

SECTION
20C

Ambulatory surgical centers

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

- 2C** The Congress should implement a 0.6 percent increase in payment rates for ambulatory surgical center services in calendar year 2011 concurrent with requiring ambulatory surgical centers to submit cost and quality data.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

Ambulatory surgical centers

Section summary

Ambulatory surgical centers (ASCs) furnish outpatient surgical services to patients not requiring hospitalization and for whom an overnight stay is not expected after surgery. In 2008,

- ASCs served 3.3 million Medicare beneficiaries, an increase of 2.8 percent over 2007,
- the number of Medicare-certified ASCs was 5,175, an increase of 3.7 percent over 2007, and
- Medicare combined program and beneficiary spending on ASC services was \$3.1 billion, an increase of 9.7 percent per fee-for-service (FFS) beneficiary over 2007.

Assessment of payment adequacy

Most of the available indicators of payment adequacy for ASC services, discussed below, are positive. The Commission therefore recommends a modest 0.6 percent increase to the payment rates for ASC services in calendar year 2011, concurrent with requiring ASCs to submit cost and quality data.

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

In this section

- Are Medicare payments adequate in 2010?
- How should Medicare payments change in 2011?
- Revisiting the ASC market basket

- **Capacity and supply of providers**—From 2003 through 2007, the number of Medicare-certified ASCs grew by an average annual rate of 6.7 percent; in 2008, this rate slowed to 3.7 percent. The slower growth in 2008 may reflect the downturn in the U.S. economy. Also, the ASC payment system underwent a substantial revision in 2008, which may have caused investors to delay opening new ASCs to see how payment system changes would affect the overall ASC market.
- **Volume of services**—From 2003 through 2007, the volume of services per FFS beneficiary grew by 10.2 percent; in 2008, volume growth rose slightly to 10.5 percent. From 2003 through 2008, the number of beneficiaries served in ASCs increased by an average of 5.7 percent per year.

Quality of care—Because CMS does not require ASCs to submit quality data, we are unable to assess ASCs’ quality of care.

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

Medicare payments and providers’ costs—From 2003 through 2008, ASCs’ Medicare revenue increased from \$2.2 billion to \$3.1 billion. Also, from 2003 through 2007, Medicare payments per FFS beneficiary increased at an annual rate of 8.0 percent and in 2008 by 9.7 percent.

Revisiting the ASC market basket

The projected change in providers’ input prices is an important part of the Commission’s annual update process. Because of concerns that the market basket index CMS uses to update ASC payments (the consumer price index for all urban consumers) may not reflect ASCs’ cost structure, we examined whether an alternative price index—such as those used for hospitals and physician practices—would better measure changes in ASC costs. We used ASC cost data from a Government Accountability Office survey to compare the distribution of ASC costs with the distribution of hospital and physician practice costs. Although the ASC cost 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 larger share of expenses related to medical supplies and drugs than the other two settings, a much smaller share of labor costs than hospitals, and a smaller share of all other costs than physician offices. Given these marked differences, the Congress should require ASCs to submit cost data to CMS, which should decide whether to use an existing Medicare price index as a proxy for ASC costs or develop an ASC-specific price index. ■

Background

An ambulatory surgical center (ASC) is a distinct entity that furnishes outpatient surgical procedures to patients who do not require an overnight stay following the procedure. Almost all ASCs are freestanding facilities rather than part of a larger facility such as a hospital. Beneficiaries may also receive surgical services in inpatient and outpatient hospital settings and sometimes in physician offices.

ASCs are a source of revenue for many physicians; about 90 percent of ASCs have at least one physician owner. In addition, about 20 percent of ASCs with physician ownership are physician–hospital joint ventures (Ambulatory Surgery Center Association 2008).

Since 1982, Medicare has made payments for surgical procedures provided in ASCs. Physicians who perform procedures in ASCs or in other facilities receive separate payments for their professional services.

To receive payments from Medicare, ASCs must meet Medicare’s conditions of coverage for ASCs, which specify minimum 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. This payment system underwent substantial revisions in 2008 (see online Appendix A to this chapter, available at <http://www.medpac.gov>). The most significant changes included a substantial increase in the number of surgical procedures covered under the ASC payment system, allowing ASCs to bill separately for certain ancillary services, and large changes in payment rates for many procedures. To help ASCs adjust to the changes in payment rates, CMS is phasing in the new payment rates over four years, from 2008 through 2011.

Medicare covers about 3,400 surgical procedures under the ASC payment system. The relative weight for most covered surgical procedures is based on its relative weight under the outpatient prospective payment system (PPS)—the system Medicare uses to set payments for most services furnished in hospital outpatient departments (HOPDs).¹ This linkage to the outpatient PPS is consistent with a previous Commission recommendation to align the relative weights in the outpatient PPS with the ASC payment system (Medicare Payment Advisory Commission 2004). For most covered surgical procedures, the payment rate is

the product of its relative weight and a conversion factor set at \$41.87 in 2010. However, the conversion factor in the outpatient PPS for 2010 is \$67.41. The reason for the difference in conversion factors is that CMS sets the ASC conversion factor so that total payments equal what the program spent on ASC services in 2007, the year before CMS implemented the revised ASC payment system. In contrast, CMS sets the outpatient PPS conversion factor so that total payments in that system equal what the program spent on hospital outpatient services in the year before CMS implemented the outpatient PPS. Note that CMS updates both the ASC and outpatient PPS conversion factors over time to reflect inflation.

An important exception to this linkage to the outpatient PPS is the procedures that are performed predominantly in physician offices and that 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 outpatient PPS relative weights or the nonfacility practice expense amount indicated on the Medicare physician fee schedule (MPFS). CMS set this limit on the rate for office-based procedures to prevent migration of these services from physician offices to ASCs for financial reasons. Because CMS updates payment rates in the outpatient PPS and the MPFS independently of each other, it is possible for the ASC payment rate for an office-based procedure to be based on the outpatient PPS rate in one year and on the MPFS rate the next year (or vice versa).

The ASC payment system generally parallels the outpatient PPS 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 these ancillary services:

- radiology services that are integral to a covered surgical procedure if separate payment is made for the radiology service in the outpatient PPS,
- brachytherapy sources implanted during a surgical procedure,
- all pass-through and non-pass-through drugs that are paid separately under the outpatient PPS when provided as part of a covered surgical procedure, and
- devices with pass-through status under the outpatient PPS.

The Commission’s Payment Basics series provides more information about the ASC payment system (available at

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

There is significant evidence that ambulatory surgical centers (ASCs) treat different types of patients than hospital outpatient departments (HOPDs). ASCs are less likely to serve medically complex patients, Medicaid patients, African Americans, and Medicare beneficiaries who are older or eligible for Medicare because of disability.

Research by the Commission showed that ASCs treat Medicare patients who are less medically complex than patients treated in HOPDs, as measured by differences in average risk scores (Medicare Payment Advisory Commission 2003).² Under a contract with the Commission, RAND Health compared the characteristics of Medicare beneficiaries who had cataract surgery or a colonoscopy in an ASC in 2001 with beneficiaries who received these procedures in an HOPD. RAND found that ASC patients were less likely

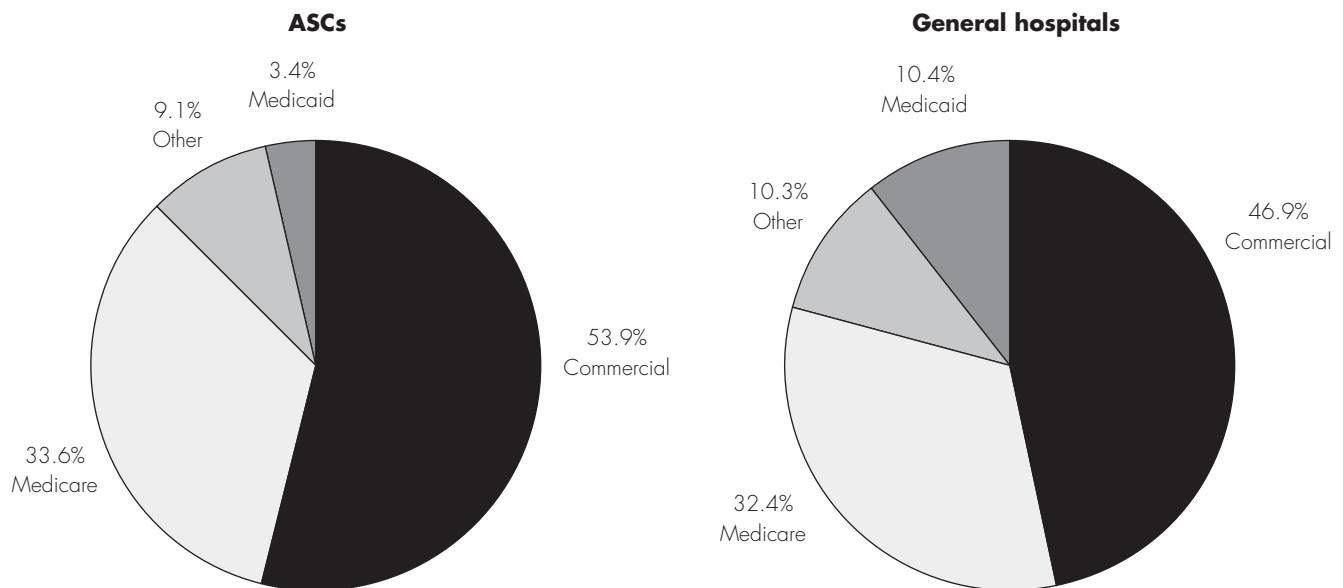
to have certain comorbidities such as dementia or an acute episode of chronic obstructive pulmonary disease than HOPD patients (Sloss et al. 2006).

According to data from Pennsylvania on Medicare and non-Medicare patients, ASCs are less likely than HOPDs to serve Medicaid patients. In 2008, Medicaid patients accounted for 3.4 percent of diagnostic and surgical procedures in ASCs, compared with 10.4 percent of procedures in HOPDs (Pennsylvania Health Care Cost Containment Council 2009) (Figure 2C-1).³ Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (87.5 percent vs. 79.3 percent). Some of these differences may be explained by the greater propensity of Medicaid patients to seek care in hospital emergency rooms or by ASCs' decisions to locate in areas with a higher proportion of commercially insured

(continued next page)

FIGURE 2C-1

Distribution of outpatient procedures by payer at ASCs and general acute care hospitals in Pennsylvania, FY 2008



Note: ASC (ambulatory surgical center), FY (fiscal year). Procedures include diagnostic and surgical services. Other payers include auto insurance, workers' compensation, and other government programs.

Source: Pennsylvania Health Care Cost Containment Council 2009.

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

patients. National estimates from the National Survey of Ambulatory Surgery (NSAS), conducted by the Centers for Disease Control and Prevention (CDC), also show that ASCs treat a smaller share of Medicaid patients than hospitals. According to NSAS data compiled for MedPAC by CDC, visits by Medicaid patients accounted for 3.9 percent of total visits to freestanding ambulatory surgery centers in 2006, compared with 8.1 percent of total visits to hospital-based centers.

A study by Gabel and colleagues of Medicare and non-Medicare patients supports the finding that ASCs in Pennsylvania are less likely to serve Medicaid patients (Gabel et al. 2008). The article examined referral patterns for physicians in Pennsylvania who sent most of their patients to physician-owned ASCs rather than to 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. This finding suggests that physicians refer their more lucrative patients to ASCs and the less lucrative patients to hospitals. However, it is also possible that physicians were more likely to refer Medicaid patients to a hospital because the patients needed a higher level of care or the patients had a Medicaid managed care plan that did not cover surgeries in an ASC.

Our analysis of Medicare claims found that the following groups are less likely to receive care in ASCs than in HOPDs: Medicare beneficiaries who also have Medicaid coverage, African Americans (who are more likely to have both Medicare and Medicaid), beneficiaries who

are eligible because of disability (under age 65), and beneficiaries who are age 85 or older (Table 2C-1).⁴ The smaller share of disabled and older beneficiaries treated in ASCs may reflect the healthier profile of ASC patients relative to HOPD patients. ■

**TABLE
2C-1**

The Medicare patient profile in ASCs is different from that in HOPDs, 2008

Characteristic	Percentage of beneficiaries	
	ASC	HOPD
Medicaid status		
Not Medicaid	87.4%	78.7%
Medicaid	12.6	21.3
Race/ethnicity		
White	89.3	85.4
African American	6.4	9.7
Other	4.3	4.9
Age		
Under 65	13.2	20.3
65 to 84	79.5	69.1
85 or older	7.4	10.6
Sex		
Male	42.0	43.4
Female	58.0	56.6

Note: ASC (ambulatory surgical center), HOPD (hospital outpatient department). Figures may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 5 percent standard analytical claims files, 2008.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_09_ASC.pdf.

The links between the ASC payment system, the outpatient PPS, and the MPFS raise broader questions about how Medicare and beneficiaries should pay for the same services that are provided in different settings. Should Medicare and beneficiaries pay the same amount

regardless of where a service is delivered? If so, how should that amount be determined? Alternatively, should the payment vary based on the cost of efficient providers in each setting, with an adjustment for the quality performance of providers? The current ASC payment system exhibits elements of each approach. Payments for many office-based procedures performed in ASCs

**TABLE
2C-2**

Number of Medicare-certified ASCs has grown, 2003–2008

	2003	2004	2005	2006	2007	2008
Number of centers	3,848	4,140	4,441	4,700	4,991	5,174
New centers	368	366	355	331	346	219
Exiting centers	65	74	54	72	55	36
Net percent growth in number of centers from previous year	8.5%	7.6%	7.3%	5.8%	6.2%	3.7%

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2008.

are equal to the nonfacility practice expense amount in the MPFS, and ASCs and HOPDs receive the same amount for pass-through drugs and devices. In contrast, payments for most ASC services are less than the comparable payment under the outpatient PPS, consistent with evidence that ASCs are a less costly setting and treat patients who are less medically complex (Medicare Payment Advisory Commission 2004). A question related to the conundrum of payments in different settings is: How should Medicare measure and reward quality for similar services provided in different settings? The Commission plans to explore these issues further in future work.

In the following sections, we consider the adequacy of payments for ASCs, focusing our analysis on beneficiaries' access to care, ASCs' access to capital, and ASCs' revenue from Medicare. As we cover these topics, we caution that the effect of Medicare payments on the financial health of ASCs is limited because Medicare spending accounts for about 20 percent of ASCs' overall revenue (Medical Group Management Association 2007).

Are Medicare payments adequate in 2010?

To address whether payments for the current year (2010) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2011), 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 change in revenue from the Medicare program. Unlike our assessments of other provider types,

we did not use quality data in our analysis because CMS does not require ASCs to submit data on quality measures. Likewise, we cannot examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.⁵

Our results show that beneficiaries have at least adequate access to care, ASCs have adequate access to capital, and Medicare payments to ASCs have grown substantially. Together, these measures suggest that payment rates were at least adequate through 2008. However, our results also indicate that ASCs are less likely than HOPDs to treat African Americans, Medicare beneficiaries who are eligible because of disability, and beneficiaries age 85 or older (see text box, p. 98–99). These demographic differences probably reflect differences in the health and Medicaid status of beneficiaries served by ASCs and HOPDs.

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

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 convenience and efficiency relative to HOPDs—the sector with the greatest overlap of surgical services with ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs; for physicians, ASCs may offer more control over their work environment, customized surgical environments, and specialized staff. In addition, Medicare has lower payment rates and beneficiaries generally face lower coinsurance in ASCs than in HOPDs. Therefore, as long as this growth in ASCs does not represent some degree of overprovision of surgical services, the Commission recognizes the benefits they offer. However,

if the growth in ASCs has resulted in overprovision of services, reductions in aggregate program spending and beneficiary coinsurance that occur because of lower payment and coinsurance rates in the ASC system would be partially offset.

Capacity and supply of providers: Number of ASCs grew rapidly over last several years, but growth has slowed

The number of Medicare-certified ASCs has increased substantially over the last several years. From 2003 through 2007, an average of 353 new facilities entered the program per year, while an average of 64 closed or merged with other facilities (Table 2C-2). The average annual growth rate during this period was 6.7 percent.

The rate of growth in the number of Medicare-certified ASCs slowed in 2008. These ASCs numbered 5,174 in 2008, representing a 3.7 percent increase over 2007. The relatively slow growth continued into 2009, as the number of ASCs increased by 1.2 percent to 5,234 during the first three quarters of 2009, for an annual growth rate of 1.5 percent. The relatively slow growth in 2008 and in the first three quarters of 2009 may reflect the downturn in the economy that occurred in the later months of 2008. The substantial changes to the ASC payment system that occurred in 2008 also may have contributed to the slower growth, as investors may have waited to see how the new system affected the overall ASC market before deciding to open new facilities.

To provide a more complete picture of ASCs, we also examined the change in the number of operating rooms. From 2003 to 2008, the mean number of operating rooms per ASC increased slightly from 2.5 to 2.6, although the median number of operating rooms remained the same at 2. This finding indicates that the growth in the number of operating rooms has been similar to the growth in the number of ASCs.

Our analysis also indicates that ASCs are concentrated geographically. As of 2008, 40 percent of ASCs were concentrated in five states that accounted for 27 percent of fee-for-service (FFS) beneficiaries—California, Florida, Maryland, Texas, and Georgia. In contrast, Vermont, Alaska, and the District of Columbia had fewer than 10.⁶ In addition, in 2008, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time (Table 2C-3). Beneficiaries who do not have access to an ASC may receive ambulatory surgical services in HOPDs and, in some cases, in physician

**TABLE
2C-3**

Most Medicare-certified ASCs are urban and for profit

ASC type	2003	2008
Urban	87%	88%
Rural	13	12
For profit	95	96
Nonprofit	5	4

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2008.

offices. In addition, beneficiaries living in remote rural areas may travel to urban areas to receive care in ASCs.

Steady growth in the number of Medicare-certified ASCs may indicate that Medicare’s payment rates have been at least adequate, despite the fact that there were no positive updates to ASC payment rates from 2004 through 2009. However, Medicare payments, according to industry surveys, are not a substantial source of revenue for ASCs, accounting for about 20 percent of all ASC revenue (Deutsche Bank 2008, Medical Group Management Association 2007). In addition, other factors have likely influenced the rapid 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.
- Medicare began covering colonoscopy for colorectal cancer screening in 1998.
- ASCs may offer patients greater convenience than HOPDs in terms of better locations, the ability to schedule surgery more quickly, and shorter waiting times.
- For most procedures covered under the ASC payment system, beneficiaries’ coinsurance is lower in ASCs than in HOPDs.⁷
- Physicians may find it more convenient and efficient to perform procedures in ASCs because they often have customized surgical environments and specialized staffing.

**TABLE
2C-4**

The set of most frequently provided services in 2008 was similar in 2007

Surgical service	2007		2008	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	19.9%	1	18.3%	1
Upper GI endoscopy, biopsy	7.9	2	7.9	2
Diagnostic colonoscopy	5.9	3	5.1	4
Colonoscopy and biopsy	5.5	4	5.5	3
After cataract laser surgery	5.4	5	4.7	5
Lesion removal colonoscopy	4.8	6	4.6	6
Injection spine: lumbar, sacral (caudal)	4.3	7	3.7	7
Inject foramen epidural: lumbar, sacral	3.1	8	3.3	8
Inject paravertebral: lumbar, sacral add on	2.9	9	2.8	9
Inject paravertebral: lumbar, sacral	1.9	10	1.9	10
Lesion remove colonoscopy	1.7	11	1.5	13
Colon cancer screen, not high-risk individual	1.7	12	1.5	14
Inject foramen epidural add on	1.6	13	1.8	11
Upper GI endoscopy, diagnosis	1.5	14	1.4	15
Colorectal screen, high-risk individual	1.4	15	1.5	12
Cystoscopy	1.3	16	1.2	17
Destruction paravertebral nerve, add on	1.1	17	1.3	16
Revision of upper eyelid	0.9	18	1.0	19
Cataract surgery, complex	0.9	19	1.1	18
Total	73.8		70.0	

Note: IOL (intraocular lens), GI (gastrointestinal). Columns may not sum to total due to rounding.

Source: MedPAC analysis of 5 percent standard analytical claims files, 2007 and 2008.

- Physicians who invest in ASCs can increase their practice revenue by receiving ASC facility payments. The federal anti-self-referral law (also known as the Stark Law) does not apply to surgical services provided in ASCs.
- Because physicians can probably perform more procedures in ASCs than in HOPDs in the same amount of time, they can increase their professional fees.

Newly covered services contributed strongly to growth in number of services in 2008; number of services provided grew rapidly during 2003–2008

Our examination of growth in service volume in ASCs focused on the number of services provided per FFS beneficiary. We used this measure rather than aggregate service volume because enrollment in FFS Medicare has been declining in recent years due to large increases in Medicare Advantage enrollment. We believe that growth in

aggregate service volume would have understated the extent to which FFS beneficiaries are receiving care in ASCs.

Our examination of the change in the number of ASC services per FFS beneficiary consisted of two parts. In the first part, we estimated how much of the growth in service volume from 2007 to 2008 was due to the increased number of services covered under the ASC payment system in 2008. We compared this value with the amount of growth attributable to services covered in both 2007 and 2008. This result gives us a sense of how well ASCs have adapted to the revised system that CMS implemented in 2008. In the second part, we compared the number of services per beneficiary in 2008 with the number in 2003 to obtain an estimate of historical growth in ASC service volume. For this part of the analysis, we limited the measure of service volume in 2008 to services covered under the ASC payment system in 2003.

**TABLE
2C-5****Volume of surgical services grew faster in ASCs than in HOPDs, 2003–2008**

Measure	Average annual percent change, 2003–2008	
	ASCs	HOPD surgical services
Number of services per FFS beneficiary	9.1%	–0.1%
Percent of FFS beneficiaries served	6.3	–1.3
Number of services per beneficiary served	2.7	1.2

Note: ASC (ambulatory surgical center), HOPD (hospital outpatient department), FFS (fee-for-service). To ensure comparability across sectors, we analyzed services that are payable by Medicare when provided in an ASC. In addition, the services included in the 2008 volume were limited to those that were covered in ASCs in 2003.

Source: MedPAC analysis of 5 percent standard analytic claims files.

Newly covered services contributed strongly to growth in service volume in 2008

Among the substantial revisions that CMS made to the ASC payment system in 2008, the large increase in the number of covered surgical services presented ASCs an opportunity to expand the array of services they provide to Medicare beneficiaries.

This year is the first time claims data were available for assessing the effects of this increase. Our analysis indicates that ASC service volume per FFS beneficiary increased by 10.5 percent in 2008.⁸ Services newly covered in 2008 accounted for 4.9 percentage points of the increase in service volume per FFS beneficiary, while services covered in both 2007 and 2008 accounted for the remaining 5.6 percentage points.⁹

Although newly covered services contributed much of the growth in service volume, the services that historically contribute the most to overall volume changed less from 2007 to 2008. For example, cataract removal with intraocular lens (IOL) insertion had the largest volume in both 2007 and 2008, accounting for 20 percent of volume in 2007 and 18 percent of volume in 2008. Moreover, the 19 most frequently provided services in 2007 were also the 19 most frequently provided in 2008, though the order differed slightly for each year (Table 2C-4). For these 19 services, service volume per FFS beneficiary increased by 4.8 percent from 2007 to 2008; but these 19 services accounted for a smaller share of total volume in 2008 than in 2007: 70 percent versus 74 percent.

Volume of services grew rapidly from 2003 through 2008

Apart from the substantial growth in 2008 in service volume per FFS beneficiary, this measure grew rapidly from 2003 through 2007—an average of 10.2 percent per year, compared with 10.5 percent in 2008.

We also examined growth in service volume per FFS beneficiary, excluding the effects of newly covered services over time. We estimated service volume only for services covered in both 2003 and 2008. This estimate provided a measure of the growth in service volume, without the effects of services that were added to the ASC payment system after 2003. Under this measure, the number of services per FFS beneficiary increased by an average of 9.1 percent per year (55 percent overall).¹⁰ This increase was driven by growth in the proportion of beneficiaries served, which increased by 6.3 percent per year from 2003 to 2008, and by growth in the number of services provided to each ASC patient, which increased by 2.7 percent per year (Table 2C-5). This growth occurred even though there were no positive updates to ASC rates from 2004 through 2009.

The growth in service volume provided in ASCs may reflect, in part, migration of services from HOPDs to ASCs. We compared growth in ASC service volume with the growth of ASC-covered services provided in HOPDs. Some results from that analysis suggest that surgical services may be migrating from HOPDs to ASCs:

- From 2003 through 2008, the number of surgical services per FFS beneficiary grew by 9.1 percent in

ASCs but decreased by 0.1 percent in HOPDs (Table 2C-5, p. 103).

- From 2003 through 2008, volume of nonsurgical services per FFS beneficiary in HOPDs grew by 4.0 percent, while surgical services declined by 0.1 percent. This result indicates that HOPD services not covered in ASCs were growing at a fairly robust rate, while ASC-covered services were declining.

Other data also suggest a shift in surgical services to ASCs. Research indicates that in Pennsylvania ASCs accounted for 10 percent of the diagnostic and surgical procedures performed in outpatient settings in 2000; the ASCs' share increased to 30 percent in 2008 (this study includes all patients, not just Medicare beneficiaries). Moreover, most of the growth in outpatient diagnostic and surgical procedures during those years occurred in ASCs (Pennsylvania Health Care Cost Containment Council 2009). This finding suggests a shift in surgical services to ASCs.

However, factors other than migration to ASCs may be contributing to the relatively slow growth of surgical services in HOPDs. HOPD services may also be migrating to physician offices. Moreover, relative to HOPDs, ASCs may offer more convenience to patients and providers. Finally, it is possible that HOPDs are finding some nonsurgical services more profitable than surgical services under the outpatient PPS.

If surgical services are shifting from HOPDs to ASCs, spending growth may slow accordingly. Starting in 2008, the payment rates for all surgical services are lower in the ASC payment system than in the outpatient PPS.¹¹ For example, we examined the number of cataract surgeries with IOL insert provided in ASCs and HOPDs. From 2003 to 2008, the proportion of these procedures provided in ASCs increased from 57 percent to 68 percent. Meanwhile, the payment rate for these procedures in 2008 was \$977 in ASCs and \$1,520 in HOPDs.

It is possible that physician ownership of ASCs could partially offset the effect of comparatively lower rates that would lead to lower Medicare spending. Most ASCs have some degree of physician ownership. Having an ownership stake may give physicians an incentive to perform more surgical services than they would if they provided outpatient surgical services only in HOPDs. To the extent that physicians act on this incentive, the reductions in spending due to lower payment rates in ASCs could be partially offset. Although there are differences between

specialty hospitals and ASCs, there is evidence that physician-owned specialty hospitals are associated with higher volume in a market. The Commission found that the entrance of a cardiac hospital in a market was associated with a greater increase in coronary artery bypass graft surgeries than would be expected (Medicare Payment Advisory Commission 2006). Because physicians are more likely to generate demand for the low-risk procedures typically provided in ASCs than the higher risk procedures provided in specialty hospitals, the effect of physician ownership on volume may be stronger in ASCs than in specialty hospitals.

Hospitals in Pennsylvania have alleged that ASCs treat healthier and better insured patients than hospitals, which places a financial strain on hospitals (DerGurahian 2009). Research conducted by the Commission and RAND found that ASCs treat less severely ill patients than HOPDs (Medicare Payment Advisory Commission 2003, Sloss et al. 2006). In addition, ASCs in Pennsylvania are less likely than HOPDs to treat Medicaid patients (see text box, p. 98–99). These factors may affect the long-term financial viability of hospitals.

Providers' access to capital: Growth in number of ASCs and ASCs' financial performance suggest 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 indicator available of ASCs' ability to obtain capital. The number of ASCs continued to increase in 2008 and the first three quarters of 2009, although at a slower rate than in prior years (Table 2C-2, p. 100). The downturn in credit markets that occurred in the latter part of 2008 likely reduced providers' access to capital and may have had a role in this slowdown. Because the dramatic changes in the credit markets were unrelated to changes in Medicare payments, changes in access to capital in 2008 may not be a good indicator of Medicare payment adequacy.

Data on the financial performance of publicly traded ASCs also provide evidence of the sector's access to capital. From 2008 to 2009, earnings per share (EPS) of stock were expected to increase by more than 10 percent for one of the two publicly traded ASC chains (Deutsche Bank 2009a). EPS for the other publicly traded chain was projected to fall by 11 percent from 2008 to 2009 due to lower volume related to the weak economy (Deutsche Bank 2009b). However, EPS for this firm is expected to rebound by 6 percent in 2010. The earnings produced

**TABLE
2C-6****Medicare payments to ASCs have grown, 2003–2008**

	2003	2004	2005	2006	2007	2008
Medicare payments (billions of dollars)	\$2.2	\$2.5	\$2.7	\$2.8	\$2.9	\$3.1
Medicare payments per FFS beneficiary	\$66	\$73	\$78	\$85	\$90	\$99
Percent change per FFS beneficiary	12.9%	10.9%	6.8%	8.5%	5.7%	9.7%

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

Source: CMS, Office of the Actuary.

by these ASCs are one source of capital they can use to establish new facilities or upgrade existing ones. We caution, however, that the publicly traded ASC chains represent only 4 percent of all Medicare-certified ASCs, so their earnings growth may not be indicative of the ASC industry.

Medicare payments: Payments have increased rapidly

In 2008, ASCs received about \$3.1 billion in payments from Medicare and beneficiaries' cost sharing (Table 2C-6). From 2003 through 2007, spending per FFS beneficiary increased by an average of 8.0 percent per year, and by a larger increase of 9.7 percent in 2008. Using data from ASC claims, we estimate that services newly covered in 2008 accounted for 2.9 percentage points of the 2008 increase; services covered in both 2007 and 2008 accounted for the remaining 6.8 percentage points.

Earlier, we showed that services newly covered in 2008 had a strong effect on service volume growth from 2007 to 2008. The strong growth in spending and volume in 2008 suggests that ASC payment rates for these newly covered services were at least adequate. It is plausible that ASCs will furnish more of the newly covered services in succeeding years as more ASCs are able to modify their operations to furnish those services.

How should Medicare payments change in 2011?

Our payment adequacy analysis indicates that the supply of Medicare-certified ASCs has increased, beneficiaries' use of ASCs has increased, and access to capital has been adequate. In addition, CMS has provided a 1.2 percent increase to the ASC conversion factor for 2010. However,

our information for assessing payment adequacy is limited because, unlike for other facilities, CMS does not require ASCs to submit cost or quality data. These data are vital for a thorough evaluation of the adequacy of ASC payments.

Update recommendation

As the Commission considers an update to the ASC conversion factor for 2011, several goals should be balanced:

- Maintain beneficiaries' access to ASC services.
- Pay providers adequately so that they continue to furnish ASC services.
- Hold down the burden on beneficiaries, workers, and firms who finance Medicare.
- Maintain the sustainability of the Medicare program by holding down spending in the ASC sector.
- Keep providers under financial pressure to hold down costs.

A concern we have about the ASC payment system is that ASCs are in the midst of a long-term transition to new payment rates that CMS implemented in 2008. The extent of the changes to the payment system and the fact that they are still being phased in bring some uncertainty about how ASCs will perform under the new system. Early indications suggest that the restructured payment system is not detrimental and may be beneficial to ASCs' long-term future:

- ASCs' revenue and volume from Medicare-covered services increased substantially from 2007 to 2008, and much of this growth was from services newly covered in 2008.

- The number of ASCs increased in 2008 and has continued to increase in 2009 despite a substantial downturn in the credit markets.
- In Pennsylvania, ASCs' average operating margins from serving all patients (not just Medicare beneficiaries) increased from 24.1 percent in 2007 to 26.0 percent in 2008, an increase of 1.9 percentage points (Pennsylvania Health Care Cost Containment Council 2009). We caution that Medicare payments are about 20 percent of ASCs' total revenue, so Medicare payments have a limited effect on ASCs' overall operating margins.¹²

However, we need cost and quality data to fully assess the effects of the revised payment system and make informed decisions about the ASC update. Cost data are also needed to examine whether an existing input price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed (see pp. 108–111). Quality data would enable CMS to assess ASCs' performance and reward high-performing providers. As part of a quality measurement program, CMS could also assess whether ASCs are performing surgery when it is indicated according to clinical guidelines.

CMS does not require ASCs to submit cost or quality data despite the Commission's recommendations in previous reports that ASCs submit such data to CMS (Medicare Payment Advisory Commission 2004, Medicare Payment Advisory Commission 2009). CMS has the authority to require ASCs to submit quality data in exchange for a full payment update. However, CMS has decided to postpone collection of those data to an undetermined date to allow ASCs time to adjust to the revised payment system and to give CMS time to identify the most appropriate quality measures (Centers for Medicare & Medicaid Services 2009a). CMS has also raised concerns about its resource constraints.

Those who argue against ASCs submitting cost data contend that ASCs typically are relatively small facilities and have limited resources for supplying the data. The Commission maintains, however, that ASCs are businesses, and businesses typically keep records of their costs such as for tax filing purposes. Moreover, other small providers submit cost data to CMS, including home health agencies and hospices. However, more than 5,000 ASCs provide services to Medicare beneficiaries, and collecting and reviewing cost reports from each ASC would place a large burden on CMS. Moreover, total Medicare

spending on ASCs is small relative to other sectors (\$3.1 billion). Consequently, CMS should seek to streamline the collection of cost data relative to other sectors. One possible mechanism is annual surveys of a random sample of ASCs—for example, a randomly selected set of facilities (with mandatory response). Positive attributes of a random sample are that all ASCs would not have to furnish data each year and that CMS would have to process data from only a fraction of them. A second possible mechanism is requiring all ASCs to submit cost reports that are more streamlined than hospital cost reports but still have enough information to fully assess the adequacy of ASC payment rates and develop a market basket for ASCs. A positive attribute of a streamlined cost report is that ASCs would not face the uncertainty presented by a random sample; each ASC would know that it has to submit a cost report each year. In addition, a complete set of cost data would be available for assessing payment adequacy and developing a market basket. The burden on CMS from auditing cost reports could be reduced by randomly selecting a fraction of all cost reports to audit.

Ensuring payment adequacy for ASCs is important to Medicare. The providers with the greatest overlap of surgical services with ASCs are HOPDs, and ASCs can offer advantages over HOPDs that are beneficial to maintain. Medicare cost per service is lower in ASCs, and beneficiaries generally have lower coinsurance in ASCs than in HOPDs for each procedure covered under the ASC payment system (Government Accountability Office 2006). Also, ASCs likely offer efficiencies to beneficiaries and physicians that are not available in HOPDs. For patients, ASCs may offer more convenient locations, shorter waiting times, and easier scheduling; for physicians, they may offer customized surgical environments and specialized staffing. Thus, it is vital that ASCs be paid adequately to ensure that beneficiaries have this option available.

RECOMMENDATION 2C

The Congress should implement a 0.6 percent increase in payment rates for ambulatory surgical center services in calendar year 2011 concurrent with requiring ambulatory surgical centers to submit cost and quality data.

RATIONALE 2C

A number of factors indicate that Medicare payments to ASCs have been at least adequate. The Commission has found continued growth in the number of Medicare-certified ASCs as well as robust growth in the volume of

services to Medicare beneficiaries, number of beneficiaries receiving care in ASCs, and number of services per beneficiary treated in ASCs. This growth occurred despite no positive updates to ASC payment rates from 2004 through 2009. In addition, the number of services covered under the ASC payment system increased substantially in 2008, providing ASCs with an opportunity to enhance their Medicare revenue. We have found that the newly covered services contributed 47 percent of the growth in service volume and 30 percent of the growth in spending from 2007 to 2008, suggesting that ASCs are adapting to the opportunities presented by the increase in covered services. In addition, the growth in the number of ASCs indicates they have at least adequate access to capital. Therefore, although we lack cost and quality data, the indicators we have suggest that payments have been adequate.

Another factor we considered in our recommendation is the advantages that ASCs offer relative to HOPDs. Specifically, ASCs can offer greater convenience to patients and providers. In addition, program spending and beneficiary cost sharing are lower in ASCs than in HOPDs on a per service basis. Therefore, a migration of surgical services from HOPDs to ASCs could reduce aggregate program spending and beneficiary cost sharing.

However, the impact on aggregate spending and cost sharing is difficult to quantify. If ASCs are drawing services away from settings where payment rates typically are lower, such as physician offices, the expansion in the number of ASCs would increase Medicare spending. In addition, most ASCs have some degree of physician ownership, which may give physicians an incentive to furnish more surgical services in ASCs than they would if they had to furnish all outpatient surgical services in HOPDs. Our analysis of physician-owned specialty hospitals suggests that such a phenomenon could occur in ASCs (Medicare Payment Advisory Commission 2006). To the extent that physicians act on this incentive, continued expansion of ASCs could offset some of the reductions in program spending and beneficiary cost sharing from lower payment and coinsurance rates.

On the basis of the results that indicate the adequacy of payments, the information we have about the effects of the revised payment system, and our concerns over the potential effect of ASC growth on program spending, we believe a moderate update is warranted. Also, the payment adequacy measures are similar to those for last year. Therefore, we recommend an update for 2011 equal to

last year's recommended update of 0.6 percent for 2010. We believe an update of this amount will enable ASCs to continue furnishing services to beneficiaries, thereby maintaining beneficiaries' access to ASC care.

It is vital that CMS begin collecting cost and quality data from ASCs without further delay. Hence, our recommendation for a modest update for 2011 is linked to a requirement that ASCs submit these data to CMS. Cost data from ASCs would enable analysts to determine the costs of an efficient provider and CMS to adjust payments accordingly. Cost data are also needed to examine whether an existing input price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. Quality data from ASCs would enable CMS to assess performance, reward providers through payment adjustments based on quality, and allow beneficiaries to compare quality across providers. ASCs that do not submit cost and quality data under such a requirement would still receive a 0.6 percent update for 2011 but could be subject to penalties. We note that not all ASCs would be required to submit cost information if CMS decides to collect cost data by surveying a random sample of ASCs.

IMPLICATIONS 2C

Spending

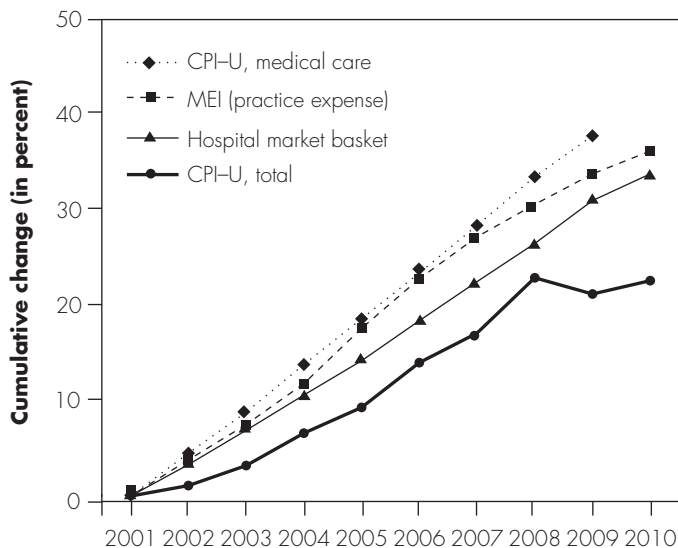
- CMS has discretion over which update factor to use for ASC payment rates, and the agency has decided to increase ASC payment rates by the consumer price index for all urban consumers (CPI-U) (Centers for Medicare & Medicaid Services 2007a). The most recently published measure of the CPI-U for 2011 is 1.4 percent (Centers for Medicare & Medicaid Services 2010). However, we recommend that the payment rates be increased by 0.6 percent. Therefore, our estimates indicate that the update recommendation for 2011 would decrease federal spending by less than \$50 million in the first year and by less than \$1 billion over five years, relative to current law.

Beneficiary and provider

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

**FIGURE
2C-2**

Cumulative growth of the CPI-U for medical care, hospital market basket, and PE component of the MEI is higher than the total CPI-U, 2001-2010



Note: CPI-U (consumer price index for all urban consumers), PE (practice expense), MEI (Medicare Economic Index), BLS (Bureau of Labor Statistics). The hospital market basket changes were forecast by CMS for fiscal years 2001-2010; they were not adjusted to reflect actual changes. Likewise, the MEI changes were forecast by CMS for calendar years 2001-2010 and were not adjusted to reflect actual changes. The MEI figures are for physician practice expenses and exclude CMS's productivity adjustment. The CPI-U data reflect changes from June of the prior year to June of the current year. With the exception of 2010, the CPI-U numbers are from BLS and reflect actual pricing changes, rather than a forecast. The 2010 total CPI-U change is a forecast published by CMS. Neither BLS nor CMS publishes a forecast for 2010 of the CPI-U for medical care.

Source: Crawford et al. 2009; Centers for Medicare & Medicaid Services 2009a; physician fee schedule and hospital inpatient prospective payment system final rules from CMS, 2000-2009.

Revisiting the ASC market basket

The projected change in providers' input prices is an important part of the Commission's annual update process. We are concerned that the market basket index that CMS uses to update ASC payments (the CPI-U) may not reflect ASCs' cost structure. Therefore, we examined whether an alternative market basket index would better measure changes in ASCs' input costs. 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 than that of hospitals and physician offices, with a much larger share of expenses related to medical supplies and drugs than the other two settings, a much smaller share of labor costs than hospitals, and a smaller share of all other costs (such as rent and capital costs) than physician offices.

The CPI-U may not be a good proxy for ASC costs

Although CMS has historically used the CPI-U as the basis for Medicare's annual updates to ASC payments, this price index may not be a reasonable proxy for ASC input costs. From the inception of the ASC payment system in 1982, CMS used the CPI-U to periodically update ASC payments. When CMS revised the ASC payment system for 2008, the agency considered whether to continue using the CPI-U to update ASC payments. CMS stated that the statute does not mandate the use of a specific update mechanism but requires that the CPI-U be used as a default update if CMS does not otherwise update ASC payments (Centers for Medicare & Medicaid Services 2007b). Therefore, CMS decided to continue using the CPI-U on an annual basis after 2009. ASCs received a full update of 1.2 percent in 2010 based on the increase in the CPI-U (Centers for Medicare & Medicaid Services 2009b).

Although the CPI-U is a widely used measure of price inflation that is updated on a regular basis by the Bureau of Labor Statistics (BLS), the mix of goods and services in this price index probably 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).

Do the market baskets for hospital or physician services better reflect ASC input costs?

Because CMS currently lacks data on ASCs' input costs, we explore 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, and the practice expense component of the Medicare Economic Index (MEI), which measures changes in physicians' practice expenses. (See online Appendix B to this chapter for more information on the hospital market basket and MEI.) 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. However, our analysis of ASC, hospital, and physician costs showed that ASCs have a different cost structure than hospitals and physician offices.

Trends in the CPI-U, hospital market basket, and MEI

As a first step in analyzing alternative price indexes, we examined how the total CPI-U, CPI-U for medical care, hospital market basket, and practice expense component of the MEI have changed over time. Between 2001 and 2010, cumulative growth in the hospital market basket (33.8 percent) and the practice expense component of the MEI (36.2 percent) is much higher than the total CPI-U (22.6 percent) (Figure 2C-2). We did not include CMS's adjustment for productivity growth in the MEI. Between 2001 and 2009, the medical care component of the CPI-U also rose faster than the total CPI-U (BLS does not publish a forecast of the CPI-U for medical care for 2010).

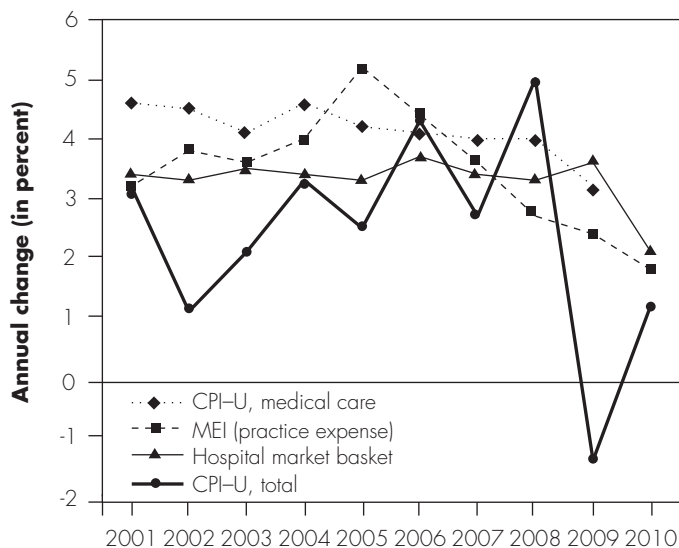
Between 2001 and 2010, the annual changes in the CPI-U for medical care, hospital market basket, and practice expense component of the MEI are more stable than the total CPI-U (Figure 2C-3).¹³ The change in the total CPI-U ranged from 5.0 percent in 2008 to -1.4 percent in 2009. The significant drop in 2009 was primarily due to a 25.5 percent decline in energy prices (Bureau of Labor Statistics 2009).

Comparing the distribution of ASC costs with hospital costs and physician practice expenses

We used 2004 ASC cost data from a 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). 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 larger share of expenses related to medical supplies and drugs than the other two settings, a much smaller share of labor costs than hospitals, and a

FIGURE 2C-3

Annual changes in total CPI-U, CPI-U for medical care, hospital market basket, and PE component of the MEI, 2001-2010



Note: CPI-U (consumer price index for all urban consumers), PE (practice expense), MEI (Medicare Economic Index), BLS (Bureau of Labor Statistics). The hospital market basket changes were forecast by CMS for fiscal years 2001-2010; they were not adjusted to reflect actual changes. Likewise, the MEI changes were forecast by CMS for calendar years 2001-2010 and were not adjusted to reflect actual changes. The MEI numbers are for physician practice expenses and exclude CMS's productivity adjustment. The CPI-U data reflect changes from June of the prior year to June of the current year. With the exception of 2010, the CPI-U figures are from BLS and reflect actual pricing changes, rather than a forecast. The 2010 total CPI-U change is a forecast published by CMS. Neither BLS nor CMS publishes a forecast for 2010 of the CPI-U for medical care.

Source: Crawford et al. 2009; Centers for Medicare & Medicaid Services 2009a; physician fee schedule and hospital inpatient prospective payment system final rules from CMS, 2000-2009.

smaller share of all other costs (such as rent and capital costs) than physician offices.

Methodology As part of a study comparing the relative costs of ASC procedures with the relative costs of procedures paid under the outpatient PPS, GAO surveyed a random sample of 600 ASCs to obtain cost and procedure data from 2004 (Government Accountability Office 2006). GAO entered the data from income statements submitted by respondents into an electronic file and tested the cost and procedure data for reliability, concluding that data from 290 facilities were sufficiently reliable.¹⁴ GAO provided us with this electronic file, which did not identify

**TABLE
2C-7**

Comparing the distribution of ASC costs to hospital costs and physician practice expenses

Share of:

Cost category	Total ASC costs	Hospital costs	Physician practice expenses
Employee compensation	40.0%	55.1%	39.2%
Other professional services	8.0	11.3	13.5
Medical supplies and drugs	25.7	7.5	9.1
All other costs	26.2	26.0	38.1

Note: ASC (ambulatory surgical center). The shares of hospital costs are derived from the hospital operating market basket (92.4 percent of total hospital costs) and the capital input price index (7.6 percent of total costs). The shares of physician practice expenses are derived from the practice expense portion of the Medicare Economic Index (MEI) and exclude CMS's productivity adjustment to the MEI. The category of other professional services includes the following hospital cost categories: professional fees (labor related and non-labor related), financial services, and administrative and business support services. The category of other professional services is equivalent to the "other expenses" category in the MEI, which includes accounting, legal, office management, continuing medical education, and other professional expenses. Medical supplies and drugs include intraocular lenses. Employee compensation includes wages and benefits. All other costs include rent, capital costs, utilities, malpractice insurance, medical equipment, maintenance, repair, housekeeping, laundry, and certain other expenses. Figures in columns may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 2004 ASC cost data from the Government Accountability Office; Centers for Medicare & Medicaid Services 2009b, Centers for Medicare & Medicaid Services 2009c.

individual ASCs. Because the file we received from GAO listed expense items at a disaggregated level (e.g., several types of medical supplies were itemized separately), we grouped hundreds of related items into standardized categories. Because GAO was primarily interested in the cost of medical equipment, medical supplies, clinical staff, and general overhead, the file did not contain data for many ASCs on several types of costs, such as rent, capital costs, utilities, malpractice insurance, and certain other expenses. However, the file had information for most ASCs on total costs, medical supplies and drugs (including IOLs), employee compensation, and other professional services (e.g., legal, accounting, and office management services).¹⁵ Therefore, we calculated the distribution of ASC costs (cost weights) for the following categories: medical supplies and drugs, employee compensation, other professional services, and all other costs. The all other costs category was calculated as a residual (total costs less costs for the first three categories).¹⁶ All other costs includes rent, capital costs, utilities, medical equipment, malpractice insurance, maintenance, repair, housekeeping, laundry, and certain other expenses.

We excluded ASCs that lacked data for any one of these cost categories and also trimmed the top and bottom 5 percent cost weights.¹⁷ The final cost weights are based on data from 233 facilities. The weights were calculated by summing the dollars within a category and dividing this amount by the sum of total costs across all the ASCs.¹⁸ We

compared these ASC cost weights with the distribution of hospital costs and physician practice expenses.

Results Table 2C-7 shows that ASCs have a different distribution of costs than hospitals and physician offices. ASCs' larger share of costs than the other settings for medical supplies and drugs could be related to their high volume of cataract removal and lens insertion procedures (20 percent of total Medicare volume in 2007). These procedures use IOLs, which are included in the medical supplies category and are relatively expensive.¹⁹ Another factor could be that ASCs furnish primarily surgical procedures but hospitals and physicians also provide a significant number of evaluation and management services, which probably have lower supply costs than surgical procedures. The share of ASC costs related to employee compensation (40.0 percent) is similar to that of physician offices (39.2 percent) but much smaller than the hospital share (55.1 percent). The share of ASC costs related to overall labor expenses (employee compensation plus other professional services) is 48 percent, which is consistent with GAO's finding that ASCs' labor costs account for half of their total costs (Government Accountability Office 2006). The share of ASC costs in the all other costs category is almost the same as the hospital share but is smaller than the physician office proportion.

CMS should use new ASC cost data to select an appropriate price index for ASCs

The ASC cost data used in our comparative analysis are five years old and do not contain information on several types of costs. Therefore, the Congress should require ASCs to submit new cost data to CMS. 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 structure of ASC costs. ■

Endnotes

- 1 Eighty-seven percent of ASC procedures have their payment rates based on the outpatient PPS relative weights.
- 2 Risk scores represent beneficiaries' expected service use given their health status, relative to that of the national average beneficiary. For the 10 categories of procedures with the highest share of Medicare payments to ASCs, patients treated in ASCs in 1999 had somewhat lower average risk scores than HOPD patients.
- 3 These data are based on 226 ASCs and 170 hospitals.
- 4 Because ASCs are disproportionately located in some states (California, Florida, Texas, Maryland, 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.
- 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 Vermont, Alaska, and the District of Columbia have certificate-of-need laws that apply to ASCs, which may explain the low number of ASCs in those states.
- 7 By statute, coinsurance for a service paid under the outpatient PPS cannot exceed the hospital inpatient deductible (\$1,100 in 2010). 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 outpatient PPS coinsurance.
- 8 Our analysis of service volume in 2008 included surgical procedures only, as nearly all of these procedures had Current Procedural Terminology codes in the range 10000–69999. Our analysis of 2008 service volume did not include services that were separately paid in 2008 but were either packaged or paid under a separate fee schedule in 2007, such as radiology services, brachytherapy sources, drugs, and pass-through devices. In addition, it did not include services that are packaged in 2008.
- 9 Office-based procedures accounted for most of the growth from newly covered services. These procedures accounted for 4.2 percentage points of the volume increase from 2007 to 2008.
- 10 If we include the services that were newly covered in 2008, the average annual increase from 2003 through 2008 in the number of services per FFS beneficiary is 10.3 percent.
- 11 In 2007, ASC payment rates could be below or equal to HOPD rates; before 2007, ASC rates could be above, below, or equal to HOPD rates.
- 12 The operating margins for ASCs have important differences from the margins in other sectors such as hospitals. In particular, the margins for most ASCs do not reflect income taxes or the income going to physician owners.
- 13 The hospital market basket changes were forecast by CMS for fiscal years 2001–2010; they were not adjusted to reflect actual changes. Likewise, the MEI changes were forecast by CMS for calendar years 2001–2010 and were not adjusted to reflect actual changes. The MEI changes are for practice expenses and exclude CMS's productivity adjustment. The CPI-U data reflect changes from June of the prior year to June of the current year. With the exception of 2010, the CPI-U numbers are from BLS and reflect actual pricing changes rather than a forecast. The 2010 CPI-U change is a forecast published by CMS.
- 14 GAO found that there was no geographic bias among the responding ASCs but did not report on the distribution of responding facilities by specialty.
- 15 Employee compensation includes wages, salaries, and benefits.
- 16 On the basis of GAO's method, we also excluded costs that are not covered by Medicare's payments for ASC services, such as bad debt, advertising, entertainment, lobbying, charity, and separately payable clinical labor (such as physicians, anesthesiologists, and other practitioners who are paid under the physician fee schedule).
- 17 We trimmed the highest and lowest cost weights to reduce the influence of outlier values. Trimming the weights did not significantly influence the final values. When calculating the hospital market basket weights, CMS also trims the top and bottom 5 percent values.
- 18 This method, which is used by CMS to calculate the hospital market basket weights, means that more costly ASCs have a greater influence on the final weights than less costly ASCs.
- 19 Under the prior ASC payment system, Medicare included a \$150 allowance for IOLs in the payment for cataract procedures. The cost of IOLs is bundled into the procedure payment rate under the current ASC payment system. However, CMS makes a separate \$50 payment for certain new technology IOLs.

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