CHAPTER 5

Ambulatory surgical center services

RECOMMENDATIONS

5-1 The Congress should eliminate the calendar year 2020 update to the Medicare conversion factor for ambulatory surgical centers.

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

5-2 The Secretary should require ambulatory surgical centers to report cost data.

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

CHAPTER 5

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Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay after the procedure. In 2017, 3.4 million fee-for-service (FFS) Medicare beneficiaries were treated in the 5,603 ASCs certified to provide services to Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about $4.6 billion.

Assessment of payment adequacy

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

***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 2012 to 2016, the number of ASCs increased by an average annual rate of 1.0 percent. In 2017, the number of ASCs increased 2.4 percent. Most new ASCs in 2017 (about 94 percent) were for-profit facilities.
- ***Volume of services*—**From 2012 through 2016, the volume of services per FFS beneficiary increased by an average annual rate of 1.2 percent. In 2017, volume increased by 1.7 percent.

In this chapter

***Quality of care*—**The first four years of ASC-reported quality data show improvement in performance, but the measures used within the ASC Quality Reporting (ASCQR) Program will change substantially in the next few years. Among the 11 quality measures for which data were available through 2016, performance among the ASCs that reported data improved for most measures. CMS will be making several changes to the ASCQR Program for 2019 and beyond. While the Commission concurs with CMS's decision to eliminate process measures and measures of limited utility, we remain concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems® measures and the lack of claims-based outcome measures that apply to all ASCs. For example, CMS could add measures targeting the frequency of ASC patients receiving subsequent hospital care or rates of surgical site infection.

***Providers' access to capital*—**Because the number of ASCs has continued to increase and hospital systems and others have significantly incorporated ASCs into their business strategies, access to capital appears to be adequate.

***Medicare payments and providers' costs*—**From 2012 to 2016, Medicare payments for ASC services per FFS beneficiary increased by an average annual rate of 3.5 percent. By contrast, in 2017, payments for ASC services increased by 7.7 percent. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to help assess payment adequacy.

On the basis of these indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2020. In addition, the Commission continues to recommend that the Secretary of Health and Human Services collect cost data from ASCs without further delay. ■

Background

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

Since 1982, Medicare has covered and paid for surgical procedures provided in ASCs. Medicare covers surgical procedures represented in about 3,500 Healthcare Common Procedure Coding System (HCPCS) codes under the ASC payment system. However, ASC volume for services covered under Medicare is concentrated in a relatively small number of HCPCS codes. For example, in 2017, 28 HCPCS codes accounted for 75 percent of the ASC volume for surgical services provided to Medicare beneficiaries. For procedures performed in an ASC, Medicare makes two payments: one to the facility through the ASC payment system and the other to the physician for his or her professional services through 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 2017, Medical Group Management Association 2009). Physicians who perform surgeries in ASCs they own receive a share of the ASC's facility payment in addition to payment for their professional services. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify standards for administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, nursing services, and other aspects of care.

Medicare pays ASCs for a bundle of facility services and items—such as nursing, recovery care, anesthetics, and supplies—through a system that is linked primarily to the outpatient prospective payment system (OPPS), which Medicare uses to set payment rates for most services provided in HOPDs. The ASC payment system is also partly linked to the PFS. A more detailed description of the ASC payment system can be found online at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_asc_final_sec.pdf?sfvrsn=0.

For most covered procedures, payment rates in the ASC payment system are the product of a relative weight and a conversion factor. The ASC relative weight, which indicates a procedure's resource intensity relative to other procedures, is based on its relative weight under the OPPS. Although the ASC payment system is linked to the OPPS, payment rates for all services covered under both systems are lower in ASCs for two reasons. First, relative weights are lower under the ASC system compared with the OPPS relative weights because CMS makes proportional adjustments to the relative weights of the OPPS to maintain budget neutrality in the ASC system. In 2019, this adjustment results in ASC relative weights that are 12.0 percent lower than 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 an ASC conversion factor, set at $46.53 for 2019, which is lower than the OPPS conversion factor set at $79.49 for 2019.

The ASC conversion factor is lower than the OPPS conversion factor because it started at a lower level in 2008 and has been updated since then at a lower rate than the OPPS conversion factor. CMS set the initial ASC conversion factor in 2008 such that total payments to ASCs under the revised payment system would equal what they would have been under the pre-2008 ASC payment system. In addition, from 2010 through 2018, CMS updated the ASC conversion factor based on the consumer price index for all urban consumers (CPI–U), while it used the hospital market basket (MB) index to update the OPPS conversion factor. The CPI–U has generally been lower than the hospital MB index. Therefore, the ASC conversion factor has been updated by smaller percentages than the OPPS conversion factor.

In a change of regulatory policy, CMS has decided to update the ASC conversion factor using the hospital MB index from 2019 through 2023. Under this change, in 2019 the update to the ASC conversion factor is higher than the update to the OPPS conversion factor because the update to the ASC conversion factor is the hospital MB index minus a multifactor productivity adjustment, while the OPPS conversion factor is the hospital MB index minus a multifactor productivity adjustment minus a statutory adjustment of 0.75 percentage points from the Patient Protection and Affordable Care Act of 2010. From 2020 through 2023, both the ASC and OPPS conversion factors will be the hospital MB index minus a multifactor productivity adjustment.

We are concerned that neither the CPI–U nor the hospital MB index reflects ASCs' cost structure (see text box,

p. 145). The Commission has recommended that CMS collect cost data from ASCs to identify a price index that would be an appropriate proxy for ASC costs (Medicare Payment Advisory Commission 2010). However, the ASC industry has opposed the collection of cost data for this purpose (Ambulatory Surgery Center Association 2012), and CMS does not yet collect these data. In 2018, CMS requested comments on whether the Secretary should collect cost data from ASCs to use in determining ASC payment rates. Representatives of individual ASCs provided comments that generally opposed a policy that would require ASCs to submit formal cost reports, but were willing to complete surveys on the condition that they would not be administratively burdensome (Centers for Medicare & Medicaid Services 2017). The Commission asserts, however, that all other institutional providers submit at least abbreviated versions of cost reports to CMS, including small entities such as hospices and home health agencies. Moreover, the ASCs in Pennsylvania are able to submit revenue and cost data each year to the Pennsylvania Health Care Cost Containment Council, so it is clear that submission of cost data is feasible for ASCs. Indeed, submitting revenue and cost data does not appear to adversely affect ASC participation: In Pennsylvania, there were seven more ASCs in 2017 than in 2016.

CMS uses a different method from the one described above to determine payment rates for procedures that are predominantly performed in physicians' offices and were first covered under the ASC payment system in 2008 or later. Payment for these "office-based" procedures is the lesser of the amount derived from the standard ASC method or the practice expense portion of the PFS rate that applies when the service is provided in a physician's office (the nonfacility practice expense, which covers the equipment, supplies, nonphysician staff, and overhead costs of a service).[1] The physicians who provide these services receive a separate payment under the PFS. CMS set this limit on the rate for office-based procedures to prevent migration of these services from physicians' offices to ASCs for financial reasons.

The ASC payment system generally parallels the OPPS in terms of which ancillary services are paid separately and which are packaged into the payment of the associated surgical procedure. In 2015, however, the connection between the ASC payment system and the OPPS was weakened when CMS implemented comprehensive ambulatory payment classifications (C–APCs) for the OPPS but not for the ASC system. C–APCs combine all hospital outpatient services reported on a claim that are covered under Medicare Part B into a single payment, with a few exceptions. CMS has not implemented C–APCs in the ASC system because the system of processing ASC claims does not allow for the type of packaging of ancillary items necessary to create C–APCs. Therefore, the payment bundles for services in the C–APCs under the OPPS have greater packaging of ancillary items than the same services under the ASC payment system. Consequently, a disconnect exists between OPPS payment rates and ASC payment rates for the services that are in C–APCs under the OPPS. The magnitude of this disconnect has grown over time because CMS has substantially expanded the number of C–APCs. Currently, about 72 percent of HCPCS codes for surgical procedures that are covered under the ASC payment system are in C–APCs under the OPPS. The Commission supports the use of C–APCs in the OPPS and encourages CMS to implement them in the ASC payment system because the greater packaging of ancillary items that occurs with C–APCs gives providers an incentive to furnish care more efficiently.

Although we do not have recent ASC cost data that would allow us to quantify cost differences between settings, evidence suggests that ASCs are a lower cost setting than HOPDs. The Government Accountability Office (GAO) compared ASC cost data from 2004 with HOPD costs and found that costs were, on average, lower in ASCs than in HOPDs (Government Accountability Office 2006).[2] In addition, studies that used data from the National Survey of Ambulatory Surgery found that the average time for ambulatory surgical visits for Medicare patients was 25 percent to 39 percent lower in ASCs than in HOPDs, which likely contributes to lower costs in ASCs (Hair et al. 2012, Munnich and Parente 2014).[3] An additional study using data from a facility that has both an ASC and a hospital found that surgeries took 17 percent less time in the ASC (Trentman et al. 2010). Trentman and colleagues and Munnich and Parente estimated less time savings in ASCs than did Hair and colleagues, likely because Trentman and colleagues and Munnich and Parente accounted for differences in health status between patients treated in ASCs and those treated in HOPDs, while Hair and colleagues did not. Beneficiaries who are sicker may require more time to treat. We have found that, on average, beneficiaries receiving surgical services in HOPDs are not as healthy

TABLE 5–1

Number of ASCs grew, 2012–2017

Type of ASC	2012	2016	2017	Average annual percent change 2012–2016	Average annual percent change 2016–2017
Total	5,216	5,474	5,603	1.0%	2.4%
New	176	159	189	N/A	N/A
Closed or merged	114	90	60	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable). The average annual percentage change data for the "new" and "closed or merged" categories are shown as "N/A" because they are outside the purpose of this table, which is to show the growth in the total number of ASCs.

Source: MedPAC analysis of Provider of Services file from CMS, 2018.

as beneficiaries receiving those services in ASCs, as indicated by risk scores from the CMS hierarchical condition categories risk adjustment model.

Are Medicare payments adequate in 2019?

To address whether payments for the current year (2019) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2020), we examine several measures of payment adequacy. We evaluate beneficiaries' access to care by examining the supply of ASC facilities and changes over time in the volume of services provided, providers' access to capital, and changes in ASC revenue from the Medicare program. However, our assessment of quality of care (another measure of payment adequacy) is limited and does not fully represent quality in ASCs. Most of our available indicators of payment adequacy are positive.

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

Beneficiaries have adequate access to care in ASCs, although some groups—such as beneficiaries dually eligible for Medicare and Medicaid, African Americans, and beneficiaries under age 65—are less likely than the average beneficiary to receive care in ASCs than in HOPDs. The number of ASC facilities has increased, and the volume of services provided to Medicare beneficiaries has been fairly stable. Access to ASCs may be beneficial to patients and physicians compared with HOPDs, the provider type most similar to ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs. ASCs offer physicians more control over their work environment and specialized staff. In addition, beneficiaries' cost sharing is lower in ASCs than in HOPDs. However, these same qualities could lead to overuse of surgical procedures.

Capacity and supply of providers: Number of ASCs is increasing

From 2016 to 2017, the number of ASCs increased 2.4 percent to 5,603 ASCs (Table 5-1). This annual growth rate was faster than the period from 2012 to 2016, when the number of ASCs increased 1.0 percent per year. In 2017, the number of new ASCs increased by 189, while 60 ASCs closed or merged with other facilities. The number of ASCs that closed or merged has declined each year from 2012 to 2017, and the number of new ASCs has outnumbered closed ASCs. In addition, through the first three-quarters of 2018, a reported 106 new ASCs have opened in several states (Dyrda 2018a, Dyrda 2018b).

Several factors may explain the relatively slower growth of ASCs between 2012 and 2016 and faster growth from 2016 to 2017. From 2012 to 2016, to expand their outpatient surgery capacity, many hospitals acquired and integrated ASCs into the hospital or developed new surgery centers that were part of the hospital.

TABLE 5–2 **Most ASCs are for profit and urban**

Type of ASC	ASCs that were: Open in 2012	Open in 2017	New in 2017
For profit	93.6%	93.8%	92.6%
Nonprofit	3.8	3.5	5.8
Government	2.7	2.7	1.6
Urban	92.5	92.9	94.2
Rural	7.4	7.1	5.8

Note: ASC (ambulatory surgical center). Some totals do not sum to 100 percent because of rounding.

Source: MedPAC analysis of Provider of Services file from CMS, 2018.

This approach may have limited the market for new freestanding ASCs (Jacobson 2014, Kochman 2014, Levingston 2014, Moody 2014, Sowa 2014). During this time, hospitals' decisions to increase their outpatient surgery capacity may have been influenced by the higher rates Medicare pays for ambulatory surgical services provided in HOPDs relative to ASCs (in 2019, Medicare's rates are 94 percent higher in HOPDs than in ASCs).[4] In addition, during this period, physicians were increasingly choosing to be employed by hospitals rather than work in an independent practice (American Medical Association 2017, Berenson et al. 2012, Mathews 2012, Medicare Payment Advisory Commission 2013a, Merritt Hawkins 2014, Physicians Advocacy Institute 2018). In general, these physicians are more likely to provide ambulatory procedures in the hospitals that employ them than in freestanding ASCs. However, from 2016 to 2017 and beyond, hospital systems such as Tenet Healthcare Corporation and HCA Healthcare Inc. have invested more substantially in outpatient surgical capacity and ASCs. Some believe this new strategy is intended to respond to the trend toward value-based care and the associated desire to conduct surgeries in lower cost settings such as ASCs (Barclays 2018, Japsen 2018, Moody's Investors Service 2018). Last, hospital systems that acquire ASCs have the option of maintaining the facility as an ASC or converting it to an off-campus provider-based department (PBD) of a hospital (most likely an outpatient surgery department). However, in response to provisions in the Bipartisan Budget Act of 2015 (Section 603), CMS has aligned payment rates for facilities established as off-campus PBDs after November 2, 2015, with PFS payment rates, which are typically lower than ASC rates. Therefore, there is little incentive for a hospital system to acquire an ASC and convert it to an off-campus PBD. Instead, it is more financially beneficial to maintain the facility as an ASC.

The number of operating rooms (ORs) in ASCs is also growing. In 2017, there were nearly 17,000 ORs in ASCs, or an average of 3.0 per facility. From 2012 to 2016, the total number of ASC ORs increased 0.8 percent per year, a slightly slower rate than the growth in the number of ASCs over the same period (1.0 percent per year). However, from 2016 to 2017, the number of ORs in ASCs increased by about 1.6 percent, also a slightly slower rate than the growth rate in the number of ASCs from 2016 to 2017, which suggests the size of ASCs has declined since 2012. For example, ASCs that entered the market in 2017 had an average of 2.7 ORs, while those operating in 2012 had an average of 3.1 ORs.

Consistent with previous years, most ASCs in 2017 were for profit (93.8 percent) and located in urban areas (92.9 percent) (Table 5-2). However, ASCs that were new in 2017 were slightly more likely to be nonprofit and urban (including urban and suburban areas) compared with existing ASCs. Beneficiaries who do not live near an ASC can obtain ambulatory surgical services in HOPDs and, in some cases, physicians' offices. Beneficiaries who live in rural areas can travel to urban areas to receive care in ASCs. In addition, most ASCs are freestanding, located off a hospital campus (99 percent) (data not shown).

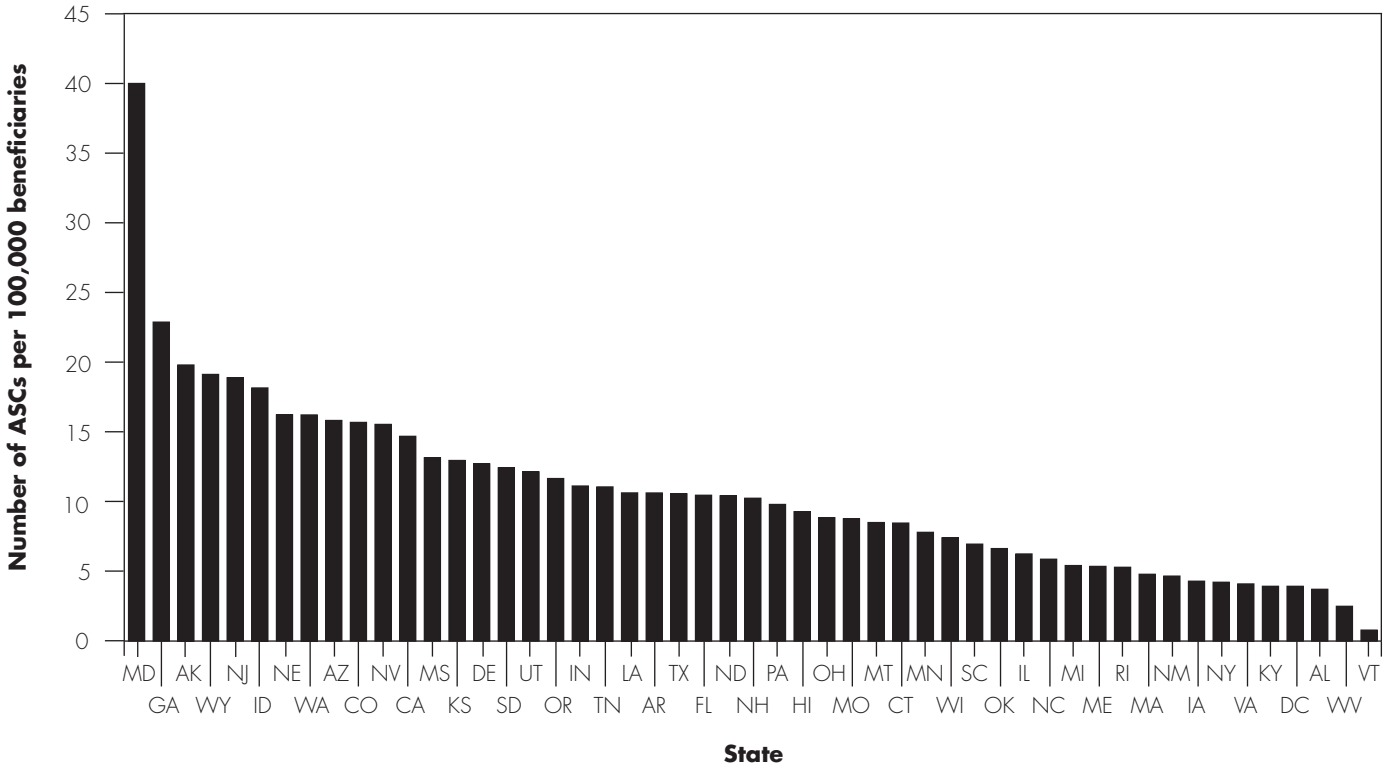
Geographic distribution of ASCs is uneven

In addition to being much more common in urban areas than rural areas, the concentration of ASCs varies widely among states. In 2017, Maryland had the most ASCs per Medicare beneficiary (40 ASCs per 100,000 Part B beneficiaries), followed by Georgia, Alaska, and Wyoming (approximately 20 ASCs per 100,000 beneficiaries) (Figure 5-1, p. 133). Kentucky, the District of Columbia, Alabama, West Virginia, and Vermont had the fewest ASCs per beneficiary (fewer than 4 ASCs per 100,000 beneficiaries). Availability in Vermont was especially low, with less than 1 ASC per 100,000 beneficiaries, and only 1 ASC in the entire state.[5]

Even though beneficiaries can largely receive the same services in HOPDs if an ASC is not located near them, the

FIGURE 5–1

Number of ASCs per beneficiary varies widely across states



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2018 and Medicare denominator file for 2017.

small number of ASCs in some states and rural areas may raise concerns about beneficiaries' access to ambulatory surgical services in the context of site-neutral payments between ASCs and HOPDs. In its June 2013 report, the Commission identified surgical services that are viable for site-neutral payments between the ASC payment system and the OPPS (Medicare Payment Advisory Commission 2013a). The impact of site-neutral payments between ASCs and HOPDs would be to lower payment for some services in HOPDs. Hospitals could respond by reducing the extent to which they provide these services. In areas that have low ASC concentration, site-neutral payments could make it more difficult for beneficiaries to access ambulatory surgical services.

We found that rural beneficiaries—defined as those who live outside metropolitan statistical areas (MSAs)—are less likely to receive care in an ASC than are urban beneficiaries—defined as those living in an MSA. In 2017, 7.2 percent of rural beneficiaries received care in an ASC versus 10.4 percent of urban beneficiaries.

Specialization of ASCs largely unchanged, some growth in pain management

The majority of ASCs that billed Medicare in 2017 specialized in a single clinical area, with gastroenterology and ophthalmology being the most common, and ASCs specializing in pain management services are growing as a share of ASCs. Overall, in 2017, 61 percent of ASCs were single-specialty facilities and 40 percent were multispecialty facilities, providing services in more than one clinical specialty (Table 5-3, p. 134).[6] In 2017, the most common single-specialty ASCs focused on gastroenterology (21 percent) and ophthalmology (21 percent). The most common multispecialty ASCs

TABLE 5–3

Specialization of ASCs billing Medicare in 2015 and 2017

Type of ASC	2015 Number of ASCs	2015 Share of all ASCs	2017 Number of ASCs	2017 Share of all ASCs
Single specialty	2,878	61%	2,890	61%
Gastroenterology	1,027	22	1,019	21
Ophthalmology	1,020	22	1,022	21
Pain management	355	8	368	8
Dermatology	191	4	179	4
Urology	124	3	125	3
Podiatry	95	2	88	2
Orthopedics/musculoskeletal	23	0	29	1
Respiratory	16	0	24	1
OB/GYN	9	0	11	0
Cardiology	10	0	18	0
Neurology	5	0	6	0
Other	3	0	1	0
Multispecialty	1,802	38	1,878	40
More than 2 specialties	1,421	30	1,415	30
Pain management and either neurology or orthopedics	221	5	288	6
Gastroenterology and ophthalmology	160	3	175	4
Total	4,680	100	4,768	100

Note: ASC (ambulatory surgical center), OB/GYN (obstetrics and gynecology). A "single-specialty ASC" is defined as one with more than 67 percent of its Medicare claims in one clinical specialty. A "multispecialty ASC" is defined as one with more than 67 percent of its Medicare claims in more than one clinical specialty. ASCs included in this analysis are limited to those in the 50 states and the District of Columbia with a paid Medicare claim in 2017. Columns containing the share of all ASCs may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2017.

that focused on two specialties in 2017 were those specializing in pain management and either neurology or orthopedic services (6 percent of all ASCs). From 2015 to 2017, ASCs specializing in pain management services grew most rapidly. Across both single-specialty and multispecialty ASCs in 2017, there were roughly 100 more pain management ASCs than in 2015.

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

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings. There is potential for this trend to continue as momentum grows for knee and hip arthroplasty (knee and hip replacement) to be done in ambulatory settings.
- ASCs can offer patients greater convenience than HOPDs, such as the ability to schedule surgery more quickly.
- For most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs.[7]
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff.

TABLE 5–4 **Volume of ASC services per FFS beneficiary increased in 2017**

				Average annual change	
	2012	2016	2017	2012–2016	2016–2017
Volume of services (in millions)	6.0	6.4	6.5	1.8%	1.4%
Volume per 1,000 FFS beneficiaries	181.2	190.1	193.3	1.2	1.7

Note: ASC (ambulatory surgical center), FFS (fee-for-service). The volume of services for 2012 and 2016 has been modified to reflect the volume of services covered under the ASC payment system in 2017 that was provided in those years.

Source: MedPAC analysis of physician/supplier standard analytic files from CMS, 2012–2017.

- Physicians who invest in ASCs and perform surgeries on their patients in those ASCs can increase their revenue by receiving a share of ASC facility payments. The federal anti-self-referral law (also known as the Stark Law) does not apply to ASC services.
- Because physicians are able to perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more revenue from professional fees.
- Increased interest across the health care industry in the concept of value-based care and the provision of care in lower cost settings has increased the strategic investment interest of hospital systems, insurers, and private equity firms in ASCs (Barclays 2018, Japsen 2018).

Number of beneficiaries treated and volume of services per beneficiary increased from 2016 to 2017

The number of fee-for-service (FFS) beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary increased from 2016 to 2017. Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries who have Part B coverage. The number of FFS beneficiaries who received ASC services grew by an average of 1.0 percent per year from 2012 through 2016 and increased by 0.4 percent in 2017 (data not shown). The volume of services per FFS beneficiary increased by an average of 1.2 percent per year from 2012 through 2016 and increased by 1.7 percent in 2017 (Table 5-4). On average, the number of services per beneficiary receiving care in ASCs increased at an average annual rate of 0.8 percent from 2012 through 2016 and 1.0 percent in 2017 (data not shown).

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2017. For example, the HCPCS code for cataract removal with intraocular lens insertion (HCPCS 66984) had the highest volume in both 2012 and 2017, accounting for 18.9 percent of the total in 2012 and 18.8 percent in 2017. Moreover, 19 of the 20 most frequently provided HCPCS codes in 2012 were among the 20 most frequently provided in 2017 (Table 5-5, p. 137). These services made up about 71 percent of ASC Medicare volume in 2012 and 70 percent in 2017.

A potential concern about the services most frequently provided in ASCs is the extent to which they are unnecessary or low value, such as spinal injections and other pain management services (Pinto et al. 2012). We have found that the volume of pain management services grew robustly from 2012 to 2017. Table 5-5 shows that from 2012 to 2017, injections of foramen epidural into either the lumbar or sacral area, injecting the paravertebral facet joint in the lumbar or sacral area, injecting an anesthetic into the sacroiliac joint, and destruction of nerves in the lumbar or sacral facet joint all grew strongly. Moreover, the volume of insertion or replacement of spinal neurostimulators increased sharply from about 2,000 in 2012 to 9,500 in 2017 (data not shown).

Volume of outpatient surgical procedures increased by a higher percentage in ASCs than in HOPDs in 2017

For the first time in several years, surgical volume in 2017 increased at a faster rate in ASCs than in HOPDs. From 2012 through 2016, average annual growth in volume per FFS beneficiary of surgical services covered by the ASC payment system was 1.2 percent in ASCs compared with 2.4 percent in HOPDs. In 2017, volume per FFS beneficiary increased by 1.7 percent in ASCs and by 0.7 percent in HOPDs.

The higher growth in ASCs in 2017 relative to HOPDs is a reversal of what occurred in previous years when growth in HOPDs was higher than in ASCs. This change is likely a reflection of the same factors that contributed to the faster growth in the number of ASCs in 2017, discussed earlier. That is, the higher volume growth in ASCs in 2017 was a response to the trend toward value-based care and the associated desire to conduct surgeries in lower cost settings, such as ASCs (Barclays 2018, Japsen 2018, Moody's Investors Service 2018). Also, beginning in 2017, when a hospital system acquires an ASC, provisions in Section 603 of the Bipartisan Budget Act of 2015 have made it more financially advantageous to maintain the facility as an ASC rather than convert it to an off-campus PBD of a hospital.

Maintaining or expanding access to ASCs can be beneficial for patients and Medicare

Maintaining beneficiaries' access to ASCs has some benefits because services provided in this setting are less costly to Medicare and beneficiaries than services delivered in HOPDs.[8] Medicare payment rates for surgical services performed in HOPDs are almost twice as high as in ASCs. For example, the payment rate in 2019 for cataract surgery with intraocular lens insertion (the service most frequently provided in ASCs) is $1,917 in HOPDs compared with $977 in ASCs. The lower payment rate in ASCs for this service has been financially beneficial to Medicare and beneficiaries. Other recent studies similarly find that ASCs are less costly than HOPDs in the Medicare and non-Medicare context and that the recent price growth at ASCs has been slower than price growth at HOPDs (Carey 2015, Robinson et al. 2015).

Medicare program spending and overall beneficiary cost sharing could be reduced if more surgical services were provided in ASCs than HOPDs or if HOPD payment rates are reduced to the level that Medicare sets for ASCs. This issue is pertinent to the ASC sector because among even the most frequently provided services in ASCs, a substantial volume is provided in HOPDs. For example, 434,000 Medicare-covered cataract surgeries with intraocular lens insertion were performed in HOPDs in 2017, which was 26 percent of the total volume for this service.

Concern remains, however, about services provided in ASCs rather than HOPDs because most ASCs have some degree of physician ownership. Studies offer some evidence that physicians who have an ownership stake in an ASC perform a higher volume of certain procedures than physicians who do not (Hollingsworth et al. 2010, Mitchell 2010, Strope et al. 2009). Other studies suggest that the presence of an ASC in a market is associated with a higher volume of outpatient surgical procedures (Hollenbeck et al. 2014, Hollingsworth et al. 2011, Koenig and Gu 2013). Although none of these studies assessed the appropriateness of the additional procedures, they suggest that the presence of ASCs might increase overall surgical volume.

Another setting that has a substantial overlap of services with ASCs is physician offices. In general, Medicare payment rates are higher in ASCs than in physician offices for the same procedure. Services that are frequently provided in both ASCs and physician offices include cystoscopy, pain management, and, to a lesser extent, cataract procedures. Cystoscopy is performed much more frequently in offices than in ASCs, pain management is about equally common in these two settings, and cataract procedures are done more frequently in ASCs than in physician offices.

Quality of care: ASC-reported quality data demonstrate modest improvement

ASC-reported quality data demonstrated modest improvement in recent years. CMS established the ASC Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this system, ASCs that do not successfully submit data that measure quality have their payment update for that year reduced by 2 percentage points. Actual performance on these quality measures does not affect an ASC's payments; ASCs are required only to submit the data to receive a full update. The Commission has recommended a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (see text box, p. 140).

TABLE 5–5

The 20 most frequently provided ASC services in 2017 were similar to those provided in 2012

	2012		2017	
Surgical service	**Percent of volume**	**Rank**	**Percent of volume**	**Rank**
Cataract surgery w/ IOL insert, 1 stage	18.9%	1	18.8%	1
Upper GI endoscopy, biopsy	8.9	2	8.0	2
Colonoscopy and biopsy	6.5	3	6.9	3
Lesion removal colonoscopy (snare technique)	5.0	4	5.9	4
Inject foramen epidural: lumbar, sacral	4.3	5	4.7	5
After cataract laser surgery	4.3	6	4.3	6
Injection spine: lumbar, sacral (caudal)	3.7	7	2.9	8
Diagnostic colonoscopy	3.3	8	1.9	10
Inject paravertebral: lumbar, sacral	2.6	9	3.3	7
Colorectal screen, high-risk individual	2.1	10	2.0	9
Colorectal screen, not high-risk individual	1.8	11	1.8	11
Cataract surgery, complex	1.5	12	1.4	13
Upper GI endoscopy, diagnosis	1.3	13	0.9	18
Revision of upper eyelid	1.1	14	0.9	19
Lesion removal colonoscopy (hot biopsy forceps)	1.0	15	0.6	23
Inject spine, cervical or thoracic	1.0	16	1.0	16
Injection procedure for sacroiliac joint, anesthetic	1.0	17	1.4	14
Cystoscopy	1.0	18	1.0	17
Upper GI endoscopy, insertion of guide wire	0.9	19	0.8	20
Destroy lumbar/sacral facet joint	0.8	20	1.6	12
Total	71.1		70.0	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal). Components do not sum to totals due to rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from CMS, 2012 and 2017.

The quality measures for which ASCs submit data continue to evolve. Over the past year, changes made to the ASCQR Program are the result of CMS's Meaningful Measures Initiative. In the last two years, CMS made several revisions to the initial ASCQR measure set, which resulted in CMS measuring ASC quality based on eight measures (plus one voluntary measure) for 2019 and four measures (plus one voluntary measure) for 2021 (Table 5-6, p. 138). In recent years, CMS has chosen to discontinue or delay several measures that were considered "topped out" (meaning full or nearly full compliance with these measures has been reached), demonstrated less utility, or were not ready for use, including the discontinuation of the current adverse event measures (ASC–1 through ASC–4) and the delay of measures of patient experience.[9] For 2022, CMS will implement two new claims-based measures of beneficiaries' visits to a hospital subsequent to an ASC orthopedic or urology procedure, respectively (ASC–17 and ASC–18).

Results from reported ASC quality data

Data reported by ASCs for four years (2013 to 2016) suggest improvement in ASC quality of care. Among the 11 quality measures for which data were available in 2016, performance improved for most measures. For the four adverse event measures (ASC–1, ASC–2, ASC–3, and ASC–4), the data show consistently low levels of these events in each of the four years and gradual improvement

TABLE 5–6

Quality measures used in the ASC Quality Reporting Program

Description of quality measure	Required in: 2019	2021
ASC–1: Patient burn	Yes[a]	No
ASC–2: Patient fall	Yes[a]	No
ASC–3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant	Yes[a]	No
ASC–4: Hospital transfer/admission	Yes[a]	No
ASC–5: Prophylactic intravenous antibiotic timing	No[b]	No
ASC–6: Safe-surgery checklist use	No[b]	No
ASC–7: ASC facility volume data on selected ASC surgical procedures	No[b]	No
ASC–8: Influenza vaccination coverage among health care personnel	Yes[c]	No
ASC–9: Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients	Yes	Yes
ASC–10: Endoscopy/polyp surveillance: Colonoscopy interval for patients with a history of adenomatous polyps—avoid inappropriate use	Yes[d]	No
ASC–11: Cataracts: Improvement in patient's visual function within 90 days following cataract surgery	Voluntary	Voluntary
ASC–12: Facility seven-day risk standardized hospital visit rate after outpatient colonoscopy	Yes	Yes
ASC–13: Normothermia outcome: Percentage of patients under anesthesia who are normothermic within 15 minutes of arrival in the post-anesthesia care unit	No[e]	Yes
ASC–14: Unplanned anterior vitrectomy: Percentage of cataract surgery patients who have an unplanned removal of the vitreous	No[e]	Yes
ASC–15: Five patient experience measures from the Consumer Assessment of Healthcare Providers and Systems® survey measures:		
ASC–15a: About facilities and staff		
ASC–15b: Communication about procedure		
ASC–15c: Preparation for discharge and recovery		
ASC–15d: Overall rating of facility		
ASC–15e: Recommendation of facility	No[f]	No
ASC–16: Toxic anterior segment syndrome (TASS)	No[f]	No
ASC–17: Hospital visits after orthopedic ASC procedures	No[g]	No
ASC–18: Hospital visits after urology ASC procedures	No[g]	No

Note: ASC (ambulatory surgical center).
[a]Retained in the ASC Quality Reporting (ASCQR) Program, but data collection is suspended by CMS starting in 2019. As a result, the measure will not be used for payment year 2021.
[b]Discontinued by CMS from the ASCQR Program beginning in 2018.
[c]Discontinued by CMS from the ASCQR Program beginning in 2020.
[d]Discontinued by CMS from the ASCQR Program beginning in 2021.
[e]CMS will activate this measure in 2020.
[f]CMS has delayed the implementation of this ASCQR measure indefinitely.
[g]CMS will activate this measure in 2022.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2019.

(Table 5-7). Specifically, the share of ASCs reporting zero adverse events increased over time. For example, from 2013 to 2016, the share of ASCs without any patient burns increased from 88 percent to 92 percent, and the share of ASCs without any patient falls increased from 91 percent to 94 percent (data not shown).

TABLE 5–7

ASC quality measure levels, 2013–2016

ASC quality measure	Mean percent among ASCs				Estimated number of events in 2016*
	2013	2014	2015	2016	
ASC–1: Share of patients suffering burns	0.36%	0.43%	0.49%	0.24%	11,500
ASC–2: Share of patients suffering falls	0.18	0.10	0.14	0.08	4,000
ASC–3: Share of patients suffering a "wrong" event	0.07	0.03	0.03	0.03	1,400
ASC–4: Share of patients transferred to a hospital	0.51	0.45	0.42	0.43	21,000
ASC–8: Share of ASC staff receiving an influenza vaccination		74	75	77	N/A
ASC–9: Share of average risk patients with appropriate endoscopy/polyp surveillance		77	80	81	N/A
ASC–10: Share of patients with polyp history with appropriate endoscopy/polyp surveillance		79	79	80	N/A
ASC–11: Share of patients with vision improvement 90 days after cataract surgery			96	96	N/A

Note: ASC (ambulatory surgery center), N/A (not applicable).
*The number of events was estimated using the average reported rate of occurrence and the total number of ASC claims in 2016 (4.9 million). The estimated number of events is not calculated for measures that do not pertain to adverse events.

Source: Medicare Hospital Compare data for ASCs, 2013–2016.

In addition to the adverse event measures, other ASCQR measures demonstrated improvement. For example, from 2013 to 2016, the share of ASCs reporting their staff received influenza vaccinations (ASC–8) increased from 74 percent to 77 percent. Improvement and generally high levels of performance were also observed for measures of the surveillance and follow-up of patients treated for certain gastroenterology or cataract surgeries. While room for improvement exists for three of these other measures (ASC–8, ASC–9, and ASC–10), these data appear to be trending in a positive direction.[10]

ASC quality measures should continue to be refined

The Commission asserts CMS should continue to improve the ASCQR Program by moving toward more CMS-calculated claims-based outcome measures that apply to all ASCs. In addition, the Commission asserts ASCQR measures should be synchronized with measures included in the Hospital Outpatient Quality Reporting (OQR) Program to facilitate comparisons between ASCs and HOPDs. The Commission commends CMS on its decisions to discontinue three process measures in 2018 and for adding the two claims-based unplanned hospitalization measures for 2022. However, the Commission maintains concern about four issues related to the ASCQR Program:

- The program does not include enough claims-based measures assessing clinical outcomes that apply to the various specialties practiced at ASCs. For example, if no further changes are made to the ASCQR measure set before 2022, the measure set will include two measures for ASCs conducting colonoscopies, one measure for ASCs conducting cataract surgeries, one measure for ASCs conducting orthopedic procedures, and one measure for ASCs conducting urology procedures. This potential measure set appears to exclude many services provided at ASCs.
- CMS's delay of the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) patient experience survey quality data excludes an important part of assessing quality of care.[11] Among the

Creating a value-based purchasing program for ambulatory surgical centers

In 2012, the Commission recommended that the Congress authorize and CMS implement a value-based purchasing (VBP) program for ambulatory surgical centers (ASCs). A VBP program would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).[12]

CMS established a quality reporting program for ASCs in 2012. However, Medicare payments to ASCs are not adjusted based on how they perform on quality measures, only on whether they report the measures. The Commission believes that high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system.

Consistent with the Commission's overall position on Medicare quality measurement, an ASC VBP program should incorporate measures that are patient-oriented, encourage coordination across providers and time, and promote change in the delivery system. The ASC VBP program should include outcome, patient experience, and value measures (a value measure would address services that are costly but of low value). Also, quality measurement should not be burdensome for providers. ASCs can choose to use more granular measures to manage their own quality improvement.

An ASC VBP should give rewards based on clear, absolute, and prospectively set performance targets (as opposed to "tournament models," which require that some providers gain while others lose). The Medicare program should take into account, as necessary, differences in a provider's population, including social risk factors. Because adjusting results for social risk factors can mask disparities in clinical performance, Medicare should account for social risk factors by directly adjusting payment through peer grouping, where benchmarks for achievement are group specific, and each provider is compared with its peers, defined as providers that have similar patient populations in terms of social risk factors. In addition, funding for VBP incentive payments should come from existing Medicare spending for ASC services. Initially, funding for the incentive payments should be set at 1 percent to 2 percent of aggregate ASC payments. The size of this pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program. (Our March 2016 report to the Congress provides more detail about our recommendation to CMS about an ASC VBP program (Medicare Payment Advisory Commission 2016). ■

Commission's quality measurement principles is that quality programs include patient experience (Medicare Payment Advisory Commission 2018b). CAHPS is the only survey in the ASCQR Program that queries patients about their experience.

- ASCQR measures should be further synchronized with OQR measures to facilitate comparison across ASCs and HOPDs. For 2019 and 2020, the ASCQR Program and the OQR Program possess five common quality measures that pertain to cataract procedures, colonoscopy procedures, and rates of influenza vaccination among health care personnel. CMS should consider further expanding the overlap of the ASCQR Program and OQR Program, relying either on measures of general surgical procedures or measures of specific surgical procedures common to both settings. For example, CMS could consider implementing OQR measure OP–36 (the number of hospital visits after any outpatient surgery) within the ASCQR Program or implementing ASCQR measures ASC–17 and ASC–18 (the number of hospital visits following orthopedic and urology procedures, respectively) within the OQR Program. In addition, the aforementioned delay in implementing the CAHPS patient experience measures affects both the ASCQR Program and OQR Program and impedes the comparison of ASCs and HOPDs.

TABLE 5–8

Share of ASC cases with subsequent hospital visits, 2014 and 2017

	Subsequent hospital visit within 7 days after discharge from ASC			
	2014		2017	
Type of ASC	Number of ASC cases	Share of cases within type of ASC	Number of ASC cases	Share of cases within type of ASC
All ASCs	90,552	1.9%	98,714	2.0%
Multispecialty	38,562	2.2	43,582	2.4
Gastroenterology and ophthalmology	4,871	1.9	5,311	2.6
Single specialty	51,990	1.7	55,132	1.8
Pain management	6,745	2.2	7,266	2.4
Urology	4,068	3.7	4,814	4.1
Cardiology	235	7.2	633	7.9

Note: ASC (ambulatory surgical center). "Subsequent hospital visit" includes inpatient admissions, observation services, and emergency department visits but excludes cases related to trauma or mental health services.

Source: MedPAC analysis of Medicare physician, hospital outpatient, and hospital inpatient claims.

- All reported quality data should continue to be made publicly available. In prior years, CMS elected to allow ASCs to voluntarily and temporarily withhold their quality data from public reporting (Medicare Payment Advisory Commission 2016). The Commission disagrees with this practice except in rare circumstances.

Other quality measures: Some ASC specialties show increases in hospitalizations subsequent to ASC discharge

Because of the concerns cited above and the potential value of clinical outcome measures that apply to all ASCs, we believe CMS could consider developing new ASC quality measures covering any or all of the three following areas:

- CMS should more broadly develop a measure of the number of Medicare beneficiaries discharged from ASCs who have subsequent unplanned hospital visits. CMS has already begun to implement these measures for certain specialties (e.g., ASC–12, ASC–17, and ASC–18), but CMS has not developed these measures for specialty areas or individual procedures that are common to ASCs. The Commission developed a version of this type of measure that applies to all specialties and procedures, similar to OQR measure OP–36 (the number of hospital visits after any outpatient surgery). We found that in 2017, 2.0 percent of ASC discharges were associated with a subsequent hospital visit within seven days after discharge from an ASC (Table 5-8).[13,14] From 2014 to 2017, the measure of subsequent hospitalizations within seven days was fairly consistent across all ASCs. However, the share of subsequent hospital visits increased slightly (suggesting quality of care worsened) at multispecialty ASCs, such as those specializing in both gastroenterology and ophthalmology (from 1.9 percent in 2014 to 2.6 percent in 2017), and some types of single-specialty ASCs. Although our measure is not risk adjusted, it should be if used in the ASCQR Program or used to compare the performance of ASCs with HOPDs.
- CMS could consider developing a measure of surgical site infections (SSIs) occurring at ASCs for the ASCQR Program. CMS could calculate this measure from claims rather than require ASCs to report it. Researchers have found that lapses in infection control were common among a sample of ASCs

in three states (Schaefer et al. 2010). The Hospital Inpatient Quality Reporting Program includes an SSI measure that applies primarily to inpatient procedures. Although CMS has considered an SSI measure for ASCs in the past (Centers for Medicare & Medicaid Services 2011), it is not currently working to develop one (Centers for Medicare & Medicaid Services 2016). In general, an SSI measure could be used to track infection rates for ASCs and identify quality improvement opportunities for ambulatory surgeries conducted in HOPDs and ASCs. In addition, measuring SSI rates could encourage providers to collaborate and better coordinate care for ambulatory surgery patients.

- CMS could consider developing new measures that rely on specialty-specific clinical guidelines to assess the appropriateness of specific services conducted at ASCs. While the ASCQR Program currently includes two ASC-reported colonoscopy measures that assess appropriate follow-up care, CMS could consider claims-based measures that assess appropriateness. For example, current American Cancer Society guidelines state that patients over the age of 85 should no longer receive colorectal cancer screening (American Cancer Society 2018). Using these guidelines, a new measure could identify the ASC-level share of colonoscopy cases in which beneficiaries are over age 85. CMS could consider similar measures of appropriateness for certain procedures that have become more common in ASCs in recent years or concerns about appropriate use have been suggested, such as spinal injections or certain orthopedic procedures.

Department of Health and Human Services will publicly report ASC-specific patient safety data

In response to the expanding scope of ASC services and the desire of ASCs to compare their performance with other ASCs, the Department of Health and Human Services (HHS), through the Agency for Healthcare Research and Quality (AHRQ), will collect and publicly report survey data on ASC-specific patient safety culture (Agency for Healthcare Research and Quality 2018, Dickson 2018a, Dickson 2018b). AHRQ worked with the ASC industry to design this program. Similar to its hospital safety survey data, AHRQ will collect survey data from ASC staff regarding their perceptions of safety culture in their workplace. This information will be reported on the AHRQ website in a format permitting the individual identification of ASCs. AHRQ asserts that these data can be used by ASCs to improve their practices and by the public to inform decisions about where to receive care (Agency for Healthcare Research and Quality 2018).

ASCs' 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 increased in 2017 by 2.4 percent, faster than in previous years (Table 5-1, p. 131). In addition, through the first three-quarters of 2018, a reported 106 new ASCs have opened in several different states (Dyrda 2018a, Dyrda 2018b). However, Medicare accounts for a small share—perhaps 20 percent—of ASCs' overall revenue, so factors other than Medicare payments may have a larger effect on access to capital for this sector (Medical Group Management Association 2009).

A series of ASC acquisitions in recent years suggests ASCs are a highly valued asset for hospital systems, private equity firms, and insurers. In 2015, Tenet Healthcare Corporation, traditionally a hospital company, began incrementally acquiring progressively larger shares of ASC chain United Surgical Partners (USP) (Kutscher 2015). Throughout 2017 and 2018, Tenet increased its investment in USP, and in mid-2018 Tenet purchased an additional 15 percent of USP from a private equity firm for $630 million (Kacik 2018). In 2018, USP was the second largest ASC firm, accounting for more than 200 ASCs. This 2018 purchase increased Tenet's ownership of USP to 95 percent, with the remaining 5 percent owned by the health system Baylor, Scott, and White. In general, hospital systems are increasingly turning their investment attention away from the inpatient setting and toward ASCs and other outpatient capacity (Barclays 2018, Japsen 2018). For example, ASCs in 2017 accounted for roughly 20 percent of Tenet's earnings. Currently, Tenet owns over 300 ASCs and HCA owns more than 120 ASCs. In addition, Tenet and HCA state in their 2018 financial reports that ASCs are a component of their business strategy moving forward (Morningstar Document Research 2018a, Morningstar Document Research 2018b). From 2016 to 2017, Tenet reported a 10 percent increase in ASC cases and a 14 percent increase in operating revenues (Morningstar Document Research

TABLE 5–9

Medicare payments to ASCs grew, 2012–2017

				Average annual change	
	2012	2016	2017	2012–2016	2016–2017
Medicare payments (in billions of dollars)	$3.6	$4.3	$4.6	4.1%	7.4%
Medicare payments per FFS beneficiary	$110	$126	$136	3.5	7.7

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

Source: MedPAC analysis of data from the Office of the Actuary at CMS and data from physician/supplier standard analytic files.

2018a). Financial analysts assert that these hospital systems are acquiring ASCs or partnering with entities that own ASCs to better acclimate to a value-based care environment that will require providing surgeries in lower cost settings (Barclays 2018).

In addition, in October 2018, private equity firm Kohlberg, Kravis, Roberts, and Company completed the purchase of Envision Healthcare for $9.9 billion (Bannow 2018). Envision Healthcare owns over 250 ASCs as a part of its 2017 purchase of AmSurg Corporation. In January 2017, Surgical Care Associates—which owned approximately 200 ASCs in 33 states—was acquired by insurer UnitedHealth Group's Optum for $2.3 billion (Mathews 2017). This acquisition is part of a larger stated effort by the insurer to provide primary care and ambulatory services.

Strong financial positions of this magnitude suggest that ASCs are attractive to investors. Security and Exchange Commission filings from Surgery Partners Inc. (SPI), which is an operator of nearly 100 ASCs and is not affiliated with a hospital or insurer, reported increases in revenue per case (11 percent) and same-store volume (14 percent) from 2017 to 2018 (Surgery Partners 2018b). SPI also demonstrated the ability to access capital by announcing in October 2018 the acquisition of a $180 million loan for use in merger and acquisition activity (Surgery Partners 2018a). Finally, data from the Pennsylvania Health Care Cost Containment Council's annual analysis of the state's ASCs show that ASCs in Pennsylvania had an average total margin of 25 percent in 2017 (Pennsylvania Health Care Cost Containment Council 2018).[15]

Although the various entities noted above appear to have adequate access to capital, we caution that these companies have ownership in a small share of the more than 5,000 ASCs. Consequently, the experience of these entities collectively may not reflect that of the entire ASC sector.

Medicare payments: Payments have steadily increased

In 2017, ASCs received $4.6 billion in Medicare payments and beneficiaries' cost sharing (Table 5-9). We estimate that spending by the Medicare program was $3.7 billion and beneficiary cost sharing was $900 million (data not shown).

Spending per FFS beneficiary increased by an average annual rate of 3.5 percent from 2012 through 2016 and by 7.7 percent in 2017 (Table 5-9). The increase in 2017 reflects a 1.9 percent increase in the ASC conversion factor, a 1.7 percent increase in per capita volume, a 3.8 percent increase in the average relative weight of ASC services, and a 0.3 percentage point increase from higher use of separately payable drugs (data not shown). The growth in spending in 2017 is unusually large. Relative to 2016, the higher growth in 2017 reflects a higher increase in the ASC conversion factor and a higher increase in per capita volume. The strong growth in the average relative weight that occurred in 2016 continued in 2017. In both 2016 and 2017, this growth was driven by increased volume for high-cost procedures, such as implantation of spinal neurostimulators, which may have resulted in lower volume for relatively low-cost injections for pain management.

How should Medicare payments change in 2020?

Our analysis indicates that the number of ASCs has increased, as has beneficiaries' use of ASCs, and access to capital has been adequate. Certain measures of ASC quality indicate improvement, although we have identified areas for improvement in ASC quality measurement. Our information for assessing payment adequacy, however, is limited because Medicare does not require ASCs to submit cost data, unlike other types of facilities. Since 2010, the Commission has recommended that the Congress require that ASCs submit cost data (Medicare Payment Advisory Commission 2010).

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 our 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, the Commission has previously expressed concern that the price index CMS used to update the ASC conversion factor from 2010 through 2018 (the CPI–U) likely does not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010). Also, the price index that CMS has said it will use to update the ASC conversion factor from 2019 through 2023—the hospital MB—does not reflect ASCs' cost structure.

CMS has concluded that it needs data on ASC input costs (Centers for Medicare & Medicaid Services 2012). To date, CMS has not required ASCs to submit cost data. However, CMS requested public comment on whether the agency should collect cost data from ASCs for use in determining ASC payment rates. ASC representatives commented that they oppose a requirement for ASCs to submit formal cost reports, but expressed willingness to complete surveys if doing so is not administratively burdensome (Centers for Medicare & Medicaid Services 2017).

We believe it is feasible for ASCs to provide cost information. All other facility providers submit cost data to CMS. Indeed, ASCs in Pennsylvania submit cost and revenue data annually to a state agency that uses the data to estimate margins for those ASCs (Pennsylvania Health Care Cost Containment Council 2018). We recognize that ASCs are generally small facilities that may have limited resources for collecting cost data. However, such businesses typically keep records of their costs for filing taxes and other purposes, and other facility providers that are typically small, such as home health agencies and hospices, furnish cost data to CMS.

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. As it did in 1986 and 1994, CMS could annually conduct a survey of a random sample of ASCs, with mandatory response. The Government Accountability Office conducted a similar random sample survey of ASC costs in 2004. CMS could also streamline ASC cost reporting by annually collecting a set of cost variables from all ASCs that is more limited than what is collected through formal cost reports, which would require less time for ASCs to complete. Alternatively, CMS could require ASCs to submit cost data from their existing cost accounting systems, provided the definitions of their reported cost variables are consistent with CMS's definitions. The Commission does not believe that a streamlined process for collecting cost data would place a large burden on ASCs. After all, individual taxpayers are able to complete and submit lengthy income tax forms. Therefore, the Commission sees no reason ASCs cannot submit at least minimal cost data.

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

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

In addition, CMS would need to collect data on specific cost categories to determine an appropriate input price index for ASCs. For example, CMS would need

Revisiting the ASC market basket index

From 2010 through 2018, CMS used the consumer price index for all urban consumers (CPI–U) as the market basket (MB) to update the conversion factor in the ambulatory surgical center (ASC) payment system. Because of our concern that the CPI–U likely does not reflect ASCs' cost structure, the Commission examined in 2010 whether an alternative MB index would better measure changes in ASCs' input costs (Medicare Payment Advisory Commission 2010). Using data from a Government Accountability Office (GAO) survey of ASC costs in 2004, we compared the distribution of ASC costs with the distribution of hospital and physician practice costs. We found that ASCs' cost structure is different from that of hospitals and physician offices. ASCs have a much higher share of expenses for 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. For more detail about our methods and findings, see Chapter 2C of our March 2010 report to the Congress (Medicare Payment Advisory Commission 2010).

Since our 2010 analysis, CMS has considered whether the hospital MB or the practice expense component of the Medicare Economic Index (MEI) is a better proxy for ASC costs than the CPI–U (Centers for Medicare & Medicaid Services 2012). Most recently, CMS has decided to use the hospital MB as the basis for updating ASC payment rates from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). As we stated above, our analysis of GAO cost data showed that ASCs have a different cost structure than hospitals. Therefore, we do not believe the hospital MB is an appropriate market basket for ASCs.

The ASC cost data from GAO used in our comparative analysis are 15 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 2018c, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010). In each of the last six years, the Commission recommended eliminating the update to the ASC conversion factor, meaning the ASC conversion factor would not change from the previous year. CMS should use cost data to examine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. A new ASC MB could include the same types of costs that appear in the hospital MB or MEI but with different cost weights that reflect ASCs' unique cost structure. ■

data on the share of ASCs' costs related to employee compensation, medical supplies, medical equipment, building expenses, and other professional expenses (such as legal, accounting, and billing services). CMS could 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 MB should be developed.

CMS used the CPI–U to update the ASC conversion factor from 2010 through 2018. Using the CPI–U, CMS increased the ASC conversion factor by 1.4 percent in 2015, 0.3 percent in 2016, 1.9 percent in 2017, and 1.2 percent in 2018. However, CMS has indicated that the CPI–U does not reflect the input costs of ASCs.

CMS has made a significant regulatory change and decided to use the hospital MB as the basis for updating the ASC conversion factor for a five-year period—2019 through 2023. CMS based its decision to use the hospital MB in place of the CPI–U on concerns that the differences in payment rates between the ASC payment system and the OPPS has caused a shift of care from ASCs to HOPDs.

CMS believes that using the same update mechanism for both ASCs and HOPDs could "encourage the migration of services from the hospital setting to the ASC setting and increase the presence of ASCs in health care markets or geographic areas where previously there were none or few, thus promoting better beneficiary access to care" (Centers for Medicare & Medicaid Services 2018). The update to the ASC conversion factor for 2019 is 2.1 percent, which is based on a projected 2.9 percent increase in the hospital MB minus a 0.8 percent reduction for multifactor productivity growth, as mandated by the Patient Protection and Affordable Care Act of 2010.

During the five-year period of using the hospital MB, CMS states that it will:

- assess whether there is a migration of services from hospitals to ASCs and
- assess the possibility of working with stakeholders to collect cost data from ASCs in a minimally burdensome manner and could propose a plan to collect cost data (Centers for Medicare & Medicaid Services 2018).

Beginning with the Commission's March 2010 report to the Congress, the Commission has stated for several years in comment letters and in published reports that the CPI–U does not likely reflect the current input costs of ASCs (Medicare Payment Advisory Commission 2010). However, the Commission does not support using the hospital MB index as an interim method for updating the ASC conversion factor because evidence indicates that the hospital MB index does not accurately reflect the costs of ASCs (Medicare Payment Advisory Commission 2018a). CMS acknowledges that the ASC cost structure is not identical to that of hospitals because ASCs tend to be single specialty and for profit, and they are not required to comply with the Emergency Medical Treatment and Labor Act of 1986. The Commission concurs with these observations and adds that, relative to hospitals, ASCs are more urban, serve a different mix of patients, have a much higher share of expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs.

The Commission asserts that CMS should forgo the five-year period to assess the feasibility of ASC cost reporting and instead use its authority and resources to act quickly in gathering ASC cost data. ASCs are profitable organizations, and the number of ASCs and the volume of services continue to grow. Therefore, we believe it is unnecessary for CMS to spend five years assessing the feasibility of collecting cost data from ASCs.

Recommendation

In evaluating a need for an update to the ASC conversion factor for 2020, the Commission balanced the following objectives:

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

In balancing these goals, the Commission concludes that the ASC update for 2020 should be eliminated and that the Secretary should collect cost data from ASCs.

RECOMMENDATION 5-1

The Congress should eliminate the calendar year 2020 update to the Medicare conversion factor for ambulatory surgical centers.

RECOMMENDATION 5-2

The Secretary should require ambulatory surgical centers to report cost data.

RATIONALE 5-1 AND 5-2

On the basis of our payment adequacy indicators and the importance of maintaining financial pressure on providers to constrain costs, we believe that the ASC conversion factor should not be increased for 2020. That is, the 2020 conversion factor in the ASC payment system should be the same as the conversion factor in 2019. Though we do not have cost data and we have reservations about the measures used within the ASCQR Program, the indicators of payment adequacy for which we have information are positive: The volume of ASC services per beneficiary increased in 2017, the complexity of ASC services provided increased, and the number of ASCs increased. Also, ASCs appear to have adequate access to capital,

ASC quality of care data have trended positive, and Medicare payments to ASCs have continued to grow.

The Commission has persistently recommended that the Secretary collect cost data from ASCs. Cost data would enable CMS and 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 payment update. Cost data are also needed to evaluate whether an alternative input price index would be an appropriate proxy for ASC costs.

We see no reason why ASCs should not be able to submit cost data. CMS collects cost data from all other institutional providers participating in the Medicare program. To date, the ASC industry has asserted that ASCs are small operations that lack the capacity and accounting expertise to enable them to complete cost reports. However, some of the sectors from which CMS collects cost data are predominantly small providers. Therefore, any ASC should be able to compile and submit a minimum set of cost data. Also, while the majority of the ASC industry consists of freestanding facilities, hospital corporations and other large health care entities have entered the ASC industry in recent years and have the capacity and expertise to complete cost reports. CMS could limit the scope of the cost reporting system to minimize administrative burden on ASCs and the program. In addition, to implement this change, CMS should make cost reporting a condition of ASC participation in the Medicare program.

IMPLICATIONS 5-1 AND 5-2

Spending

- The Secretary has the authority to update the ASC conversion factor and has decided to use the hospital MB index as the basis for updating the conversion factor from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). The Patient Protection and Affordability Act of 2010 requires that the update factor be reduced by a multifactor productivity measure. The currently projected hospital MB index increase for 2020 is 3.2 percent, and the forecast of productivity growth for 2020 is 0.6 percent, resulting in a projected update of 2.6 percent to the conversion factor for 2020. Relative to current Medicare law, our recommendation would decrease federal spending by between $50 million and $250 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 ASCs and the increase in ASCs' revenue from Medicare, we do not anticipate that this recommendation will diminish beneficiaries' access to ASC services or providers' willingness or ability to provide those services.

- ASCs may incur some minimal administrative costs to track and submit cost data, but we believe cost accounting is standard practice in the ASC industry, and ASCs should be able to draw cost data from that source. ■

Endnotes

1 The payment rates in the ASC system are determined independently from the payment rates in the PFS. Therefore, it is possible for an office-based procedure to have its payment rate based on the standard method in one year and based on the PFS nonfacility rate the next year, or vice versa.

2 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004. They received reliable cost data from 290 facilities.

3 Munnich and Parente (2014) also found that the highest risk patients that underwent the five highest volume outpatient procedures were less likely to have a subsequent visit to an emergency department or a hospital inpatient stay when they received the outpatient procedure in an ASC rather than a hospital.

4 For services that CMS has defined as device intensive (at least 30 percent of the cost of the service is attributable to a device), the differences in the payment rates between HOPDs and ASCs are smaller than 94 percent because the reimbursement for the applicable device is the same in ASCs and HOPDs.

5 State certificate of need (CON) laws for ASCs appear to affect the number of ASCs in the state. Twenty-seven states and the District of Columbia have CON laws for ASCs. Nine of the 10 states with the fewest ASCs per capita have a CON law in place, while only 4 of the 10 states that have the most ASCs per capita have CON laws. Among these four states, Maryland and Georgia have exceptions in their CON requirements that make it easier to establish new ASCs.

6 We define *single-specialty* ASCs as those with more than 67 percent of their Medicare claims in one clinical specialty. We define *multispecialty* ASCs as those with more than 67 percent of their Medicare claims in more than one clinical specialty.

7 By statute, coinsurance for a service paid under the OPPS cannot exceed the hospital inpatient deductible ($1,364 in 2019). The ASC payment system does not have the same limitation on coinsurance; for a small share of HCPCS codes covered under the ASC payment system, the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the OPPS coinsurance.

8 Cost sharing is lower under the ASC payment system for 96.8 percent of HCPCS codes that are covered under the ASC payment system.

9 Rather than a full discontinuation of measures ASC–1 through ASC–4, CMS has decided to suspend these four measures. Suspension means that ASCs are no longer required to report data on these measures, but CMS will retain them in the ASCQR Program for possible future use. Patient experience will be assessed using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey measures, but implementation of CAHPS measures has been delayed.

10 We did not include data for ASC–6 (safe-surgery checklist) because ASC response rates were low, which we assume to be related to CMS discontinuing the measure for 2018.

11 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. government agency.

12 The Commission also described its principles for a VBP program for ASCs in a letter to the Congress commenting on the Secretary's report to the Congress on a VBP program for ASCs (Medicare Payment Advisory Commission 2011a).

13 Subsequent hospital visits include emergency department services, outpatient observation services, and inpatient services.

14 Among the approximately 100,000 ASC discharges associated with subsequent hospital stays within 7 days, roughly two-thirds had subsequent inpatient hospital stays and one-third had subsequent visits to an emergency department (data not shown).

15 The margins for ASCs have important differences from the margins in other sectors such as hospitals. In particular, the cost data used to determine margins for most ASCs do not include compensation for physician owners or the taxes paid on that compensation.

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