

CHAPTER

5

**Ambulatory surgical center
services: Status report**

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

- 5** *The Commission reiterates its March 2022 recommendation that the Secretary require ambulatory surgical centers to report cost data.*

Ambulatory surgical center services: Status report

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay. In 2021, the 6,075 ASCs certified by Medicare treated 3.3 million fee-for-service (FFS) Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$5.7 billion. The number of ASC facilities continued to increase, growing 2.7 percent in 2021. After dropping substantially in 2020, the volume of ASC surgical procedures per FFS beneficiary rose in 2021 to above prepandemic levels. Numerous factors likely have contributed to this sector's growth, including changes in clinical practice and health care technology that have expanded the provision of surgical procedures in ambulatory settings. For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to hospital outpatient departments. ASCs also offer physicians specialized staff and more control over their work environment.

The vast majority of ASCs are for profit and located in urban areas. The concentration of ASCs varies widely across states, ranging from 38 ASCs per 100,000 Part B beneficiaries in Maryland to 4 or fewer ASCs per 100,000 Part B beneficiaries in Alabama, West Virginia, and Vermont. About 65 percent of ASCs that billed Medicare in 2021 specialized in a single clinical area, of which gastroenterology and ophthalmology were

In this chapter

- Supply of ASCs and volume of services continued to grow in 2021
- The ASC Quality Reporting Program does not have enough measures for meaningful analysis
- Aggregate Medicare payments rose substantially in 2021 and were well above the prepandemic level
- Ambulatory surgical centers should submit cost data

the most common. The remainder were multispecialty facilities, providing services in more than one clinical specialty (often pain management and orthopedic services or gastroenterology and ophthalmology). From 2016 to 2021, the ASC specialty that grew most rapidly was pain management.

The most common service in ASCs, accounting for almost 19 percent of volume in 2021, was extracapsular cataract removal with intraocular lens insertion. The 20 most frequently provided services made up about 68 percent of FFS Medicare volume in 2021. A potential concern is the extent to which certain frequently provided services, such as spinal injections and other pain management services, are unnecessary or of low value.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 7.7 percent from 2016 through 2019 and at an average annual rate of 8.7 percent from 2019 to 2021. However, policymakers know little about the costs ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its cost data requirements for other types of facilities. The Commission contends that ASCs could feasibly provide such information, and we have recommended since 2010 that the Congress require them to submit cost data. Until these data are available, the Commission cannot properly assess the adequacy of Medicare's payments to ASCs. ■

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. In addition to ASCs, providers perform outpatient surgical procedures in hospital outpatient departments (HOPDs) and, in some cases, physicians' offices.

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 their 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 2021, Ambulatory Surgery Center Association 2017, Leapfrog 2019). Physician owners of ASCs receive additional income through distributions of facility profits according to their ownership interest.

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.

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. The conversion factor transforms the relative weight for a service into a payment rate. For 2023, CMS has set the ASC conversion factor at \$51.85. From 2010 through 2018, CMS updated the ASC conversion factor each year based on the consumer price index for all urban consumers. In a change of regulatory policy beginning in 2019, CMS has updated the ASC conversion factor using the hospital market basket index. Under this change, the annual updates to the ASC conversion factor have aligned with the updates to the OPPS conversion factor.¹

Supply of ASCs and volume of services continued to grow in 2021

The number of ASC facilities increased in 2021, as did the volume of services provided to Medicare beneficiaries in ASCs. 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 specialized staff and more control over their work environment. However, these same qualities could lead to overuse of some surgical procedures.

The number of ASCs increased

From 2020 to 2021, the number of ASCs increased 2.7 percent to 6,075 ASCs (Table 5-1, p. 158). This annual growth rate exceeded the rate from 2016 to 2020, when the number of ASCs increased, on average, 1.9 percent per year. In 2021, 254 new ASCs opened while 95 ASCs closed or merged with other facilities, for a net increase of 159 facilities.

Because the central purpose of ASCs is to provide surgical procedures, the number of operating rooms (ORs) is an indicator of the supply in this sector. In 2021, there were 18,689 ORs in ASCs, or an average of 3.1 per facility. From 2016 to 2020, the total number of ASC ORs increased 1.7 percent per year, a lower rate than the increase in the number of ASCs over the same period (1.9 percent per year). From 2020 to 2021, the number of ORs in ASCs increased by 2.9 percent, a higher rate than the growth in the number of ASCs.

Numerous factors have likely influenced this long-term growth in the number of ASCs and ORs:

- 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 performing knee and hip arthroplasty (knee and hip replacement) in ambulatory settings.²
- 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).

**TABLE
5-1**

Number of ASCs and operating rooms grew, 2016–2021

	2016	2020	2021	Average annual change	
				2016–2020	2020–2021
Total number of ASCs	5,489	5,916	6,075	1.9%	2.7%
New	172	184	254	N/A	N/A
Closed or merged	117	73	95	N/A	N/A
Total number of ORs	16,982	18,156	18,689	1.7	2.9
New	443	505	755	N/A	N/A
Closed or merged	329	199	222	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable), OR (operating room). We display the average annual percentage change for the “new” and “closed or merged” categories as “N/A” because they are outside the purpose of this table, which is to show the growth in the number of ASCs and ORs.

Source: MedPAC analysis of Provider of Services, 2022.

- For most procedures covered under the ASC payment system, beneficiaries’ coinsurance is lower in ASCs than in HOPDs.³
- 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.
- Increased interest across the health care industry in value-based care and the provision of care in lower-cost settings has boosted interest in strategic investment of hospital systems, insurers, and private equity firms in ASCs (Barclays 2018, Japsen 2018).

Most ASCs are for profit, and geographic distribution is uneven

Consistent with previous years, the vast majority of ASCs in 2021 were for profit (95 percent) and located in urban areas (93 percent) (Table 5-2). A discussion with representatives from the Ambulatory Surgical Center Association revealed that rural areas typically lack the surgical specialists needed for ASCs, and the lower population density in rural areas makes them less attractive locations for ASCs. Beneficiaries who do not live near an ASC usually 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.

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

**TABLE
5-2**

Most ASCs are for profit and urban

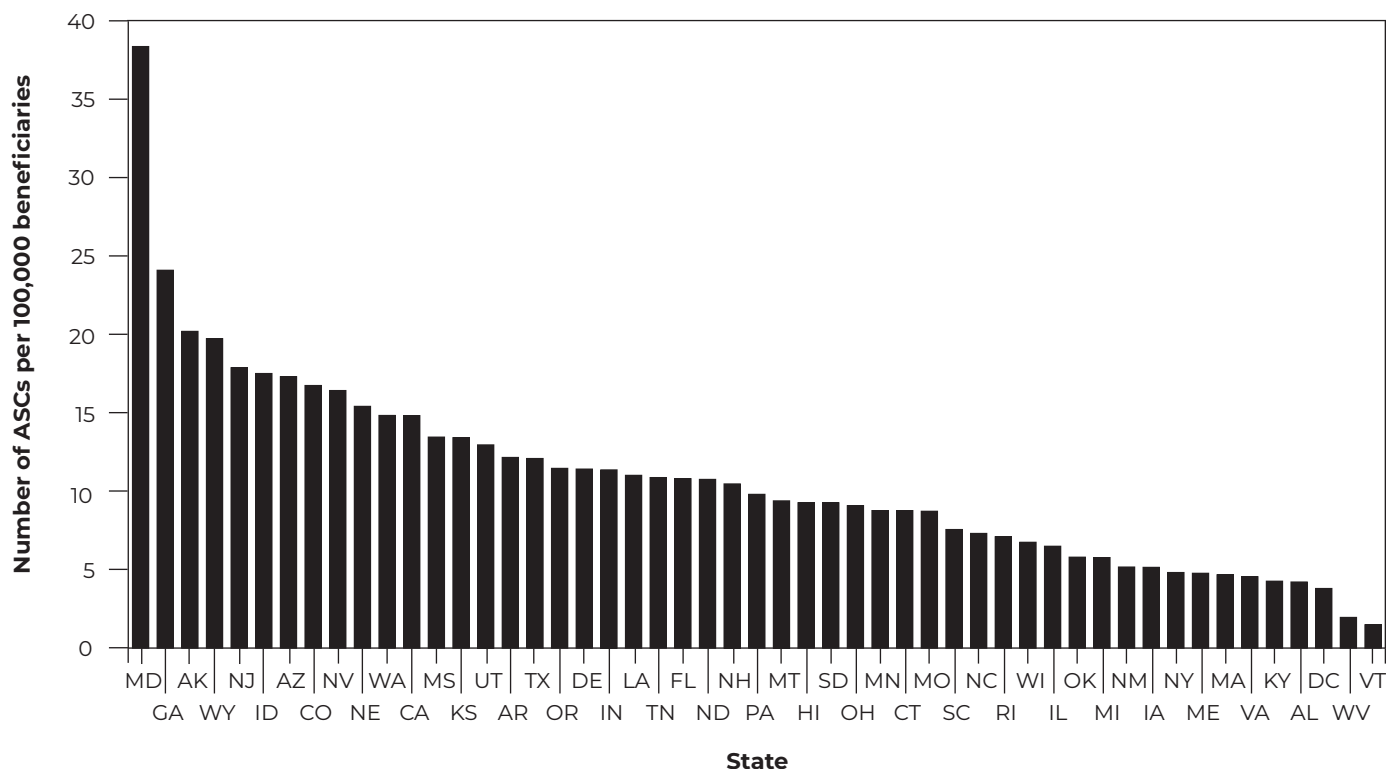
Type of ASC	ASCs that were:		
	Open in 2016	Open in 2021	New in 2021
For profit	95.2%	95.3%	95.2%
Nonprofit	3.6	3.7	4.3
Government	1.2	1.0	0.4
Urban	93.0	93.4	92.1
Rural	7.0	6.6	7.9

Note: ASC (ambulatory surgical center). The “New in 2021” column for the first three ASC types does not sum to 100 percent due to rounding.

Source: MedPAC analysis of CMS Provider of Services file, 2022.

FIGURE 5-1

Number of ASCs per beneficiary varied widely by state, 2021



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2022 and Common Medicare Environment file.

urban beneficiaries, defined as those living in an MSA. In 2021, 7.8 percent of rural beneficiaries received care in an ASC compared with 11.5 percent of urban beneficiaries.

In addition to ASCs having greater presence in urban locations than rural locations, the concentration of ASCs varies widely across states. In 2021, Maryland had the most ASCs per Medicare beneficiary (38 ASCs per 100,000 Part B beneficiaries), followed by Georgia, Alaska, and Wyoming (respectively, 24, 20, and 20 ASCs per 100,000 Part B beneficiaries) (Figure 5-1). Alabama, the District of Columbia, West Virginia, and Vermont had the fewest ASCs per beneficiary (4 or fewer ASCs per 100,000 beneficiaries). The primary driver of this variation is certificate-of-need (CON) laws. States that have CON laws tend to have fewer ASCs than states that do not.

Specialization of ASCs is largely unchanged; some growth in pain management

In 2021, the majority of ASCs that billed Medicare specialized in a single clinical area. Gastroenterology and ophthalmology were the most common, with each comprising about 20 percent of all ASCs that provided services to FFS Medicare beneficiaries. Overall, 65 percent of ASCs were single-specialty facilities and 35 percent were multispecialty facilities, providing services in more than one clinical specialty (Table 5-3, p. 160).⁴ In 2021, multispecialty ASCs most commonly focused on two specialties: pain management and orthopedic services or gastroenterology and ophthalmology (combined, 9 percent of all ASCs). From 2016 to 2021, the number of ASCs specializing in pain management services grew most rapidly.

**TABLE
5-3**

Specialization of ASCs billing Medicare in 2016 and 2021

Type of ASC	2016		2021	
	Number of ASCs	Share of all ASCs	Number of ASCs	Share of all ASCs
Single specialty	2,876	61%	3,535	65%
Gastroenterology	1,025	22	1,112	20
Ophthalmology	1,015	21	1,123	21
Pain management	356	6	643	12
Dermatology	180	4	192	4
Urology	123	3	143	3
Cardiology	13	0	118	2
Podiatry	90	2	71	1
Orthopedics/musculoskeletal	29	1	61	1
Respiratory	20	0	30	1
OB/GYN	15	0	12	0
Neurology	6	0	7	0
Other	4	0	33	1
Multispecialty	1,855	39	1,914	35
More than 2 specialties	1,403	30	1,489	27
Pain management and orthopedics	273	6	247	5
Gastroenterology and ophthalmology	179	4	198	4
Total	4,731	100	5,449	100

Note: ASC (ambulatory surgical center), OB/GYN (obstetrics and gynecology). We define a single-specialty ASC as one with more than 67 percent of their Medicare claims in one clinical specialty. We define a multispecialty ASC as one with less than 67 percent of their Medicare claims in one clinical specialty. ASCs included in this analysis are limited to those in the 50 states and the District of Columbia that had a paid Medicare claim in 2021. Some Medicare-certified ASCs did not have a paid Medicare claim in 2021. Therefore, this table has fewer ASCs than Table 5-1, which includes all Medicare-certified ASCs. Columns containing the shares of all ASCs do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2021.

Volume of services per beneficiary rose in 2021 to levels above 2019

From 2016 to 2021, the number of FFS beneficiaries with Part B coverage declined from 33.7 million to 30.8 million, resulting from a substantial increase in the number of beneficiaries enrolled in Medicare Advantage plans. Because there were fewer Part B FFS beneficiaries, the aggregate number of ASC services provided to those beneficiaries increased very little (0.1 percent per year) from 2016 to 2019 and decreased by an average of 2.9 percent from 2019 to 2021 (Table 5-4).

However, from 2016 to 2021, the share of Part B FFS beneficiaries who received services in ASCs rose steadily from 10.6 percent to 10.8 percent (data not shown). Consequently, from 2016 through 2019, the volume of services per Part B FFS beneficiary rose on average 0.8 percent per year and an average 0.6 percent from 2019 to 2021, indicating that volume per beneficiary in 2021 exceeded the prepandemic level (Table 5-4).

ASCs appear to have substituted lower-complexity services with higher-complexity services, as the share of ASCs services attributable to complex services,

**TABLE
5-4**

Volume of ASC services per FFS beneficiary exceeded prepandemic levels in 2021

	2016	2019	2020	2021	Average annual change	
					2016–2019	2019–2021
Volume of services (in millions)	6.7	6.7	5.6	6.4	0.1%	-2.9%
Part B beneficiaries (in thousands)	33,702	33,073	32,240	30,825	-0.6	-3.5
Volume per 1,000 FFS beneficiaries	197.6	202.3	174.7	204.6	0.8	0.6

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

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2016–2021.

such as knee arthroplasty and implantation of spinal neurostimulators, rose. As the shift to higher-complexity services continued from 2019 to 2021, the number of ASC services per FFS user of ASCs fell 0.4 percent (data not shown).

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2021. For example, in both 2016 and 2021, extracapsular cataract removal with intraocular lens insertion had the highest volume, accounting for 18.5 percent of the total in 2016 and 18.6 percent in 2021 (Table 5-5, p. 162). Moreover, 19 of the 20 most frequently provided ASC services in 2016 were among the 20 most frequently provided in 2021. These services made up about 71 percent of ASC Medicare volume in 2016 and 68 percent in 2021.

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 (Corp et al. 2021). Seven of the 20 procedures listed in Table 5-5 (p. 162) were pain management services. Moreover, the volume for the procedure that accrued the second highest Medicare revenue for ASCs in 2021—the insertion or replacement of spinal neurostimulators—grew by about 4 percent from 2019 to 2021 while falling about 25 percent in HOPDs (data not shown).

Maintaining or expanding access to ASCs can be beneficial to 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 (paid under the OPPS).⁵ Medicare payments for surgical services performed in HOPDs are almost twice as high as in ASCs.

Medicare program spending and overall beneficiary cost sharing could be reduced if medical professionals provided more surgical services in ASCs than in HOPDs or if Medicare reduced HOPD payment rates to the level of ASCs’. This issue is pertinent to the ASC sector because even among the most frequently provided services in ASCs, a substantial volume is provided in HOPDs. For example, in 2021, ASCs performed 500,000 Medicare-covered upper gastrointestinal endoscopies with biopsy, but volume in HOPDs was even higher at 530,000.

The ASC Quality Reporting Program does not have enough measures for meaningful analysis

CMS established the Ambulatory Surgical Center 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).

**TABLE
5-5**

The 20 most frequently provided ASC services in 2016 were similar in 2021

Procedure name	2016		2021	
	Percent of volume	Rank	Percent of volume	Rank
Extracapsular cataract removal w / IOL insert	18.5%	1	18.6%	1
Upper GI endoscopy, with biopsy: single or multiple	8.2	2	7.8	2
Colonoscopy and biopsy	6.8	3	6.9	4
Colonoscopy with lesion removal, snare technique	5.7	4	7.0	3
Inject transforaminal epidural: lumbar or sacral	4.8	5	4.4	5
After cataract laser surgery	4.3	6	3.8	6
Injection interlaminar epidural: lumbar or sacral	3.2	7	2.2	9
Injection paravertebral facet joint: lumbar or sacral, single level	3.2	8	3.1	7
Diagnostic colonoscopy	2.1	9	1.4	11
Colorectal cancer screening, high-risk individual	2.0	10	2.3	8
Colorectal cancer screening, not high-risk individual	1.9	11	1.4	14
Extracapsular cataract removal complex without ECP	1.5	12	1.4	12
Destroy lumbar/sacral facet joint, single	1.4	13	1.7	10
Injection procedure for sacroiliac joint, anesthetic	1.3	14	1.4	13
Cystourethroscopy	1.2	15	1.2	15
Injection interlaminar epidural: cervical or thoracic	1.1	16	0.9	18
Inject paravertebral facet joint: cervical or thoracic, single level	1.0	18	1.0	16
Upper GI endoscopy diagnostic brush wash	1.0	17	0.7	19
Blepharoplasty upper eyelid	0.9	19	0.9	17
Upper GI endoscopy, guide wire insertion	0.8	20	0.7	23
Total	70.9		68.1	
Total volume for all ASC services	6,660,141		6,372,853	

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

Source: MedPAC analysis of physician/supplier standard analytic files from 2016 and 2021.

Currently, the ASCQR Program has only four measures that can be used to evaluate ASC quality, and these measures do not provide an adequate representation of ASC quality. Therefore, we do not discuss the quality of ASC care. CMS will add 12 measures for which ASCs will submit data from 2023 for ASC payment determination in 2025. However, we believe CMS should add additional quality measures to make the ASCQR Program more effective (see text box, pp. 164-165).

Aggregate Medicare payments rose substantially in 2021 and were well above the prepandemic level

In 2021, ASCs received \$5.7 billion in Medicare payments and beneficiaries' cost sharing (Table 5-6). We estimate that spending by the Medicare program was \$4.6 billion and beneficiary cost sharing was \$1.1 billion (data not shown).

**TABLE
5-6**

Medicare payments to ASCs in 2021 were above the prepandemic 2019 level

	2016	2019	2020	2021	Average annual change	
					2016–2019	2019–2021
Medicare payments (billions of dollars)	\$4.3	\$5.2	\$4.9	\$5.7	7.1%	4.9%
Medicare payments per FFS beneficiary	\$126	\$158	\$152	\$186	7.7	8.7

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

Spending per FFS beneficiary rose an average annual rate of 7.7 percent from 2016 through 2019 and by an average annual rate of 8.7 percent from 2019 to 2021 (Table 5-6). We compare 2019 with 2021 because of anomalous patterns of use and spending during 2020 in response to the coronavirus pandemic. In 2020, ASCs experienced large reductions in use and spending followed by rapid volume growth in 2021. From 2020 to 2021, spending per FFS beneficiary increased 23 percent.⁶

Ambulatory surgical centers should submit cost data

The Commission has frequently expressed concern that Medicare does not require ASCs to submit cost data, unlike other types of facilities. Every year since 2010, the Commission has recommended that the Congress require ASCs to submit cost data (Medicare Payment Advisory Commission 2010). CMS has shown some interest in collecting cost data to help determine ASC payment rates and has requested comments from stakeholders on whether the Secretary should collect cost data from ASCs. However, the ASC industry opposes the collection of cost data for this purpose (Centers for Medicare & Medicaid Services 2017).

Cost data would enable the Commission to examine the growth of ASCs’ costs over time and analyze Medicare payments relative to ASCs’ costs, which would help inform the Commission about the financial performance of the ASCs that serve Medicare beneficiaries. Cost data also are needed to determine whether an alternative

input price index would be an appropriate proxy for ASC costs. The Commission has previously expressed concern that the price index that CMS used to update the ASC conversion factor from 2010 through 2018 (the consumer price index for all urban consumers) likely does not reflect ASCs’ cost structure (Medicare Payment Advisory Commission 2010). Similarly, the price index that CMS has used to update the ASC conversion factor since 2019—the hospital market basket—likely does not reflect ASCs’ cost structure.

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, hospices, and rural health clinics, furnish cost data to CMS.

Until cost data are available, the Commission cannot properly assess the adequacy of Medicare’s payments to ASCs. Therefore, we do not offer an update recommendation in this status report. However, we reiterate our 2022 recommendation pertaining to the collection of cost data from ASCs:

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

CMS will add measures to the ASC Quality Reporting Program, but further improvement is needed

CMS has made substantial changes to the quality measures in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, which will result in CMS measuring ASC quality based on 12 measures (plus 1 voluntary measure) based on ASC data from 2023 and used to determine ASC payments in 2025 (Table 5-7). These changes include:

- four reintroduced measures that had previously been discontinued (ASC-1, ASC-2, ASC-3, and ASC-4),
- a claims-based measure of beneficiaries' visits to a hospital subsequent to orthopedic procedures (ASC-17),

(continued next page)

**TABLE
5-7**

Quality measures used in the Medicare ASC Quality Reporting Program

Description of quality measure	Required in 2025
ASC-1: Patient burn	Yes
ASC-2: Patient fall	Yes
ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant	Yes
ASC-4: All-cause hospital transfer/admission	Yes
ASC-9: Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients	Yes
ASC-11: Cataracts: Improvement in patient's visual function within 90 days following cataract surgery	Voluntary
ASC-12: Facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy	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
ASC-14: Unplanned anterior vitrectomy: Percentage of cataract surgery patients who have an unplanned removal of the vitreous	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*
ASC-17: Hospital visits after orthopedic ASC procedures	Yes
ASC-18: Hospital visits after urology ASC procedures	Yes
ASC-19: Hospital visits after general surgery ASC procedures	Yes
ASC-20: COVID-19 vaccination coverage among health care personnel	Yes

Note: ASC (ambulatory surgical center). CAHPS is a registered trademark of the Agency for the Healthcare Research and Quality.
*CMS has made this measure voluntary in 2025 and mandatory in 2027.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2022.

CMS will add measures to the ASC Quality Reporting Program, but further improvement is needed (cont.)

- a claims-based measure of beneficiaries' visits to a hospital subsequent to urology procedures (ASC-18),
- a claims-based measure of beneficiaries' visits to a hospital subsequent to general surgery procedures (ASC-19), and
- a measure for the rate of COVID-19 vaccination coverage among health care personnel in each ASC (ASC-20).

The Commission asserts that CMS should continue to improve the ASCQR by moving toward more outcome measures that apply to all ASCs. 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. To improve the ASCQR Program, CMS should include more claims-based measures that assess clinical outcomes for the various specialties practiced at ASCs.

In addition, CMS should synchronize ASCQR measures with measures included in the Hospital Outpatient Quality Reporting (OQR) Program to facilitate comparisons between ASCs and hospital outpatient departments (HOPDs). Currently, the ASCQR and the OQR possess four common quality measures that pertain to cataract procedures, colonoscopy procedures, and patient assessments. CMS should consider 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.

Because clinical outcomes can be effective measures of quality, we contend that CMS should also

consider developing new ASC quality measures covering these two categories:

- **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 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 procedures that have drawn concern about appropriate use, such as spinal injections or certain orthopedic procedures. ■

Endnotes

- 1 The ASC payment system has several nuances that we have not discussed here. For a discussion of these nuances, see the Commission's *Payment Basics* for ambulatory surgical centers at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_ASC_FINAL_SEC.pdf.
- 2 Total knee arthroplasty (Current Procedural Terminology Code 27447) was first covered under the ASC payment system in 2020. About 10,800 of these procedures were provided to FFS Medicare beneficiaries in ASCs in 2020. The number of these procedures nearly doubled, to 20,900, in 2021.
- 3 By statute, coinsurance for a service paid under the OPPS 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 billing codes covered under the ASC payment system, beneficiary coinsurance exceeds the inpatient deductible. In these instances, coinsurance for an ASC-delivered procedure exceeds coinsurance for an HOPD-delivered procedure.
- 4 We define single-specialty ASCs as having more than 67 percent of their Medicare claims in one clinical specialty. We define multispecialty ASCs as having less than 67 percent of their Medicare claims in one clinical specialty.
- 5 Cost sharing is lower under the ASC payment system for 99 percent of Healthcare Common Procedure Coding System codes that are covered under the ASC payment system.
- 6 The substantial increase in spending from 2020 to 2021 reflects a 2.4 percent increase through the ASC conversion factor, a 16.6 percent increase through a change in volume per beneficiary, a 2.0 percent increase through the average relative weight of ASC services, a 1.1 percent rise due to increased spending on separately payable drugs and devices provided to beneficiaries treated in ASCs, and a 0.5 percent increase from the relaxation of the Medicare sequester for all of 2021.

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