

CHAPTER

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**Ambulatory surgical  
center services**

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

**5-1** For calendar year 2023, the Congress should eliminate the update to the 2022 Medicare conversion factor for ambulatory surgical centers.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

# Ambulatory surgical center services

## Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay. In 2020, the 5,930 ASCs that were certified by Medicare treated 3.0 million fee-for-service (FFS) Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$4.9 billion.

In this chapter, we make a recommendation on a payment rate update for 2023. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2020. We have considered the effects of the coronavirus public health emergency (PHE) and associated relief policies on our indicators and whether those effects are likely to be temporary or permanent. To the extent that the effects of the PHE are temporary changes—even across multiple years—or vary significantly across individual ASCs, they are best addressed through targeted temporary funding policies rather than a permanent change to all ASCs' payment rates in 2023 and future years. Based on information available at the time of publication, we do not anticipate any long-term PHE-related effects that would warrant inclusion in the annual update to ASC payments in 2023, other than increased wage rates, which will be

## In this chapter

- Are Medicare payments adequate in 2022?  
.....
- How should Medicare payment rates change in 2023?  
.....

accounted for under current-law updates to the hospital market basket (CMS currently uses the hospital market basket to update ASC payment rates).

### **Assessment of payment adequacy**

To examine the adequacy of Medicare's payments to ASCs, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, and provider access to capital. Cost data are not available for ASCs. The available indicators of payment adequacy for ASC services are generally positive.

In 2020, some ASC payment adequacy indicators improved while others diminished. However, the decreasing measures very likely reflect the temporary effects of the PHE rather than the adequacy of Medicare payments to ASCs.

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

- **Capacity and supply of providers**—From 2015 to 2019, the number of ASCs increased by an average annual rate of 2.1 percent. In 2020, the number of ASCs increased 2.0 percent. Most new ASCs in 2020 (95 percent) were for-profit facilities.
- **Volume of services**—From 2015 through 2019, the volume of services per Part B FFS beneficiary grew by an average annual rate of 1.5 percent. In 2020, volume per beneficiary declined by 13.6 percent, largely due to a substantial drop in the spring of 2020 caused by the PHE. ASC volume rebounded strongly, and volume in December 2020 was 97 percent of the volume in December 2019.

**Quality of care**—From 2013 through 2017, ASC-reported quality data showed improvement in performance; improvement plateaued from 2017 to 2019. For 2020, CMS collected data on five quality measures; these measures were generally unchanged from 2019 to 2020. However, CMS did not require ASCs to submit quality data for the first six months of 2020. We continue to be concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems® measures, the lack of a value-based purchasing program for the ASC sector, and the lack of outcome measures that apply to all ASCs. For example, CMS could add measures targeting the frequency of ASC patients receiving hospital care after ASC discharge or rates of surgical site infection.

**Providers' access to capital**—Because the number of ASCs, especially for-profit ASCs, has continued to increase and consolidation in the ASC market has maintained a steady pace, access to capital appears to be adequate.

**Medicare payments and providers' costs**—From 2015 through 2019, Medicare payments for ASC services per FFS beneficiary grew by an average annual rate of 6.7 percent. However, in 2020, payments fell by 3.9 percent, reflecting the effects of the PHE. 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.

The Commission contends that cost data would support more informed decisions about updating ASC payment rates and for identifying an appropriate input price index for ASCs. Therefore, the Commission continues to recommend that the Secretary of Health and Human Services collect cost data from ASCs without further delay. Considering the available evidence of payment adequacy, the Commission recommends that, for calendar year 2023, the Congress eliminate the update to the 2022 Medicare conversion factor for ambulatory surgical centers. ■



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## Background

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

Since 1982, Medicare has covered and paid for surgical procedures provided in ASCs. Medicare covers surgical procedures represented in about 3,800 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 2020, 32 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, known as the physician fee schedule (PFS). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2017, Leapfrog 2019). Physicians who perform surgeries in ASCs they own receive a share of the ASC's facility payments 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.<sup>1</sup>

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 for a procedure, which indicates the procedure's

resource intensity relative to other procedures, is based on its relative weight under the OPPS. Although CMS links the ASC payment system to the OPPS, payment rates for all services covered under both systems are lower in ASCs for two reasons. First, CMS makes proportional adjustments to the relative weights of the OPPS because budget-neutrality requirements do not allow changes in the relative weights to affect the level of Medicare spending from one year to the next. In 2022, this adjustment results in ASC relative weights that are 14.5 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 \$49.92 for 2022, which is 41 percent lower than the OPPS conversion factor of \$84.18 for 2022.

The ASC conversion factor is lower than the OPPS conversion factor because it was set at a lower level in 2008 and was updated each year at a lower rate than the OPPS conversion factor until 2019. 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. 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 index to update the OPPS conversion factor. The CPI-U has generally increased at a lower rate than the hospital market basket index. Therefore, before 2019, the ASC conversion factor was updated by smaller percentages than the OPPS conversion factor.

In a change of regulatory policy, CMS has instituted a policy of updating the ASC conversion factor using the hospital market basket index from 2019 through 2023. Under this change, the updates to the ASC conversion factor will align with the updates to the OPPS conversion factor.

We are concerned that neither the CPI-U nor the hospital market basket index reflects ASCs' cost structure (see the text box on revising the ASC market basket index, p. 184). Beginning in 2010, the Commission has repeatedly recommended that CMS collect cost data from ASCs with the purpose of identifying a price index that would be an appropriate proxy for ASC costs (Medicare Payment Advisory

Commission 2010). However, the ASC industry opposes the collection of cost data for this purpose (Centers for Medicare & Medicaid Services 2017). CMS has shown some interest in collecting cost data and requested comments from stakeholders 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 requirement for ASCs to submit formal cost reports but indicated a willingness to complete surveys on the condition that they 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, ASCs in Pennsylvania 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. Nevertheless, CMS has not acted on this issue.

CMS uses a different method from the one described above to determine payment rates for “office-based” procedures, which are procedures that are predominantly performed in physicians’ offices and were first covered under the ASC payment system in 2008 or later. Payment for 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).<sup>2</sup> 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. Physicians who provide office-based procedures in ASCs receive a separate payment under the PFS (the full facility payment rate, which includes the work, facility practice expense, and professional liability insurance payments).

The ASC payment system somewhat parallels the OPPS in terms of which ancillary items are paid separately and which are packaged into the payment of the associated surgical procedure. An important distinction between the ASC payment system and the OPPS is that

CMS uses comprehensive APCs (C-APCs) in the OPPS but not in the ASC system. C-APCs are an advanced version of APCs in which all Part B-covered hospital outpatient services reported on a claim are combined into a single payment. CMS has stated that the reason that C-APCs have not been used in the ASC system is that 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. Forty-four percent of ASC surgical volume in 2020 comprised procedures that 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. Studies that used data from the National Survey of Ambulatory Surgery found that the average length of time for ambulatory surgical visits for Medicare patients was 25 percent to 39 percent shorter in ASCs than in HOPDs, which likely contributes to lower costs in ASCs (Hair et al. 2012, Munnich and Parente 2014). An additional study using data from a facility that has both an ASC and a hospital found that surgeries took 17 percent less time in the ASC (Trentman et al. 2010). Beneficiaries who are sicker may require more time to treat, and the studies that accounted for differences in health status between patients treated in ASCs and those in HOPDs generally estimated a somewhat smaller differential in average surgical time between ASCs and HOPDs.

ASCs have a small role in total Medicare fee-for-service (FFS) spending, which has likely contributed to the fact that little is known about the effect of the coronavirus public health emergency (PHE) on the ASC industry. To the extent that information is available, we include the effects of the coronavirus PHE on ASCs throughout our discussion of payment adequacy in the ASC sector (see text box on the Commission’s framework for assessing payment adequacy).



## The coronavirus public health emergency and the Commission's payment adequacy framework

**O**n January 31, 2020, the Secretary of Health and Human Services first declared the coronavirus public health emergency (PHE). In late March 2020, the nation's health care system began to experience major changes in service use, as elective procedures were postponed, preserving clinical staff's availability and equipment for COVID-19 patients. The PHE has had tragic and disproportionate effects on the health of Medicare beneficiaries. (For details on the effects of COVID-19 on beneficiaries' health and access to care, see Chapter 1.) It has also had damaging effects on the nation's health care workforce, with frontline health care workers facing burnout and risks to their health and safety. The tragedy is ongoing, with a substantial number of cases and mortalities.

The PHE has also had material effects on all of the Commission's payment adequacy indicators. Because of standard data lags, the most recent complete data we have are from 2020 for most indicators; however, we also include preliminary data from 2021 where possible. As described in more detail later in this chapter, the effects of the PHE on indicators of Medicare's payment adequacy to ambulatory surgical centers (ASCs) in 2020 included:

- dramatic drops in patient volume in spring 2020, largely rebounding by summer 2020, and
- PHE-related Medicare payment policy changes that increased payments to ASCs, including the suspension of the 2 percent sequestration on Medicare payments.

In this chapter, we use available data and changes in payment policy to recommend payment rate updates for ASCs for 2023. However, significant uncertainty remains about how long the pandemic will last as well as the extent to which certain changes to ASC volume and financial performance will persist after the PHE. Therefore, while analyzing 2020 data is important to understand what happened to beneficiaries' access to care, quality of care, provider's access to capital, and Medicare's payments, it will be more difficult to interpret these indicators than is typically the case.

As the Commission stated last year, to the extent that the effects of the coronavirus pandemic are temporary—even if lasting multiple years—they are best addressed through targeted temporary funding policies rather than a permanent change to all ASCs' payment rates in 2023 and future years. Only permanent effects of the pandemic will be factored into the Commission's recommended changes in Medicare base payment rates. ■

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### Are Medicare payments adequate in 2022?

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To address whether payments for the current year (2022) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2023), 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.

**TABLE  
5-1**

**Number of ASCs and operating rooms grew, 2015–2020**

	2015	2019	2020	Average annual percent change	
				2015–2019	2019–2020
Total number of ASCs	5,352	5,811	5,930	2.1%	2.0%
New	170	240	174	N/A	N/A
Closed or merged	110	91	55	N/A	N/A
Total number of ORs	16,556	17,723	18,066	1.7	1.9
New	393	700	481	N/A	N/A
Closed or merged	300	267	138	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable), OR (operating room). 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 and ORs.

Source: MedPAC analysis of Provider of Services file from CMS, 2021.

In 2020, some ASC payment adequacy indicators improved while others declined. However, the aggregate changes reflect temporary changes during the PHE rather than the adequacy of Medicare payments to ASCs. Overall, 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. The number of ASC facilities has increased, and the volume of services provided to Medicare beneficiaries in ASCs had increased before the PHE. 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, lower cost sharing, and easier scheduling relative to HOPDs. ASCs offer physicians more control over their work environment and specialized staff. However, these same qualities could lead to overuse of surgical procedures.

**Capacity and supply of providers: Number of ASCs is increasing**

From 2019 to 2020, the number of ASCs increased 2.0 percent to 5,930 ASCs (Table 5-1). This annual growth

rate was similar to the growth in the period from 2015 to 2019, when the number of ASCs increased, on average, 2.1 percent per year. In 2020, 174 new ASCs opened, while 55 ASCs closed or merged with other facilities, for a net increase of 119 facilities. Both the number of new facilities and the number of facilities that closed or merged in 2020 were slightly lower than in recent years. The number of ASCs that billed Medicare for at least one surgical service was 5,219 in 2020 versus 5,143 in 2019, a 1.5 percent increase (data not shown). Finally, the number of ASCs continued to increase in the first six months of 2021 as the number of new ASCs increased by 94, offset by 27 ASCs that closed or merged, for a net increase of 67 facilities.

Because the central purpose of ASCs is the provision of surgical procedures, the number of operating rooms (ORs) is another useful measure of supply in this sector. In 2020, there were 18,066 ORs in ASCs, or an average of 3.0 per facility. From 2015 to 2019, the total number of ASC ORs increased 1.7 percent per year, a slower rate than the growth in the number of ASCs over the same period (2.1 percent per year). From 2019 to 2020, the number of ORs in ASCs increased by 1.9 percent, slightly slower than the growth in the number of ASCs.

Consistent with previous years, the vast majority of ASCs in 2020 were for profit (95.2 percent) and located in urban areas (93.4 percent) (Table 5-2). 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 may travel to urban areas to receive care in ASCs.

**Geographic distribution of ASCs is uneven, and a low share of ASC claims are for dual-eligible beneficiaries**

In addition to ASCs being located more in urban than rural areas, the concentration of ASCs varies widely across states. In 2020, Maryland had the most ASCs per Medicare beneficiary (38 ASCs per 100,000 Part B beneficiaries), followed by Georgia, Alaska, and New Jersey (23 to 18 ASCs per 100,000 Part B beneficiaries) (Figure 5-1, p. 172). Kentucky, the District of Columbia, West Virginia, and Vermont had the fewest ASCs per beneficiary (fewer than 4 ASCs per 100,000 beneficiaries).

We found that rural beneficiaries—defined as those who live outside metropolitan statistical areas (MSAs)—are less likely to receive care in ASCs than are urban beneficiaries, defined as those living in an MSA. In 2020, 6.3 percent of rural beneficiaries received care in an ASC compared with 9.1 percent of urban beneficiaries. Also, rural beneficiaries' access to ASC services relative to the access of urban beneficiaries has likely declined as the number of ASCs located in rural areas has been stable while the number of ASCs in urban areas has increased.

The Commission is concerned about access to care among vulnerable populations, such as those with low incomes and Medicare beneficiaries who are also eligible for Medicaid (dual-eligible beneficiaries). In 2020, about 14 percent of FFS Medicare beneficiaries were fully dual eligible, and about 4 percent had partial dual eligibility. We calculated for each ASC the share of FFS Medicare claims for surgical procedures that were for Medicare dual-eligible beneficiaries (both fully and partially dual eligible). Relative to other settings, dual-eligible beneficiaries accounted for a smaller share of total Medicare FFS claims in ASCs. In 2020, 8.2 percent of ASC claims were for fully dual-eligible beneficiaries and 3.3 percent were for partially dual-eligible beneficiaries. Also, we found that for 56 percent of ASCs, less than 10 percent of their Medicare

**TABLE 5-2**

**Most ASCs are for profit and urban**

**ASCs that were:**

Type of ASC	Open in 2015	Open in 2020	New in 2020
For profit	95.1%	95.2%	94.8%
Nonprofit	3.5	3.6	4.0
Government	1.4	1.2	1.1
Urban	92.9	93.4	95.4
Rural	7.1	6.6	4.6

Note: ASC (ambulatory surgical center). Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS, 2021.

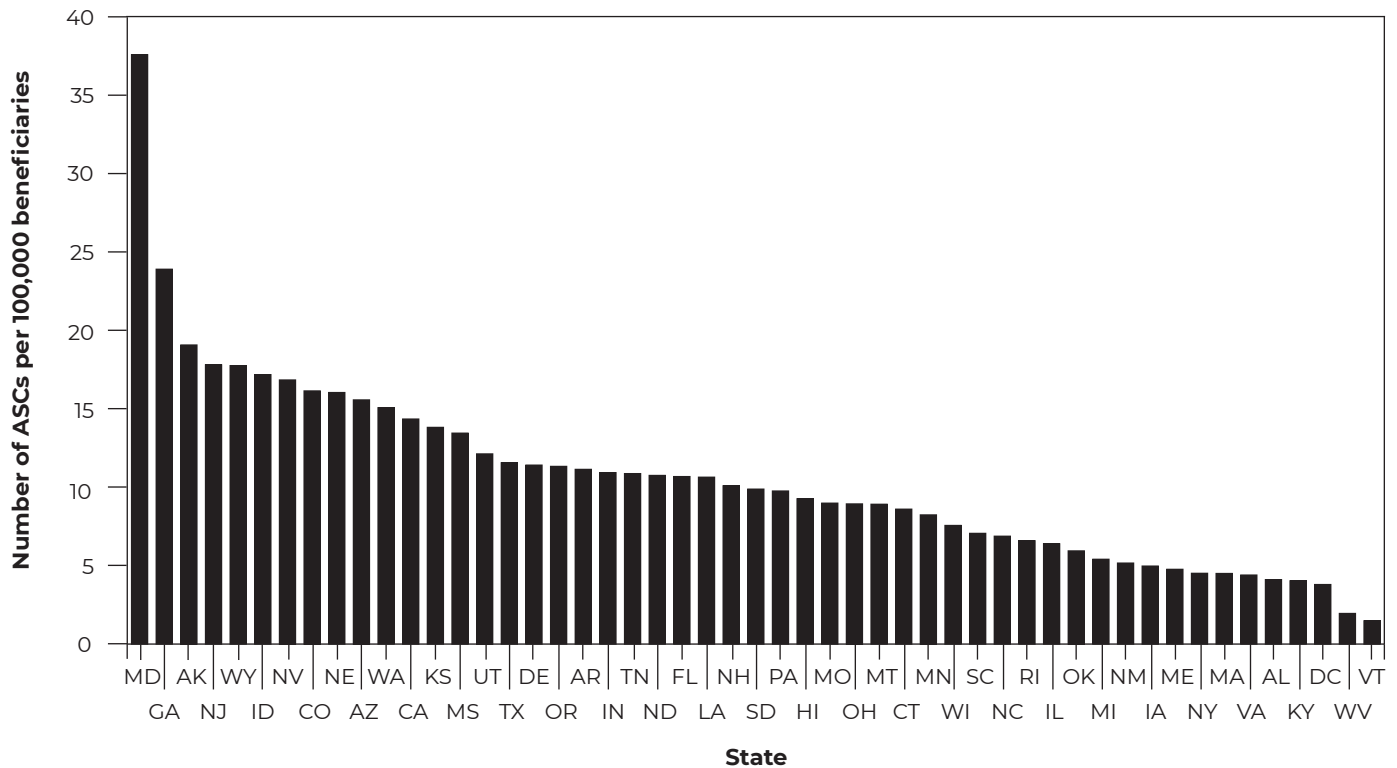
FFS claims were for dual-eligible beneficiaries (Figure 5-2, p. 173). Only 12 percent of ASCs had more than 30 percent of their Medicare FFS claims for dual-eligible beneficiaries. In 2020, dual-eligible beneficiaries were much more likely to receive care in HOPDs than in ASCs: 17.5 percent of HOPD claims were for fully dual-eligible beneficiaries (versus 8.2 percent for ASCs), and 4.8 percent of HOPD claims were for partially dual-eligible beneficiaries (versus 3.3 percent for ASCs) (data not shown).

**Specialization of ASCs largely unchanged, some growth in pain management**

In 2020, the majority of ASCs that billed Medicare specialized in a single clinical area, of which gastroenterology and ophthalmology were the most common, with each comprising 20 percent of all ASCs that provided services to FFS Medicare beneficiaries. Overall, 64 percent of ASCs were single-specialty facilities and 36 percent were multispecialty facilities, providing services in more than one clinical specialty (Table 5-3, p. 174).<sup>3</sup> In 2020, multispecialty ASCs most commonly focused on two specialties: pain management and orthopedic services or gastroenterology and ophthalmology (combined, 8 percent of all ASCs). From 2015 to 2020, ASCs specializing in pain management services grew most rapidly.

**FIGURE 5-1**

**Number of ASCs per beneficiary varies widely by state, 2020**



Note: ASC (ambulatory surgical center).

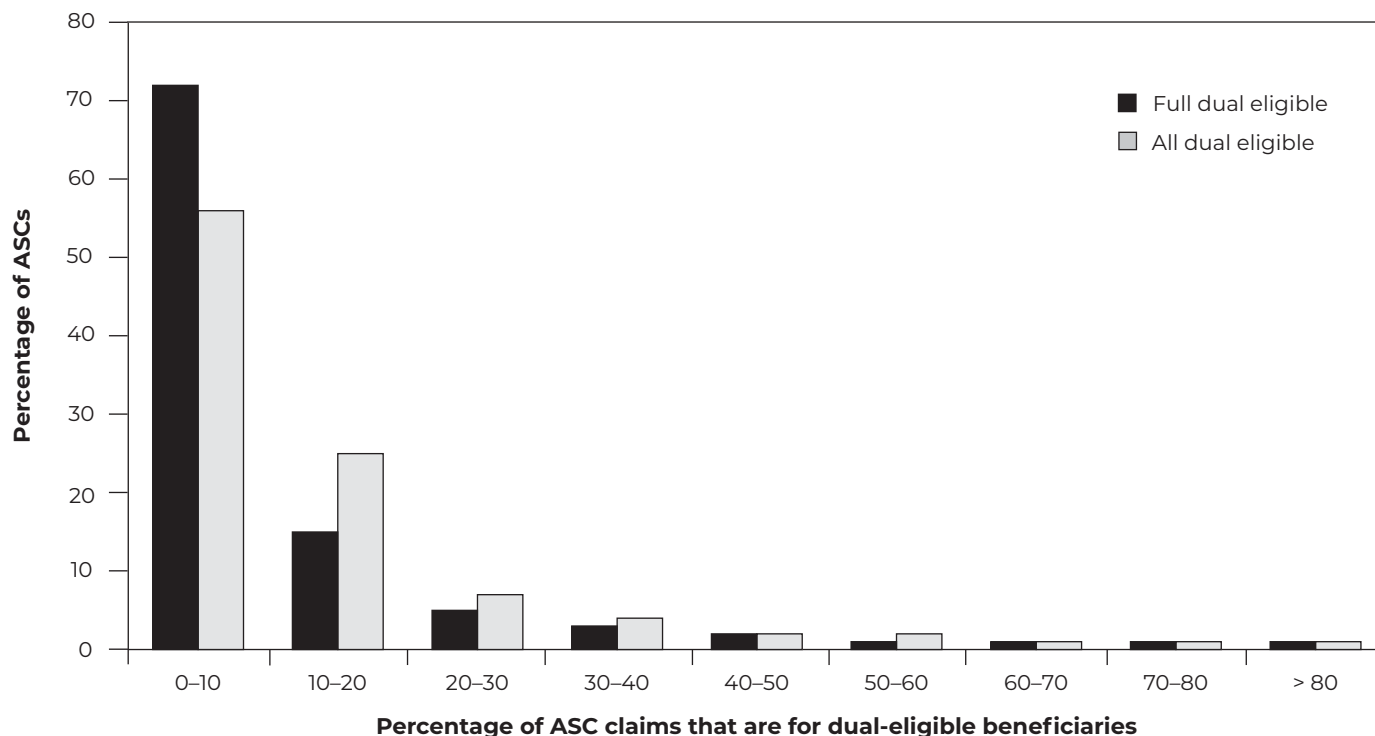
Source: MedPAC analysis of CMS Provider of Services file for 2021 and Common Medicare Environment file.

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. This trend could continue as momentum grows for doing knee and hip arthroplasty (knee and hip replacement) in ambulatory settings.<sup>4</sup>
- ASCs can offer patients greater convenience than HOPDs, such as shorter waiting times for surgery (patients can face delays for surgery in HOPDs because emergencies often take precedence over scheduled procedures).
- For most procedures covered under the ASC payment system, beneficiaries’ coinsurance is lower in ASCs than in HOPDs.<sup>5</sup>
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff. These features of ASCs allow physicians to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees.
- Physicians who invest in ASCs and perform surgeries on their patients in those ASCs can increase their revenue, by receiving a share of the ASC facility payments.

**FIGURE 5-2**

**Fifty-six percent of ASCs had less than 10 percent of claims billed for dual-eligible beneficiaries, 2020**



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Medicare carrier file claims, 2020.

- Increased interest across the health care industry in 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 decreased from 2019 to 2020, reflecting effects of the PHE**

Although the number of ASCs grew from 2019 to 2020, the volume of ASC surgical procedures per FFS beneficiary fell substantially. Also, the number of FFS beneficiaries treated in ASCs declined. Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries who have Part B coverage.

The volume of services per FFS beneficiary rose by an average of 1.5 percent per year from 2015 through 2019 but fell by 13.6 percent in 2020 (Table 5-4, p. 175).

In addition, from 2015 through 2019, the number of FFS beneficiaries who received ASC services grew an average of 0.4 percent per year but dropped by 15 percent in 2020 (data not shown). Also, the number of services per beneficiary receiving care in ASCs from 2015 through 2019 grew at an average annual rate of 0.9 percent but dropped by 0.9 percent in 2020 (data not shown).

The PHE clearly affected the volume of ASC services in 2020. We investigated how the PHE affected ASC volume throughout 2020 by evaluating ASC volume

**TABLE  
5-3****Specialization of ASCs billing Medicare in 2015 and 2020**

Type of ASC	2015		2020	
	Number of ASCs	Share of all ASCs	Number of ASCs	Share of all ASCs
Single specialty	2,878	61%	3,365	64%
Gastroenterology	1,027	22	1,072	20
Ophthalmology	1,020	22	1,061	20
Pain management	355	8	626	12
Dermatology	191	4	197	4
Urology	124	3	129	2
Cardiology	10	0	106	2
Podiatry	95	2	67	1
Orthopedics/musculoskeletal	23	0	40	1
Respiratory	16	0	33	1
OB/GYN	9	0	14	0
Neurology	5	0	5	0
Other	3	0	13	0
Multispecialty	1,802	39	1,854	36
More than 2 specialties	1,421	30	1,421	27
Pain management and orthopedics	146	3	238	4
Gastroenterology and ophthalmology	160	3	195	4
Other with 2 specialties	75	2	0	0
Total	4,680	100	5,219	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 less 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 2020. Columns containing the share of all ASCs do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2015 and 2020.

in each month of 2019 and 2020 for the 30 most frequently provided ASC services in 2020, which constituted nearly 75 percent of ASC volume in both 2019 and 2020. The large decrease in ASC volume in 2020 was driven by a substantial drop in spring 2020, as the volume in April 2020 was 11 percent of the volume in April 2019 (Figure 5-3). ASC volume had rebounded by summer 2020, and the December 2020 volume was 97 percent of the December 2019 volume.

The rebound in volume appears to have been stronger among services that are more urgent relative to those that are more discretionary. For example, the December 2020 volume per beneficiary for HCPCS code G0105 (colon cancer screening for high-risk individuals) was the same as the December 2019 level, while the December 2020 volume per beneficiary for HCPCS code G0121 (colon cancer screening for low-risk individuals) was below the December 2019 level by 11 percent (data not shown).

**TABLE  
5-4**

**Volume of ASC services per FFS beneficiary decreased in 2020**

	2015	2019	2020	Average annual change	
				2015–2019	2019–2020
Volume of services (in millions)	6.3	6.7	5.6	1.3%	-15.8%
Volume per 1,000 FFS beneficiaries	190.9	202.3	174.8	1.5	-13.6

Note: ASC (ambulatory surgical center), FFS (fee-for-service). The volume of services for 2015 and 2019 has been modified to reflect the volume of services covered under the ASC payment system in 2020 that were provided in those years.

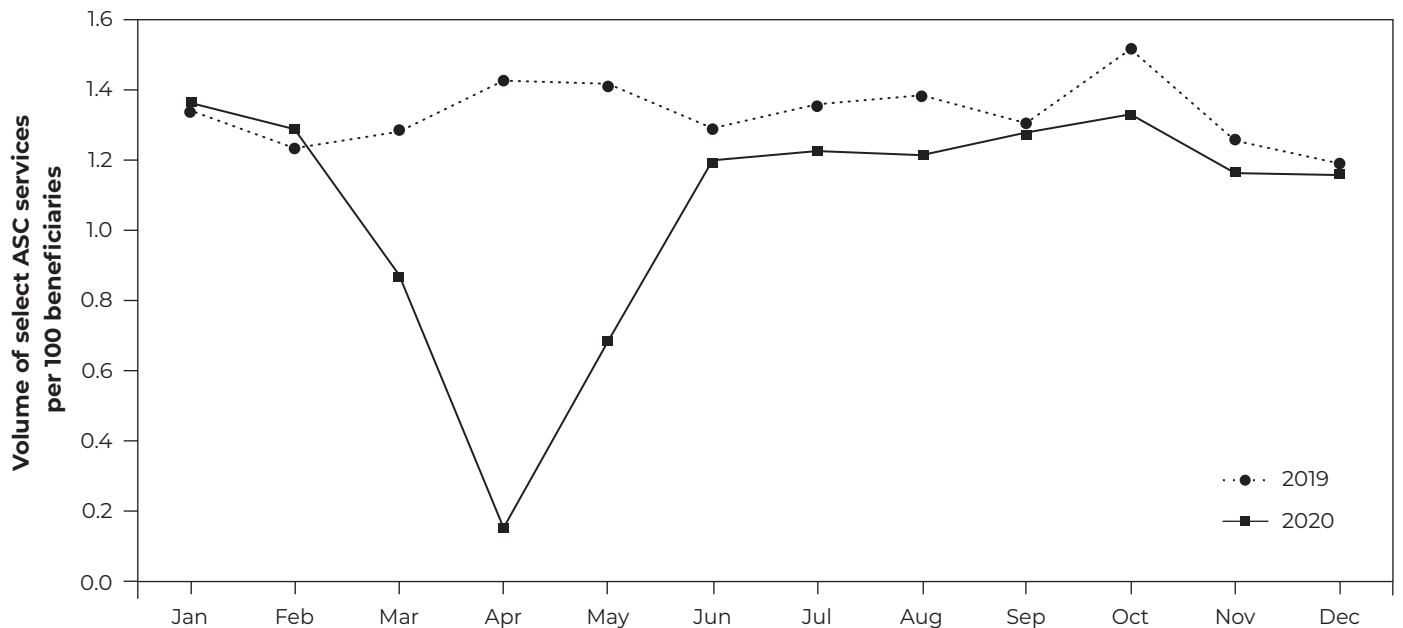
Source: MedPAC analysis of physician/supplier standard analytic files from CMS, 2015–2020.

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2020. For example, the HCPCS code for extracapsular cataract removal with intraocular lens insertion (HCPCS 66984) had the highest volume in both 2015 and 2020, accounting for 18.6 percent of

the total in 2015 and 17.7 percent in 2020 (Table 5-5, p. 176). Moreover, 19 of the 20 most frequently provided HCPCS codes in 2015 were among the 20 most frequently provided in 2020. These services made up about 71 percent of ASC Medicare volume in 2015 and 68 percent in 2020.

**FIGURE  
5-3**

**Volume of ASC services substantially declined in spring 2020 but rebounded by the end of 2020**



Note: ASC (ambulatory surgical center). This graph includes the 30 most frequently provided ASC services in 2020. These services constituted 75 percent of the ASC volume in 2019 and 2020.

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2019 and 2020.

**TABLE  
5-5**

**The 20 most frequently provided ASC services in 2020 were similar to those provided in 2015**

Surgical procedure	2015		2020	
	Percent of volume	Rank	Percent of volume	Rank
Extracapsular cataract removal w/IOL insert	18.6%	1	17.7%	1
Upper GI endoscopy, with biopsy: single or multiple	8.2	2	7.7	2
Colonoscopy and biopsy	6.8	3	6.6	3
Colonoscopy with lesion removal, snare technique	5.6	4	6.4	4
Inject transforaminal epidural: lumbar or sacral	4.8	5	4.7	5
After cataract laser surgery	4.4	6	3.9	6
Injection interlaminar epidural: lumbar or sacral	3.3	7	2.4	8
Injection paravertebral facet joint: lumbar or sacral, single level	3.1	8	3.4	7
Diagnostic colonoscopy	2.3	9	1.6	11
Colorectal cancer screening, high-risk individual	2.0	10	2.0	9
Colorectal cancer screening, not high-risk individual	1.9	11	1.2	15
Extracapsular cataract removal complex without ECP	1.6	12	1.3	13
Destroy lumbar/sacral facet joint, single	1.3	13	1.8	10
Injection procedure for sacroiliac joint, anesthetic	1.3	14	1.5	12
Cystourethroscopy	1.2	15	1.3	14
Injection interlaminar epidural: cervical or thoracic	1.0	16	1.0	17
Upper GI endoscopy diagnostic brush wash	1.0	17	0.8	19
Inject paravertebral facet joint: cervical or thoracic, single level	1.0	18	1.1	16
Blepharoplasty upper eyelid	0.9	19	0.8	18
Upper GI endoscopy, guide wire insertion	0.8	20	0.7	22
Total	71.1		68.1	
Total volume for all ASC services	6,349,005		5,631,959	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), ECP (endoscopic cyclophotocoagulation). In both percentage columns, the numbers do not add to the listed total because of rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from 2015 and 2020.

A potential concern about the services most frequently provided in ASCs is the extent to which they are unnecessary or of low value, such as spinal injections and other pain management services (Pinto et al. 2012). Seven of the 20 procedures listed in Table 5-5 were pain management services. Moreover, the second-highest revenue procedure for ASCs

in 2020 was for insertion or replacement of spinal neurostimulators. Volume for this procedure rose sharply from about 4,000 in 2015 to 12,000 in 2020, much faster than in HOPDs, where volume for the procedure increased from 12,000 in 2015 to 14,000 in 2020 (data not shown).



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

Maintaining beneficiaries' access to ASCs is beneficial because services provided in this setting are less costly to Medicare and beneficiaries than services delivered in HOPDs.<sup>6</sup> Medicare payment rates for surgical services performed in HOPDs are almost twice as high as in ASCs.

For example, the base payment rate in 2021 for cataract surgery with intraocular lens insertion (the service most frequently provided in ASCs) is \$2,121 in HOPDs compared with \$1,062 in ASCs. The lower payment rate in ASCs for this service has been financially beneficial to Medicare and beneficiaries. Other studies similarly find that ASCs are less costly than HOPDs in the Medicare and non-Medicare context and that price growth at ASCs has been slower than at HOPDs (Carey 2015, Robinson et al. 2015).

The higher payment rates for HOPDs relative to ASCs coupled with the increased employment of physicians by hospitals could lead to ambulatory surgical services shifting from ASCs to HOPDs. However, data on the most frequently provided services in ASCs suggest that such a shift has not occurred. We evaluated the growth in the 30 most frequently provided surgical services in ASCs, which constitute almost 75 percent of ASC volume, from 2015 through 2019. We found that the average annual growth in volume per FFS beneficiary for these surgical services was 0.9 percent in ASCs, compared with a decrease of 1.2 percent in HOPDs. The PHE reduced the provision of these services in both settings in 2020, with volume per FFS beneficiary for these surgical procedures decreasing by 15.6 percent in ASCs and by 10.5 percent in HOPDs. It is not clear how volume would have compared in the absence of the PHE.

The lower cost of ASCs relative to HOPDs may encourage health care management companies to enter into relationships with corporate entities that own many ASCs. In 2017, Optum Health (a subsidiary of United Health Group) acquired Surgical Care Affiliates, which operates about 230 ASCs, and in 2019 Humana and SurgCenter Development agreed to add more than 100 ASCs operated by SurgCenter Development to Humana's national provider network. These relationships can make it easier for the health plan operators to encourage use of lower-cost ASCs instead of higher-cost HOPDs. (If enrollees of Medicare Advantage plans use ASCs for ambulatory surgical procedures more frequently than do FFS beneficiaries,

MA plans would have a persistent source of savings because the plans' benchmarks would reflect the use of ASCs among FFS beneficiaries, while MA enrollees would be using the lower-cost ASCs at a higher rate.)

Medicare program spending and overall beneficiary cost sharing could be reduced if medical professionals provided more surgical services in ASCs than HOPDs or if Medicare reduced HOPD payment rates to the level of ASC payment rates. 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, in 2020, HOPDs provided 329,000 Medicare-covered cataract surgeries with intraocular lens insertion, which was 25 percent of the total volume for this service.

However, most ASCs have some degree of physician ownership, and as owners of a business, these physicians have an incentive to perform more surgical services than if they provided outpatient surgery only in facilities they do not own. It is not clear whether the physician owners of ASCs act on this incentive. The most recent studies on the effect of ASC physician ownership are somewhat dated, but these 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, Strobe et al. 2009). At the same time, hospital acquisition of physician practices could also result in increased surgical volume in HOPDs if hospitals encourage their physician employees to change their methods of practice to improve the hospitals' financial position.

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. 2015, 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. It is plausible, based on the results of these studies, that reductions in Medicare spending due to lower payment rates for ASCs relative to HOPDs could be partially offset by a higher number of surgical procedures provided overall.

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

**TABLE  
5-6**

**Quality measures used in the Medicare ASC Quality Reporting Program**

Description of quality measure	Required in:	
	2021	2024
ASC-9: Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients	Yes	Yes
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	Yes	Yes
ASC-14: Unplanned anterior vitrectomy: Percentage of cataract surgery patients who have an unplanned removal of the vitreous	Yes	Yes
ASC-15: Five patient experience measures from the Outpatient and Ambulatory Surgery Survey Consumer Assessment of Healthcare Providers and Systems (CAHPS®): 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 <sup>a</sup>	No
ASC-17: Hospital visits after orthopedic ASC procedures	No <sup>b</sup>	Yes
ASC-18: Hospital visits after urology ASC procedures	No <sup>b</sup>	Yes
ASC-19: Hospital visits after general surgery ASC procedures	No <sup>c</sup>	Yes

Note: ASC (ambulatory surgical center).  
<sup>a</sup>CMS has made this measure voluntary in 2025 and mandatory in 2027.  
<sup>b</sup>CMS activates this measure in 2022.  
<sup>c</sup>CMS will activate this measure in 2024.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2021.

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 offices. The procedures that are more frequently provided in physician offices than ASCs have their ASC payment rate set equal to the lesser of the standard ASC

payment rate or the nonfacility practice expense component from the PFS.

**Quality of care: Changing quality measures limits cross-year comparison**

ASC-reported quality data demonstrated modest improvement from 2013 to 2017 and largely plateaued from 2017 to 2019. Quality data from 2020 reflect about the same level of quality as in 2019. 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 quality measurement data 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; CMS requires ASCs 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 (Medicare Payment Advisory Commission 2012).

CMS has made substantial changes to the quality measures in the ASCQR, which resulted in CMS measuring ASC quality based on four measures (plus one voluntary measure) for 2021 and seven measures (plus one voluntary measure) for 2024 (Table 5-6). In recent years, CMS discontinued or delayed 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 adverse event measures (ASC-1 through ASC-4) and the delay of measures of patient experience.<sup>7</sup> For 2022 and subsequent years, CMS will implement two new claims-based measures of beneficiaries' visits to a hospital subsequent to an ASC orthopedic or urology procedure (ASC-17 and ASC-18, respectively). For 2024 and subsequent years, CMS will implement a new claims-based measure of beneficiaries' visits to a hospital subsequent to general surgery procedures (ASC-19).

### **Results from reported ASC quality data**

CMS has made available quality data from 2020, but we caution that CMS did not require ASCs to submit quality data for the first six months of 2020.

Data reported by ASCs for 2015 to 2019 suggest improvement in ASC quality of care from 2015 to 2017, but there was little change in the data from 2017 to 2019. From 2019 to 2020, there again was not much change in the quality data. Performance on the four adverse event measures (ASC-1 through ASC-4) generally improved from 2015 through 2018, and CMS did not collect data on these measures for 2019 or 2020.<sup>8</sup> The data show consistently low levels of these adverse events in each of the four years. Also, the share of ASCs reporting zero adverse events increased for three of these measures and stayed at the same level for one of these measures. For example, from 2015

to 2018, the share of ASCs without any patient burns increased from 92 percent to 93 percent, and the share of ASCs without any patient falls increased from 93 percent to 94 percent (data not shown).

In addition to the adverse events measures, other ASCQR measures have shown little change from 2015 to 2020 (Table 5-7, p. 180). For example, the measure for endoscopy for polyp surveillance and follow-up for average-risk patients (ASC-9) improved slightly from 2015 to 2019 and was unchanged from 2019 to 2020. Two relatively new measures—unplanned vitrectomy after cataract surgery (ASC-13) and normothermia (normal body temperature) after anesthesia (ASC-14)—did not change from 2019 to 2020. Room for improvement exists for measures ASC-9, ASC-12, ASC-13, and ASC-14.

We also compared the performance of ASCs with the performance of HOPDs in 2020 on the two measures from the ASCQR (ASC-9 and ASC-12) that match measures in the Hospital Outpatient Quality Reporting (OQR) Program (OP-29 and OP-32) (the data from the OQR are not shown). The data indicate that ASCs performed better, on average, on 7-day risk-standardized hospital visit rate after outpatient colonoscopy (1.2 percent in ASCs and 1.6 percent in HOPDs). Conversely, HOPDs performed better than ASCs on share of average-risk patient with appropriate endoscopy/polyp surveillance (90 percent in HOPDs versus 84 percent in ASCs).

### **CMS should continue to refine ASC quality measures**

The Commission asserts that CMS should continue to improve the ASCQR by moving toward more outcome measures that apply to all ASCs. In addition, CMS should synchronize ASCQR measures with measures included in the Hospital OQR Program to facilitate comparisons between ASCs and HOPDs. The Commission commends CMS on its decisions to discontinue a measure in 2021 (ASC-10: Endoscopy/polyp surveillance, colonoscopy interval for patients with a history of adenomatous polyps) because cost of collection exceeds the benefit and to add the three claims-based unplanned hospitalization measures by 2024. The Commission also commends CMS on its decision to begin using the Consumer Assessment of Healthcare Providers and Systems<sup>®</sup> patient experience survey quality data in 2025.<sup>9</sup> Among the Commission's

**TABLE  
5-7**

**Results for required ASC quality variables, 2015–2020**

ASC quality measure	Mean percent among ASCs					
	2015	2016	2017	2018	2019	2020
ASC-9: Share of average-risk patients with appropriate endoscopy/polyp surveillance	80%	81%	83%	83%	84%	84%
ASC-10: Share of patients with polyp history with appropriate endoscopy/polyp surveillance	79	80	81	80	N/A	N/A
ASC-12: 7-day risk standardized hospital visit rate after outpatient colonoscopy*	N/A	1.3	1.2	1.2	1.2	1.2
ASC-13: Normothermia outcome	N/A	N/A	N/A	N/A	96	96
ASC-14: Unplanned anterior vitrectomy	N/A	N/A	N/A	N/A	0.7	0.7

Note: ASC (ambulatory surgical center), N/A (not applicable). Items are marked N/A when CMS did not collect data for the measure in that year.  
\*CMS reports this measure as the rate per 1,000 colonoscopies, but we report this measure as a percentage (the rate per 100 colonoscopies).

Source: Medicare Hospital Compare data for ASCs, 2015–2020.

quality measurement principles is that quality programs should include patient experience (Medicare Payment Advisory Commission 2018b). However, the Commission maintains concern about three issues related to the ASCQR:

- The four ASCQR measures that are claims based and measure clinical outcomes (ASC-12, ASC-17, ASC-18, and ASC-19) exclude many services provided at ASCs, such as eye procedures and pain management. Therefore, CMS could improve the ASCQR Program by including more claims-based measures that assess clinical outcomes for the various specialties practiced at ASCs. CMS made one such improvement by adding a measure for payment determination in 2024, ASC-19: facility-level 7-day hospital visits after general surgery procedures performed at ASCs. The general surgery procedures included in this measure are abdominal, alimentary tract, skin/soft tissue, wound, and varicose vein stripping. We applaud CMS’s decision to add this measure to the ASCQR.

However, the procedures included in this measure accounted for just 3.4 percent of ASC surgical procedures provided to FFS Medicare patients in 2020, underscoring the need for CMS to add more claims-based measures that assess clinical outcomes.

- ASCQR measures should be further synchronized with OQR measures to facilitate comparison across ASCs and HOPDs. For 2021, the ASCQR and the OQR possess four common quality measures that pertain to cataract procedures, colonoscopy procedures, and patient assessments. CMS should consider further expanding the overlap of the ASCQR and OQR, relying on either measures of general surgical procedures or measures of specific surgical procedures common to both settings. For example, CMS could consider including OQR measure OP-36 (the number of hospital visits after any outpatient surgery) in the ASCQR or including ASCQR measures ASC-17 and ASC-18 (the number of hospital visits following orthopedic and urology procedures, respectively) in the OQR.

## CMS should develop other quality measures

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:

- **The share of Medicare beneficiaries discharged from ASCs who have subsequent unplanned hospital visits.** CMS has already begun to implement these measures for certain specialties through ASC-12, ASC-17, ASC-18, and ASC-19, but has not developed these measures for some specialty areas or individual procedures that are common to ASCs, such as pain management. Ideally, CMS will develop measures that reflect the performance of all ASC specialties.
- **Surgical site infections (SSIs) occurring at ASCs.** In the past, researchers have found that lapses in infection control were common among a sample of ASCs in three states (Schaefer et al. 2010). 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.
- **Specialty-specific clinical guidelines to assess the appropriateness of services provided in ASCs.** While the ASCQR currently includes an ASC-reported colonoscopy measure that assesses 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 ASCs' share of colonoscopy cases for beneficiaries over age 85. CMS could consider similar appropriateness measures for certain procedures that have become more common in ASCs in recent years, or for

which concerns about appropriate use have been suggested, such as spinal injections or certain orthopedic procedures.

## 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 2020 by 2.0 percent (Table 5-1, p. 170). However, Medicare accounts for a small share—perhaps 20 percent—of ASCs' overall revenue, so factors other than Medicare payments could have a larger effect on access to capital for this sector (Medical Group Management Association 2009).

Large health care management companies continued to acquire ASCs in 2020. The six largest of these organizations (United Surgical Partners International, AmSurg, Surgical Care Affiliates, SurgCenter Development, HCA, and Surgery Partners Holding) increased the number of ASCs they held from 1,152 to 1,245—an 8.1 percent increase (Park 2021). In 2020, a large acquisition of ASCs was made by Tenet Health, which owns United Surgical Partners International. On December 10, 2020, Tenet Health acquired 45 ASCs from SurgCenter Development for \$1.1 billion in cash. In addition, according to one recent report, conversations with 25 ASC leaders revealed ASCs' interest in selling and larger entities' interest in buying: “As the value of ASCs increases along with operational costs, more surgery center owners are tempted to sell. Hospitals, private equity firms, and insurers are all hunting for ASC deals and willing to pay top dollar” (Dyrda 2021).

Data from the annual analysis of Pennsylvania's ASCs, conducted by the Pennsylvania Health Care Cost Containment Council (PHC4), indicate that ASCs are very profitable. PHC4 found that ASCs in Pennsylvania had an average total margin (an all-payer margin that includes Medicare) of 23 percent in 2020 (Pennsylvania Health Care Cost Containment Council 2021).<sup>10</sup>

Although the various entities noted above appear to have adequate access to capital, we caution that these companies have ownership in 20 percent of the more than 5,900 ASCs. Consequently, the experience of

**TABLE  
5-8**

**Medicare payments to ASCs grew from 2015 through 2019 but fell in 2020**

	2015	2019	2020	Average annual change	
				2015–2019	2019–2020
Medicare payments (billions of dollars)	\$4.1	\$5.2	\$4.9	6.5%	-6.4%
Medicare payments per FFS beneficiary	\$122	\$158	\$152	6.7	-3.9
Number of beneficiaries receiving services (millions)	3.4	3.5	3.0	0.4	-15.0
Spending per beneficiary served	\$1,177	\$1,489	\$1,640	6.1	10.2

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. We calculated the percent change columns using unrounded numbers.

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

these entities collectively may not reflect that of the entire ASC sector.

**Medicare payments: Aggregate payments decreased in 2020, but by less than declines in volume**

In 2020, ASCs received \$4.9 billion in Medicare payments and beneficiaries' cost sharing (Table 5-8). We estimate that spending by the Medicare program was \$3.9 billion and beneficiary cost sharing was \$1.0 billion (data not shown).

Spending per FFS beneficiary rose by an average annual rate of 6.7 percent from 2015 through 2019 and fell by 3.9 percent in 2020 (Table 5-8). The drop in per beneficiary spending in 2020 reflects a 2.6 percent increase through the ASC conversion factor, a 13.4 percent decrease through a change in volume per beneficiary, a 6.3 percent increase through the average relative weight of ASC services, a 0.7 percent rise due to increased spending from 2019 to 2020 on separately paid drugs and devices provided to Medicare beneficiaries treated in ASCs, and a 1.0 percent increase due to the relaxation of the Medicare sequester adjustments in 2020.<sup>11</sup>

The decrease in ASC spending per FFS beneficiary from 2019 to 2020 resulted from fewer beneficiaries receiving ASC services rather than a decrease in spending per beneficiary using services. From 2019 to 2020, the number of FFS beneficiaries who received ASC services declined by 15 percent, but the spending per beneficiary who received a service increased by 10.2 percent (Table 5-8).

In 2020, the coronavirus PHE reduced ASC volume and ASC revenue. However, ASCs also received Provider Relief Fund (PRF) payments in 2020. Because ASCs do not submit cost reports, we cannot determine the magnitude of the PRF amounts received. We were able to determine the PRF amounts received by some of the health care management companies. Tenet and Surgery Partners each received \$59 million in PRF payments for their ambulatory care providers.

**How should Medicare payments change in 2023?**

Our analysis indicates that the number of ASCs has increased, beneficiaries' use of ASCs had been increasing before the PHE, and access to capital

has been at least adequate. Measures of ASC quality through 2020 indicate that quality had been improving but that improvement appears to have plateaued. Also, CMS will implement some quality measures that address the need for outcome measurements. 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 ASCs to 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 also are needed to determine whether an alternative input price index would be an appropriate proxy for ASC costs. As discussed in the text box on revising the ASC market basket index (p. 184), 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). Similarly, the price index that CMS is using to update the ASC conversion factor from 2019 through 2023—the hospital market basket—does not reflect ASCs' cost structure.

CMS has concluded that it needs data on ASC input costs (Centers for Medicare & Medicaid Services 2012), but to date has not required ASCs to submit cost data. CMS has requested public comment on whether the agency should collect cost data from ASCs for use in determining ASC payment rates. CMS reports that 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). In 2021, CMS solicited public comment on methods that would mitigate the burden of reporting costs on ASCs while collecting data sufficient to reliably determine ASC costs and stated that cost data would be beneficial in establishing an ASC-specific market basket index for updating payment rates under the ASC payment system (Centers for Medicare & Medicaid Services 2021).

We contend that 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 2021). 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.

If the reporting burden on ASCs is of legitimate concern, CMS could create a streamlined process for ASCs to track and submit a limited amount of cost data. CMS has conducted surveys of random samples of ASCs (in 1986 and 1994), and we believe CMS could do these surveys annually, with mandatory response. 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 complete and submit lengthy income tax forms. Therefore, the Commission sees no reason why 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

## 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 to update the payment rates 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 market basket 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 market basket 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). The hospital market basket and the MEI reflect different mixes of inputs and, therefore,

a different mix of costs from what is typical in ASCs. Most recently, CMS has decided to use the hospital market basket as the basis for updating ASC payment rates from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). However, because of differences between the ASC and hospital cost structures, we find that the hospital market basket is not an appropriate market basket for ASCs.

The ASC cost data from GAO used in our comparative analysis are 18 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 2021, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2018c, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2010). CMS should use cost data to examine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. A new ASC market basket could include the same types of costs that appear in the hospital market basket or MEI but with different cost weights that reflect ASCs' unique cost structure. ■

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 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 ASCs' cost structure and determine whether an existing Medicare price index is an appropriate proxy for ASC costs or whether an ASC-specific market basket should be developed.



CMS used the CPI-U to update the ASC conversion factor from 2010 through 2018. However, CMS has indicated that the CPI-U does not reflect ASCs' input costs. CMS made a significant regulatory change and decided to use the hospital market basket as the basis for updating the ASC conversion factor for a five-year period—2019 through 2023. CMS used the hospital market basket to increase the ASC conversion factor by 2.6 percent in 2020, 2.4 percent in 2021, and 2.0 percent in 2022. CMS based its decision to use the hospital market basket in place of the CPI-U on concerns that the differences in payment rates between the ASC payment system and the OPPS had 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). However, our analysis of growth in the surgical services provided in ASCs and HOPDs suggests that surgical services were already shifting from HOPDs to ASCs before CMS began using the hospital market basket to update the ASC payment rates. We evaluated the growth in HOPDs and ASCs for the 30 surgical procedures most frequently provided in ASCs from 2015 through 2019. We found that the volume for these procedures increased in ASCs and decreased in HOPDs.

During the five-year period of using the hospital market basket, 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 possibly 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 in comment letters and in published reports that the CPI-U likely does not reflect the current input costs of ASCs. However, the Commission does not support using the hospital market basket index as an interim method for updating the ASC conversion factor because this index also does not accurately reflect ASCs' costs

(Medicare Payment Advisory Commission 2018a). CMS acknowledges that the ASC and hospital cost structures are not identical because ASCs tend to be single specialty and for profit and are not required to comply with the Emergency Medical Treatment and Labor Act. 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 use of the hospital market basket to encourage migration of services to the less expensive ASC setting is unnecessary because surgical procedure volume covered under the ASC payment system is already increasing at a faster rate in ASCs than in HOPDs. Moreover, ASCs are profitable organizations, and the number of ASCs and the volume of services continue to grow (Medicare Payment Advisory Commission 2010). 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 2023, 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 2023 should be eliminated and that the Secretary should collect cost data from ASCs.

### RECOMMENDATION 5-1

**For calendar year 2023, the Congress should eliminate the update to the 2022 Medicare conversion factor for ambulatory surgical centers.**

## RECOMMENDATION 5-2

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

#### RATIONALES 5-1 AND 5-2

On the basis of our payment adequacy indicators, combined with the importance of maintaining financial pressure on providers to constrain costs, we believe that the ASC conversion factor should not be increased for 2023. That is, the 2023 conversion factor in the ASC payment system should be the same as the conversion factor in 2022. Though we do not have cost data, and we have reservations about the measures used within the ASCQR, the indicators of payment adequacy for which we have information are positive: The volume of ASC services per beneficiary increased in 2019 and rebounded strongly by December 2020 following a pandemic-related drop in the spring of 2020; the complexity of ASC services provided increased; and the number of ASCs increased in 2020 in spite of the pandemic. Given the return to near-normal volume levels by the end of 2020, we believe the effects of the PHE are temporary and we do not expect any long-term effects on ASC volume and revenue. Also, ASCs appear to have adequate access to capital, and Medicare payments to ASCs had strong growth through 2019.

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 also are predominantly made up of small providers. Therefore, any ASC should be

able to compile and submit a minimum set of cost data. Also, while the most ASCs are freestanding facilities, hospital corporations and other large health care entities have acquired more ASCs. These entities 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. 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 market basket index as the basis for updating the conversion factor from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). The Affordable Care Act of 2010 (ACA) requires that the update factor be reduced by a multifactor productivity measure. The currently projected hospital market basket index increase for 2023 is 2.6 percent, and the forecast of productivity growth for 2023 is 0.6 percent, resulting in a projected update of 2.0 percent to the conversion factor for 2023. Relative to current Medicare law, our recommendation would decrease federal spending by between \$50 million to \$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 these recommendations 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

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- 1 A more detailed description of the ASC payment system can be found online at [https://www.medpac.gov/wp-content/uploads/2021/11/medpac\\_payment\\_basics\\_21\\_asc\\_final\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_asc_final_sec.pdf).
- 2 CMS determines the payment rates in the ASC system 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 on the PFS nonfacility rate the next year, or vice versa.
- 3 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 less than 67 percent of their Medicare claims in one clinical specialty.
- 4 The first year that total knee arthroplasty was covered under the ASC payment system was 2020. About 10,800 of these procedures were provided to FFS Medicare beneficiaries in ASCs in 2020.
- 5 By statute, coinsurance for a service paid under the OPPTS cannot exceed the hospital inpatient deductible (\$1,556 in 2022). The ASC payment system does not have the same limitation on coinsurance; for a small percentage of HCPCS codes covered under the ASC payment system, the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the OPPTS coinsurance.
- 6 Cost sharing is lower under the ASC payment system for 96 percent of HCPCS codes that are covered under the ASC payment system.
- 7 Rather than enact a full discontinuation of measures ASC-1 through ASC-4, CMS 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. CMS later decided to end the suspension of these measures and will use them for ASC payment determination in 2025. In addition, CMS will begin voluntary submission for payment determination in 2025 of the patient experience measures based on the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey measures. CMS will make mandatory the submission of these measures for payment determination in 2027.
- 8 For measures ASC-1, ASC-2, ASC-3, and ASC-4, we removed from this analysis ASCs that reported that more than 30 percent of patients had one of these events.
- 9 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. government agency.
- 10 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.
- 11 We estimate that the volume per beneficiary had a 13.4 percent impact on spending per beneficiary, while we estimate that the change in volume per beneficiary from 2019 to 2020 was 13.6 percent (p. 173). This discrepancy is due to the fact that the volume per beneficiary indicates volume of surgical procedures, and these procedures constitute 98.5 percent of all ASC Medicare spending. Therefore, the drop in surgical volume per beneficiary affected spending per beneficiary by 98.5 percent of 13.6 percent, which is 13.4 percent.

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