013

Characteristic	Percent of beneficiaries	
	ASC	HOPD
Medicaid status		
Not Medicaid	86.2%	77.0%
Medicaid	13.8	23.0
Race/ethnicity		
White	87.4	83.6
African American	6.9	10.3
Other	5.7	6.0
Age		
Under 65	14.7	22.2
65 to 84	78.7	67.2
85 or older	6.6	10.6
Sex		
Male	42.5	44.4
Female	57.5	55.6

Note: ASC (ambulatory surgical center), HOPD (hospital outpatient department). All of the differences between ASC and HOPD beneficiaries are statistically significant ($p < 0.05$). The analysis excludes beneficiaries who received services that are not covered in the ASC payment system.

Source: MedPAC analysis of physician/supplier and outpatient standard analytic files, 2013.

Beneficiaries' access to care: Supply of ASCs and volume growth indicate adequate access

Increases in the number of Medicare-certified facilities and volume of services provided to Medicare beneficiaries suggest that beneficiaries have adequate access to care in ASCs. This growth may be beneficial to patients and physicians because ASCs can offer them greater convenience and efficiency compared with HOPDs, the provider type most similar to ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs; for physicians,

ASCs offer more control over their work environment and specialized staff. In addition, Medicare's payment rates and beneficiaries' cost sharing are generally lower in ASCs than in HOPDs. However, the growth of ASCs may lead to an increase in the overall volume of surgical procedures (see discussion on pp. 124–125).

Capacity and supply of providers: Number of ASCs has increased, but growth has slowed

Between 2008 and 2012, the number of Medicare-certified ASCs increased by an average annual rate of 1.7 percent,

Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments (cont.)

In a separate analysis, we found that patients treated in HOPDs in 2010 were, on average, more medically complex than patients treated in ASCs, as measured by differences in average patient risk scores (Medicare Payment Advisory Commission 2013b). We used risk scores from the CMS–hierarchical condition categories (CMS–HCC) risk adjustment model used in Medicare Advantage to measure patient severity.¹⁰ CMS–HCC risk scores predict beneficiaries’ relative costliness based on their diagnoses from the prior year and their demographic information (e.g., age and sex). Beneficiaries of average health status have a risk score of about 1.0. The average risk score for HOPD patients across all procedures in 2010 was 1.64 compared with 1.23 for ASC patients; this difference is statistically significant ($p < 0.05$). Beneficiaries who have higher risk scores are likely to be sicker and may require more time and resources to treat. Sicker patients may be referred to HOPDs instead of ASCs because hospitals offer emergency services and access to onsite specialists if complications arise.

We also compared average patient risk scores within each ambulatory payment classification (APC) group, which is a group of similar services. For 46 percent of the APCs in our analysis (representing 30 percent of ASC volume), the average HOPD risk score was significantly higher than the average ASC risk score ($p < 0.05$). However, for the remaining 54 percent of APCs (representing 70 percent of ASC volume), the severity of patients in HOPDs was similar to or less than the severity of patients in ASCs.

There is evidence that ASCs treat fewer Medicaid patients than do HOPDs. According to data from Pennsylvania on Medicare and non-Medicare patients, ASCs are less likely than HOPDs to serve Medicaid patients (Pennsylvania Health Care Cost Containment Council 2014). In Pennsylvania in 2013, Medicaid patients accounted for 5.2 percent of ASCs’ diagnostic and surgical procedures compared with 11.8 percent of HOPDs’ procedures.¹¹ Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (87.0 percent vs.

78.2 percent). Although Pennsylvania data may not be nationally representative, national estimates from the National Survey of Ambulatory Surgery (NSAS), conducted by the Centers for Disease Control and Prevention, show that ASCs treated a smaller share of Medicaid patients than hospitals did in 2006. According to the NSAS data, ambulatory surgery visits by Medicaid patients accounted for 3.9 percent of total visits to freestanding ASCs compared with 8.1 percent of total visits to hospital-based surgery centers.¹²

Several factors could explain why ASCs treat a smaller share of Medicaid patients (including dual eligibles) than HOPDs do. A study by Gabel and colleagues suggests that insurance coverage influences a physician’s decision to refer a patient to an ASC or to a hospital (Gabel et al. 2008). This study found that physicians in Pennsylvania were much more likely to refer their commercially insured and Medicare patients than their Medicaid patients to a physician-owned ASC. The location of ASCs may also lead to a smaller share of Medicaid patients; for example, ASC owners may choose to locate in areas with a high proportion of commercially insured patients. In addition, many state Medicaid programs do not pay Medicare’s cost sharing for dual eligibles if the Medicare rate for a service minus the cost sharing is higher than the Medicaid rate for the service (Medicare Payment Advisory Commission 2010a). In states that do not pay the cost sharing for ASC services used by dual eligibles, ASCs could be discouraged from treating these patients. Finally, dual-eligible beneficiaries are more likely to report that their usual source of care is an HOPD or ED than are Medicare beneficiaries who have other types of supplemental coverage (Centers for Medicare & Medicaid Services 2014a). If a patient’s usual source of care is an HOPD or ED, physicians may be more likely to refer the patient to an HOPD for surgery than to another setting. The relatively low rate of ASC use among dual-eligible beneficiaries may partly explain the relatively low rate of ASC use among African Americans (Table 5-1, p. 119). ■

**TABLE
5-2**

Number of Medicare-certified ASCs grew by 8 percent, 2008-2013

	2008	2009	2010	2011	2012	2013
Number of centers	4,955	5,064	5,152	5,228	5,307	5,364
New centers	280	220	193	190	165	108
Closed or merged centers	81	111	105	114	86	51
Net percent growth in number of centers from previous year	4.2%	2.2%	1.7%	1.5%	1.5%	1.1%

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2013.

but the growth rate slowed to 1.1 percent in 2013 (Table 5-2). In 2013, 108 ASCs entered the market while 51 closed or merged with other facilities; 91 percent of the new ASCs were for profit, 5 percent were nonprofit, and 5 percent were government owned.¹³ The slower growth appears to have continued into 2014: The number of ASCs increased by 0.9 percent to 5,414 during the first three quarters of 2014 (an annual growth rate of 1.2 percent).

Several factors might explain the relatively slow growth of ASCs from 2009 through the first three quarters of 2014:

- National health care spending and total Medicare spending have grown very slowly since 2010 (see Chapter 1).
- The ASC payment system underwent a substantial revision in 2008, and investors may have responded cautiously to the large changes in payment rates that occurred under that revision.
- Many hospitals have been expanding their outpatient surgery capacity by acquiring ASCs and integrating them into the hospital or developing new surgery centers that are part of the hospital, which limits the market for new freestanding ASCs (Hirst 2010, Jacobson 2014, Kochman 2014, Levingston 2014, Moody 2014, North Carolina Department of Health and Human Services 2011, Sowa 2014, State of Connecticut 2011). Hospitals' decisions to increase their outpatient surgery capacity may be influenced by the higher rates Medicare pays for ambulatory surgical services provided in HOPDs relative to those in ASCs (in 2015, the Medicare rates are 82 percent higher in HOPDs than in ASCs).

- Physicians are increasingly choosing to be employed by hospitals rather than work in an independent practice (Berenson et al. 2012, Mathews 2012, Medicare Payment Advisory Commission 2013a). These physicians are more likely to provide ambulatory procedures in the hospitals that employ them than in freestanding ASCs.

To provide a more complete picture of capacity in ASCs, we also examined the change in the number of ASC operating rooms. From 2008 through 2013, the total number of ASC operating rooms increased at almost the same rate as the number of ASCs (1.4 percent per year vs. 1.6 percent per year). The mean number of operating rooms per ASC (2.9) and the median number of operating rooms per ASC (2.0) did not change during this period.

ASCs are concentrated geographically. In 2013, Maryland had the most ASCs per Part B fee-for-service (FFS) beneficiary, followed by Georgia and Idaho; each state had at least 30 ASCs per 100,000 Part B FFS beneficiaries. Vermont had the fewest ASCs per FFS beneficiary, followed by West Virginia and the District of Columbia, each of which had fewer than 5 per 100,000 FFS beneficiaries.¹⁴ In addition, in 2013, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time (Table 5-3, p. 122). Urban areas include both cities and suburban areas; it is possible that more ASCs are located in suburban areas than in cities.

Beneficiaries who do not live near an ASC can obtain ambulatory surgical services in HOPDs and, in some cases, physicians' offices. In addition, beneficiaries who live in rural areas may travel to urban areas to receive care in ASCs.

**TABLE
5-3**

Most Medicare-certified ASCs are urban and for profit

ASC type	2008	2013
Urban	91%	91%
Rural	9	9
For profit	96	96
Nonprofit	4	3

Note: ASC (ambulatory surgical center). In 2013, 1 percent of ASCs were government owned.

Source: MedPAC analysis of Provider of Services file from CMS, 2013.

Continued growth in the number of Medicare-certified ASCs suggests that Medicare’s payment rates have been adequate. Other factors have also likely influenced the long-term growth in the number of Medicare-certified ASCs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings.
- ASCs may offer patients greater convenience than HOPDs (e.g., the ability to schedule surgery more quickly).
- For most procedures covered under the ASC payment system, beneficiaries’ coinsurance is lower in ASCs than in HOPDs.¹⁵
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff.

- Physicians who invest in ASCs and perform surgery there can increase their revenue by receiving a share of ASC facility payments. The federal anti-self-referral law (also known as the Stark Law) does not apply to services that are part of the ASC bundled payment rate (42 CFR § 411.351).¹⁶
- Because physicians can probably perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more professional fees.

Number of beneficiaries treated and volume of services grew from 2008 to 2013

We examined growth in the number of FFS beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary. Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries who have Part B coverage. From 2008 through 2012, the number of FFS beneficiaries who received ASC services grew by an average of 1.2 percent per year and by 0.7 percent in 2013 (data not shown). From 2008 through 2012, the volume of services per FFS beneficiary increased by an average of 2.1 percent per year and by 0.5 percent in 2013 (Table 5-4).

The services that have historically contributed the most to overall volume continued to constitute a large share of the total in 2013. For example, we evaluated Healthcare Common Procedure Coding System (HCPCS) codes and found that cataract removal with intraocular lens insertion (HCPCS 66984) had the highest volume in both 2008 and 2013, accounting for 18 percent of volume in 2008 and 17 percent in 2013. Also, upper gastrointestinal procedure with biopsy (HCPCS 43239) had the second highest volume in both 2008 and 2013. Moreover, 19 of the 20

**TABLE
5-4**

Volume of ASC services per FFS beneficiary has continued to grow

	2008	2009	2010	2011	2012	2013
Volume of services (in millions)	6.1	6.3	6.5	6.7	6.9	6.9
Volume per 1,000 FFS beneficiaries	192.4	199.3	202.6	206.1	209.2	210.3
Percent change per FFS beneficiary from previous year	5.0%*	3.6%	1.7%	1.7%	1.5%	0.5%

Note: ASC (ambulatory surgical center), FFS (fee-for-service).

*Comparison of volume from 2007 to 2008 is restricted to services covered in 2007 because of the substantial change in the services covered in the ASC payment system in 2008.

Source: MedPAC analysis of physician/supplier standard analytic files, 2007–2013.

**TABLE
5-5**

Most frequently provided ASC services in 2013 were similar to those provided in 2008

Surgical service	2008		2013	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	18.2%	1	17.0%	1
Upper GI endoscopy, biopsy	7.9	2	7.8	2
Colonoscopy and biopsy	5.5	3	6.0	3
Diagnostic colonoscopy	5.1	4	2.6	9
After cataract laser surgery	4.6	5	4.0	5
Lesion removal colonoscopy	4.6	6	4.6	4
Injection spine: lumbar, sacral (caudal)	3.7	7	3.2	8
Inject foramen epidural: lumbar, sacral	3.3	8	3.9	6
Injection paravertebral: lumbar, sacral add on*	2.8	9	3.4	7
Injection paravertebral: lumbar, sacral*	1.9	10	2.4	10
Injection foramen epidural add on	1.8	11	2.0	11
Colorectal screen, high-risk individual	1.5	12	1.9	12
Lesion remove colonoscopy	1.5	13	0.8	22
Colorectal screen, not high-risk individual	1.5	14	1.7	13
Upper GI endoscopy, diagnosis	1.4	15	1.1	18
Destruction paravertebral nerve, add on**	1.3	16	1.4	15
Cystoscopy	1.2	17	1.1	17
Cataract surgery, complex	1.1	18	1.4	14
Revision of upper eyelid	1.0	19	0.9	20
Injection spine, cervical or thoracic, add on	0.9	20	1.1	16
Total	70.6		68.3	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal). The numbers listed in the percent of volume column for 2008 do not sum to the total of 70.6 because of rounding.

*The description of these services changed in 2010 to include imaging guidance.

**The description of this service changed in 2012 to include imaging guidance.

Source: MedPAC analysis of physician/supplier standard analytic files, 2008 and 2013.

most frequently provided HCPCS codes in 2008 were among the 20 most frequently provided in 2013 (Table 5-5). These services comprised about 71 percent of ASC Medicare volume in 2008 and about 68 percent in 2013, and volume per FFS beneficiary increased by an average of 1.1 percent per year from 2008 through 2013.

Services that were outside the 20 most frequently provided HCPCS codes comprised 29 percent of total ASC volume in 2008 and 32 percent in 2013. We organized the HCPCS codes for these services into service categories that are broader than the HCPCS codes listed in Table 5-5 and found that eye procedures, nerve injections (for pain management), arthroscopy, and skin

repair had the highest volume. These four categories comprised 13 percent of total ASC volume in 2008 and 15 percent in 2013.

Outpatient surgical procedures have been growing faster in HOPDs than ASCs

In previous reports, we indicated that growth in outpatient surgical volume was higher in ASCs than in HOPDs, which suggests that surgical services were migrating from HOPDs to ASCs (Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010b, Medicare Payment Advisory Commission 2009). However, in recent years, the growth

in ASC volume appears to have slowed and the growth in HOPD volume appears to have picked up. For example, from 2012 to 2013, volume per FFS beneficiary increased by 0.5 percent in ASCs compared with 3.1 percent in HOPDs.

Some may think that the higher growth rate in HOPDs suggests that services have shifted from ASCs to HOPDs. However, the data do not support that viewpoint. We examined whether a shift in setting occurred among the 31 most frequently provided ASC services, which account for about 75 percent of ASC surgical volume. If a shift had occurred from ASCs to HOPDs, the share of the combined ASC and HOPD volume for these 31 services provided in HOPDs should have increased, but it did not. The share of these services provided in HOPDs stayed fairly constant: 44.9 percent in 2011, 43.3 percent in 2012, and 43.3 percent in 2013.¹⁷ Much of the increase in HOPD surgical volume from 2012 to 2013 occurred among services that are rarely provided in ASCs.

Other evidence also shows that there has not been a shift of surgical services from ASCs to HOPDs. The growth in surgical volume in HOPDs was inconsistent from 2008 through 2013. For example, surgical volume in HOPDs declined by 0.7 percent in 2012 and then increased by 3.1 percent in 2013. In contrast, the growth in ASC volume has been much more consistent over this period (Table 5-4, p. 122). If there had been a shift from ASCs to HOPDs, the rate of growth in ASC volume should have been as inconsistent as that in HOPDs.

The higher growth in HOPDs could be due to factors other than a shift from ASCs to HOPDs, such as a shift of surgical services from freestanding physician offices to HOPDs. A migration of services from freestanding offices to HOPDs would be consistent with evidence of hospitals purchasing physicians' practices and converting them to HOPDs. In prior reports, we have provided evidence of a shift of some nonsurgical services—office visits, echocardiograms, and nuclear cardiology—from freestanding offices to HOPDs, and it is plausible that surgical services also have shifted from freestanding offices to HOPDs (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013a, Medicare Payment Advisory Commission 2012). For example, some of the surgical services that had the largest volume increases in HOPDs in 2013 were wound debridement procedures and a strapping procedure for the lower leg, which are frequently performed in freestanding offices. The growth

of these services in freestanding offices was either negative or much slower than the growth in HOPDs.

Other data also suggest that surgical procedures are no longer migrating from HOPDs to ASCs. In Pennsylvania, ASCs' share of outpatient diagnostic and surgical procedures performed on all patients increased dramatically between 2000 and 2009, from 10.2 percent to 31.3 percent, but remained about the same from 2009 to 2011 and decreased to about 30.5 percent in 2012 and 2013 (Pennsylvania Health Care Cost Containment Council 2014).

We believe it is desirable to maintain beneficiaries' access to ASCs because Medicare and beneficiaries pay less for services provided in ASCs than in HOPDs. Our comparison of the number of cataract surgeries with intraocular lens insertion provided in ASCs with those in HOPDs illustrates this point. We found that, from 2008 through 2013, the proportion of these procedures provided in ASCs increased from 68 percent to 72 percent. Meanwhile, the payment rate for these procedures in 2013 was \$971 in ASCs compared with \$1,730 in HOPDs. Medicare's portion of this payment was \$777 in ASCs and \$1,240 in HOPDs, while the beneficiary's coinsurance was \$194 in ASCs and \$490 in HOPDs.

However, most ASCs have some degree of physician ownership, and this ownership could give physicians an incentive to perform more surgical services than if they provided outpatient surgery only in HOPDs. This additional volume could partly offset the effect of lower rates in ASCs on Medicare spending. Some studies offer limited evidence that physicians with an ownership stake in an ASC perform a higher volume of certain procedures than non-owning physicians (Hollingsworth et al. 2010, Mitchell 2010, Strobe et al. 2009).

Other studies suggest that the presence of an ASC in a market is associated with a higher volume of outpatient surgical procedures (Hollenbeck et al. 2014, Hollingsworth et al. 2011, Koenig and Gu 2013). The most recent study may be the most convincing because it is based on a nationwide sample of Medicare beneficiaries and includes all surgical procedures (Hollenbeck et al. 2014). This study found that introducing ASCs into service areas that previously did not have any resulted in a larger rate of increase in ambulatory surgical procedures than in areas that already had at least one ASC or did not have any ASCs. However,

this study found a smaller effect of ASCs on outpatient surgical volume than did the earlier studies. Although none of these studies assessed whether the additional procedures were inappropriate, they suggest that the presence of ASCs may increase overall surgical volume.

Quality of care: Insufficient data to examine quality of ASCs

Under CMS's Quality Reporting Program for ASCs, ASCs began submitting data in October 2012 on five measures (see text box, pp. 126–127). In early 2014, CMS's contractor (FMQAI) released preliminary national rates for these five measures based on data collected during 2013 (FMQAI 2014). CMS has not yet released final data for 2013 but plans to do so during 2015 (Centers for Medicare & Medicaid Services 2014b). Therefore, we do not yet have sufficient information to assess the quality of ASCs, including changes in quality over time.

CMS's contractor released preliminary data for 2013 on four claims-based patient safety indicators:

- patient fall in the ASC;
- patient burn (such as a chemical, thermal, or electrosurgical burn);
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant; and
- hospital transfer or admission after an ASC procedure when the patient is transferred directly to the hospital from the ASC.

According to the preliminary national data, these events occur very rarely; each type of incident occurred less than once per 1,000 visits to ASCs in 2013 (FMQAI 2014). However, there may be individual ASCs that perform poorly on these measures. CMS has not yet released data for individual facilities but plans to do so during 2015 (Centers for Medicare & Medicaid Services 2014b).

CMS's contractor also released preliminary data from 2013 for a claims-based process measure: timely administration of prophylactic intravenous (IV) antibiotics. This measure assesses the share of ASC patients with a preoperative order for an IV antibiotic to prevent surgical site infection who received the antibiotic on time (within one or two hours before the incision). At the national level, 96 percent of ASC visits met this standard in 2013 (FMQAI 2014).

The Commission has recommended that CMS develop a value-based purchasing program that would use ASC quality data to reward high-performing providers and penalize low-performing providers, but CMS does not have the statutory authority to implement such a program (see text box, pp. 126–127).

Providers' access to capital: Growth in number of ASCs suggests adequate access

Owners of ASCs require capital to establish new facilities and upgrade existing ones. The change in the number of ASCs is the best available indicator of ASCs' ability to obtain capital. The number of ASCs continued to increase in 2013 and the first three quarters of 2014, although at a slower rate than in previous years. However, Medicare accounts for less than 20 percent of ASCs' overall revenue, on average, so other factors may have a larger effect than Medicare payments on access to capital for this sector (Medical Group Management Association 2009a).

In addition, the company that owns and operates the largest number of ASCs in the country—AmSurg—appears to have adequate access to capital. In 2014, it was able to borrow \$1.7 billion from the debt markets to acquire Sheridan Healthcare, a physician outsourcing company (Moody's Investors Service 2014b).¹⁸ AmSurg also continues to have robust earnings growth, which provides it with funds to acquire new ASCs and improve its existing facilities. A market research firm projects that AmSurg's earnings per share of stock will increase by 19 percent in 2014 and 24 percent in 2015 (Deutsche Bank 2014). We caution, however, that AmSurg includes only 5 percent of all Medicare-certified ASCs, so its experience may not represent the entire ASC sector.¹⁹

Medicare payments: Payments have increased steadily

In 2013, ASCs received \$3.7 billion in Medicare payments and beneficiaries' cost sharing (Table 5-6, p. 126). From 2008 through 2012, spending per FFS beneficiary increased by an average of 3.4 percent per year and by 2.0 percent in 2013. The 2.0 percent increase in 2013 reflects a 0.7 percent increase in the ASC conversion factor, a 0.5 percent increase in volume per beneficiary, a 2.1 percent increase in the average relative weight, and a 1.2 percent reduction in spending because of the sequester. The 2.1 percent increase in the average relative weight is fairly large and primarily reflects the growth of cataract surgeries (represented by HCPCS codes 66984 and 66982), which have relative weights well above the average.

Creating a value-based purchasing program for ambulatory surgical centers

To improve the quality of care provided to beneficiaries in ambulatory surgical centers (ASCs), the Commission previously recommended that CMS implement a value-based purchasing (VBP) program to reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).²⁰ CMS should also publicly report quality measurement results to help researchers and consumers compare quality among facilities. CMS established a Quality Reporting Program for ASCs in 2012; ASCs that do not submit data have their annual update reduced by 2.0

percentage points starting in 2014. However, Medicare payments to ASCs are not adjusted based on how they perform on quality measures, only on whether they successfully reported the measures. CMS currently lacks the statutory authority to implement a VBP program for ASCs.

The Commission supports the ASC Quality Reporting Program but believes that, eventually, high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system. In

(continued next page)

How should Medicare payments change in 2016?

Our payment adequacy analysis indicates that the number of Medicare-certified ASCs has increased, beneficiaries' use of ASCs has increased, and access to capital has been adequate. Our information for assessing payment adequacy is limited because, unlike other types of facilities, Medicare does not require ASCs to submit cost data. In addition, there is not yet sufficient information to assess the quality of ASC care or how it has changed over time.

Cost data would enable the Commission to examine the growth of ASCs' costs over time and analyze Medicare payments relative to the costs of efficient providers, which

would help inform decisions about the ASC update. Cost data are also needed to examine whether an alternative input price index would be an appropriate proxy for ASC costs. As discussed in the text box, pp. 128–129, the Commission previously expressed concern that the price index that CMS uses to update ASC payments (the CPI-U) may not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010b). CMS has also concluded that it needs data on ASC costs to determine whether there is a better alternative than the CPI-U to measure changes in ASCs' input costs (Centers for Medicare & Medicaid Services 2012). To date, however, CMS has not decided to collect cost data.

Although CMS and ASCs have expressed concern that requiring ASCs to submit cost data may impose a burden on

**TABLE
5-6**

Medicare payments to ASCs have grown, 2008–2013

	2008	2009	2010	2011	2012	2013
Medicare payments (in billions of dollars)	\$3.1	\$3.2	\$3.3	\$3.4	\$3.6	\$3.7
Medicare payments per FFS beneficiary	\$97	\$102	\$104	\$106	\$110	\$112
Percent change per FFS beneficiary from previous year	8.1%	5.3%	2.0%	2.0%	4.2%	2.0%

Note: ASC (ambulatory surgical center), FFS (fee-for-service). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new technology intraocular lenses.

Source: MedPAC analysis of data from the Office of the Actuary at CMS.

Creating a value-based purchasing program for ambulatory surgical centers (cont.)

our March 2012 report, the Commission made the following recommendation:

The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016.

The ASC Quality Reporting Program could lay the foundation for a VBP program. Under the Quality Reporting Program, ASCs began submitting data in 2012 on four patient safety indicators and one process measure. In 2013 and 2014, ASCs began reporting data on two structural measures and a measure of influenza vaccination coverage among health care personnel. In 2015, they began reporting data on two chart-abstracted measures that relate to appropriate follow-up intervals for colonoscopy (Centers for Medicare & Medicaid Services 2013).²¹ CMS recently adopted a new measure of the rate of hospital visits within seven days after an outpatient colonoscopy; CMS will calculate this measure for 2018 using claims data from 2016 (Centers for Medicare & Medicaid Services 2014b). CMS plans to make data collected under the Quality Reporting Program publicly available beginning in 2015 (Centers for Medicare & Medicaid Services 2014b).

Consistent with the Commission's overall position on VBP (also known as pay-for-performance) programs in Medicare, an ASC VBP program should include a relatively small set of measures to minimize the administrative burden on ASCs and CMS. These measures should focus on clinical outcomes because Medicare's central concern should be improving patient outcomes across all ASCs. The program should also minimize the use of measures that require providers to extract data from patients' medical records. Several of the indicators that are reported through the ASC Quality Reporting Program could be used for an ASC VBP program.

An ASC VBP program should reward ASCs for improving their prior year performance and for exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services. Initially, funding for the incentive payments should be set at 1 percent to 2 percent of aggregate ASC payments. The size of this

pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program.

CMS should consider incorporating the following patient safety and outcome measures into an ASC VBP program:

- patient fall in the ASC;
- patient burn (such as a chemical, thermal, or electrosurgical burn);
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant;
- hospital transfer or admission after an ASC procedure because of a problem related to the procedure, whether the patient is transferred directly to the hospital from the ASC or admitted to the hospital after returning home from the procedure;²² and
- the rate of surgical site infections (SSIs).

The first three measures listed above are patient safety indicators that ASCs currently report under the ASC Quality Reporting Program. Because these indicators represent errors that are usually preventable, they could be measured against an absolute national benchmark that starts very low and is reduced over time to a rate that approaches zero.

By contrast, the last two indicators listed above (hospital transfer or admission after an ASC procedure and SSI rate) may occasionally occur even in the highest quality facilities. Therefore, an ASC's performance on these indicators should be measured against the performance of other ASCs rather than an absolute national benchmark. Because certain ASCs may report small numbers of cases for the calculation of these measures, the rates reported for these providers could vary substantially from one observation period to the next, due solely to random statistical variation. To address this issue, CMS could consider using composite measures that would aggregate the rates for several measures of rare events into a single rate or using data from multiple years for a single measure. ■

Revisiting the ambulatory surgical center market basket

CMS uses the consumer price index for all urban consumers (CPI-U) as the market basket to update ambulatory surgical center (ASC) payment rates. Because of our concern that the CPI-U may not reflect ASCs' cost structure, in 2010 the Commission examined whether an alternative market basket index would better measure changes in ASCs' input costs (Medicare Payment Advisory Commission 2010b). Using data from a Government Accountability Office (GAO) survey of ASC costs in 2004, we compared the distribution of ASC costs with the distribution of hospital and physician practice costs. We found that ASCs' cost structure is different from that of hospitals and physician offices.

Although CMS has historically used the CPI-U as the basis for Medicare's annual updates to ASC payments, the mix of goods and services in this price index likely does not reflect ASC inputs. The CPI-U is based on a sample of prices for a broad mix of goods and services, including food, housing, apparel, transportation, medical care, recreation, personal care, education, and energy (IHS Global Insight 2009). The weight of each item is based on spending for that item by a sample of urban consumers during the survey period. Although

some of these items are probably used by ASCs, their share of spending on each item is likely very different from the CPI-U weight. For example, housing accounts for 43.4 percent of the entire CPI-U (Bureau of Labor Statistics 2009).

We explored whether one of two existing Medicare indexes would be an appropriate proxy for ASC input costs: the hospital market basket, which is used to update payments for inpatient and outpatient hospital services, or the practice expense component of the Medicare Economic Index (MEI), which measures changes in physicians' practice expenses. It is reasonable to expect that ASCs have many of the same types of costs as hospitals and physician offices, such as medical equipment, medical supplies, building-related expenses, clinical staff, administrative staff, and malpractice insurance.

We used ASC cost data from the GAO survey to compare the distribution of ASC costs with the distribution of hospital costs (derived from the hospital market basket) and physician practice expenses (derived from the practice expense portion of the MEI). Our March 2010 report has more details on the method (Medicare Payment Advisory Commission

(continued next page)

these facilities (Centers for Medicare & Medicaid Services 2011), we believe it is feasible for ASCs to provide a limited amount of cost information. Even though ASCs are generally small facilities that may have limited resources for collecting cost data, such businesses typically keep records of their costs for filing taxes and other purposes. To minimize the burden on CMS and ASCs, CMS should create a streamlined process for ASCs to track and submit a limited amount of cost data. One such mechanism could be annual surveys of a random sample of ASCs, with mandatory response. CMS conducted cost surveys of a sample of ASCs in 1986 and 1994, and the Government Accountability Office conducted a survey of ASC costs in 2004. Another approach would be to require all ASCs to submit streamlined cost reports on an annual basis.

To enable the Commission to determine the relationship between Medicare payments and the costs of efficient ASCs, ASCs would optimally submit the following information:

- total costs for the facility;
- Medicare unallowable costs (e.g., entertainment, promotion, and bad debt);
- the costs of clinical staff who bill Medicare separately, such as anesthesiologists and clinical nurse anesthetists (these costs would be excluded from the facility's costs because these clinicians are paid separately under Medicare);
- total charges across all payers and charges for Medicare patients (CMS could allocate total facility

Revisiting the ambulatory surgical center market basket (cont.)

2010b). Although the GAO data are not sufficient for comparing each category of costs across settings, they suggest that ASCs have a different cost structure from hospitals and physician offices. ASCs appear to have a much higher share of expenses related to medical supplies and drugs than the other two settings, a much smaller share of employee compensation costs than hospitals, and a smaller share of all other costs (such as rent and capital costs) than physician offices.

Since our 2010 analysis, CMS also considered whether the hospital market basket or the practice expense component of the MEI is a better proxy for ASC costs than the CPI-U (Centers for Medicare & Medicaid Services 2012). However, CMS believes that the hospital market basket does not align with the cost structure of ASCs because hospitals provide a much wider range of services than ASCs, such as room and board and emergency care. Therefore, the agency concluded that it needs data on the cost inputs of ASCs to determine whether there is a better alternative than the CPI-U to measure changes in ASCs' input costs.

CMS asked for public comment on the feasibility of collecting cost information from ASCs but did not propose a plan to collect cost data.

The ASC cost data from GAO used in our comparative analysis are 11 years old and do not contain information on several types of costs. Therefore, the Commission has recommended several times that the Congress require ASCs to submit new cost data to CMS (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010b). CMS should use this information to examine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. A new ASC market basket could include the same types of costs that appear in the hospital market basket or MEI but with different cost weights that reflect the unique cost structure of ASCs. ■

costs to Medicare based on Medicare's proportion of total charges); and

- total Medicare payments.

In addition to the information described above, CMS would need to collect data on specific cost categories to determine an appropriate input price index for ASCs. For example, CMS would need data on the share of ASCs' costs related to employee compensation, medical supplies, medical equipment, building expenses, and other professional expenses (e.g., legal, accounting, and billing services). CMS should use this information to examine the cost structure of ASCs and determine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed.

CMS increased the ASC conversion factor by 0.7 percent in 2013, 1.3 percent in 2014, and 1.4 percent in 2015. The update for 2015 was based on a projected 1.9 percent increase in the CPI-U minus a 0.5 percent reduction

for multifactor productivity growth, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA).²³

Update recommendation

In recommending an update to ASC payment rates for 2016, the Commission balanced the following objectives:

- maintain beneficiaries' access to ASC services;
- pay providers adequately;
- hold down the burden on the beneficiaries, workers, and firms who finance Medicare;
- maintain the sustainability of the Medicare program by appropriately restraining spending on ASC services;
- keep providers under financial pressure to constrain costs; and
- require ASCs to submit cost data.

In balancing these goals, the Commission concludes that the ASC update for 2016 should be eliminated and that the Congress should require ASCs to submit cost data.

RECOMMENDATION 5

The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

RATIONALE 5

On the basis of our payment adequacy indicators and the importance of maintaining financial pressure on providers to constrain costs, we believe that ASC payment rates should not be increased for 2016. That is, the 2016 base payment rate under the ASC payment system should be the same as the base rate in 2015. The indicators of payment adequacy for which we have information are positive: the number of Medicare-certified ASCs and the volume of services have increased, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow. Although we do not have cost data or sufficient information to assess quality, the indicators we do have suggest that payments have been adequate.

As we have stated in prior reports, it is vital that CMS begin collecting cost data from ASCs without further delay. Cost data would enable the Commission to examine the growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of efficient providers, which would help inform decisions about

the ASC payment update. Cost data are also needed to evaluate whether an alternative input price index would be an appropriate proxy for ASC costs.

IMPLICATIONS 5

Spending

- The Secretary has the discretionary authority to select an update mechanism for ASC payment rates and has decided to use the CPI-U as the basis for updating payments (Centers for Medicare & Medicaid Services 2007). PPACA requires that the update factor be reduced by a multifactor productivity measure. The currently projected CPI-U increase for 2016 is 1.4 percent, and the forecast of productivity growth for 2016 is 0.5 percent, resulting in a projected update of 0.9 percent to the base payment rates for 2016 (IHS Global Insight, forthcoming). However, we recommend that the update be eliminated. Therefore, relative to current Medicare law, our recommendation would decrease federal spending by less than \$50 million in the first year and by less than \$1 billion over five years.

Beneficiary and provider

- Because of the growth in the number of Medicare-certified ASCs and the volume of ASC services, we do not anticipate that this recommendation will diminish beneficiaries' access to ASC services or providers' willingness or ability to provide those services.
- ASCs would incur some administrative costs to track and submit cost data. ■

Endnotes

- 1 A survey conducted by the ASC Association found that 91 percent of ASCs had at least some physician owners in 2008 (Ambulatory Surgery Center Association 2008). A survey conducted by the Medical Group Management Association found that 74 percent of ASCs were either completely owned by physicians or were physician–hospital joint ventures in 2008 (Medical Group Management Association 2009b).
- 2 The adjustment to the relative weights to maintain budget neutrality could have been done instead through an adjustment to the ASC conversion factor. However, CMS decided to make separate adjustments to the relative weights and the conversion factor. These separate adjustments distinguish the effects of changes to the relative weights from changes to ASCs’ input costs.
- 3 Because CMS updates payment rates in the OPPS and the PFS independently of each other, it is possible for the ASC payment rate for an office-based procedure to be based on the OPPS rate in one year and the PFS rate the next year (or vice versa).
- 4 ASCs and HOPDs receive the same amount for drugs that are paid for separately under the OPPS and for devices that have pass-through status.
- 5 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004; they received reliable cost data from 290 facilities.
- 6 The average time for a surgical visit includes time spent by the patient in the operating room and postoperative recovery room. This study included only visits in which a single procedure was performed.
- 7 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated a prior requirement that the Secretary collect cost data from ASCs every five years.
- 8 Medicare’s share of total ASC revenue varies by type of ASC, ranging from 7 percent for ASCs that specialize in orthopedic procedures to 43 percent for ASCs that specialize in ophthalmology cases (Medical Group Management Association 2009b).
- 9 Because some states have a disproportionately high number of ASCs per beneficiary (e.g., Maryland, Idaho, and Georgia), we weighted beneficiaries so that in each state the percentage of beneficiaries receiving care in ASCs matched the national percentage. This process prevented idiosyncrasies in states that have high concentrations of ASCs from biasing the results. The analysis excluded beneficiaries who received services that Medicare does not cover in ASCs.
- 10 The CMS–HCC model is an abbreviated version of the full HCC model. The full HCC model includes 189 disease categories, while the version of the CMS–HCC we used includes 70. We excluded beneficiaries who had missing risk scores and beneficiaries who were new Medicare enrollees in 2010 because those beneficiaries’ risk scores were not based on diagnosis data. Our analysis included only surgical procedures that were covered in the ASC payment system in 2010.
- 11 These data are based on 272 ASCs and 173 hospitals.
- 12 The sample of freestanding ASCs in the NSAS includes facilities listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database and Medicare-certified ASCs from CMS’s Provider of Services file (Cullen et al. 2009).
- 13 The numbers do not sum to 100 percent due to rounding.
- 14 Whether a state has certificate-of-need (CON) laws for ASCs appears to affect the number of ASCs in the state. Twenty-six states and the District of Columbia (DC) have CON laws for ASCs. Each of the 12 states with the fewest ASCs per FFS beneficiary, as well as DC, has a CON law, while only 3 of the 10 states that have the most ASCs per FFS beneficiary have CON laws. Among these three states, Maryland and Georgia have exceptions in their CON requirements that make it easier to establish new ASCs.
- 15 By statute, coinsurance for a service paid under the OPPS cannot exceed the hospital inpatient deductible (\$1,260 in 2015). The ASC payment system does not have the same limitation on coinsurance, and for a few services the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the OPPS coinsurance.
- 16 In addition, the anti-self-referral law does not apply to separately paid ancillary services provided in ASCs, such as radiology services and implantable devices.
- 17 Although there was not much change from 2011 through 2013 in the percentage of these 31 services that were provided in HOPDs, there was some appreciable change in specific services. For 15 of these services, the percentage of the volume that was provided in HOPDs decreased by more than 1 percentage point, and for 6 of these services, the percentage that was provided in HOPDs increased by more than 1 percentage point. Pain management services had an especially large decline in the percentage that was provided in HOPDs.

- 18 With the acquisition of Sheridan, AmSurg was expected to double its annual revenue to over \$2 billion (Moody's Investors Service 2014a).
- 19 AmSurg owns 242 ASCs in partnership with physicians (Moody's Investors Service 2014a). About one-quarter of AmSurg's ASC revenue is from government programs, primarily FFS Medicare and Medicare Advantage (AmSurg Corp. 2014).
- 20 The Commission also described its principles for a VBP program for ASCs in a letter to the Congress commenting on the Secretary's report to the Congress on a VBP program for ASCs (Medicare Payment Advisory Commission 2011a).
- 21 In 2016, ASCs may choose to begin reporting data on a voluntary, chart-abstracted measure of improvement in visual function after cataract surgery. Because this measure is voluntary, ASCs that fail to report this measure will not be subject to a payment reduction.
- 22 The ASC Quality Reporting Program includes a measure of hospital transfer or admission after an ASC procedure when the patient is transferred directly to the hospital from the ASC. We are suggesting that the measure be expanded to include a hospital admission after the patient returns home from the ASC procedure.
- 23 Unlike update factors for other providers, such as the hospital market basket, the CPI-U is an output price index that already accounts for productivity changes (Centers for Medicare & Medicaid Services 2012). Nevertheless, CMS is mandated to subtract multifactor productivity growth from the ASC update factor.

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