

SECTION

7

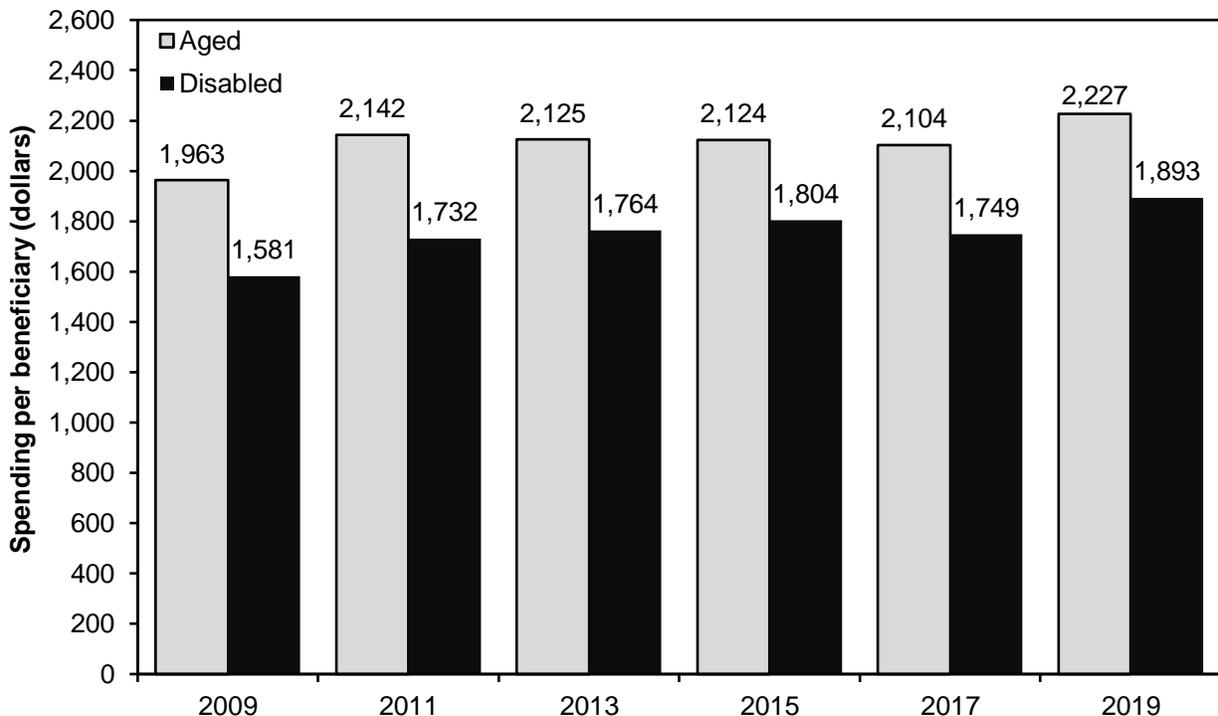
Ambulatory care

**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, 2009–2019

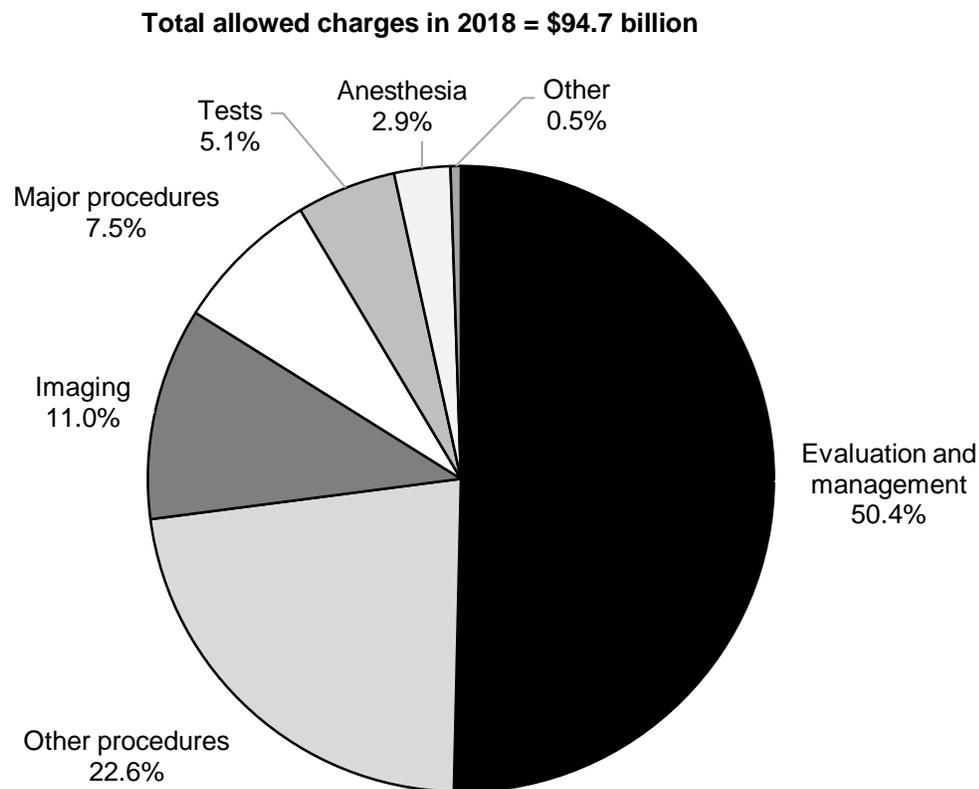


Note: Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The category “disabled” excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries age 65 and over are included in the “aged” category.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- 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 (excluding beneficiary cost sharing) was \$73.5 billion in 2019 (data not shown).
- Spending per fee-for-service beneficiary for fee schedule services increased between 2009 and 2011, remained stable between 2011 and 2017, and began growing again after 2017. From 2009 to 2019, spending per beneficiary (across aged and disabled beneficiaries) grew at a cumulative rate of 15 percent.
- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries (ages 65 and over). In 2019, for example, per capita spending for disabled beneficiaries was \$1,893 compared with \$2,227 for aged beneficiaries. However, spending per capita grew much faster for disabled beneficiaries than aged beneficiaries between 2009 and 2019 (20 percent vs. 13 percent, respectively).

Chart 7-2. Physician fee schedule—allowed charges by type of service, 2018



Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries.

- In 2018, allowed charges for physician fee schedule services totaled \$94.7 billion. Allowed charges include both program spending and beneficiary cost sharing.
- In 2018, about half of all allowed charges were for evaluation and management (E&M) services.
- Within the E&M category, about half of allowed charges were for office/outpatient visits. The remaining allowed charges within the E&M category were for various types of services that occurred across a broad range of settings, including hospital inpatient departments, emergency departments, and nursing facilities (data not shown).

Chart 7-3. Total encounters per beneficiary increased and mix of clinicians furnishing them changed from 2013 to 2018

| Specialty category | Encounters per beneficiary | | Percent change in encounters per beneficiary | |
|-------------------------|----------------------------|------|--|-------|
| | 2013 | 2018 | Average annual | Total |
| Total (all clinicians) | 20.8 | 21.9 | 1.0% | 5.0% |
| Primary care physicians | 4.1 | 3.6 | -2.9 | -13.7 |
| Specialists | 12.5 | 12.8 | 0.4 | 2.0 |
| APRNs/PAs | 1.3 | 2.2 | 11.5 | 72.1 |
| Other practitioners | 2.8 | 3.3 | 2.8 | 15.1 |

Note: APRN (advanced practice registered nurse), PA (physician assistant). We define “encounters” as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service. Figures may not sum to totals due to rounding. Figures do not account for “incident to” billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare’s “incident to” rules are included in the physician totals. We use the number of fee-for-service beneficiaries enrolled in Part B to define encounters per beneficiary.

Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries and 2019 annual report of the Boards of Trustees of the Medicare trust funds.

- Encounters measure beneficiary interactions with clinicians. For example, if a physician billed for an office visit and an X-ray on the same claim, we count that as one encounter.
- The number of encounters per beneficiary grew 1 percent per year from 2013 to 2018, suggesting stable access to care.
- Encounters with specialist physicians accounted for a majority of all encounters and grew modestly from 2013 to 2018.
- In contrast, encounters with APRNs or PAs grew rapidly from 2013 to 2018, and encounters with primary care physicians declined substantially. These changes continue a longer term trend of declines in services billed by primary care physicians and rapid increases in services billed by APRNs and PAs (data not shown).
- The decline in encounters with primary care physicians occurred across a broad range of services, including evaluation and management services, tests, procedures, and imaging services (data not shown).

Chart 7-4. Medicare beneficiaries' ability to get timely appointments with physicians was comparable with privately insured individuals, 2016–2019

| Survey question | Medicare (ages 65 and older) | | | | Private insurance (ages 50–64) | | | |
|--|------------------------------|------------------|-------------------|------|--------------------------------|-------------------|-------------------|------|
| | 2016 | 2017 | 2018 | 2019 | 2016 | 2017 | 2018 | 2019 |
| 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 | 68% ^b | 73% ^a | 70% ^{ab} | 72% | 67% ^b | 69% ^{ab} | 64% ^{ab} | 74% |
| Sometimes | 22 | 20 ^a | 20 ^a | 20 | 23 ^b | 22 ^{ab} | 26 ^{ab} | 19 |
| Usually | 4 ^b | 3 | 5 ^b | 3 | 5 | 4 | 5 | 4 |
| Always | 3 | 3 | 3 ^a | 3 | 4 ^b | 3 | 4 ^{ab} | 3 |
| For illness or injury | | | | | | | | |
| Never | 79 ^a | 80 ^a | 79 ^a | 80 | 75 ^{ab} | 76 ^{ab} | 74 ^{ab} | 81 |
| Sometimes | 16 ^a | 15 ^a | 15 ^a | 14 | 19 ^{ab} | 18 ^{ab} | 19 ^{ab} | 15 |
| Usually | 2 ^a | 2 | 2 | 2 | 3 ^{ab} | 2 | 3 ^b | 2 |
| Always | 2 ^a | 1 ^a | 2 | 2 | 3 ^{ab} | 2 ^a | 2 | 1 |

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 approximately 4,000 in all years. Sample sizes for individual questions varied.

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

^bStatistically significant difference (at a 95 percent confidence level) from 2019 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys conducted 2016–2019.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Their ability to schedule timely appointments is one indicator of access that we examine.
- Medicare beneficiaries (ages 65 and older) report similar access to physicians for appointments as compared with privately insured individuals ages 50 to 64. For example, in 2019, 72 percent of Medicare beneficiaries reported that they never had to wait longer than they wanted for routine care, and 80 percent reported the same for illness or injury care. Medicare beneficiaries’ ability to obtain either type of care when needed was statistically no different compared with privately insured individuals (the comparable rates for privately insured individuals were 74 percent for routine care and 81 percent for illness or injury care).
- Appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

Chart 7-5. Medicare and privately insured patients who were looking for a new physician reported more difficulty finding one in primary care, 2016–2019

| Survey question | Medicare (ages 65 and older) | | | | Private insurance (ages 50–64) | | | |
|---|------------------------------|-----------------|------------------|-----------------|--------------------------------|-------------------|------------------|-----------------|
| | 2016 | 2017 | 2018 | 2019 | 2016 | 2017 | 2018 | 2019 |
| Looking for a new physician: “In the past 12 months, have you tried to get a new ...?” (Percent answering “Yes”) | | | | | | | | |
| Primary care physician | 8% ^a | 9% ^a | 10% ^b | 8% | 10% ^a | 11% ^{ab} | 10% | 9% |
| Specialist | 18 | 17 ^a | 19 ^{ab} | 17 | 18 ^b | 20 ^{ab} | 21 ^{ab} | 15 |
| 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 | 64 | 69 ^a | 71 | 72 ^a | 63 | 59 ^a | 67 | 62 ^a |
| Small problem | 15 | 13 | 13 | 13 ^a | 16 | 18 | 16 | 20 ^a |
| Big problem | 20 | 14 ^a | 14 | 14 | 20 | 22 ^a | 16 | 17 |
| Specialist | | | | | | | | |
| No problem | 82 | 83 | 84 | 85 ^a | 79 | 81 | 80 | 79 ^a |
| Small problem | 10 ^b | 11 ^b | 7 | 6 ^a | 9 | 11 | 9 | 11 ^a |
| Big problem | 8 ^a | 5 ^{ab} | 8 | 8 | 11 ^a | 8 ^a | 10 | 9 |

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 approximately 4,000 in all years. Sample sizes for individual questions varied.

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

^bStatistically significant difference (at a 95 percent confidence level) from 2019 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys, conducted 2016–2019.

- In 2019, only 8 percent of Medicare beneficiaries and 9 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.
- In 2019, Medicare beneficiaries and privately insured individuals were more likely to report problems finding a new primary care physician than a new specialist.
- Of the 8 percent of Medicare beneficiaries who looked for a new primary care physician in 2019, 27 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 less than 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 9 percent of privately insured individuals who looked for a new primary care physician in 2019, 37 percent reported problems finding one: 17 percent reported their problem as “big,” and 20 percent reported their problem as “small.”

Chart 7-6. Medicare beneficiaries' access to physician care was comparable with privately insured individuals, and minorities in both groups reported unwanted delays more frequently, 2019

| 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 | 72% | 74% ^b | 68% ^b | 74% | 76% ^b | 68% ^b |
| Sometimes | 20 | 19 | 22 | 19 | 18 ^b | 22 ^b |
| Usually | 3 | 3 | 3 ^a | 4 | 3 ^b | 6 ^{ab} |
| Always | 3 | 2 | 3 | 3 | 2 | 3 |
| For illness or injury | | | | | | |
| Never | 80 | 82 ^b | 76 ^b | 81 | 83 ^b | 77 ^b |
| Sometimes | 14 | 13 ^b | 18 ^b | 15 | 14 ^b | 18 ^b |
| Usually | 2 | 2 | 3 | 2 | 2 | 2 |
| Always | 2 | 2 | 1 | 1 | 1 ^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 approximately 4,000 in 2019. Sample size for individual questions varied.

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

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

Source: MedPAC-sponsored telephone surveys conducted in 2019.

- In 2019, Medicare beneficiaries (ages 65 and older) reported similar 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 2019, 82 percent of White Medicare beneficiaries reported “never” having to wait longer than they wanted to get an appointment for an illness or injury compared with 76 percent of minority beneficiaries.

Chart 7-7. Minorities in Medicare and with private insurance were more likely to report problems finding a new specialist, 2019

| 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 | 8% | 8% | 8% | 9% | 9% | 9% |
| Specialist | 17 | 18 ^b | 14 ^b | 15 | 16 | 13 |
| 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 | 72 ^a | 74 | 66 | 62 ^a | 65 | 56 |
| Small problem | 13 ^a | 12 | 14 | 20 ^a | 19 | 23 |
| Big problem | 14 | 12 | 20 | 17 | 16 | 20 |
| Specialist | | | | | | |
| No problem | 85 ^a | 88 ^{ab} | 75 ^b | 79 ^a | 81 ^{ab} | 72 ^b |
| Small problem | 6 ^a | 6 | 9 | 11 ^a | 9 ^b | 18 ^b |
| Big problem | 8 | 7 ^b | 16 ^b | 9 | 9 | 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 size for each group (Medicare and privately insured) was approximately 4,000 in 2019. Sample size for individual questions varied.

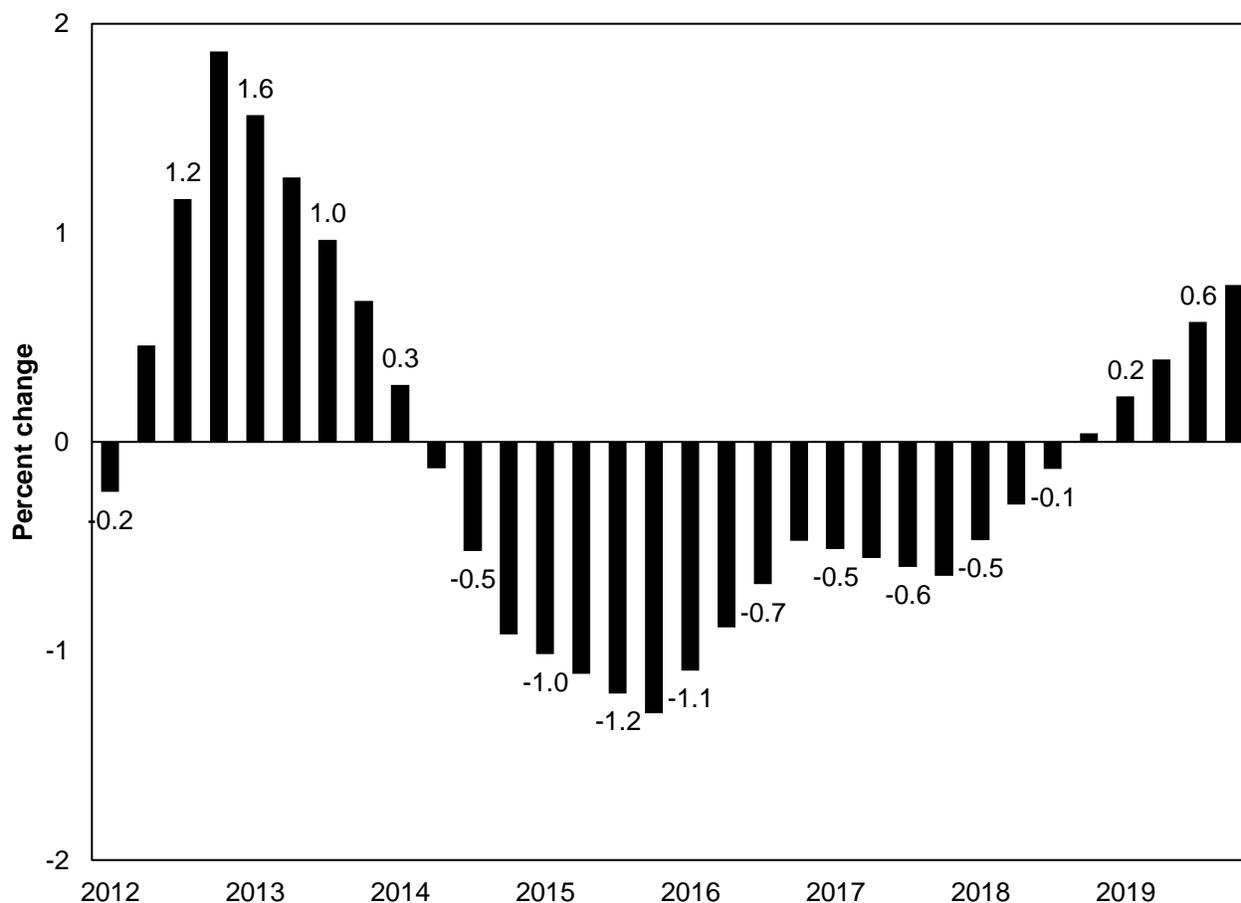
^aStatistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given category.

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

Source: MedPAC-sponsored telephone surveys conducted in 2019.

- Overall, Medicare beneficiaries reported fewer problems finding a new primary care physician or specialist than those with private insurance.
- Among those looking for a specialist, minorities were more likely than Whites to report problems finding one. This pattern held for Medicare beneficiaries and for privately insured individuals ages 50 to 64.

Chart 7-8. Changes in physicians' professional liability insurance premiums, 2012–2019

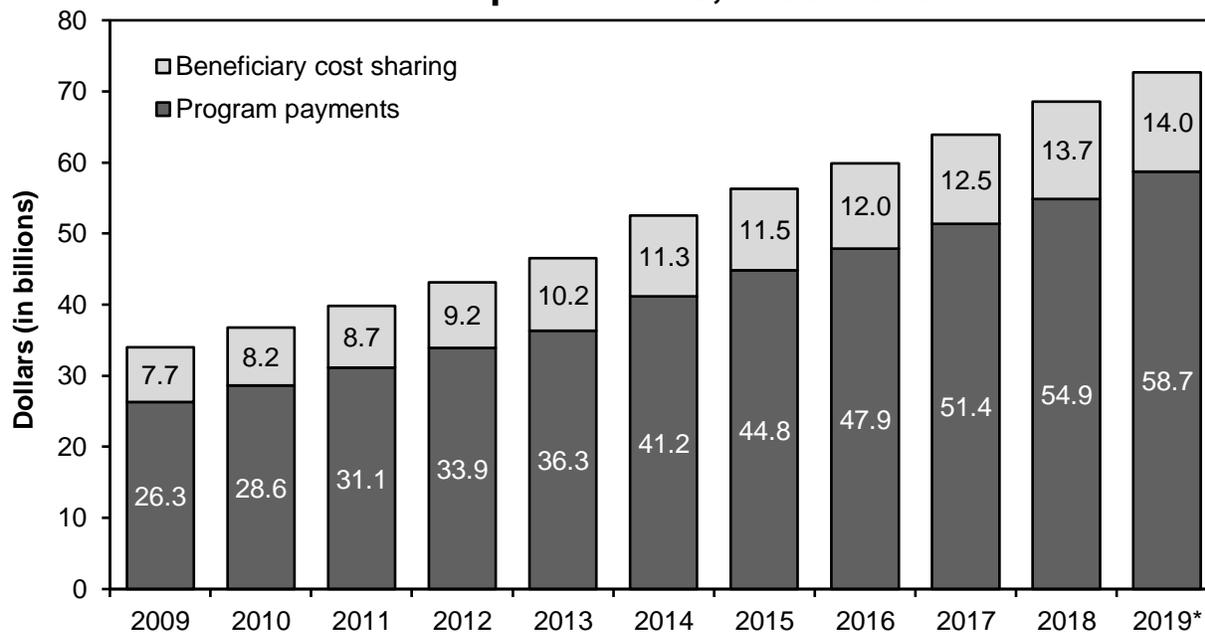


Note: Bars represent a four-quarter moving average percentage change.

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

- Medicare's fee schedule for physicians and other health professionals includes payments to clinicians that are intended to cover the relative cost of professional liability insurance (PLI) premiums. Payments for PLI account for 4.3 percent of total payments under the fee schedule (data not shown).
- Changes in the PLI premiums paid by physicians and other health professionals 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 grew slowly from the second quarter of 2012 through the first quarter of 2014, declined from the second quarter of 2014 through the third quarter of 2018, and began increasing again in the first quarter of 2019.

Chart 7-9. Spending on hospital outpatient services covered under the outpatient PPS, 2009–2019



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 \$72.7 billion in 2019 (\$58.7 billion in program spending, \$14.0 billion in beneficiary copayments). We estimate that the outpatient PPS accounted for about 7 percent of total Medicare program spending in 2019 (data not shown).
- Overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS from calendar years 2009 to 2019 increased by 114 percent, an average of 7.9 percent per year. The Office of the Actuary projects continued growth in total spending, averaging 10.4 percent per year from 2019 to 2021 (data not shown).
- 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 2019 (data not shown).

Chart 7-10. Most hospitals provide outpatient services

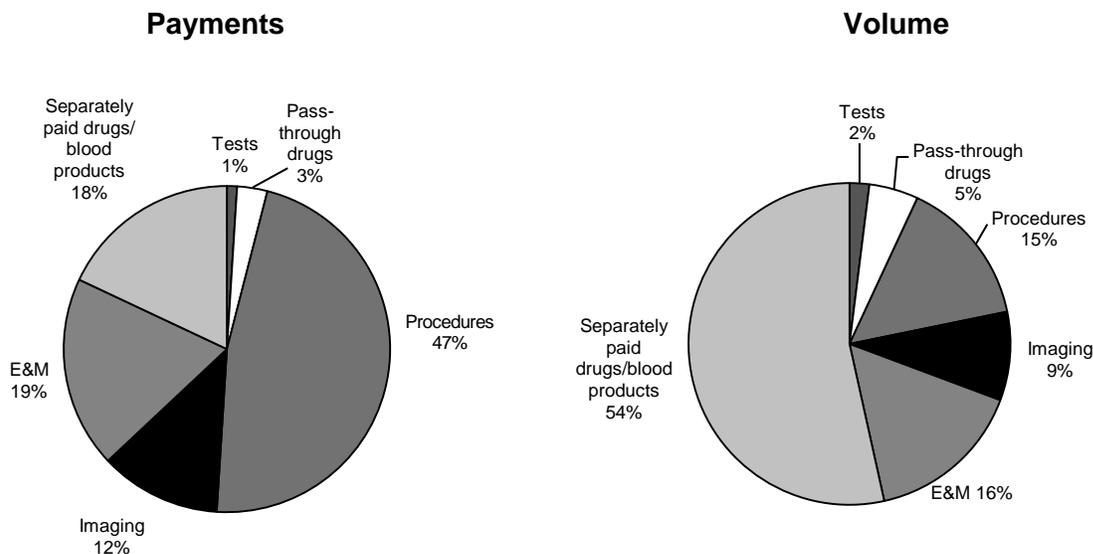
| Year | Acute care hospitals | Share offering | | |
|------|----------------------|---------------------|--------------------|--------------------|
| | | Outpatient services | Outpatient surgery | Emergency services |
| 2008 | 3,607 | 94% | 87% | N/A |
| 2010 | 3,518 | 95 | 90 | N/A |
| 2012 | 3,483 | 95 | 91 | 93% |
| 2014 | 3,429 | 96 | 92 | 93 |
| 2016 | 3,370 | 96 | 93 | 93 |
| 2018 | 3,301 | 96 | 93 | 90 |
| 2019 | 3,245 | 96 | 93 | 91 |

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 3,245 in 2019.
- 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, 2018



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. The percentages in the “volume” figure do not sum to 100 due to rounding.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2018.

- 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 2018, procedures accounted for 47 percent of payments but only 15 percent of volume.
- Procedures (e.g., endoscopies, surgeries, and skin and musculoskeletal procedures) accounted for the greatest share of payments for services (47 percent) in 2018, followed by evaluation and management services (19 percent), separately paid drugs and blood products (18 percent), and imaging services (12 percent).
- Payments for separately payable drugs and blood products and pass-through drugs have increased in relation to other categories in the outpatient PPS, increasing from 15 percent of total outpatient PPS spending in 2013 to 21 percent of total outpatient PPS spending in 2018 (data not shown). 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, 2018

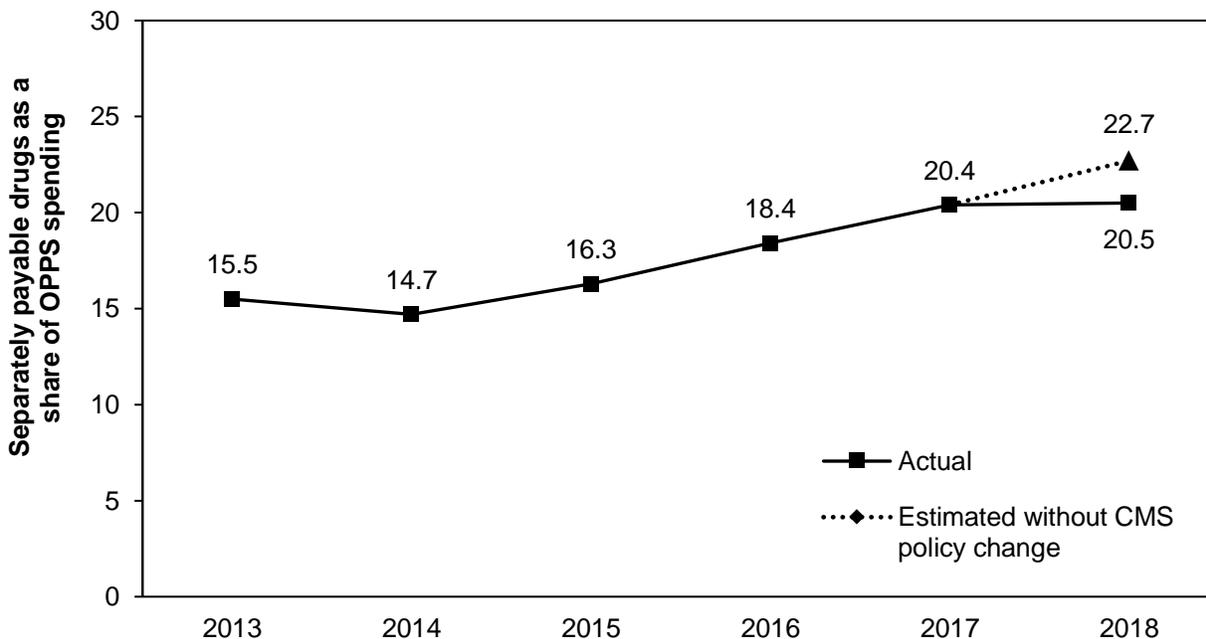
| APC title | Share of Medicare expenditures | Volume (thousands) | Payment rate |
|--|--------------------------------|--------------------|--------------|
| Total | 52% | | |
| All emergency visits | 7 | 13,010 | \$337 |
| Clinic visits | 6 | 32,462 | 114 |
| Comprehensive observation services | 5 | 1,430 | 2,350 |
| Level 3 endovascular procedures | 3 | 189 | 10,510 |
| Level 5 musculoskeletal procedures | 2 | 135 | 10,123 |
| Level 3 electrophysiologic procedures | 2 | 68 | 18,516 |
| Level 3 drug administration | 2 | 6,544 | 191 |
| Level 2 ICD and similar procedures | 2 | 41 | 30,962 |
| Level 4 musculoskeletal procedures | 2 | 224 | 5,606 |
| Level 1 endovascular procedures | 2 | 355 | 2,814 |
| Level 3 radiation therapy | 1 | 1,843 | 522 |
| Level 2 imaging without contrast | 1 | 8,413 | 114 |
| Level 4 imaging without contrast | 1 | 1,828 | 487 |
| Level 1 intraocular procedures | 1 | 458 | 1,921 |
| Level 1 laparoscopy and related procedures | 1 | 193 | 4,489 |
| Level 3 nuclear medicine and related services | 1 | 706 | 1,203 |
| Level 2 lower GI procedures | 1 | 996 | 936 |
| Level 3 imaging without contrast | 1 | 3,498 | 232 |
| Level 5 urology and related services | 1 | 204 | 3,706 |
| Level 4 drug administration | 1 | 2,373 | 298 |
| Level 1 imaging with contrast | 1 | 2,802 | 253 |
| Level 3 pacemaker and similar procedures | 1 | 69 | 9,748 |
| Level 1 upper GI procedures | 1 | 963 | 743 |
| Level 4 endovascular procedures | 1 | 40 | 16,020 |
| Level 4 neurostimulator and related procedures | 1 | 23 | 27,892 |
| Level 2 excision/biopsy/incision and drainage | 1 | 451 | 1,348 |
| Level 3 vascular procedures | 1 | 249 | 2,493 |
| Average APC | | 585 | 174 |

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 (52 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 2018.

- 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. Separately payable drugs have increased as a share of total spending in the outpatient prospective payment system, 2013–2018



Note: OPSS (outpatient prospective payment system). The dotted line segment indicates our estimate of the share of total OPSS spending in 2018 that would have been attributable to separately payable drugs if CMS had not implemented a policy in 2018 that substantially reduced the OPSS payment rates for drugs obtained through the 340B Drug Pricing Program.

Source: MedPAC analysis of hospital outpatient standard analytic claims files from 2013 through 2018.

- The OPSS packages the cost of most drugs into the payment for the related services. However, the OPSS has two programs that provide separate payment for higher cost drugs: the pass-through program, which is focused on drugs that are new to the market, and the program for separately payable non-pass-through (SPNPT) drugs, which is focused on drugs that have been established in the drug market. Pass-through drugs can hold that status for two to three years, after which they can become SPNPT drugs. Most SPNPT drugs were previously pass-through drugs.
- Separately payable drugs have become an increasingly larger share of OPSS spending, increasing from 15.5 percent in 2013 to 20.5 percent in 2018.
- The share of OPSS spending attributable to separately payable drugs decreased slightly from 2013 to 2014 and increased only slightly from 2017 to 2018. The decrease from 2013 to 2014 in separately payable drugs' share of spending was the result of an unusually large increase in total OPSS spending caused by a change in policy that allowed for many clinical lab tests to be paid under the OPSS rather than the clinical lab fee schedule. The small increase from 2017 to 2018 was the result of a policy implemented by CMS that substantially decreased the payment rates for SPNPT drugs that hospitals obtained through the 340B Drug Pricing Program. Without that policy, we estimate that separately payable drugs would have been 22.7 percent of OPSS spending in 2018.

Chart 7-14. Number of Medicare-certified ASCs increased by 10 percent, 2012–2018

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|-------|-------|-------|-------|-------|-------|-------|
| Medicare payments (billions of dollars) | \$3.6 | \$3.7 | \$3.8 | \$4.1 | \$4.3 | \$4.6 | \$4.9 |
| New centers (during year) | 179 | 179 | 190 | 170 | 168 | 215 | 224 |
| Closed or merged centers (during year) | 114 | 120 | 123 | 108 | 100 | 94 | 78 |
| Net total number of centers (end of year) | 5,194 | 5,253 | 5,320 | 5,382 | 5,450 | 5,571 | 5,717 |
| Net percent growth in number of centers | 1.3% | 1.1% | 1.3% | 1.2% | 1.3% | 2.2% | 2.6% |
| Share of all centers that are: | | | | | | | |
| For profit | 94 | 95 | 95 | 95 | 95 | 95 | 95 |
| Nonprofit | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Government | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Urban | 93 | 93 | 93 | 93 | 93 | 93 | 93 |
| Rural | 7 | 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 7-15 in our 2019 data book because CMS updated 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 2018. 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 5 percent per year, on average, from 2012 through 2018 (data not shown). Payments per FFS beneficiary served in an ASC grew by 4.9 percent per year during this period. From 2017 to 2018, total payments rose by 6.4 percent, and payments per beneficiary grew by 7.4 percent (per beneficiary data not shown).
- The number of Medicare-certified ASCs grew at an average annual rate of 1.6 percent from 2012 through 2018. In this same period, an annual average of 189 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 2012 through 2018. The slower growth may reflect the substantially higher rates that Medicare pays for ambulatory surgical services provided in hospital outpatient departments than in ASCs and the significant increase in hospital employment of physicians.