

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 2017. 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 procedures to patients who do not require an overnight stay after the procedure. In 2014, over 5,400 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was over \$3.8 billion.

Assessment of payment adequacy

Our results indicate that beneficiaries' access to ASC services is adequate: Most of the available indicators of payment adequacy for ASC services, discussed below, are positive. However, the volume of ASC services declined in 2014.

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 2009 through 2013, the number of Medicare-certified ASCs grew by an average annual rate of 1.5 percent; in 2014, the number increased by 1.9 percent (the vast majority of new ASCs were for-profit facilities).
- **Volume of services**—From 2009 through 2013, the volume of services per beneficiary grew by an average annual rate of 1.3 percent. In 2014,

In this chapter

- Are Medicare payments adequate in 2016?
- How should Medicare payments change in 2017?

volume decreased by 0.8 percent, in contrast to earlier years, when ASC volume growth was much higher. The growth in previous years appeared to be due, in part, to a shift of services from hospital outpatient departments (HOPDs) to ASCs. However, the data do not appear to indicate that the slower growth in ASC volume in recent years is due to a shift of services from ASCs to HOPDs. For example, ASC volume is heavily concentrated in a fairly small number of services. We examined the volume of these services provided in HOPDs as a percent of the volume provided in HOPDs and ASCs combined. We found the share provided in HOPDs has stayed fairly constant in recent years.

Quality of care—ASCs began submitting data on quality measures to CMS in October 2012. CMS has made data publicly available for two of these measures and intends to make data on five others publicly available in April 2016. We commend CMS for creating a system for ASCs to submit data on measures that reflect the quality of their care and for making these data available to the public. However, we are concerned that the data on the two measures that CMS has made publicly available are of limited value in assessing the quality of care in ASCs. In addition, for the data on the five quality measures that CMS intends to make publicly available in April 2016, the agency is allowing ASCs to suppress their data on these measures if they wish to, which may limit the usefulness of these data.

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 2009 through 2013, Medicare payments per FFS beneficiary increased by an average of 2.6 percent per year and by 3.1 percent in 2014. Although volume per beneficiary decreased by 0.8 percent in 2014, Medicare payments per beneficiary increased because of increases in the ASC conversion factor and the average relative weight of the services provided. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin like 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 2017. 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 2011, Medical Group Management Association 2009b). 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, nursing services, and other aspects of care.

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://www.medpac.gov/documents/payment-basics/ambulatory-surgical-center-services-payment-system-15.pdf?sfvrsn=0>). The ASC payment system is also partly linked to the PFS. The ASC system underwent substantial revisions in 2008 (see online Appendix 2C-A from Chapter 2C of our March 2010 report to the Congress at http://www.medpac.gov/documents/reports/Mar10_Ch02C_APPENDIX.pdf?sfvrsn=0). 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 making large changes in payment rates for many procedures.¹

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 OPSS. Although the ASC payment system is linked to the OPSS, 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 OPSS to maintain budget neutrality in the ASC system. In 2016, this adjustment has reduced the ASC relative weights by 6.7 percent below the relative weights in the OPSS. 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 \$44.18 for 2016, which is lower than the OPSS conversion factor (\$73.73 for 2016).

The ASC conversion factor is lower than the OPSS conversion factor because the ASC conversion factor started at a lower level in 2008 and has been updated at a lower rate than the OPSS conversion factor since then. CMS set the initial ASC conversion factor in 2008 so that total ASC payments under the revised payment system would equal what they would have been under the previous ASC payment system. The resulting ASC conversion factor for 2008 was lower than the OPSS conversion factor in 2008. In addition, since 2008, CMS has updated the ASC conversion factor based on the consumer price index for all urban consumers (CPI-U), whereas it has used the hospital market basket to update the OPSS conversion factor. The CPI-U has generally been lower than the hospital market basket, so the updates to the ASC conversion factor have been smaller than the updates to the OPSS conversion factor.

We are concerned that the CPI-U may not reflect ASCs' cost structure (see text box, pp. 138–139). However, CMS does not collect ASC cost data, which we could use to determine 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 one 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. 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 office-based procedures to prevent migration of these services from physicians' offices to ASCs for financial reasons.² The Commission has investigated payment rate differences across multiple ambulatory settings, including ASCs, HOPDs, and physicians' offices (Medicare Payment Advisory Commission 2014b, 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 implemented comprehensive ambulatory payment classifications (C-APCs) for the OPPS but not for the ASC system. C-APCs largely combine all hospital services reported on a claim that are covered under Medicare Part B into a single payment, 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 drugs that are paid for separately under the OPPS when provided as part of a covered surgical procedure (pass-through and non-pass-through drugs); and
- devices with pass-through status under the OPPS.³

Although we do not have recent ASC cost data that would allow us to quantify cost differences between settings, some evidence suggests that ASCs are a lower cost setting than HOPDs. The Government Accountability Office (GAO) compared ASC cost data from 2004 with HOPD costs and found that costs were, on average, lower in ASCs than in HOPDs (Government Accountability Office 2006).⁴ In addition, studies that used data from the

National Survey of Ambulatory Surgery found that the average time for ambulatory surgical visits for Medicare patients was 25 percent to 39 percent lower in ASCs than HOPDs, which likely contributes to lower costs in ASCs (Hair et al. 2012, Munnich and Parente 2014). An additional study using data from a facility that has both an ASC and a hospital found that surgeries took 17 percent less time in the ASC (Trentman et al. 2010). Trentman and colleagues and Munnich and Parente estimated less time savings in ASCs than did Hair and colleagues, likely because Trentman and colleagues and Munnich and Parente accounted for differences in health status between patients treated in ASCs and those treated in HOPDs, while Hair and colleagues did not.

Are Medicare payments adequate in 2016?

To address whether payments for the current year (2016) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2017), we examine several measures of payment adequacy. We evaluate 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. Data from two quality measures are now publicly available, but those data do not provide sufficient information to assess ASC quality or the change in quality over time. Moreover, CMS will allow ASCs to suppress data on five other quality measures on the website that displays these data. This policy may compromise the usefulness of the quality data. Also, we cannot examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.⁵ Finally, we caution that the effect of Medicare payments on the financial health of ASCs may be limited. Existing studies suggest that Medicare accounts for about 20 percent of ASCs' revenue (Medical Group Management Association 2009b), and AmSurg Corp.—the largest owner of ASCs in the United States, with 250 facilities—indicates in its financial statements that Medicare accounted for approximately 13 percent of their revenues in 2014 (AmSurg Corp. 2014).

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 in hospital outpatient departments (HOPDs). Our analysis of Medicare claims from 2014 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).⁶ 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 2015a).

In a separate analysis, we found that patients 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. CMS–HCC risk scores predict beneficiaries’ relative costliness

TABLE 5-1

Medicare patients treated in ASCs differ from patients treated in HOPDs, 2014

| Characteristic | Percent of beneficiaries | |
|------------------|--------------------------|-------|
| | ASC | HOPD |
| Medicaid status | | |
| Not Medicaid | 86.4% | 77.2% |
| Medicaid | 13.6 | 22.8 |
| Race/ethnicity | | |
| White | 87.0 | 83.8 |
| African American | 6.9 | 10.0 |
| Other | 6.0 | 6.1 |
| Age | | |
| Under 65 | 14.7 | 21.9 |
| 65 to 84 | 78.9 | 67.4 |
| 85 or older | 6.4 | 10.7 |
| Sex | | |
| Male | 42.8 | 44.7 |
| Female | 57.2 | 55.3 |

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, 2014.

(continued next page)

Most of our available indicators of payment adequacy in 2014 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.

Beneficiaries’ access to care: Supply of ASCs and volume of services indicate adequate access

Increases in the number of Medicare-certified facilities and fairly stable volume of services provided to Medicare beneficiaries suggest that beneficiaries have adequate access to care in ASCs. Although growth in the number of ASCs may lead to an increase in the overall volume of

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

based on their diagnoses from the prior year, whether they are dual eligible, whether they are currently age 65 or older but were originally eligible for Medicare because of disability, and their age and sex. 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 from 2010 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 statistically 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 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 2015). In Pennsylvania in 2014, Medicaid patients accounted for 5.3 percent of ASCs' diagnostic and surgical procedures, compared with 12.0 percent of HOPDs' procedures.⁷ Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (86.8 percent vs. 77.4 percent, respectively). 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 did hospitals 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.⁸

Several factors could explain why ASCs treat a smaller share of Medicaid patients (including dual eligibles) than HOPDs. A study by Strobe and colleagues indicates that people living in areas that have relatively low socioeconomic status (measured by median household income; value of owner-occupied housing; percentage of households with dividend or rental income; educational attainment; and percentage of residents employed in managerial, professional, and related occupations) are less likely to receive surgical services in ASCs than are people living in areas that have high socioeconomic status (Strobe et al. 2009b). Further, 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. Also, research indicates that ASCs are most likely to enter markets that did not previously have an ASC if a market has relatively high per capita income (Suskind et al. 2015).⁹ 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 2015a). 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. 127). ■

**TABLE
5-2**

Number of Medicare-certified ASCs grew by 8 percent, 2009–2014

| Type of center | 2000 | 2009 | 2013 | 2014 | Average annual percent change | | |
|------------------|-------|-------|-------|-------|-------------------------------|-----------|-----------|
| | | | | | 2000–2009 | 2009–2013 | 2013–2014 |
| Total | 3,028 | 5,039 | 5,343 | 5,446 | 5.8% | 1.5% | 1.9% |
| New | 295 | 221 | 171 | 176 | | | |
| Closed or merged | 53 | 111 | 105 | 73 | | | |

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2015.

surgical procedures, access to ASCs 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.

Capacity and supply of providers: Number of ASCs is increasing

From 2013 through 2014, the number of Medicare-certified ASCs increased 1.9 percent, a rate comparable with recent years and slower than observed roughly a decade earlier (Table 5-2). By contrast, the number of ASCs increased 1.5 percent per year from 2009 to 2013 and 5.8 percent per year from 2000 to 2009. In 2014, 176 ASCs entered the market and 73 ASCs either closed or merged with other facilities. Through the first half of 2015, 43 additional ASCs entered the market and 13 closed or merged (data not shown). Since 2000, the number of new ASCs has outnumbered ASCs that have closed or merged, leading to an 80 percent increase in the number of ASCs from 2000 to 2014.

Several factors might explain the relatively slow growth of ASCs from 2009 through the first half of 2015:

- 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.

- To expand their outpatient surgery capacity, many hospitals have acquired and integrated ASCs into their hospitals or developed new surgery centers that are part of their hospitals, which may limit 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 ASCs (in 2016, the Medicare rates are 79 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, Physicians Foundation 2014). 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 (ORs). In 2014, there were more than 16,000 ORs in ASCs, or an average of 2.9 per facility. From 2009 through 2014, the total number of ASC ORs increased 1.3 percent per year, a slightly slower rate than the growth in the number of ASCs (1.6 percent per year).

ASCs are concentrated geographically. In 2014, 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.

**TABLE
5-3**

**Most Medicare-certified ASCs
are urban and for profit**

| ASC type | Open in 2009 | Open in 2014 | New in 2014 |
|------------|--------------|--------------|-------------|
| Urban | 92.0% | 92.7% | 94.7% |
| Rural | 8.0 | 7.2 | 5.3 |
| For profit | 95.1 | 95.0 | 92.0 |
| Nonprofit | 3.3 | 3.1 | 5.7 |
| Government | 1.6 | 1.9 | 2.3 |

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2015.

Vermont had the fewest ASCs per FFS beneficiary, followed by West Virginia and Alabama; each had fewer than 5 per 100,000 FFS beneficiaries.¹⁰

In addition, in 2014, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time. ASCs in 2014 were largely urban (about 93 percent), for profit (95 percent), and freestanding (99 percent, data not shown) (Table 5-3). The characteristics of ASCs that were open in 2009 were similar. In 2014, compared with existing ASCs, a slightly larger share of new ASCs was urban and nonprofit, perhaps due to the observed increase in the number of hospitals opening ASCs in recent years. Urban areas include cities and suburban areas. 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 can travel to urban areas to receive care in ASCs.

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, such as 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.¹¹
- 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 ASC services.
- Because physicians are able to perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more revenue from professional fees.

Number of beneficiaries treated and volume of services grew from 2009 to 2013 but decreased in 2014

We found that the number of FFS beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary has been fairly stable in recent years. Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries who have Part B coverage. A factor we had to address to make a meaningful evaluation of volume growth over time is that CMS changed the status in the OPPS of many services from separately payable in 2013 to packaged when provided with another service in 2014. This packaging change carried over to the ASC payment system. In response, we made two estimates of ASC volume for 2013. One estimate reflects the actual 2013 volume that results from packaging rules that existed in 2013, and the other reflects the estimated 2013 volume that would have resulted had 2014 packaging rules been in place in 2013. If we had not made the latter estimate, we would not have been able to make a fair comparison between 2013 volume and 2014 volume. Table 5-4 includes both estimates of the 2013 volume. We estimate that the number of FFS beneficiaries who received ASC services grew by an average of 1.1 percent per year from 2009 through 2013 and *decreased* by 1.2 percent in 2014 (data not shown). The volume of services per FFS beneficiary increased by an average of 1.3 percent per year from 2009 through 2013 and *decreased* by 0.8 percent in 2014 (Table 5-4). Finally, the average number of services provided to beneficiaries who received services in ASCs increased at an annual rate of 1.2 percent from 2009 through 2013 and by 0.4 percent in 2014 (data not shown).

**TABLE
5-4**

Volume of ASC services per FFS beneficiary declined slightly in 2014

| | 2009 | 2010 | 2011 | 2012 | 2013 (actual) | 2013* (adjusted) | 2014 |
|-----------------------------------------------------------------|-------|-------|-------|-------|------------------|---------------------|-------|
| Volume of services (in millions) | 6.3 | 6.5 | 6.7 | 6.9 | 6.9 | 6.3* | 6.2 |
| Volume per 1,000 FFS beneficiaries | 199.3 | 202.6 | 206.1 | 209.2 | 210.3 | 189.7* | 188.3 |
| Percent change in volume per FFS beneficiary from previous year | 3.6% | 1.7% | 1.7% | 1.5% | 0.5% | | -0.8% |

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

*The adjusted 2013 values reflect adjustments we made to the larger actual values for 2013. The adjusted 2013 values reflect policies established in 2014 that changed the status of many services that had been separately payable in 2013 to packaged with another service in 2014. The purpose is to make the method for counting services in 2013 consistent with the method for counting services in 2014.

Source: MedPAC analysis of physician/supplier standard analytic files, 2009–2014.

The services that have historically contributed the most to overall volume continued to constitute a large share of the total in 2014. 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 both in 2009 and 2014, accounting for about 20 percent of volume in 2009 and about 19 percent in 2014. Moreover, 18 of the 20 most frequently billed HCPCS codes in 2009 were among the 20 most frequently provided in 2014 (Table 5-5, p. 132). These services comprised about 72 percent of ASC Medicare volume in 2009 and about 70 percent in 2014.¹²

Services that were outside the 20 most frequently billed HCPCS codes composed about 28 percent of total ASC volume in 2009 and about 30 percent in 2014. We grouped the HCPCS codes for these services into broader service categories and found that eye procedures, nerve injections (for pain management), arthroscopy, and skin repair had the highest volume. These four categories composed 24 percent of total ASC volume in 2009 and 20 percent in 2014.

Outpatient surgical procedures grew faster in HOPDs than in ASCs in 2014

From 2009 through 2014, average annual growth in volume per FFS beneficiary of surgical services covered by the ASC payment system was 0.7 percent both in ASCs and HOPDs. However, in 2014, volume per FFS beneficiary decreased by 0.8 percent in ASCs and increased by 1.1 percent in HOPDs.

Through 2009, ASC volume growth was much higher than in more recent years. The higher growth through 2009 appears to have been due, in part, to a shift of services

from HOPDs to ASCs. That shift appears to have ended. One reason may be that Medicare payment rates have become much higher in HOPDs than in ASCs, which might make it less financially attractive to provide surgical services for Medicare patients in ASCs. For example, in 2016, Medicare payment rates for most surgical services are 79 percent higher in HOPDs than in ASCs. Another reason for the slower growth in ASC volume is that physicians continue to move away from working in private practices toward working for hospitals or medical groups (Physicians Foundation 2014). Physicians working for hospitals may be more inclined to perform procedures at the hospitals that employ them than at freestanding ASCs.

We emphasize, however, that even though surgical volume in 2014 decreased in ASCs and increased in HOPDs, data do not indicate that surgical services have shifted from ASCs to HOPDs. We examined whether a shift in setting occurred among the 27 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 HOPD share of the combined ASC and HOPD volume for these 27 services should have increased, but it did not. The share of these services provided in HOPDs stayed fairly constant, in the range of 46 percent to 47 percent from 2011 through 2014. For example, the share of these services provided in HOPDs was 46.1 percent in 2013 and 46.3 percent in 2014. Moreover, the share provided in HOPDs was lower in 2014 than in 2011 for 15 of these HCPCS codes. Much of the increase in HOPD surgical volume from 2013 to 2014 occurred among services that are rarely provided in ASCs. Therefore, the data suggest a state of equilibrium between ASCs and HOPDs in recent years.

**TABLE
5-5**

Most frequently provided ASC services in 2014 were similar to those provided in 2009

| Surgical service | 2009 | | 2014 | |
|------------------------------------------------------|-------------------|------|-------------------|------|
| | Percent of volume | Rank | Percent of volume | Rank |
| Cataract surgery w/ IOL insert, 1 stage | 19.7% | 1 | 18.6% | 1 |
| Upper GI endoscopy, biopsy | 8.7 | 2 | 8.5 | 2 |
| Colonoscopy and biopsy | 6.0 | 3 | 6.0 | 3 |
| Diagnostic colonoscopy | 5.0 | 4 | 2.6 | 9 |
| After cataract laser surgery | 4.8 | 5 | 4.5 | 6 |
| Lesion removal colonoscopy | 4.8 | 6 | 5.4 | 4 |
| Injection spine: lumbar, sacral (caudal) | 4.0 | 7 | 3.4 | 7 |
| Inject foramen epidural: lumbar, sacral | 4.0 | 8 | 4.6 | 5 |
| Inject paravertebral: lumbar, sacral* | 2.1 | 9 | 2.8 | 8 |
| Colorectal screen, high-risk individual | 1.7 | 10 | 2.1 | 10 |
| Lesion remove colonoscopy | 1.5 | 11 | 1.1 | 15 |
| Colorectal screen, not high-risk individual | 1.4 | 12 | 0.9 | 20 |
| Upper GI endoscopy, diagnosis | 1.4 | 13 | 1.9 | 11 |
| Cystoscopy | 1.3 | 14 | 1.2 | 13 |
| Cataract surgery, complex | 1.3 | 15 | 1.6 | 12 |
| Revision of upper eyelid | 1.1 | 16 | 1.0 | 18 |
| Inject spine, cervical or thoracic | 0.9 | 17 | 1.0 | 17 |
| Upper GI endoscopy, insertion of guide wire | 0.8 | 18 | 0.8 | 21 |
| Injection procedure for sacroiliac joint, anesthetic | 0.8 | 19 | 1.1 | 14 |
| Carpal tunnel surgery | 0.7 | 20 | 0.7 | 22 |
| Total | 71.9 | | 70.5 | |

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal). The numbers listed in the "Percent of volume" columns may not sum to stated totals because of rounding.

*The description of this service changed in 2010 to include imaging guidance.

Source: MedPAC analysis of physician/supplier standard analytic files, 2009 and 2014.

The higher growth in HOPDs could be due to a shift of surgical services from freestanding physician offices to HOPDs. Such a shift 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 2015, Medicare Payment Advisory Commission 2014b, 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 2014—wound debridement procedures—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.

It is desirable to maintain beneficiaries' access to ASCs because services provided in this setting are less costly to Medicare and beneficiaries than services delivered in HOPDs. For example, the most frequently provided service in ASCs is cataract surgery with intraocular lens insertion. The payment rate for these procedures in 2014 was \$976 in ASCs compared with \$1,766 in HOPDs. The lower payment rate in ASCs for this service has been financially beneficial to Medicare and beneficiaries, as the share of these procedures provided in ASCs rose from 69 percent in 2009 to 72 percent in 2014. Other recent studies

similarly find that ASCs are less costly than HOPDs in the Medicare and non-Medicare context and that the recent price growth at ASCs has been slower than price growth at HOPDs (Carey 2015, Robinson et al. 2015).

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 partially offset the effect of lower rates in ASCs on Medicare spending. 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, Strope et al. 2009a).

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 might increase overall surgical volume.

Quality of care: Insufficient data to evaluate quality of ASCs

CMS established the ASC Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this system, ASCs must submit data on quality measures to receive the full update to the payment rates in the ASC payment system each year. ASCs that do not successfully submit the data have their payment update reduced by 2.0 percentage points. Performance on these quality measures does not affect an ASC's payments; ASCs are required only to successfully submit the data to receive a full update. The Commission has recommended a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (see text box, p. 135).

CMS has identified 12 quality measures for which ASCs submit data. CMS adopted five of the measures that affected ASC payment updates in 2014 and subsequent years, two measures that affected ASC payment updates in 2015 and subsequent years, three measures that affect ASC payment updates in 2016 and subsequent years, one measure that will affect payment updates in 2018 and subsequent years, and one measure that is voluntary and does not affect payment updates (Table 5-6, p. 134) (Centers for Medicare & Medicaid Services 2015b).

CMS reports that the majority of ASCs participate in the ASCQR program and successfully reported the necessary quality data in the first three years of the program to avoid the 2 percentage point reduction to their annual payment update. For data collection that determined payments in 2014 and 2015, more than 98 percent of ASCs reported quality data to CMS. For data collection that determined payments in 2016, approximately 96 percent of ASCs reported their quality data to CMS. It is unclear exactly why there was a slight decline in reporting in 2016, but we will monitor this trend as the ASCQR program matures.

CMS has made data for two of the quality measures publicly available: whether ASCs use a safe-surgery checklist and the facility volume on selected ASC surgical procedures. CMS also plans to release data on five other measures in April 2016, which are the first through fifth measures listed in Table 5-6 (p. 134) (Quality Reporting Center 2015). We commend CMS for the steps taken to assess the quality of care provided by ASCs. Although we have some concerns about these initial steps, CMS is moving in the right direction, and we look forward to working with CMS to improve the reporting of ASC quality data.

A concern we have regarding the data on the two quality measures that CMS has made publicly available is that these data are of limited use in assessing the quality of care provided by ASCs. Nearly 99 percent of ASCs use a safe-surgery checklist, so this measure does little to differentiate performance among ASCs. The rationale for using a measure of volume of surgical procedures is based on research that found a correlation between higher volume of surgical procedures and better patient outcomes. However, this research is based on analyses of high-risk procedures that are not typically performed in ASCs. Moreover, adoption of this measure could lead ASCs to increase their volume to improve their performance on this measure (Medicare Payment Advisory Commission 2014a).

**TABLE
5-6**

Quality measures that CMS uses in the ASC Quality Reporting Program

| Description of quality measure | First year measure used for payment determination |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Patient burn | 2014 |
| Patient fall | 2014 |
| Wrong site, wrong side, wrong patient, wrong procedure, wrong implant | 2014 |
| Hospital transfer/admission | 2014 |
| Prophylactic intravenous antibiotic timing | 2014 |
| Safe-surgery checklist use | 2015 |
| ASC facility volume data on selected ASC surgical procedures | 2015 |
| Influenza vaccination coverage among health care personnel | 2016 |
| Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients | 2016 |
| Endoscopy/polyp surveillance: Colonoscopy interval for patients with a history of adenomatous polyps—avoid inappropriate use | 2016 |
| Facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy | 2018 |
| Cataracts: Improvement in patient’s visual function within 90 days following cataract surgery | Voluntary |

Note: ASC (ambulatory surgical center).

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2015.

Another concern is that CMS will allow ASCs to choose to have CMS suppress their information on the five quality measures that will be made publicly available in April 2016 (Quality Reporting Center 2015). Suppressing some ASCs’ data has the potential to distort the data on ASCs’ performance on these quality measures, which could diminish the usefulness of these data. CMS’s rationale for allowing ASCs to suppress these data is that some ASCs experienced difficulties in implementing the changes to their billing processes that are necessary for these data to be collected. It appears that suppression of these data is applicable only to the data that will be made available in April 2016. Unless CMS decides to suppress data in the future, data on these five measures that are made publicly available after April 2016 will include all ASCs.

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 2014 and the first two quarters of 2015. However, Medicare accounts for a small share—perhaps 20 percent—of ASCs’ overall revenue, so other factors may

have a larger effect than Medicare payments on access to capital for this sector (Medical Group Management Association 2009a).

The company that owns and operates the largest number of ASCs in the country—AmSurg Corp.—appears to have adequate access to capital.¹³ In 2014, AmSurg was able to borrow \$1.7 billion from the debt markets to acquire Sheridan Healthcare, a physician outsourcing company (Moody’s Investors Service 2014). AmSurg also continues to have robust earnings growth, which provides it with funds to acquire new ASCs and improve its existing facilities (Deutsche Bank 2015). A market research firm projects that AmSurg’s earnings per share of stock in 2015 increased by nearly 50 percent over the 2014 level (Zacks Equity Research 2015, Zacks Equity Research 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.

Other recent activity in the ASC marketplace includes the consolidation of two large ASC entities owned by private equity firms. In November 2015, H.I.G. Capital, owner of the 50 ASCs associated with Surgery Partners, acquired the 50 ASCs associated with Symbion Holdings Corporation and owned by Crestview Partners. The

Creating a value-based purchasing program for ambulatory surgical centers

In 2012, the Commission recommended that the Congress authorize and CMS implement a value-based purchasing (VBP) program for ambulatory surgical centers (ASCs). A VBP would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).¹⁴

CMS established a Quality Reporting Program for ASCs in 2012. However, Medicare payments to ASCs are not adjusted based on how they perform on quality measures, only on whether they successfully report the measures. 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.

The ASC Quality Reporting Program could lay the foundation for a VBP program. 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 reduce 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 an 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 a patient is transferred directly to a hospital from an ASC or admitted to a hospital after returning home from the procedure;¹⁵ 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. ■

purchase price of this acquisition was \$792 million, and the purchase made Surgery Partners the second largest independent ASC operator in the United States, with 100

ASCs in 26 states. In 2014, Surgery Partners borrowed over \$1 billion from Jeffries Group LLC, an investment banking firm, to complete this acquisition (Tan 2014).

**TABLE
5-7****Medicare payments to ASCs have grown, 2009–2014**

| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|-------------------------------------------------------|-------|-------|-------|-------|-------|-------|
| Medicare payments (in billions of dollars) | \$3.2 | \$3.3 | \$3.4 | \$3.6 | \$3.7 | \$3.8 |
| Medicare payments per FFS beneficiary | \$102 | \$104 | \$106 | \$110 | \$113 | \$116 |
| Percent change per FFS beneficiary from previous year | 5.3% | 2.0% | 2.0% | 4.2% | 2.1% | 3.1% |

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 and data from physician/supplier standard analytic files.

Medicare payments: Payments have increased steadily

In 2014, ASCs received over \$3.8 billion in Medicare payments and beneficiaries' cost sharing (Table 5-7). Spending per FFS beneficiary increased by an average of 2.6 percent per year from 2009 through 2013 and by 3.1 percent in 2014. Medicare payments per FFS beneficiary increased in 2014, despite a 0.8 percent decline in the volume of ASC services per FFS beneficiary and a 0.4 percent decrease in payments because of the sequester. These reductions were more than offset by a 1.3 percent increase in the ASC conversion factor and a 3.0 percent increase in the average relative weight of the ASC services provided to FFS beneficiaries. The 3.0 percent increase in the average relative weight largely reflects two factors: (1) an increase in 2014 in the packaging of ancillary services in the OPPS (especially add-on codes and clinical laboratory tests), which increases the relative weights in the ASC payment system and (2) an increase in services that have high relative weights (those related to implantation of neurostimulators, high-level eye procedures, and some types of arthroscopy) and a decrease in services that have low relative weights (colonoscopies and upper gastrointestinal procedures).

How should Medicare payments change in 2017?

Our payment adequacy analysis indicates that the number of Medicare-certified ASCs has increased, beneficiaries' use of ASCs has declined slightly, 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, although some quality data are available, there is not yet sufficient information to assess the quality of care provided by ASCs or changes in quality 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. The Commission has previously expressed concern that the price index that CMS uses to update ASC payments (the CPI-U) likely does not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010b) (see text box, pp. 138–139). CMS has also concluded that it needs data on ASC costs to determine whether there is an alternative to the CPI-U that better measures changes in ASCs' input costs (Centers for Medicare & Medicaid Services 2012). To date, however, CMS has not required ASCs to submit cost data.

Although CMS and ASCs have expressed concern that requiring ASCs to submit cost data may impose a burden on 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. Moreover, a Pennsylvania state agency is able to collect the cost and revenue data from ASCs in Pennsylvania and is able to estimate the margins for those ASCs. The cost and revenue data are from all sources. This agency estimates that ASCs in Pennsylvania had an average total margin of 25.8 percent in 2014 (Pennsylvania Health Care Cost Containment Council 2015).¹⁶

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, these facilities would optimally submit the following information:

- total costs for the facility;
- Medicare unallowable costs such as 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 costs to Medicare based on Medicare's proportion of total charges); and
- total Medicare payments.

In addition to this information, 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 (such as 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, 1.4 percent in 2015, and 0.3 percent in 2016. The update for 2016 was based on a projected 0.8 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).¹⁷

Update recommendation

In recommending an update to the ASC conversion factor for 2017, 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 2017 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 2017. 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 2017. That is, the 2017 base payment rate under the ASC payment system should be the same as the base rate in 2016. The indicators of payment adequacy for which we have information are stable: The volume of services decreased slightly in 2014, while the number of Medicare-certified ASCs increased. Also, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow. Moreover, even though we do not have cost data or sufficient information to assess quality, the indicators we 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 an efficient

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 likely does not reflect ASCs' cost structure, the Commission examined in 2010 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 a measure of the average change in the price of consumer items that people buy for day-to-day living and is based on a wide range of goods and services, including food, housing, apparel, transportation, medical care, recreation, and education (Bureau of Labor Statistics 2015). 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 42.2 percent of the entire CPI-U (Bureau of Labor Statistics 2015).

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 details the method (Medicare

(continued next page)

provider, 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 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 2017 is 2.2 percent, and the forecast of productivity growth for 2017 is 0.5 percent, resulting in a projected update of 1.7 percent

to the base payment rates for 2017 (IHS Global Insight 2015). 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 increase in ASCs' revenue from Medicare, 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. ■

Revisiting the ambulatory surgical center market basket (cont.)

Payment Advisory Commission 2010b). Although the GAO data are not sufficient for comparing each category of costs across settings, they suggest that ASCs have a cost structure different 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 has 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, emergency care, and inpatient care. Therefore, the agency concluded that it needs data on the cost inputs of ASCs to determine whether there is a better option 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 12 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 2015, Medicare Payment Advisory Commission 2014b, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010b). In 2013, 2014, and 2015, the Commission recommended eliminating the update to the ASC payment rates, meaning the ASC payment rates would not change from the previous year. In the future, the Commission may consider reductions in ASC payment rates from the previous year to motivate the collection of cost data. CMS should use cost data 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. ■

Endnotes

- 1 For 84 percent of the Healthcare Common Procedure Coding System codes covered under the ASC payment system in 2007, payment rates were higher in 2008 than in 2007.
- 2 Because CMS updates payment rates in the OPPIs 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 OPPI rate in one year and the PFS rate the next year (or vice versa).
- 3 ASCs and HOPDs have the same payment rates for drugs that are paid for separately under the OPPIs and for devices that have pass-through status.
- 4 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004; they received reliable cost data from 290 facilities.
- 5 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.
- 6 Because some states (Maryland, Idaho, and Georgia) have a disproportionately high number of ASCs per beneficiary, we produced these results by weighting 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.
- 7 These results are based on data from 268 ASCs and 170 hospitals.
- 8 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).
- 9 The study by Suskind and colleagues also found that ASCs are more likely to enter a market that did not previously have an ASC if the outpatient procedures in that market are concentrated among a relatively small number of providers, which implies relatively low competition in that market.
- 10 Whether a state has certificate-of-need (CON) laws for ASCs appears to affect the number of ASCs in the state. Twenty-seven 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.
- 11 By statute, coinsurance for a service paid under the OPPIs cannot exceed the hospital inpatient deductible (\$1,288 in 2016). 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 OPPIs coinsurance.
- 12 For the 2014 payment year, CMS changed the status of many services covered under the ASC payment system from separately payable to packaged with a primary service. Three of the services in the 20 most frequently provided services in 2009 are in this category, and we excluded them from this analysis.
- 13 AmSurg Corp. owns 250 ASCs in 34 states and the District of Columbia in partnership with approximately 2,000 physicians. About 13 percent of AmSurg's ASC revenue is from Medicare, with another 75 percent from commercial and managed care payers (AmSurg Corp. 2014).
- 14 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).
- 15 The ASC Quality Reporting Program includes a measure of hospital transfer or admission after an ASC procedure when the patient is transferred directly to a hospital from an ASC. We are suggesting that the measure be expanded to include a hospital admission after the patient returns home from an ASC procedure.
- 16 The margins for ASCs have important differences from the margins in other sectors such as hospitals. In particular, the cost data used to determine margins for most ASCs do not include the compensation for physician owners or the taxes paid on that compensation.
- 17 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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