

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 2015. 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 2012, 5,357 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries, and combined Medicare program and beneficiary spending on ASC services was \$3.6 billion.

Assessment of payment adequacy

Our results indicate that beneficiaries' access to ASC services is at least adequate because the available indicators of payment adequacy for ASC services, discussed below, are positive. However, our results also indicate slower growth in the number of ASCs and volume of services in 2012 than in previous years.

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

- **Capacity and supply of providers**—From 2007 through 2011, the number of Medicare-certified ASCs grew by an average annual rate of 2.5 percent; in 2012, the number increased by 1.2 percent. The relatively slow growth may be related to the higher Medicare payment rates for most ambulatory procedures in hospital outpatient departments (HOPDs)

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?

than in ASCs; for 2014, the Medicare rates are 81 percent higher in HOPDs than in ASCs. This payment difference may have led some ASC owners to sell their facilities to hospitals. In addition, physicians have increasingly been selling their practices to hospitals and becoming hospital employees. Physicians who are hospital employees may be more inclined to provide surgical services at hospitals than at ASCs.

- **Volume of services**—From 2007 through 2011, the volume of services per beneficiary grew by an average annual rate of 4.6 percent; in 2012, volume increased by 1.7 percent.

Quality of care—ASCs began submitting quality data to CMS in October 2012, but CMS has not yet publicly released complete quality information. Consequently, we do not have sufficient information to assess ASCs' quality of care.

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—Medicare payments per FFS beneficiary increased by an average of 4.3 percent per year from 2007 through 2011 and increased by 4.3 percent in 2012. 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. ■

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. Most ASCs are freestanding facilities rather than part of a larger facility, such as a hospital. 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 3,700 procedures under the ASC payment system. Physicians who perform procedures in ASCs or other facilities receive a separate payment for their professional services under the payment system for physicians and other health professionals, also known as the physician fee schedule (PFS). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2008, Medical Group Management Association 2009).¹ Physicians who perform surgeries in ASCs they own receive a share of the ASC's facility payment in addition to payment for their professional services. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify standards for administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, nursing services, and other areas.

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/MedPAC_Payment_Basics_13_ASC.pdf). The ASC payment system is also partly linked to the PFS. The ASC system underwent substantial revisions in 2008 (see online Appendix A from Chapter 2C of our March 2010 report to the Congress at http://medpac.gov/chapters/Mar10_Ch02C_APPENDIX.pdf). The most significant changes included a substantial increase in the number of ASC-covered surgical procedures, allowing ASCs to bill separately for certain ancillary services, and large changes in payment rates for many procedures.

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

procedure, is based on its relative weight under the OPPS (the standard ASC method). This link to the OPPS is consistent with a previous Commission recommendation to align the relative weights in the OPPS with the ASC payment system (Medicare Payment Advisory Commission 2004).

Although the ASC payment system is linked to the OPPS, payment rates for all services covered under both systems are lower in the ASC system for two reasons. First, the relative weights are lower in the ASC system because CMS makes proportional adjustments to the relative weights from the OPPS to maintain budget neutrality in the ASC system. In 2014, this adjustment reduced the ASC relative weights by 7.7 percent below the relative weights in the OPPS. 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 \$43.47 in 2014, which is lower than the OPPS conversion factor (\$72.67 in 2014).

The ASC conversion factor is lower for two reasons. First, CMS set the initial ASC conversion factor for 2008 such that total ASC payments under the revised payment system would equal what they would have been under the previous payment system. By comparison, the initial OPPS conversion factor was based on total payments for hospital outpatient services in 2000. Second, CMS updates the ASC conversion factor based on the consumer price index for all urban consumers (CPI-U), whereas it uses the hospital market basket as the basis for updating the OPPS conversion factor. We are concerned that the CPI-U may not reflect ASCs' cost structure. The Commission has recommended that CMS collect ASC cost data and use these data to examine whether an alternative input price index would be an appropriate proxy for ASC costs or an ASC-specific market basket should be developed (Medicare Payment Advisory Commission 2010b).

CMS uses a method different from the standard ASC method to determine payment rates for procedures that are predominantly performed in physicians' offices and were first covered under the ASC payment system in 2008 or later (under the standard ASC method, ASC rates are based on OPPS relative weights). Payment for these "office-based" procedures is the lesser of the amount derived from the standard ASC method or the practice expense portion of the PFS rate that applies when the service is provided in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and

overhead costs of a service). CMS set this limit on the rate for certain office-based procedures to prevent migration of these services from physicians' offices to ASCs for financial reasons.² The Commission has been investigating payment rate differences across multiple ambulatory settings, including ASCs, HOPDs, and physicians' offices (Medicare Payment Advisory Commission 2013a, Medicare Payment Advisory Commission 2012).

The ASC payment system generally parallels the OPSS in terms of which ancillary services are paid separately and which are packaged into the payment of the associated surgical procedure. Starting in 2008, ASCs receive separate payment 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 OPSS;
- brachytherapy sources implanted during a surgical procedure;
- all pass-through and non-pass-through drugs that are paid for separately under the OPSS when provided as part of a covered surgical procedure; and
- devices with pass-through status under the OPSS.

Because Medicare pays ASCs less than HOPDs for procedures, movement of surgical services from HOPDs to ASCs can reduce aggregate program spending and beneficiary cost sharing. If, however, the growth of ASCs results in an increase in the overall number of surgical services, this growth could partially offset reduced spending and cost sharing. 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 are, on average, lower in ASCs than in HOPDs (Government Accountability Office 2006).³ In addition, data from the National Survey of Ambulatory Surgery indicate that the average time for ambulatory surgical visits was 50 percent higher in HOPDs than ASCs (147 minutes vs. 98 minutes) (Cullen et al. 2009).⁴ Average times were also higher in HOPDs than ASCs for specific diagnoses such as cataract, benign neoplasm of the colon, and intervertebral disc disorders. ASCs may have lower costs because they treat a healthier mix of patients than HOPDs or because they are more efficient.

Are Medicare payments adequate in 2014?

To address whether payments for the current year (2014) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2015), we examine several measures of payment adequacy. We assess beneficiaries' access to care by examining the supply of ASC facilities and changes over time in the volume of services provided, providers' access to capital, and changes in ASC revenue from the Medicare program. Unlike our assessments of other provider types, we could not use quality data in our analysis. Although ASCs began submitting information on quality measures to CMS in 2012, complete quality data are not yet publicly available (Centers for Medicare & Medicaid Services 2013b). Moreover, 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 is limited because Medicare accounts for a minority of ASC revenue. According to the Medical Group Management Association's most recent national survey of ASCs, Medicare's share of overall ASC revenue was about 17 percent in 2008 (Medical Group Management Association 2009).⁶ This share may vary regionally; for example, Medicare accounted for 24 percent of revenue for ASCs in Pennsylvania in 2012 (Pennsylvania Health Care Cost Containment Council 2013).

Beneficiaries have at least adequate access to care in ASCs, although there is some variation among subgroups of beneficiaries (see text box). In addition, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow. Together, these measures suggest that Medicare's payment rates for ASCs were at least adequate through 2012.

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

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

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

There is evidence that patients treated in ambulatory surgical centers (ASCs) are different in several ways from those treated in hospital outpatient departments (HOPDs). Our analysis of Medicare claims from 2012 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 ages 85 or older (Table 5-1).⁷ 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 as their usual source of care (Centers for Medicare & Medicaid Services 2013a).

In a separate analysis, we found that patients treated in HOPDs in 2010 were, on average, more medically complex than patients treated in ASCs, as measured by differences in average patient risk scores (Medicare Payment Advisory Commission 2013b). We used

(continued next page)

TABLE 5-1

Medicare patients treated in ASCs differ from patients treated in HOPDs, 2012

| Characteristic | Percent of beneficiaries | |
|------------------|--------------------------|-------|
| | ASC | HOPD |
| Medicaid status | | |
| Not Medicaid | 86.0% | 76.6% |
| Medicaid | 14.0 | 23.4 |
| Race/ethnicity | | |
| White | 87.7 | 83.8 |
| African American | 6.9 | 10.3 |
| Other | 5.3 | 5.9 |
| Age | | |
| Under 65 | 15.2 | 22.4 |
| 65 to 84 | 78.0 | 66.8 |
| 85 or older | 6.8 | 10.8 |
| Sex | | |
| Male | 42.1 | 44.0 |
| Female | 57.9 | 56.0 |

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 5 percent carrier and outpatient standard analytic files, 2012.

control over their work environment and specialized staff. In addition, Medicare has lower payment rates, and beneficiaries generally pay lower coinsurance in ASCs than in HOPDs. However, the growth in ASCs may lead to an increase in the overall volume of surgical procedures (see discussion on p. 130).

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

The number of Medicare-certified ASCs increased significantly in 2007 and 2008 but has grown more slowly since then. The number of ASCs increased by 5.9 percent

in 2007 and 4.2 percent in 2008. However, the growth rate decelerated to 2.2 percent in 2009 and reached 1.2 percent in 2012 (Table 5-2, p. 127). This slower growth continued into 2013, as the number of ASCs increased by 0.4 percent to 5,377 during the first three quarters of 2013 (an annual growth rate of 0.5 percent).

Several factors might explain the relatively slow growth from 2009 through 2012:

- Health care spending at the national level has experienced a significant slowdown, which many analysts attribute to the sluggish economic recovery

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

risk scores from the CMS–hierarchical condition category (CMS–HCC) risk adjustment model used in Medicare Advantage to measure patient severity.⁸ CMS–HCC risk scores predict beneficiaries’ relative costliness based on their diagnoses from the prior year and their demographic information (e.g., age and sex). Beneficiaries of average health status have a risk score of around 1.0. The average risk score for HOPD patients across all procedures in 2010 was 1.64, compared with 1.23 for ASC patients; this difference is statistically significant ($p < 0.05$). Beneficiaries who have higher risk scores are likely to be sicker and may require more time and resources to treat. Sicker patients may be referred to HOPDs instead of ASCs because hospitals offer emergency services and access to onsite specialists if complications arise.

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

Other data sources also suggest that ASCs treat patients who are different from those treated by 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 2013). In Pennsylvania in 2012, Medicaid patients accounted for 5.1 percent of ASCs’ diagnostic and surgical procedures, compared with 12 percent of HOPDs’ procedures.⁹ Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (87.2 percent vs. 78.2 percent). Although Pennsylvania data may not be nationally representative, national estimates from the National Survey of Ambulatory Surgery (NSAS), conducted by the Centers for Disease Control and Prevention, also show that ASCs treat a smaller share of Medicaid

patients than hospitals. According to the NSAS data, ambulatory surgery visits by Medicaid patients in 2006 accounted for 3.9 percent of total visits to freestanding ASCs, compared with 8.1 percent of total visits to hospital-based surgery centers.¹⁰

Several factors could explain why ASCs treat a smaller share of Medicaid patients (including dual eligibles) than HOPDs. 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 examined referral patterns for physicians in Pennsylvania who sent most of their patients to physician-owned ASCs rather than HOPDs. These physicians were much more likely to refer their commercially insured and Medicare patients than their Medicaid patients to a physician-owned ASC. They sent more than 90 percent of their commercial and Medicare patients—but only 55 percent of their Medicaid patients—to an ASC instead of a hospital.

The location of ASCs may also lead to a smaller share of Medicaid patients; for example, ASC owners may choose to locate in areas with a high proportion of commercially insured patients. In addition, many state Medicaid programs do not pay Medicare’s cost sharing for dual eligibles if the Medicare rate for a service minus the cost sharing is higher than the Medicaid rate for the service (Medicare Payment Advisory Commission 2010a). In states that do not pay the cost sharing for ASC services used by dual eligibles, ASCs could be discouraged from treating these patients. Finally, dual-eligible beneficiaries are more likely to report that their usual source of care is an HOPD or hospital emergency department (ED) than are Medicare beneficiaries who have other types of supplemental coverage (Centers for Medicare & Medicaid Services 2013a). If a patient has an HOPD or ED as his or her usual source of care, physicians may be more likely to refer the patient to an HOPD for surgical care than another setting. The relatively low rate of ASC use among dual-eligible beneficiaries may partially explain the relatively low rate of ASC use among African Americans because African Americans are more likely to be dual eligibles (Table 5-1, p. 125). ■

**TABLE
5-2****Number of Medicare-certified ASCs grew by 12 percent, 2007-2012**

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--|-------|-------|-------|-------|-------|-------|
| Number of centers | 4,798 | 5,001 | 5,111 | 5,203 | 5,291 | 5,357 |
| New centers | 345 | 282 | 219 | 192 | 190 | 113 |
| Exiting centers | 77 | 79 | 109 | 100 | 102 | 47 |
| Net percent growth in number of centers from previous year | 5.9% | 4.2% | 2.2% | 1.8% | 1.7% | 1.2% |

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2012.

from the recession that began in the fall of 2008 (Cuckler et al. 2013, Deutsche Bank 2012, Kaiser Family Foundation 2013).

- The ASC payment system underwent a substantial revision in 2008, and investors may be responding to the large changes in payment rates that occurred under that revision.
- Payment rates for most ambulatory surgical services are 81 percent higher in the OPPS than in the ASC payment system, which has influenced some ASC owners to sell their facilities to hospitals and caused some health care systems to expand their HOPDs rather than establish new ASCs (North Carolina Department of Health and Human Services 2008, State of Connecticut 2011).
- 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 employed by hospitals are more likely to provide ambulatory surgical services in their hospitals' HOPDs than in a freestanding ASC.

To provide a more complete picture of capacity in ASCs, we also examined the change in the number of ASC operating rooms. From 2007 through 2012, the number of ASC operating rooms increased at about the same rate as the number of ASCs (2.3 percent per year vs. 2.2 percent per year). The mean number of operating rooms per ASC (2.8) and the median number of operating rooms (2.0) did not change during this period.

ASCs are concentrated geographically. As of 2012, Maryland had the most ASCs per fee-for-service (FFS) beneficiary, followed by Idaho, Washington, and Georgia;

each state had at least 30 ASCs per 100,000 Part B FFS beneficiaries. Vermont had the fewest ASCs per FFS beneficiary, followed by West Virginia and Kentucky; each state had fewer than 6 per 100,000 FFS beneficiaries.¹¹ In addition, in 2012, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time (Table 5-3). Urban areas include both cities and suburban areas; it is possible that more ASCs are located in suburban areas than in cities.

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

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

**TABLE
5-3****Most Medicare-certified ASCs are urban and for profit**

| ASC type | 2007 | 2012 |
|------------|------|------|
| Urban | 91% | 91% |
| Rural | 9 | 9 |
| For profit | 96 | 97 |
| Nonprofit | 4 | 3 |

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2012.

**TABLE
5-4**

Volume of ASC services per FFS beneficiary has continued to grow

| Time period | Average annual volume growth per FFS beneficiary |
|--|--|
| 2007 to 2011 | 4.6% |
| 2011 to 2012 | 1.7 |
| Services covered in both 2007 and 2012 | 1.7 |
| Services newly covered after 2007 | 2.4 |

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

Source: MedPAC analysis of 5 percent carrier standard analytic files, 2007, 2011, and 2012.

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings.
- ASCs may offer patients greater convenience than HOPDs (e.g., better locations and 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.¹²
- 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 surgical services in ASCs.
- Because physicians can probably 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 2007 to 2012

We examined growth in the number of FFS beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary.¹³ Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries

who have Part B. From 2007 through 2011, the number of FFS beneficiaries who received ASC services grew by an average of 1.5 percent per year and by 1.9 percent in 2012. From 2007 through 2011, the volume of surgical services per FFS beneficiary increased by an average of 4.6 percent per year and by 1.7 percent in 2012 (Table 5-4).

The 2008 revision of the ASC payment system substantially increased the number of covered services. We divided the growth in service volume from 2011 through 2012 into two parts: the portion due to surgical services newly covered after 2007 and the portion due to surgical services covered in both 2007 and 2012. Our analysis indicates that services newly covered after 2007 grew by 2.4 percent in 2012, and services covered in both 2007 and 2012 grew by 1.7 percent in 2012 (Table 5-4).¹⁴ The most commonly provided services that were newly covered after 2007—which also showed strong growth in other ambulatory settings—include two laser eye surgeries (trabeculectomy by laser eye surgery and iridotomy) and an orthopedic procedure (arthrocentesis by aspiration and/or injection of a major joint or bursa).

Although newly covered services had strong growth in 2012, they accounted for only 5.5 percent of total ASC volume. The services that have historically contributed the most to overall volume continued to constitute a large share of the total in 2012. For example, cataract removal with intraocular lens insertion had the highest volume in both 2007 and 2012, accounting for 20 percent of volume in 2007 and 17 percent in 2012. Moreover, 19 of the 20 most frequently provided services in 2007 were among the 20 most frequently provided in 2012 (Table 5-5). For these 20 services, volume per FFS beneficiary increased by an average of 1.7 percent per year from 2007 through 2012. However, these 20 services accounted for a smaller share of total ASC volume in 2012 than in 2007 (69 percent vs. 74.6 percent), which indicates that ASCs are providing an increasingly diverse set of procedures.

Surgical services migrated from HOPDs to ASCs between 2007 and 2010, but trend has slowed

Although the growth of services provided in ASCs from 2007 to 2010 may reflect the migration of procedures from HOPDs to ASCs, this trend appears to have slowed. We compared volume growth from 2007 through 2012 for services provided in ASCs with the growth of ASC-covered services provided in HOPDs. We limited this analysis to services that were covered in the ASC payment system in 2007 because the inclusion of services covered

**TABLE
5-5**

Most frequently provided ASC services in 2012 were similar to those provided in 2007

| Surgical service | 2007 | | 2012 | |
|---|-------------------|------|-------------------|------|
| | Percent of volume | Rank | Percent of volume | Rank |
| Cataract surgery w/ IOL insert, 1 stage | 19.9% | 1 | 16.9% | 1 |
| Upper GI endoscopy, biopsy | 7.9 | 2 | 8.1 | 2 |
| Diagnostic colonoscopy | 5.9 | 3 | 3.0 | 9 |
| Colonoscopy and biopsy | 5.5 | 4 | 5.8 | 3 |
| After cataract laser surgery | 5.4 | 5 | 3.9 | 6 |
| Lesion removal colonoscopy | 4.8 | 6 | 4.5 | 4 |
| Injection spine: lumbar, sacral (caudal) | 4.3 | 7 | 3.4 | 7 |
| Injection foramen epidural: lumbar, sacral | 3.1 | 8 | 4.1 | 5 |
| Injection paravertebral: lumbar, sacral add on* | 2.9 | 9 | 3.4 | 8 |
| Injection paravertebral: lumbar, sacral* | 1.9 | 10 | 2.4 | 10 |
| Lesion removal colonoscopy | 1.7 | 11 | 0.9 | 20 |
| Colon cancer screen, not high-risk individual | 1.7 | 12 | 1.6 | 13 |
| Injection foramen epidural add on | 1.6 | 13 | 2.1 | 11 |
| Upper GI endoscopy, diagnosis | 1.5 | 14 | 1.1 | 16 |
| Colorectal screen, high-risk individual | 1.4 | 15 | 1.9 | 12 |
| Cystoscopy | 1.3 | 16 | 1.1 | 17 |
| Destruction paravertebral nerve, add on** | 1.1 | 17 | 1.5 | 14 |
| Revision of upper eyelid | 0.9 | 18 | 0.9 | 18 |
| Cataract surgery, complex | 0.9 | 19 | 1.3 | 15 |
| Injection spine: cervical or thoracic | 0.9 | 20 | 0.9 | 20 |
| Total | 74.6 | | 69.0 | |

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal).
 *The description of these services changed in 2010 to include imaging guidance.
 **The description of this service changed in 2012 to include imaging guidance.

Source: MedPAC analysis of 5 percent carrier standard analytic files, 2007 and 2012.

in the OPSS in 2007 that became covered in the ASC payment system after 2007 would have biased the results.

From 2007 through 2010, the number of ASC-covered surgical services per FFS beneficiary grew by 3 percent per year in ASCs and by 0.3 percent in HOPDs, which suggests that at least some services migrated from HOPDs to ASCs during that period. In 2011, however, surgical services increased at a lower rate in ASCs than in HOPDs (1.7 percent vs. 3.7 percent). In 2012, surgical services increased by 1.7 percent in ASCs and decreased by 1.3 percent in HOPDs. However, the decline in HOPD volume in 2012 was largely driven by a strong decrease of 10.5 percent in the volume of pain management services. Excluding the decline in pain management services, the volume of HOPD surgical services increased by 0.5 percent in 2012.

Other data also suggest that the migration of services from HOPDs to ASCs has stalled. In Pennsylvania, ASCs' share of outpatient diagnostic and surgical procedures performed on all patients increased dramatically between 2000 and 2009, from 10.2 percent to 32.5 percent, but remained about the same in 2010 and 2011 and decreased to 31.5 percent in 2012 (Pennsylvania Health Care Cost Containment Council 2013).

We believe it is desirable to maintain beneficiaries' access to ASCs because services provided there are less costly to Medicare and beneficiaries than services delivered in HOPDs. Our comparison of the number of cataract surgeries with intraocular lens insertion provided in ASCs with those in HOPDs illustrates this point. We found that, from 2007 through 2012, the proportion of these

procedures provided in ASCs increased from 67 percent to 71 percent. Meanwhile, the payment rate for these procedures in 2012 was \$964 in ASCs compared with \$1,672 in HOPDs. Medicare's portion of this payment was \$771 in ASCs and \$1,182 in HOPDs, while the beneficiary's coinsurance was \$193 in ASCs and \$490 in HOPDs. Moreover, ASCs offer patients additional advantages over HOPDs, such as more convenient locations and shorter waiting times.

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 payment rates in ASCs on Medicare spending. Recent 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. 2009). One study compared practice patterns of physician-owners of ASCs in Florida, before and after they acquired an ASC, with physicians who did not own an ASC. The authors found that ASC owners increased their volume of four common surgical procedures more rapidly than non-ASC owners during the same period of time (Hollingsworth et al. 2010).¹⁵ Although this study had limitations (it was based on a single state, used a proxy measure of physician ownership, and did not examine whether the additional procedures were inappropriate), it suggests that physician ownership of ASCs is associated with greater overall volume of surgical procedures.

Two studies found that the growth of ASCs in a market is associated with higher overall volume of certain endoscopic procedures (Hollingsworth et al. 2011, Koenig and Gu 2013). The first study, which was limited to Florida, found that the volume of colonoscopies and upper gastrointestinal endoscopies in ambulatory settings increased at a faster rate in health care markets after ASCs entered the markets compared with markets that had no ASC entry (Hollingsworth et al. 2011). The authors found no significant relationship between ASC entry and the growth of cataract surgery or cancer-directed breast surgery. The second study examined national Medicare data and found that an increase in the number of ASC operating rooms in a state was associated with additional colonoscopy procedures in all outpatient settings (Koenig and Gu 2013). However, there was no significant relationship between growth in the number of ASC operating rooms and the volume of cataract surgery, upper

gastrointestinal procedures, or arthroscopy. Based on the results of these studies, it is plausible that reductions in Medicare spending due to lower payment rates for ASCs could be partially offset by a higher overall number of certain procedures.

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 2012 and the first three quarters of 2013, although at a slower rate than in previous years (Table 5-2, p. 127). This slowing growth may reflect the sluggish pace of recovery from the downturn in the economy that began in the fall of 2008, the widening difference between payment rates in the ASC payment system and the OPDS, and the increase in physician employment by hospitals. In 2008, the average payment rate for most services provided in ASCs was 65 percent of what would have been paid in HOPDs; this ratio fell to 55 percent in 2014. However, Medicare accounts for a relatively small share of ASCs' overall revenue on average, so factors other than Medicare payments may have a larger effect on access to capital for this sector.

In addition, the company that operates the largest number of ASCs in the country—Amsurg—continues to acquire new ASCs, which indicates that it has sufficient access to capital. Through the third quarter of 2013, Amsurg had acquired 5 new facilities in 2013 (it currently has 243 ASCs). The earnings per share (EPS) of stock for Amsurg is projected to increase by 12 percent in 2013 and 16 percent in 2014 (Deutsche Bank 2013). Greater EPS will provide more capital for Amsurg to acquire new ASCs and expand its existing ASCs. We caution, however, that this company includes only 5 percent of all Medicare-certified ASCs, so its experience may not represent the entire ASC sector.

Medicare payments: Payments have increased rapidly

In 2012, ASCs received about \$3.6 billion in Medicare payments and beneficiaries' cost sharing (Table 5-6). Spending per FFS beneficiary increased by an average of 4.3 percent per year from 2007 through 2011 and by 4.3 percent in 2012. The 4.3 percent increase in 2012 reflects a 1.6 percent increase in the ASC conversion factor, a 1.7 percent increase in volume per beneficiary, a 0.7 percent

**TABLE
5-6****Medicare payments to ASCs have grown, 2007-2012**

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|-------|-------|-------|-------|-------|-------|
| Medicare payments (billions of dollars) | \$2.9 | \$3.1 | \$3.2 | \$3.3 | \$3.4 | \$3.6 |
| Medicare payments per FFS beneficiary | \$89 | \$97 | \$102 | \$104 | \$106 | \$110 |
| Percent change per FFS beneficiary from previous year | 5.0% | 8.1% | 5.3% | 2.0% | 2.1% | 4.3% |

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

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

increase in the average relative weight, and a 0.2 percent increase in revenue from drugs. We examined how much of the ASC revenue growth in 2012 was from surgical services newly covered after 2007 and how much was from surgical services covered in both 2007 and 2012. In 2012, per capita spending on surgical services newly covered after 2007 (which accounted for 3.6 percent of ASC revenue from surgical services) increased 8.5 percent, and spending on surgical services covered in both 2007 and 2012 increased 4.4 percent. The increased spending on surgical services in ASCs was slightly offset by a decrease in spending on new technology intraocular lenses (NTIOLs). Spending on NTIOLs declined by \$7.4 million in 2012 because no NTIOLs were eligible for separate payment in 2012 (some NTIOLs were eligible for separate payment in 2011).

How should Medicare payments change in 2015?

Our payment adequacy analysis indicates that the number of Medicare-certified ASCs has increased, beneficiaries' use of ASCs has increased, and access to capital has been adequate. However, our information for assessing payment adequacy is limited because, unlike other types of facilities, Medicare does not require ASCs to submit cost data. We also do not have information on the quality of care in ASCs. Although ASCs began submitting quality data to CMS in 2012, CMS has not yet publicly released complete quality information (Centers for Medicare & Medicaid Services 2013b). The Commission has recommended that CMS develop a value-based purchasing program that would use ASC quality data to reward high-performing and penalize low-performing providers, but

CMS does not have the statutory authority to implement such a program (see text box, pp. 132-133).

Cost data would enable the Commission to examine the growth of ASCs' costs over time and analyze Medicare payments relative to the costs of efficient providers, which would help inform decisions about the ASC update. Cost data are also needed to examine whether an alternative input price index would be an appropriate proxy for ASC costs. As discussed in the text box (pp. 134-135), the Commission previously expressed concern that the price index that CMS uses to update ASC payments (the CPI-U) may not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010b). CMS has also concluded that it needs data on ASC costs to determine whether there is a better alternative than the CPI-U to measure changes in ASCs' input costs (Centers for Medicare & Medicaid Services 2012).

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

Creating a value-based purchasing program for ambulatory surgical centers

To improve the quality of care provided to beneficiaries in ambulatory surgical centers (ASCs), the Commission previously recommended that CMS implement a value-based purchasing (VBP) program to reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).¹⁶ CMS should also publicly report quality measurement results to help researchers and consumers compare quality among facilities. CMS established a Quality Reporting Program for ASCs in 2012; ASCs that do not submit data have their annual update reduced by 2 percentage points starting in 2014. However, Medicare payments to ASCs are not adjusted based on how they perform on quality measures, only on whether they successfully reported the measures. CMS currently lacks the statutory authority to implement a VBP program for ASCs.

The Commission supports the ASC Quality Reporting Program but believes that, eventually, high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system. In our March 2012 report, the Commission made the following recommendation:

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

Under the ASC Quality Reporting Program, ASCs began submitting data in 2012 and 2013 on four patient safety indicators, one process measure, and two structural measures. In 2014, ASCs began reporting data on influenza vaccination coverage among health care personnel. In 2015, they will begin reporting data on three chart-abstracted measures that relate to appropriate follow-up intervals for colonoscopy and improvement in visual function following cataract surgery (Centers for Medicare & Medicaid Services 2013b). Although CMS has not yet announced a time frame for publicly releasing the data collected under the Quality Reporting Program, this 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 outcomes across all ASCs. Several of the indicators that are reported through the ASC Quality Reporting Program could be used for an ASC VBP program. However, a measure on surgical site infections (SSIs) should be developed. 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

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

- total costs for the facility;
- Medicare unallowable costs (e.g., entertainment, promotion, and bad debt);
- the costs of clinical staff that 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 the information described above, CMS would need to collect data on specific cost categories to determine an appropriate input price index for ASCs.

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

should come from existing Medicare spending for ASC services. Initially, funding for the incentive payments should be set at 1 percent to 2 percent of aggregate ASC payments. The size of this pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program.

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

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

The first three measures listed 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 (hospital transfer or admission after an ASC procedure and SSI rate) may occur at low rates 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. ■

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

CMS increased the ASC conversion factor by 1.6 percent in 2012, 0.6 percent in 2013, and 1.2 percent in 2014. The update for 2014 was based on a projected 1.7 percent increase in the CPI-U minus a 0.5 percent deduction 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 ASC payment rates for 2015, 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.

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) payments. Because of our concern that the CPI-U may 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 (Government Accountability Office 2006). We found that ASCs' cost structure is different from that of hospitals and physician offices.

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

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

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

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

(continued next page)

In balancing these goals, the Commission concludes that the ASC update for 2015 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 2015. 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 2015. That is, the 2015 base payment rate under the ASC payment system should

be the same as the base rate in 2014. The indicators of payment adequacy for which we have information are positive: The number of Medicare-certified ASCs and the volume of services have increased, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow. Therefore, although we do not have cost and quality data, 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 provider, which would help inform decisions about the ASC update. Such data are also needed to analyze whether

Revisiting the ambulatory surgical center market basket (cont.)

(Medicare 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 different cost structure from hospitals and physician offices. ASCs appear to have a much higher share of expenses related to medical supplies and drugs than the other two settings, a much smaller share of employee compensation costs than hospitals, and a smaller share of all other costs (such as rent and capital costs) than physician offices. ASCs' larger share of costs for medical supplies and drugs could be related to their high volume of cataract removal and lens insertion procedures. These procedures use intraocular lenses, which are included in the medical supplies category and are relatively expensive. Another factor could be that ASCs primarily perform surgical procedures, whereas hospitals and physician offices provide a significant number of imaging and evaluation and management services, which probably have lower supply costs than surgical procedures.

Since our 2010 analysis, CMS also considered whether the hospital market basket or the practice expense component of the MEI is a better proxy for ASC costs than the CPI-U (Centers for Medicare & Medicaid Services 2012). However, CMS believes that the hospital market basket does not align with the cost

structure of ASCs because hospitals provide a much wider range of services than ASCs, such as room and board and emergency care. Therefore, the agency concluded that it needs data on the cost inputs of ASCs to determine whether there is a better alternative than the CPI-U to measure changes in ASC 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 10 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 2013b, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010b). CMS should use this information to examine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. A new ASC market basket could include the same types of costs that appear in the hospital market basket or MEI but with different cost weights that reflect the unique cost structure of ASCs. ■

an alternative input price index would be an appropriate proxy for ASC costs.

IMPLICATIONS 5

Spending

- CMS has decided to increase ASC payment rates based on the change in the CPI-U (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 2015 is 1.8 percent, and the forecast of productivity growth for 2015 is 0.4 percent, resulting in a projected update of 1.4 percent to the base payment rates for 2015 (IHS Global Insight forthcoming). However, we recommend that

the update be eliminated. Therefore, relative to current Medicare law, our recommendation would decrease federal spending by less than \$50 million in the first year and by less than \$1 billion over five years.

Beneficiary and provider

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

Endnotes

- 1 A survey conducted by the ASC Association found that 91 percent of ASCs had at least some physician owners in 2008 (Ambulatory Surgery Center Association 2008). A survey conducted by the Medical Group Management Association found that 74 percent of ASCs were either completely owned by physicians or physician–hospital joint ventures in 2008 (Medical Group Management Association 2009).
- 2 Because CMS updates payment rates in the OPPS and the PFS independently of each other, it is possible for the ASC payment rate for an office-based procedure to be based on the OPPS rate in one year and the PFS rate the next year (or vice versa).
- 3 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004; they received reliable cost data from 290 facilities.
- 4 The average time includes time spent by the patient in the operating room and postoperative recovery room.
- 5 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated a requirement that the Secretary collect cost data from ASCs every five years.
- 6 Medicare’s share of total ASC revenue varies by type of ASC, ranging from 7 percent for ASCs that specialize in orthopedic procedures to 43 percent for ASCs that specialize in ophthalmology cases (Medical Group Management Association 2009).
- 7 Because some states have a disproportionately high number of ASCs per beneficiary (Maryland, Washington, Idaho, and Georgia), we weighted beneficiaries so that in each state the percentage of beneficiaries receiving care in ASCs matched the national percentage. This process prevented idiosyncrasies in states that have high concentrations of ASCs from biasing the results. The analysis excluded beneficiaries who received services that Medicare does not cover in ASCs.
- 8 The CMS–HCC model is an abbreviated version of the full HCC model. The full HCC model includes 189 disease categories, while the version of the CMS–HCC we used includes 70. We excluded beneficiaries who had missing risk scores and beneficiaries who were new Medicare enrollees in 2010 because those beneficiaries’ risk scores were not based on diagnosis data. Our analysis included only surgical procedures that were covered in the ASC payment system in 2010.
- 9 These data are based on 269 ASCs and 171 hospitals.
- 10 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).
- 11 Whether a state has certificate of need (CON) laws for ASCs appears to affect the number of ASCs in the state. Twenty-six states and the District of Columbia have CON laws for ASCs. Each of the 13 states with the fewest ASCs per FFS beneficiary has a CON law, while only 4 of the 10 states that have the most ASCs per beneficiary have CON laws. Among these four states, Maryland and Georgia have exceptions in their CON requirements that make it easier to establish new ASCs.
- 12 By statute, coinsurance for a service paid under the OPPS cannot exceed the hospital inpatient deductible (\$1,216 in 2014). The ASC payment system does not have the same limitation on coinsurance, and for a few services the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the OPPS coinsurance.
- 13 Our analysis excluded radiology services provided in ASCs because the ASC payment system did not pay separately for radiology services before 2008.
- 14 Our analysis of service volume in 2012 included only surgical procedures (Current Procedural Terminology codes in the range of 10000–69999). Our analysis did not include nonsurgical services, such as radiology services, brachytherapy sources, drugs, and pass-through devices. In addition, it did not include services that were packaged in 2012.
- 15 This study assumed that physicians who performed at least 30 percent of their outpatient surgeries at a given ASC within a year were ASC owners. The four procedures for which there was a significant relationship between ASC ownership and volume were carpal tunnel release, cataract excision, colonoscopy, and knee arthroscopy. There was no significant relationship for myringotomy with tube placement.
- 16 The Commission also described its principles for a value-based purchasing (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).
- 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.

References

- Ambulatory Surgery Center Association. 2008. Medicare ASC payment rates: An industry in the midst of change. Presentation at MedPAC. December 12.
- Berenson, R. A., P. B. Ginsburg, J. B. Christianson, et al. 2012. The growing power of some providers to win steep payment increases from insurers suggests policy remedies may be needed. *Health Affairs* 31, no. 5 (May): 973–981.
- Bureau of Labor Statistics, U.S. Department of Labor. 2009. *Consumer price index: June 2009*. Washington, DC: Bureau of Labor Statistics. July 15.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013a. The characteristics and perceptions of the Medicare population: Data from the 2011 Medicare Current Beneficiary Survey. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html?DLPage=1&DLSortDir=descending>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013b. Medicare and Medicaid programs: Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; hospital value-based purchasing program; organ procurement organizations; quality improvement organizations; Electronic Health Records (EHR) Incentive Program; provider reimbursement determinations and appeals. Final rule. *Federal Register* 78, no. 237 (December 10): 74825–75200.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012. Medicare and Medicaid programs: Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; electronic reporting pilot; inpatient rehabilitation facilities quality reporting program; revision to quality improvement organization regulations. Final rule. *Federal Register* 77, no. 221 (November 15): 68210–68565.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2011. Medicare and Medicaid programs: Hospital outpatient prospective payment; ambulatory surgical center payment; hospital value-based purchasing program; physician self-referral; and patient notification requirements in provider agreements. Final rule. *Federal Register* 76, no. 230 (November 30): 74122–74584.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2007. Medicare program; revised payment system policies for services furnished in ambulatory surgical centers (ASCs) beginning in CY 2008. Final rule. *Federal Register* 72, no. 148 (August 2): 42469–42626.
- Cuckler, G. A., A. M. Sisko, S. P. Keehan, et al. 2013. National health expenditure projections, 2012–22: Slow growth until coverage expands and economy improves. *Health Affairs* 32, no. 10 (October): 1820–1831.
- Cullen, K. A., M. J. Hall, and A. Golosinskiy. 2009. *Ambulatory surgery in the United States, 2006*. National Health Statistics Reports, no. 11. National Center for Health Statistics, Centers for Disease Control and Prevention, Department of Health and Human Services. Hyattsville, MD: NCHS. September 4.
- Deutsche Bank. 2013. *Amsurg Corp: Q3 wrap: Results in-line/maintain hold*. Markets research. New York, NY: Deutsche Bank Securities. October 23.
- Deutsche Bank. 2012. *Health care providers: February physician office visits*. Markets research. New York, NY: Deutsche Bank. March 20.
- Gabel, J. R., C. Fahlman, R. Kang, et al. 2008. Where do I send thee? Does physician-ownership affect referral patterns to ambulatory surgery centers? *Health Affairs* 27, no. 3 (May–June): w165–174.
- Government Accountability Office. 2006. *Medicare: Payment for ambulatory surgical centers should be based on the hospital outpatient payment system*. Washington, DC: GAO.
- Hollingsworth, J. M., S. L. Krein, Z. Ye, et al. 2011. Opening of ambulatory surgery centers and procedure use in elderly patients: Data from Florida. *Archives of Surgery* 146, no. 2 (February): 187–193.
- Hollingsworth, J. M., Z. Ye, S. A. Strobe, et al. 2010. Physician-ownership of ambulatory surgery centers linked to higher volume of surgeries. *Health Affairs* 29, no. 4 (April): 683–689.
- IHS Global Insight. Forthcoming. IHS Global Insight 2013q4 forecast. Released to MedPAC by the Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.
- IHS Global Insight. 2009. *Healthcare cost review: First quarter 2009*. Washington, DC: IHS Global Insight.
- Kaiser Family Foundation. 2013. Assessing the effects of the economy on the recent slowdown in health spending. Issue brief. <http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/>.
- Koenig, L., and Q. Gu. 2013. Growth of ambulatory surgical centers, surgery volume, and savings to Medicare. *American Journal of Gastroenterology* 108: 10–15.

- Mathews, A. W. 2012. Same doctor visit, double the cost: Insurers say rates can surge after hospitals buy private physician practices; Medicare spending rises, too. *Wall Street Journal*, August 27.
- Medical Group Management Association. 2009. *ASC performance survey: 2009 report based on 2008 data*. Washington, DC: MGMA.
- Medicare Payment Advisory Commission. 2013a. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2013b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2011a. MedPAC comment letter on the Department of Health and Human Services' *Report to the Congress: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan*, August 30.
- Medicare Payment Advisory Commission. 2011b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2010a. *Report to the Congress: Aligning incentives in Medicare*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2010b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2004. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Mitchell, J. M. 2010. Effect of physician ownership of specialty hospitals and ambulatory surgery centers on frequency of use of outpatient orthopedic surgery. *Archives of Surgery* 145, no. 8 (August): 732–738.
- North Carolina Department of Health and Human Services, Division of Health Service Regulation. 2008. Declaratory ruling to the Presbyterian Hospital and SameDay Surgery Center at Presbyterian Hospital, LLC.
- Pennsylvania Health Care Cost Containment Council. 2013. *Financial analysis 2012. Volume two, ambulatory surgery centers*. Harrisburg, PA: PHC4.
- State of Connecticut, Department of Public Health, Office of Health Care Access. 2011. Notice of final decision for an application for a certificate of need filed by Hartford Hospital & Constitution Eye Surgery Center, LLC. Change of ownership and control of Constitution Eye Surgery Center, LLC to Hartford Hospital. January 20.
- Strope, S. A., S. Daignault, J. M. Hollingsworth, et al. 2009. Physician ownership of ambulatory surgery centers and practice patterns for urological surgery: Evidence from the state of Florida. *Medical Care* 47, no. 4 (April): 403–410.