CHAPTER 10

Ambulatory surgical center services: Status report

RECOMMENDATION

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

CHAPTER 10

Ambulatory surgical center services: Status report

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures to patients who do not require an overnight stay. In 2022, about 6,100 ASCs treated 3.3 million fee-for-service (FFS) Medicare beneficiaries. FFS Medicare program spending and beneficiary cost sharing on ASC services was about $6.1 billion. The volume of ASC surgical procedures per FFS beneficiary rose by 2.8 percent in 2022. Numerous factors 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 36 ASCs per 100,000 Part B beneficiaries in Maryland to 4 or fewer ASCs per 100,000 Part B beneficiaries in Kentucky, West Virginia, and Vermont. ASCs are more concentrated in areas with low social risk factors than in areas with high social risk factors. About 68 percent of ASCs that billed Medicare in 2022 specialized in a single clinical area, of which

In this chapter

- Supply of ASCs and volume of services continue to grow
- The ASC Quality Reporting Program does not have enough measures for meaningful analysis
- Aggregate FFS Medicare payments rose substantially in 2022, continuing a trend
- Ambulatory surgical centers should submit cost data

gastroenterology and ophthalmology were 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 2017 to 2022, the specialties that grew most rapidly were pain management and cardiology.

The most common ASC procedure in 2022 was extracapsular cataract removal with intraocular lens insertion, accounting for almost 19 percent of volume and 20 percent of spending. The 20 most common surgical procedures made up about 69 percent of ASCs' FFS Medicare volume in 2022, though questions have been raised about the value of some of these procedures.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 8.2 percent from 2017 through 2021 and by 10.0 percent in 2022. Because FFS Medicare payment rates are lower in ASCs than in hospital outpatient departments (HOPDs) for all services that are covered in both settings, the cost to Medicare (and the taxpayers who fund the program) is lower if a surgical procedure is provided in an ASC rather than an HOPD. The beneficiary's cost-sharing obligation is lower as well. However, it is possible that the continuing shift of services from HOPDs to ASCs could increase the overall volume of surgical procedures, which would partially offset the reduction in Medicare spending and beneficiaries' cost sharing. Greater provision of services is especially likely if FFS Medicare's payments for ASC services are higher than the costs of providing them. But policymakers know little about the costs that 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. As a result, the Commission has determined that it is not possible to properly evaluate the level of Medicare's payments relative to costs for ASCs. In addition, available data do not permit a meaningful assessment of the quality of care provided in ASCs.

The Commission contends that ASCs could feasibly provide cost data, and we reiterate our long-standing recommendation that the Congress require ASCs to submit cost data. In addition, we encourage CMS to synchronize ASC Quality Reporting Program measures with measures included in the Hospital Outpatient Quality Reporting Program to facilitate comparisons between ASCs and HOPDs. ■

Background

An ambulatory surgical center (ASC) is a facility 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). For the facility portion, Medicare pays ASCs for a bundle of 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 services that were first covered under the ASC payment system in 2008 or later and for which volume is greater in freestanding physician offices than in ASCs, the ASC payment rate is set to the lesser of the standard ASC payment rate or the nonfacility practice expense from the Medicare 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 2024, CMS has set the ASC conversion factor at $53.51. 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, from 2019 through 2025, CMS has instituted a policy of updating 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]

The ASC payment system in fee-for-service (FFS) Medicare covers over 3,600 surgical procedures, but in 2022 the provision of ASC services was concentrated in a relatively small number of procedures. Of the surgical procedures provided to Medicare FFS beneficiaries in ASCs, 75 percent of the volume was concentrated in 31 procedures. A potential factor limiting the breadth of services provided by ASCs is the inpatient-only (IPO) list maintained by CMS, which is a list of services (including surgical procedures) that cannot be provided to Medicare beneficiaries anywhere but the hospital inpatient setting. The extent to which eliminating the IPO list would expand the services that ASCs actually provide is not clear.[2] CMS has steadily removed surgical procedures from the IPO list, but ASCs generally have provided low quantities of these procedures. Important exceptions include knee arthroplasty and hip arthroplasty, which have increased in ASC volume since CMS removed them from the IPO list and made them covered services under the ASC payment system.

Another factor that may limit the breadth of ASC services is that over 350 surgical procedures that are not on the IPO list are covered under the OPPS but not the ASC payment system. Because these procedures are provided in another ambulatory setting (HOPDs), coverage of these procedures under the ASC system could result in nontrivial provision in ASCs. However, most of these services are low volume in HOPDs, so it is likely they would be low volume in ASCs.

Supply of ASCs and volume of services continue to grow

The number of ASC facilities increased in 2022, as did the volume of services provided to Medicare FFS beneficiaries in ASCs. Access to ASCs may be preferable 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 provide physicians with 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 is increasing

We usually use data from the last full calendar year reported in the Provider of Services (POS) file to estimate the number of ASCs that serve Medicare

TABLE 10–1

Number of ASCs and operating rooms grew, 2017–2022

	2017	2021	1st quarter 2022	Average annual change 2017–2021
Total number of ASCs	5,581	6,075	6,088	2.1%
New	211	254	34	N/A
Closed or merged	126	95	21	N/A
Total number of ORs	17,137	18,689	18,739	2.2
New	492	755	104	N/A
Closed or merged	339	222	54	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 file from CMS, 2023.

beneficiaries. Ordinarily, our analysis for this report would have used a full year of data from 2022. However, CMS is in the process of changing the system of data processing for the POS, which has delayed updating the ASC data. Consequently, the most recent ASC data available on the POS are from the first quarter of 2022. We expect that the number of ASCs we report would be greater if a full year of ASC data for 2022 were included in the POS.

From 2021 through the first quarter of 2022, the number of Medicare-certified ASCs rose 0.2 percent to 6,088 ASCs, and from 2017 through 2021, the average annual growth rate was 2.1 percent (Table 10-1). Through the first quarter of 2022, 34 new ASCs opened while 21 ASCs closed or merged with other facilities, for a net increase of 13 facilities. Data from the ASC Association website indicates that there are currently 6,223 Medicare-certified ASCs (Ambulatory Surgery Center Association 2023a).[3]

Because the central purpose of ASCs is to provide surgical procedures, the number of operating rooms (ORs) is an indicator of supply in this sector. After the first quarter of 2022, there were 18,739 ORs in ASCs, or an average of 3.1 per facility. From 2017 to 2021, the total number of ASC ORs increased 2.2 percent per year, a slightly higher rate than the increase in the number of ASCs over the same period (2.1 percent per year). From 2021 to the first quarter of 2022, the number of ORs in ASCs increased by 0.3 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.[4]
- ASCs can offer patients greater convenience than HOPDs, such as patients having less "nonoperative" time (the total time a patient spends in an operating room, minus the procedure time) in ASCs (Imran et al. 2019).
- For most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs.[5]

- 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 2022 were for profit (95.3 percent) (Table 10-2). Because most ASCs are for-profit entities, they have an incentive to provide profitable services. As the number of ASCs grows, if ASCs act on this incentive, there is the potential for ASCs to account for an increasingly larger share of the profitable ambulatory procedures, leaving the less profitable ambulatory procedures to other settings, primarily HOPDs. However, because ASCs do not submit cost report data, we cannot identify which ambulatory procedures are profitable, so we cannot determine the share of the profitable services that are provided in ASCs versus HOPDs.

ASCs are also disproportionately located in urban areas (93.5 percent) (Table 10-2). Stakeholders contend 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. In addition to low ASC penetration in rural areas, ASC penetration in 2022 was also low in areas with high social risk factors, which we measured using the area deprivation index (based on an area's income, unemployment, education level, and housing quality) (Table 10-3, p. 302). Even though some areas have low ASC penetration, beneficiaries who do not live near an ASC can 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 at 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 urban beneficiaries, defined as those living in an MSA. In 2022, 8.1 percent of rural beneficiaries received care in an ASC compared with 11.9 percent of urban beneficiaries (data not shown).

TABLE 10–2 **Most ASCs are for profit and urban**

	ASCs that were:		
Type of ASC	Open in 2017	Open in 2022	New in 2022
For profit	95.2%	95.3%	91.2%
Nonprofit	3.6	3.7	8.8
Government	1.2	1.0	0.0
Urban	93.2	93.5	100
Rural	6.8	6.5	0.0

Note: ASC (ambulatory surgical center). We defined "urban" as being in metropolitan statistical areas (MSAs) and "rural" as being outside MSAs. The results in the third column are from the first quarter of 2022.

Source: MedPAC analysis of CMS Provider of Services file, 2023.

The concentration of ASCs varies widely across states. In the first quarter of 2022, Maryland had the most ASCs per Medicare beneficiary (36 ASCs per 100,000 Part B beneficiaries (both fee-for-service and Medicare Advantage)), followed by Georgia, Alaska, and Wyoming (respectively, 22, 18, and 18 ASCs per 100,000 Part B beneficiaries) (Figure 10-1, p. 303).[6] Kentucky, the District of Columbia, West Virginia, and Vermont had the fewest ASCs per Part B beneficiary (4 or fewer ASCs per 100,000 Part B beneficiaries). Differences in certificate-of-need (CON) laws among states likely has a strong influence on the differences in ASC concentration between states. States that have CON laws tend to have fewer ASCs than states that do not.

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

TABLE 10–3

Number of ASCs per Part B beneficiary decreased as ADI, a measure of social risk, increased, 2021

Range of ADI scores	Number of ASC ORs per 100,000 Part B beneficiaries	Number of ASCs per 100,000 Part B beneficiaries
1–10 (lowest)	42.7	15.5
11–20	39.5	13.3
21–30	39.9	12.5
31–40	36.0	11.4
41–50	32.5	10.1
51–60	27.1	9.1
61–70	26.8	8.8
71–80	18.0	5.5
81–90	12.7	4.1
91–100 (highest)	4.6	1.7

Note: ASC (ambulatory surgical center), ADI (Area Deprivation Index), OR (operating room).

Source: MedPAC analysis of Provider of Services file from CMS (2022), ADI measures from University of Wisconsin School of Medicine and Public Health.

interest. Other owners of ASCs include hospitals and corporate entities. One change that is occurring in the structure of ASC ownership is the extent of corporate involvement. In the ASC industry, six corporate entities are considered major holders of ASCs: United Surgical Partners International (USPI), AmSurg, Surgical Care Affiliates, SurgCenter Development, HCA Healthcare, and Surgery Partners Holdings. From 2017 to 2022, the number of ASCs in which these 6 entities have some degree of ownership increased by 20.6 percent from 1,041 to 1,255, and the share of ASCs in which these entities have an ownership stake increased from 18.6 percent to 20.8 percent (Hawkins et al. 2023).

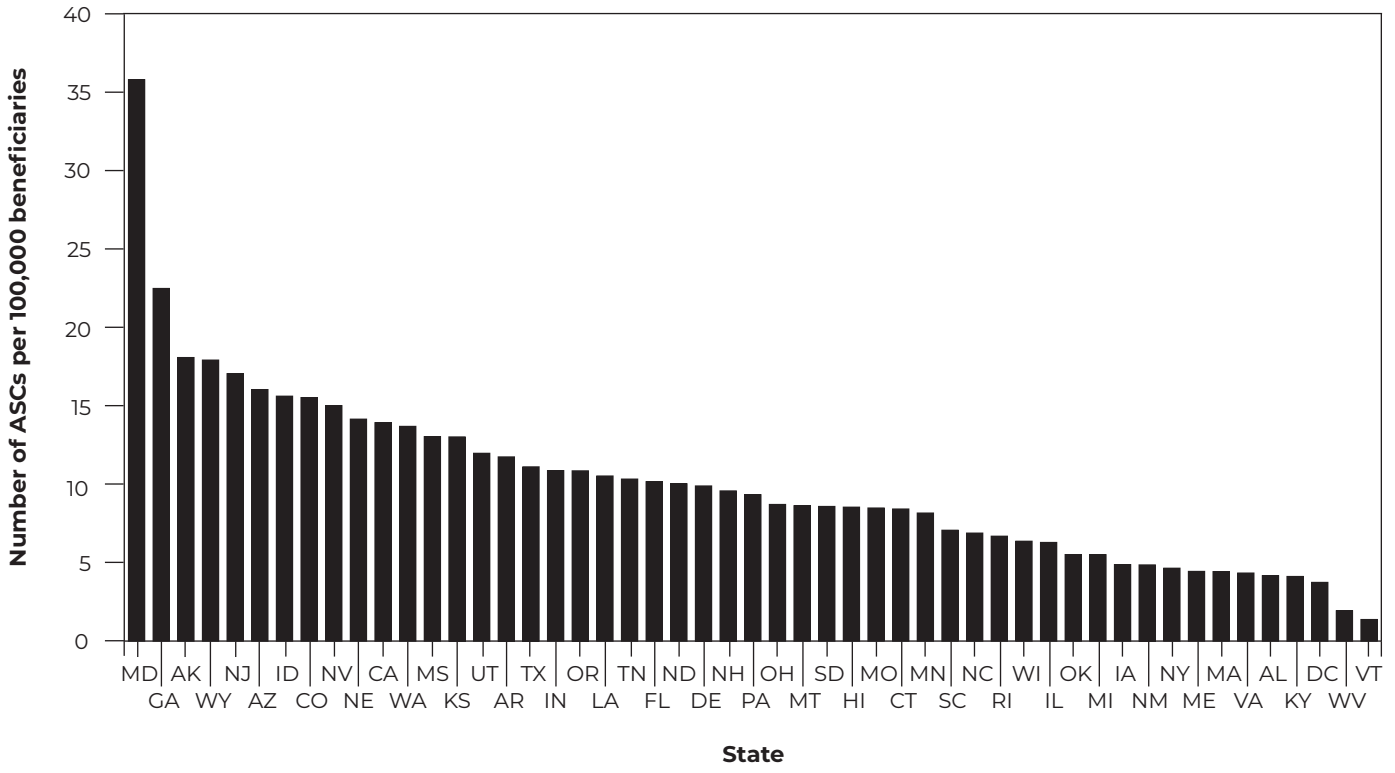
For providers, ASCs offer several advantages over HOPDs because surgeons can customize their surgical environments and hire specialized staff, which allow them to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees. ASCs also offer benefits over HOPDs for the Medicare program and beneficiaries. Medicare payment rates are lower in ASCs than in HOPDs for all services that are covered in both settings (for most services, the ASC payment rates are 46 percent lower than the HOPD payment rates). Therefore, the cost to the Medicare program (as well as taxpayers) is lower if a surgical procedure is provided in an ASC rather than an HOPD, as is the beneficiary's cost-sharing obligation.[7] However, it is possible that shifting services from HOPDs to ASCs could increase the volume of surgical procedures, which would partially offset the reduction in Medicare spending and beneficiaries' cost sharing. An additional advantage for beneficiaries is that, relative to HOPDs, patients have less nonoperative time in ASCs (Imran et al. 2019).

Because of these advantages of ASCs, it could be beneficial for surgical procedures to migrate from the HOPD setting to ASCs. However, the low concentration of ASCs in many states, in rural areas, and in areas with high social risk limits the extent to which beneficiaries can access care in ASCs.

Research indicates that when an ASC enters a market or a physician who performs surgical procedures in outpatient settings (HOPDs and ASCs) becomes an ASC owner, surgical procedures shift from HOPDs to ASCs and surgical volume in the outpatient settings

FIGURE 10–1

Number of ASCs per beneficiary varies widely by state, 2022



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2023 and Common Medicare Environment file.

may slightly increase. Courtemanche and Plotzke found that the addition of an ASC to a hospital's market reduces a hospital's outpatient surgical volume by 2 percent to 4 percent if the facilities are within four miles of each other, but they found that this impact on HOPD surgical volume is unlikely to have a serious impact on the financial viability of a typical hospital (Courtemanche and Plotzke 2010). Hollenbeck and colleagues found that the entry of an ASC into a market that previously did not have any ASCs reduced outpatient surgical procedures provided in HOPDs by 7 percent, while in other markets outpatient surgical procedures in HOPDs increased by 7 percent (Hollenbeck et al. 2015). Munnich and colleagues found that most physicians who provide surgical procedures in outpatient settings furnish those services in both ASCs and HOPDs (Munnich et al. 2021). They also found that two years after physicians obtained an ownership stake in an ASC, the share of the surgical procedures that those physicians provided in ASCs had increased by 22 percent, while the share they provided in HOPDs had decreased by about the same percentage. At the same time, the total number of outpatient surgical procedures they provided to both Medicare and non-Medicare patients increased by 9 percent. However, the total number of outpatient surgical procedures provided to FFS Medicare patients increased by a small amount, though this change was not statistically significant. In summary, research indicates that increased presence of ASCs in a market causes a shift of outpatient procedures from HOPDs to ASCs, and it might or might not increase the total number of outpatient procedures by a small amount.

TABLE 10–4

Specialization of ASCs billing Medicare in 2017 and 2022

Type of ASC	2017 Number of ASCs	2017 Share of all ASCs	2022 Number of ASCs	2022 Share of all ASCs
Single specialty	2,890	61%	3,763	68%
Ophthalmology	1,022	21	1,134	21
Gastroenterology	1,019	21	1,197	22
Pain management	368	8	753	14
Dermatology	179	4	197	4
Urology	125	3	151	3
Podiatry	88	2	76	1
Orthopedics/musculoskeletal	29	1	71	1
Respiratory	24	1	30	1
Cardiology	18	0	126	2
OB/GYN	11	0	13	0
Neurology	6	0	4	0
Other	1	0	11	0
Multispecialty	1,878	39	1,767	32
More than 2 specialties	1,415	30	1,314	24
Pain management and orthopedics	288	6	240	4
Gastroenterology and ophthalmology	175	4	213	4
Total	4,768	100	5,530	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 its Medicare claims in one clinical specialty. We define a multispecialty ASC as one with less than 67 percent of its 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 2022. Columns containing the shares of all ASCs do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2022.

Specialization of ASCs largely unchanged; some growth in pain management and cardiology

In 2022, 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, 68 percent of ASCs were single-specialty facilities and 32 percent were multispecialty facilities, providing services in more than one clinical specialty (Table 10-4).[8] In 2022, multispecialty ASCs most commonly focused on two specialties: pain management and orthopedic services or gastroenterology and ophthalmology (combined, 8 percent of all ASCs were multispecialty and focused on one of those two specialties). From 2017 to 2022, the number of ASCs specializing in pain management and cardiology services grew most rapidly.

Volume of services per beneficiary rose in 2022

From 2017 to 2022, the share of Part B FFS beneficiaries who received services in ASCs rose steadily from 10.7

TABLE 10–5

Volume of ASC services per FFS beneficiary rose in 2022

				Average annual change	
	2017	2021	2022	2017–2021	2021–2022
Volume of Medicare FFS services (in millions)	6.7	6.3	6.2	–1.7%	–1.2%
Part B FFS beneficiaries (in millions)	33.6	30.8	29.6	–2.1	–3.9
Volume per 1,000 FFS beneficiaries	200.9	204.5	210.2	0.4	2.8

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

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2017–2022.

percent to 11.3 percent (data not shown). Consequently, the volume of services per Part B FFS beneficiary rose on average by 0.4 percent per year from 2017 to 2021 and by 2.8 percent from 2021 to 2022 (Table 10-5).

However, from 2017 to 2022, the number of FFS beneficiaries with Part B coverage declined from 33.6 million to 29.6 million due to 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 declined by 1.7 percent per year from 2017 to 2021 and by 1.2 percent from 2021 to 2022 (Table 10-5).

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2022. For example, in both 2017 and 2022, extracapsular cataract removal with intraocular lens insertion had the highest volume, accounting for 18.6 percent of the total in 2017 and 18.7 percent in 2022 (Table 10-6, p. 306). Moreover, 18 of the 20 most frequently provided ASC services in 2017 were among the 20 most frequently provided in 2022. These services made up about 70 percent of ASC Medicare volume in 2017 and 69 percent in 2022.

A potential concern about the services most frequently provided in ASCs is the extent to which they are unnecessary or of low value. Seven of the 20 procedures listed in Table 10-6 (p. 306) were pain management services, such as spinal injections and other pain management services, which some researchers have found to be of low value (Chant et al. 2023, Corp et al. 2021, Ganguli et al. 2021). Moreover, the volume for the procedure that accrued the second-highest Medicare revenue for ASCs in 2022—the insertion or replacement of spinal neurostimulators, which is a pain management procedure—grew by about 4 percent from 2021 to 2022 while being unchanged in HOPDs (data not shown). However, in situations in which these pain management procedures are efficacious, they could be a substitute for opioid use.

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 that CMS implement a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).

TABLE 10–6

For FFS beneficiaries, the 20 most frequently provided ASC services in 2017 were similar to those provided in 2022

	2017		2022	
Procedure name	**Percent of volume**	**Rank**	**Percent of volume**	**Rank**
Extracapsular cataract removal with IOL insert	18.6%	1	18.7%	1
Upper GI endoscopy, with biopsy: single or multiple	8.0	2	7.6	2
Colonoscopy and biopsy	6.9	3	7.0	4
Colonoscopy with lesion removal, snare technique	5.9	4	7.5	3
Inject transforaminal epidural: lumbar or sacral	4.8	5	4.1	5
After cataract laser surgery	4.2	6	3.8	6
Injection paravertebral facet joint: lumbar or sacral, single level	3.3	7	3.1	7
Injection interlaminar epidural: lumbar or sacral	2.9	8	2.0	9
Colorectal cancer screening, high-risk individual	2.0	9	2.4	8
Diagnostic colonoscopy	1.9	10	1.4	14
Colorectal cancer screening, not high-risk individual	1.8	11	1.5	11
Destroy lumbar/sacral facet joint, single	1.6	12	1.7	10
Injection procedure for sacroiliac joint, anesthesia	1.4	13	1.4	12
Extracapsular cataract removal complex without ECP	1.4	14	1.4	13
Cystourethroscopy	1.2	15	1.2	15
Inject paravertebral facet joint: cervical or thoracic, single level	1.1	16	1.0	16
Injection interlaminar epidural: cervical or thoracic	1.0	18	0.8	18
Upper GI endoscopy diagnostic brush wash	0.9	17	0.7	21
Blepharoplasty upper eyelid	0.9	19	1.0	17
Upper GI endoscopy, guide wire insertion	0.8	20	0.7	22
Total	70.4		69.1	

Note: FFS (fee-for-service), ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal), ECP (endoscopic cyclophotocoagulation). 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 2017 and 2022.

Currently, the ASCQR Program has seven measures for which data are available to evaluate ASC quality, plus a voluntary measure for which too few ASCs report data for the measure to represent a reliable result (ASC–11, improvement in patient's visual function within 90 days following cataract surgery). The currently available quality measures include outcome measures for four important ASC specialties: gastrointestinal, ophthalmology, orthopedics, and urology. Hence, the measures provide some degree of representation of ASC quality. However, in recent years, CMS has deleted several quality measures and added some new measures. As a result, data are available for only three quality measures in each year over the 2017 through 2022 period, so we cannot make a meaningful assessment of whether ASC quality has been improving. Therefore, we do not have a basis for evaluating the quality of care in ASCs.

CMS will add several measures for which ASCs will submit data from 2025 for ASC payment determination in 2027. However, we believe that CMS should

TABLE 10–7

FFS Medicare payments to ASCs rose rapidly, 2017–2022

				Average annual change	
	2017	2021	2022	2017–2021	2021–2022
Medicare payments (billions of dollars)	$4.6	$5.7	$6.1	5.9%	5.8%
Medicare payments per FFS beneficiary	$136	$186	$205	8.2	10.0

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

implement additional quality measures to make the ASCQR Program more effective (see text box on CMS's new measures, pp. 308–309).

Aggregate FFS Medicare payments rose substantially in 2022, continuing a trend

In 2022, ASCs received $6.1 billion in FFS Medicare payments and beneficiaries' cost sharing (Table 10-7). We estimate that spending by the FFS Medicare program was $4.9 billion and beneficiary cost sharing was $1.2 billion (data not shown).

Payments per FFS beneficiary rose at an average annual rate of 8.2 percent from 2017 through 2021 and by 10.0 percent in 2022 (Table 10-7). The increase in 2022 reflects a 1.9 percent increase in the ASC conversion factor, a 2.6 percent increase in per capita volume, a 6.2 percent increase in the average relative weight of ASC services, a 0.2 percent effect from an increase in spending from 2021 to 2022 on separately paid drugs provided to Medicare beneficiaries treated in ASCs, and a 1.0 percent reduction from the reinstatement of the sequester in 2022.

Although the ASC payment system covers over 3,600 surgical procedures, the revenue that ASCs receive for providing services to FFS Medicare beneficiaries is concentrated in a relatively small number of procedures. In 2022, 53 procedures accounted for 75 percent of the Medicare revenue from surgical procedures (data not shown).

Despite the strong growth in FFS Medicare revenue in 2022, there is evidence from one state that ASC operating margins declined, though they remained very high. The Pennsylvania Health Care Cost Containment Council collects total operating costs and total operating revenue from all ASCs in Pennsylvania, which allows for the calculation of operating margins for those ASCs. Historically, the operating margins for the Pennsylvania ASCs have been in the 23 percent to 25 percent range. In 2022, however, the operating costs for the Pennsylvania ASCs rose by a much higher percentage than did operating revenue (15.1 percent versus 10.3 percent, respectively). Consequently, the 2022 operating margins for Pennsylvania ASCs declined to 20.2 percent (Pennsylvania Health Care Cost Containment Council 2023).[9]

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 from 2010 to 2022, the Commission recommended that the Congress require ASCs to submit cost data (Medicare Payment Advisory Commission 2010); the Commission reiterated this recommendation in 2023. Cost data

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

The Ambulatory Surgical Center Quality Reporting (ASCQR) Program currently has data on seven quality measures, plus data on a voluntary measure. CMS will increase the number of quality measures in the ASCQR Program over the next few years so that the program will have 17 measures from which data from 2025 will be used to determine ASC payments in 2027 (Table 10-8).

The Commission asserts that CMS should continue to improve the ASCQR by moving toward outcome measures that apply to all ASCs. Although the ASCQR Program will eventually have four measures that are claims based and measure clinical outcomes (ASC–12, ASC–17, ASC–18, and ASC–19), these measures exclude many services provided at ASCs, such as eye procedures and pain management. To improve the ASCQR Program and to be consistent with MedPAC principles, it is important that the Secretary 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, CMS should also consider developing new ASC quality measures covering these three 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 whether services provided in ASCs are appropriate.*** While the ASCQR Program 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).[10] Using these guidelines, a new measure could identify ASCs' share of colonoscopy cases for beneficiaries over age 85. CMS could consider similar measures for whether certain procedures that have become more common in ASCs in recent years are appropriate or for procedures that have drawn concern about appropriate use, such as spinal injections or certain orthopedic procedures (Chant et al. 2023, Ganguli et al. 2021).

(continued next page)

would enable policymakers to establish payment rates that accurately reflect ASC costs. Currently, ASC payment rates are not based on ASC cost data but instead are largely derived from the OPPS payment rates, which are based on HOPD charges adjusted to cost. To the extent that there is a difference in the cost

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

TABLE 10–8 **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®):	Yes
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	
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
ASC–21: Risk-standardized patient-reported outcome-based performance measure following elective primary total hip arthroplasty and/or total knee arthroplasty*	No, required in 2028

Note: ASC (ambulatory surgical center), COVID-19 (coronavirus disease 2019).
*The measure ASC–21 will be voluntary for submission by facilities in 2025, 2026, and 2027. It will become mandatory in 2028.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2023.

- ***Claims-based outcome measure for cardiology services.*** Stakeholders in the ASC industry expect cardiology to be a growth area for ASCs as providers become more comfortable performing angiograms and angioplasties in ASCs. One projection predicts that by 2025, 33 percent of cardiology procedures will be provided in ASCs (Van Biesen and Johnson 2023). As cardiology procedures become more common in ASCs, it would be beneficial for CMS to add a claims-based measure to evaluate the quality of those procedures. ■

structures of HOPDs and ASCs, ASC payment rates do not accurately reflect the cost of ASCs. Though some evidence suggests that FFS Medicare's payments for ASC services are higher than ASC costs on average, it is plausible that ASC payment rates are higher than ASC costs for some services and lower than ASC costs for others. This disparity would create incentives for ASCs to focus on providing high-margin services, which would narrow their scope of services relative to what they might offer if the payment rate for each service accurately reflected ASC costs.

Cost data are also 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.

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. Most recently, the ASC industry has shown openness to submitting cost data, but the industry believes that the only credible reason for ASCs to submit cost data is to develop a market basket. Stakeholders have argued that a single market basket should be applicable to both the ASC and the HOPD settings to ensure that ASC and HOPD payment rates continue to be based on the same relative weights (Ambulatory Surgery Center Association 2023b).

However, it is likely that ASC payment rates and HOPD payment rates should be based on different relative weights. The Commission has asserted that the cost structure of ASCs and HOPDs are different. ASCs tend to be single specialty, for profit, and are not required to comply with the Emergency Medical Treatment and Labor Act (EMTALA), while HOPDs are multispecialty, typically nonprofit, and many of them must comply with EMTALA. In addition, relative to hospitals, ASCs are more urban, serve a different mix of patients demographically and by payer type, have a much higher share of expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs (Medicare Payment Advisory Commission 2018).

The Commission recognizes that ASCs are small facilities and requiring them to submit cost data would place a burden on them, but we have contended that it is feasible for ASCs to provide cost information. Small businesses like ASCs typically keep records of their costs for filing taxes and other purposes. In addition, all other facility providers submit cost data to CMS, including other small facilities such as rural health clinics, home health agencies, and hospices. 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 2023). The requirement that ASCs in Pennsylvania collect and submit cost data does not appear to have adversely affected the growth of ASCs in the state; from 2017 to 2021, the number of Medicare-certified ASCs rose by 10.3 percent in Pennsylvania versus 8.9 percent nationwide.

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.

The Commission has coupled this recommendation with assertions that cost reporting for ASCs should be more streamlined and less burdensome relative to cost reporting for hospitals. As a template, CMS could use the cost reporting used in Pennsylvania, which provides the data needed to estimate margins for each ASC in the state. ■

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/2022/10/MedPAC_Payment_Basics_23_ASC_FINAL_SEC.pdf.

2 The IPO list consists of Healthcare Common Procedure Coding System codes that are typically provided in an inpatient setting and cannot be paid under the ASC payment system or the OPPS. Throughout its rulemaking for the ASC payment system and OPPS, CMS has received comments from stakeholders recommending that CMS eliminate the IPO list, while other stakeholders have recommended that CMS should maintain the list (Centers for Medicare & Medicaid Services 2020).

3 We chose not to use data from the ASC Association in Table 10-1 (p. 300) because it does not allow for estimates of historical trends.

4 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 tripled, to 29,000, in 2022.

5 By statute, coinsurance for a service paid under the OPPS cannot exceed the Medicare Part A inpatient hospital deductible ($1,632 in 2024). 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. Nearly all of these services are "device-intensive" procedures, which are procedures in which the cost of a device is at least 30 percent of the ASC payment rate for the procedure. Of these procedures, the most frequently provided in 2022 were insertion of a spinal neurostimulator generator or receiver and total knee arthroplasty.

6 The relatively high number of ASCs per Part B beneficiary in Maryland is due, at least in part, to a response to a Medicare waiver under which Maryland hospitals operate under global budgets. Under this system, hospital budgets are capped, and they receive no additional revenue if they exceed their budgets. However, medical care received in ASCs falls outside the budgets, so there is an incentive for hospitals to shift outpatient surgical care to ASCs.

7 For some services, the OPPS cost sharing is lower than the ASC cost sharing because under the OPPS the cost sharing for a service cannot exceed the Medicare Part A inpatient hospital deductible ($1,632 in 2024), while the ASC system does not have a limit on beneficiary cost sharing. These services constituted 1.5 percent of the total ASC volume in 2022.

8 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.

9 The margins for the ASCs in Pennsylvania are different from the margins for other facilities because the margins for the ASCs do not include taxes or distributions to physician owners.

10 The American Cancer Society states that "people who are in good health and with a life expectancy of more than 10 years should continue regular colorectal cancer screening through the age of 75. For people ages 76 through 85, the decision to be screened should be based on a person's preferences, life expectancy, overall health, and prior screening history. People over 85 should no longer get colorectal cancer screening."

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