CHAPTER 11

Ambulatory surgical center services: Status report

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Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures to patients who do not require an overnight stay. In 2024, about 6,400 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries. (Beneficiaries enrolled in Medicare Advantage (MA) may also be treated in ASCs, but due to data limitations, the focus of this chapter is on FFS volume and spending.) FFS Medicare program and beneficiary spending on ASC services was about $7.5 billion in 2024. Signs point to a robust industry: The number of ASCs nationwide grew over 2 percent per year, on average, between 2019 and 2024, and the volume of ASC surgical procedures per FFS beneficiary increased by 3.5 percent in 2024 and at an annual average rate of 1.3 percent from 2019 to 2023. 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 (HOPDs). ASCs can also offer physicians more specialized staff and control over their work environment.

Over 95 percent of ASCs are for profit, and about 94 percent are located in urban areas. The concentration of ASCs varies widely across states, ranging from more than 36 ASCs per 100,000 Part B beneficiaries

In this chapter

(FFS and MA combined) in Maryland to 3 or fewer ASCs per 100,000 Part B beneficiaries in the District of Columbia, West Virginia, and Vermont. Relative to HOPDs, ASCs are less likely to provide surgical procedures to FFS Medicare beneficiaries who are disabled, have Medicaid coverage, or are age 85 or older. About 68 percent of ASCs that billed FFS Medicare in 2024 specialized in a single clinical area, of which gastroenterology and ophthalmology were the most common. The remainder were multispecialty facilities, providing services in more than one clinical specialty, of which pain management and orthopedics were the most common. From 2023 to 2024, the ASC specialties that grew most rapidly were pain management and cardiology.

The most common FFS Medicare procedure in ASCs in 2024 was extracapsular cataract removal with intraocular lens insertion, accounting for 18 percent of FFS Medicare volume. The 20 most common surgical procedures performed in ASCs made up about 68 percent of ASCs' FFS Medicare volume in 2024.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 9.4 percent from 2019 through 2023 and by 15.9 percent from 2023 to 2024. Because FFS Medicare payment rates are lower in ASCs than in 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. Beneficiaries' cost-sharing obligation is lower as well. However, it is possible that additional services provided in ASCs could increase the overall volume of surgical procedures, which would partially offset the reduction in total FFS Medicare spending associated with a shift in the site of care. A greater volume of service provision is especially likely if FFS Medicare's payments for ASC services are substantially 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 requirements for other types of facilities.

The Commission contends that ASCs could feasibly provide cost data and for many years has recommended that the Congress require ASCs to submit such data. In addition, we encourage CMS to synchronize measures in the ASC Quality Reporting Program with measures included in the Hospital Outpatient Quality Reporting Program to facilitate comparisons between ASCs and HOPDs. More expansive ASC quality data would also inform and facilitate FFS beneficiaries' decision-making about where they choose to receive care. ■

An ambulatory surgical center (ASC) is a facility that primarily provides outpatient surgical procedures to patients who do not require an overnight stay. Outpatient surgical procedures are also provided in hospital outpatient departments (HOPDs) and, in some cases, physicians' offices. Fee-for-service (FFS) Medicare covers more than 3,700 surgical procedures in ASCs, though historically volume has been concentrated in a small number of procedures. (Beneficiaries enrolled in Medicare Advantage (MA) may also be treated in ASCs, but due to data limitations, the focus of this chapter is on FFS volume and spending.)

For procedures performed in an ASC, FFS 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. Payment rates in the ASC payment system are the product of a set of relative weights and a conversion factor (or base payment amount). The relative weights used in the ASC payment system, which indicate each procedure's resource intensity relative to other procedures, are based on those in the OPPS. The ASC conversion factor ($56.32 in 2026) is less than the factor used in the OPPS ($90.97 in 2026). However, since 2019 CMS has updated the ASC conversion factor using the same method used to update the OPPS conversion factor: the hospital market basket index minus the multifactor productivity.[1]

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. The rationale for this policy is to encourage provision of these services in the lowest-cost setting.

In this status report, we examine FFS beneficiaries' access to ASC care, growth in FFS Medicare's payments to ASCs, and, to the extent possible, the quality of care provided in ASCs. Signs point to a robust industry, with long-term growth in the number of ASCs, the volume of services provided to FFS Medicare beneficiaries, and total FFS Medicare payments. Although CMS has never required ASCs to submit cost data and information, the Commission has recommended that CMS require ASCs to do so.

Supply of ASCs and volume of services continue to grow

The number of ASC facilities increased in 2024, as did the volume of ASC services provided to FFS Medicare beneficiaries. Access to ASCs may be preferable to patients and physicians compared with HOPDs, the provider type that is most like 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

From 2023 through 2024, the number of Medicare-certified ASCs rose 2.2 percent to 6,436 ASCs, aligned with the average annual growth of 2.2 percent from 2019 through 2023 (Table 11-1, p. 328). During 2024, 248 new ASCs opened while 108 ASCs closed or merged with other facilities, for a net increase of 140 facilities.

Numerous factors have likely influenced the steady growth in the number of ASCs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings. The share of hip, knee, and shoulder arthroplasties (replacements) performed in ambulatory settings has continued to grow.[2]
- Physicians may have greater autonomy in ASCs than in HOPDs, enabling them to design customized surgical environments and hire specialized staff. These features of ASCs may allow

TABLE 11–1

Number of ASCs grew, 2019–2024

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
Total number of ASCs	5,760	5,857	6,015	6,145	6,296	6,436	2.2%	2.2%
New	243	189	266	225	256	248	N/A	N/A
Closed	128	92	108	95	105	108	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable). We display the average annual percentage change for the "new" and "closed" categories as "N/A" because they are outside the purpose of this table, which is to show the growth in the number of ASCs. "New" refers to a new location for ASC services, while "closed" refers to an ASC that terminated operations, either because it closed operations or merged with another facility. The number of ASC closures and openings in a given year can change from prior publications as ASCs reopen and newer data become available.

Source: MedPAC analysis of Provider of Services file from CMS, 2025.

physicians to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees (Munnich and Parente 2014).

- 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, FFS beneficiaries' coinsurance is lower in ASCs than in HOPDs.[3]
- State certificate-of-need (CON) laws have been reduced, such as South Carolina eliminating CON requirements for ASCs in 2023, Georgia implementing CON exemptions for some single-specialty ASCs owned by individual physicians or practices in 2024, and North Carolina eliminating CON requirements for ASCs locating in counties with populations over 125,000 in 2025.

Most ASCs are for profit, and geographic distribution is uneven

Consistent with previous years, most ASCs in 2024 were for profit (95.3 percent) (Table 11-2). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2023, Leapfrog 2019). Physician owners of ASCs receive additional income through distributions of facility profits according to their ownership interest. Other owners of ASCs include hospitals and corporate entities, such as payers and private equity (PE) firms. One change that is occurring in the structure of ASC ownership is the extent of corporate involvement. In the ASC industry, five corporate entities are considered major holders of ASCs: United Surgical Partners International (USPI), AmSurg, HCA Healthcare, Surgery Partners Holdings, and Surgical Care Affiliates (which is owned by the largest private payer, UnitedHealthcare). From 2019 to 2024, the number of ASCs in which these 5 entities have some degree of ownership increased by 19.1 percent (rising from 1,152 to 1,372), and the share of ASCs in which these entities have an ownership stake increased from 20.0 percent to 21.5 percent (Hawkins et al. 2025). While factors associated with corporate-owned ASCs are not well-understood, early evidence suggests that PE firms may target high-volume ASCs and that payer-owned ASCs tend to operate in competitive outpatient procedure markets where the payer has substantial beneficiary market share (Lin et al. 2023, Zhao et al. 2024).

ASCs were also disproportionately located in urban areas in 2024 (93.7 percent) (Table 11-2). Stakeholders contend that rural areas typically lack the surgical specialists needed for ASCs and that the lower

TABLE 11–2

Most ASCs are for profit and located in urban areas, 2019–2024

						2024	
Type of ASC	**2019**	**2020**	**2021**	**2022**	**2023**	**All**	**New**
For profit	95.3%	95.3%	95.2%	95.2%	95.2%	95.3%	95.0%
Nonprofit	3.8	3.8	3.9	3.9	3.8	3.8	5.0
Government	0.9	0.9	0.9	0.9	0.9	0.9	0.0
Urban	96.1	93.4	93.4	93.6	93.7	93.7	94.4
Rural	3.9	6.6	6.6	6.4	6.3	6.3	5.6

Note: ASC (ambulatory surgical center). We defined "urban" as being in metropolitan statistical areas (MSAs) and "rural" as being outside MSAs.

Source: MedPAC analysis of CMS Provider of Services file, 2025.

population density in rural areas makes them less viable locations for ASCs. 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 FFS 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 (data not shown).

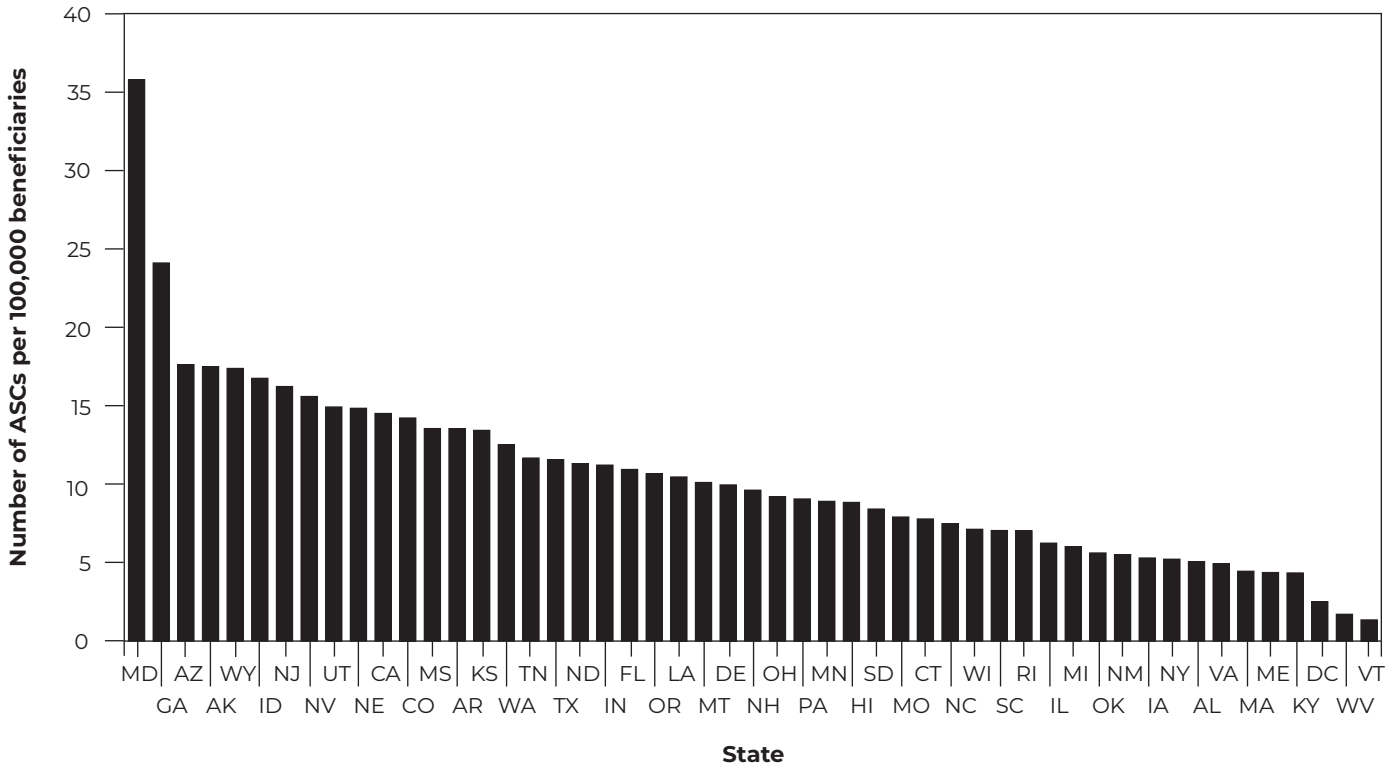
The concentration of ASCs varies widely across states. At the close of calendar year (CY) 2024, Maryland had the most ASCs per Medicare beneficiary (36 ASCs per 100,000 Part B beneficiaries (both FFS and MA)), followed by Georgia, Arizona, and Alaska (respectively, 24, 18, and 17 ASCs per 100,000 Part B beneficiaries) (Figure 11-1, p. 330). The District of Columbia, West Virginia, and Vermont had the fewest ASCs per Part B beneficiary (three or fewer ASCs per 100,000 Part B beneficiaries).

Several factors contribute to variation in ASCs per Part B beneficiary among states. One factor that appears to have a strong effect is whether a state has a CON law for ASCs. However, even among the 22 states (plus the District of Columbia) that have CON laws, the stringency varies substantially. For example, Nevada, which has a relatively weak CON law for ASCs, has one of the highest concentrations of ASCs per Medicare beneficiary; by contrast, Vermont has very strict CON laws and has by far the lowest number of ASCs per Medicare beneficiary.

Moreover, some states have characteristics that appear to overwhelm the effects of having or not having a CON law. For example, Maryland has a strong CON law but has by far the most ASCs per Medicare beneficiary, likely due to the presence of an all-payer global budget revenue model in the state that provides an incentive for hospitals to shift care from HOPDs to ASCs.[4] To help hospitals meet their budgets, it appears that they avoid providing many ambulatory surgical procedures in the hospitals, resulting in these procedures being provided in ASCs. New Mexico, by contrast, does not have a CON law for ASCs but has only about half as many ASCs per 100,000 Part B beneficiaries (6) as the average among all states (10), perhaps due to the large number of sparsely populated rural areas in the state.

FIGURE 11–1

Number of ASCs per beneficiary varied widely by state, 2024



Note: ASC (ambulatory surgical center). The count of beneficiaries includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage.

Source: MedPAC analysis of CMS Provider of Services file for 2025 and the Common Medicare Environment file.

Specialization of ASCs remained mostly unchanged; largest growth in pain management and orthopedics

In 2024, 68 percent of ASCs that billed FFS Medicare specialized in a single clinical area. Gastroenterology and ophthalmology were the most common specialties, with each comprising about 21 percent of all ASCs that provided services to FFS Medicare beneficiaries. The remaining 32 percent of ASCs were multispecialty facilities, providing services in more than one clinical specialty (Table 11-3).[5] In 2024, the most common multispecialty ASCs were those focusing on pain management, orthopedics, and other surgeries. Multispecialty ASCs that included a focus on gastroenterology and ophthalmology were also common. From 2023 to 2024, the number of single-specialty ASCs specializing in cardiology (6.3 percent), respiratory (8.3 percent) and orthopedic (18.9 percent) services grew most, though their share of all ASCs did not change. The number of multispecialty ASCs specializing in both pain management and orthopedics grew most (20.9 percent), and their share of all ASCs increased by 1 percentage point.

Volume of services per FFS beneficiary rose in 2024

In 2024, 3.4 million FFS Medicare beneficiaries received ASC services. For several years, aggregate volume of ASC services provided to FFS Part B beneficiaries declined as the number of beneficiaries in FFS Medicare decreased and the number in MA rose. That decline in the number of FFS beneficiaries was somewhat mitigated by a slow but steady increase in the number of services per FFS Part B beneficiary,

TABLE 11–3

Specialization of ASCs billing FFS Medicare, 2023–2024

Type of ASC	2023 Number of ASCs	2023 Share of all ASCs	2024 Number of ASCs	2024 Share of all ASCs	Percent change in number of ASCs, 2023–2024
Single specialty	3,917	68%	3,955	68%	1.0%
Gastroenterology	1,193	21	1,208	21	1.3
Ophthalmology	1,152	20	1,162	20	0.9
Pain management	800	14	808	14	1.0
Cardiology	221	4	235	4	6.3
Dermatology	197	3	178	3	–9.6
Urology	152	3	156	3	2.6
Orthopedic	53	1	63	1	18.9
Podiatry	62	1	59	1	–4.8
Respiratory	36	1	39	1	8.3
OB/GYN	15	<1	14	<1	–6.7
Other	36	1	33	1	–8.3
Multispecialty	1,827	32	1,848	32	1.2
Pain management and orthopedics	172	3	208	4	20.9
Gastroenterology and ophthalmology	220	4	191	3	–13.2
Pain management and other surgery	182	3	174	3	–4.4
Pain management, orthopedics, and other surgery	470	8	497	9	5.7
Pain management, gastroenterology, and ophthalmology	329	6	298	5	–9.4
Other	454	8	480	8	5.7
Total	5,744	100	5,803	100	N/A

Note: ASC (ambulatory surgical center), FFS (fee-for-service), OB/GYN (obstetrics and gynecology). We define a "single-specialty ASC" as one with more than 67 percent of their FFS Medicare claims in one clinical specialty. We define a "multispecialty ASC" as one with less than 67 percent of their FFS Medicare claims in one clinical specialty. The total number of ASCs in this table is less than the total number of ASCs listed in Table 11–1 (p. 328) because the ASCs included in this table are limited to those in the 50 states and the District of Columbia that had a paid FFS Medicare claim while the ASCs in Table 11–1 include all ASCs in the 50 states, the District of Columbia, and Puerto Rico. Values may differ from prior years due to small methodological changes.

Source: MedPAC analysis of Medicare physician/supplier standard analytic files, 2023–2024.

which rose at an average annual rate of 1.3 percent from 2019 to 2023. However, in 2024, the number of services per FFS Part B beneficiary increased by 3.5 percent, resulting in an aggregate increase in ASC services provided to FFS Part B beneficiaries of 0.8 percent (Table 11–4, p. 332).

The growth in volume in 2024 was partly driven by large percentage increases in the volume of total knee arthroplasty (27.6 percent) and total hip arthroplasty (28.7 percent) procedures, as well as total shoulder arthroplasty procedures (which Medicare began reimbursing in ASCs starting in 2024). Smaller, albeit still notable, growth in volume was observed for some colonoscopy procedures and several pain management procedures.

Services that historically contributed the most to overall ASC volume continued to be a large share of the total in 2024. For example, in both 2019 and 2024,

TABLE 11–4

Volume of ASC services per FFS beneficiary rose in 2024

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
FFS Part B beneficiaries (in millions)	33.1	32.3	30.9	29.7	28.6	27.9	–3.6%	–2.5%
Volume of FFS Medicare services (in millions)	7.0	5.6	6.3	6.2	6.4	6.4	–2.2	0.8
Volume per 1,000 FFS beneficiaries	211.3	174.7	204.5	210.2	222.1	229.9	1.3	3.5

Note: ASC (ambulatory surgical center), FFS (fee-for-service). Numbers may differ from prior years due to small methodological changes. Percent changes were calculated using unrounded data.

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2019–2024.

extracapsular cataract removal with intraocular lens insertion had the highest volume, accounting for 18.2 percent of the total in 2019 and 18.0 percent in 2024 (Table 11-5). Moreover, 18 of the 20 most frequently provided ASC services in 2019 were among the 20 most frequently provided in 2024. These services made up about 70 percent of ASC FFS Medicare volume in 2019 and 68 percent in 2024. Of the surgical procedures provided to FFS Medicare beneficiaries in ASCs in 2024, 50 percent of the volume was concentrated in seven procedures.

Of the surgical procedures provided to FFS Medicare beneficiaries in ASCs in 2024, 50 percent of the FFS Medicare revenue was concentrated in 12 procedures. Relative to the highest-volume surgical procedures though, there was more change among the highest-revenue surgical procedures, reflecting a shift to higher-complexity services in ASCs. Four of the highest-revenue services in 2024—total knee arthroplasty, total hip arthroplasty, total shoulder arthroplasty, and a cataract removal procedure that includes insertion of an aqueous drainage device—were not covered under the ASC payment system in 2019. For another high-revenue procedure in 2024—percutaneous laminotomy or laminectomy—revenue increased by a factor of 13 over the 2019 level.

Factors affecting the shift in services from hospital-based settings to ASCs

It could be beneficial for surgical procedures to migrate from the HOPD setting to ASCs. As noted above, ASCs offer several advantages for surgeons, because they can customize their surgical environments and hire specialized staff, which allows them to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees. For beneficiaries, ASCs offer shorter nonoperative times than HOPDs (Imran et al. 2019). In addition, because FFS 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), the cost to FFS beneficiaries (via cost sharing) and the Medicare program (as well as taxpayers) is lower.[6]

However, because ASCs can select their patients, as the number of ASCs grows, there is potential for ASCs to account for an increasingly larger share of the more profitable ambulatory procedures, leaving the less profitable ambulatory procedures

TABLE 11–5

For FFS beneficiaries, the 20 most frequently provided ASC services in 2019 were similar to those provided in 2024

	2019		2024	
Procedure	**Percent of volume**	**Rank**	**Percent of volume**	**Rank**
Extracapsular cataract removal with IOL insert	18.2%	1	18.0%	1
Upper GI endoscopy, with biopsy: single or multiple	7.8	2	7.3	3
Colonoscopy and biopsy	6.9	3	6.4	4
Colonoscopy with lesion removal, snare technique	6.4	4	8.0	2
Injection transforaminal epidural: lumbar or sacral	4.7	5	4.2	5
After cataract laser surgery	4.0	6	3.7	6
Injection paravertebral facet joint: lumbar or sacral, single level	3.4	7	3.2	7
Injection interlaminar epidural: lumbar or sacral	2.6	8	1.9	10
Colorectal cancer screening, high-risk individual	2.1	9	2.3	8
Destroy lumbar/sacral facet joint, single	1.8	10	2.0	9
Diagnostic colonoscopy	1.7	11	1.1	16
Colorectal cancer screening, not high-risk individual	1.5	12	1.6	11
Injection procedure for sacroiliac joint, anesthesia	1.5	13	1.5	12
Extracapsular cataract removal complex without ECP	1.3	14	1.3	13
Cystoscopy	1.2	15	1.3	14
Injection paravertebral facet joint: cervical or thoracic, single level	1.2	16	1.1	15
Injection interlaminar epidural: cervical or thoracic	1.0	17	0.8	18
Blepharoplasty, upper eyelid	0.9	18	1.0	17
Upper GI endoscopy diagnostic brush wash	0.9	19	0.6	23
Upper GI endoscopy, guide wire insertion	0.7	20	0.6	25
Total	69.8	N/A	67.9	N/A

Note: FFS (fee-for-service), ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal), ECP (endoscopic cyclophotocoagulation), N/A (not applicable). 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 2019 and 2024.

to other settings, primarily HOPDs (Plotzke and Courtemanche 2011). Further, it is possible that this shift could result in higher-complexity patients clustering in HOPDs. Currently, the profile of FFS beneficiaries who receive their ambulatory surgeries in ASCs is different from those who receive their ambulatory surgeries in HOPDs. ASCs are less likely than HOPDs to serve FFS Medicare beneficiaries who are dually eligible, those who are age 85 or older, and those who are eligible for Medicare because of disability (Table 11-6, p. 334).

Research indicates that when an ASC enters a market or a physician who performs surgical procedures in HOPDs and/or ASCs becomes an ASC owner, surgical procedures shift from HOPDs to ASCs and overall outpatient surgical volume in the market may slightly increase. Courtemanche and Plotzke found

TABLE 11–6 **FFS Medicare patients treated in ASCs differed from patients treated in HOPDs, 2024**

	Characteristics of FFS Medicare patients who received at least one ASC and/or HOPD service	
Characteristic	**ASC**	**HOPD**
Dually eligible status		
Not dually eligible	92.0%	86.2%
Dually eligible	8.0	13.8
Age		
<65	5.3	8.6
65-84	89.3	82.5
85+	5.5	8.9
Sex		
Male	43.9	46.6
Female	56.1	53.4

Note: FFS (fee-for-service), ASC (ambulatory surgical center), HOPD (hospital outpatient department). All differences between ASC and HOPD patients are statistically significant ($p < 0.05$). This analysis excludes FFS beneficiaries who received services that are not covered under the ASC payment system. The numbers in the age categories for the ASC column do not sum to 100 due to rounding.

Source: MedPAC analysis of carrier and outpatient standard analytic claims files for 2024 and the Common Medicare Environment file.

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. Within these markets, the volume of procedures provided in ASCs was significantly greater than the decline in procedures provided in hospitals, and thus the volume of outpatient surgical procedures increased overall (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 FFS Medicare and non-FFS-Medicare patients increased by 9 percent. However, the total number of outpatient surgical procedures provided to FFS Medicare patients increased by a small amount, and this change was not statistically significant.

Impact of CMS's inpatient-only list on ASC-covered procedures

The ASC covered procedure list (CPL) is the list of procedures covered under the ASC payment system. A potential factor affecting the breadth of services included on the ASC CPL is the inpatient-only (IPO) list maintained by CMS, which, as of 2026, consists of more than 1,400 Healthcare Common Procedure

Coding System (HCPCS) codes that are typically provided in an inpatient setting and cannot be paid under the ASC payment system or the OPPS. Each year, CMS reviews the procedure codes on the IPO list and determines whether any services should be added or removed.

Throughout its rulemaking for the ASC payment system and the OPPS, CMS has received comments from some stakeholders recommending that CMS eliminate the IPO list, while others have recommended that CMS should maintain the list (Centers for Medicare & Medicaid Services 2025). In the rulemaking for CY 2026, CMS finalized the phase-out of the IPO list over a three-year period, beginning January 1, 2026, and ending January 1, 2029. As part of the first step of the IPO phase-out, for 2026, CMS removed 285 HCPCS codes (mostly for musculoskeletal procedures) from the IPO list and added 271 of these HCPCS codes, including total hip arthroplasty revisions and spinal procedures, to the ASC CPL.[7]

The extent to which the elimination of the IPO list will expand the volume of services that ASCs provide is not clear. 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 in 2018 and 2020, respectively.

Further expansion of ASC-covered procedures

There are many surgical procedures (not on the IPO list) that are covered under the OPPS but not the ASC payment system, due to certain CMS regulatory criteria that restrict which services can be included on the ASC CPL. However, in the CY 2026 final rule, CMS finalized revisions to their regulatory criteria to evaluate potential additions to the ASC CPL (Centers for Medicare & Medicaid Services 2025). Under the revised criteria beginning in CY 2026, 276 surgical or surgery-like procedures (that were not on the CY 2025 IPO list) were added to the ASC CPL, including laparoscopy, laminectomy, and several cardiovascular procedures.

As noted above, a longstanding feature of the services provided in ASCs to FFS Medicare beneficiaries is that although the ASC payment system covers over 3,700 procedures, the provision of ASC services has been concentrated in a relatively small number of procedures (Table 11-5, p. 333). It is not yet clear to what extent the addition of more than 500 procedures to the ASC CPL in 2026 will expand the volume of services that ASCs provide.

Performance on measures in the ASC Quality Reporting Program was mixed in 2024

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 rate reduced by 2 percentage points for that year. 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).

The ASCQR Program currently has four claims-based measures tied to unplanned hospitalizations in four ASC specialties: gastrointestinal, orthopedics, urology, and general surgery (Table 11-7, p. 336). However, CMS should implement additional quality measures to make the ASCQR Program more effective.

From 2019 to 2023, ASCs statistically significantly improved their performance on ASC–12: Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy (Table 11-7, p. 336). From 2023 to 2024, measure outcomes were generally stable. However, two of the four measures (ASC-17 and ASC-18) had statistically significant outcome rates that were slightly worse, though it is not clear if these changes are representative of clinically meaningful differences.

CMS should implement additional quality measures to make the ASCQR Program more effective. More expansive data about the quality of care provided in ASCs would also inform and facilitate beneficiaries'

TABLE 11–7

ASCs' performance on quality measures was mixed in 2024 after improvement from 2019–2023

Description of quality measure	2019	2020	2021	2022	2023	2024
ASC–12: Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy (per 1,000 colonoscopies)	12.0%	12.0%	11.4%	9.8%	9.8%	9.9%
ASC–17: Unplanned hospital visits within 7 days after orthopedic ASC procedure (per 1,000 procedures)	N/A	N/A	2.2	2.2	2.2	2.3*
ASC–18: Unplanned hospital visits within 7 days of urology ASC procedure (per 1,000 procedures)	N/A	N/A	5.5	5.1	5.1	5.2*
ASC–19: Facility-level 7-day hospital visit rate after general surgery procedures performed at ASCs (per 1,000 procedures)	N/A	N/A	N/A	1.0	1.0	1.0

Note: ASC (ambulatory surgical center). N/A (not applicable). "General surgery procedures" includes abdominal, alimentary tract, breast, skin, wound, and varicose vein–stripping procedures. All results represent median outcome rates.
* 2024 value is statistically different from 2023 value ($p < 0.05$).

Source: MedPAC analysis of data on quality measures for ambulatory surgical centers from CMS, 2019–2024.

decision-making about where they choose to receive care. Although the ASCQR Program includes four measures that are claims based and measure clinical outcomes (ASC–12, ASC–17, ASC–18, and ASC–19, Table 11–7), these measures exclude many services provided at ASCs, such as eye procedures and pain management. To improve the ASCQR Program, and consistent with the Commission's principles, we assert that 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 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.

Aggregate FFS Medicare payments rose substantially in 2024, continuing a trend

In 2024, ASCs received $7.5 billion in FFS Medicare payments and beneficiaries' cost sharing (Table 11-8). Spending by the FFS Medicare program was $6 billion, and beneficiary cost-sharing liability was $1.5 billion (data not shown).

Payments per FFS beneficiary rose at an average annual rate of 9.4 percent from 2019 through 2023 and by 15.9 percent in 2024 (Table 11-8). The increase in 2024 reflects a 3.2 percent increase in the ASC conversion factor, a 0.8 percent increase in per capita volume, an 8.4 percent increase in the average relative weight of ASC services provided, and a 0.4 percent effect from an increase in spending from 2023 to 2024 on separately

TABLE 11–8

FFS Medicare payments to ASCs rose rapidly, 2019–2024

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
FFS Medicare payments (billions)	$5.3	$4.8	$5.7	$6.0	$6.6	$7.5	5.6%	13.0%
FFS Medicare payments per FFS beneficiary	161	150	185	201	231	268	9.4	15.9
FFS Medicare payments per FFS beneficiary using ASC services	1,458	1,619	1,710	1,790	1,954	2,211	7.6	13.1

Note: FFS (fee-for-service), ASC (ambulatory surgical center). Medicare payments include FFS 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. Numbers may differ from prior years due to small methodological changes and updates to data.

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

paid drugs provided to FFS Medicare beneficiaries treated in ASCs. Also, payments per FFS beneficiary who used ASC services rose at an average annual rate of 7.6 percent from 2019 through 2023 and by 13.1 percent in 2024.

Although the ASC payment system covers over 3,700 surgical procedures, the revenue that ASCs receive for providing services to FFS Medicare beneficiaries is concentrated in a relatively small number of procedures. In 2024, 12 procedures accounted for 50 percent of the FFS Medicare revenue from surgical procedures (data not shown).

ASCs do not submit cost reports, so we cannot analyze the financial standing for all ASCs. However, the Pennsylvania Health Care Cost Containment Council collects data on total operating costs and total operating revenue from all ASCs in Pennsylvania, which allows for the calculation of operating margins for those ASCs. For 2024, the operating margin for the Pennsylvania ASCs was 29.5 percent, which is substantially higher than the range of their historical operating margins of 22.3 percent to 25.6 percent from 2015 through 2023 (Pennsylvania Health Care Cost Containment Council 2025).[8]

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 2024 and 2025 (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2024). Cost data 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 relative weights, which are based on HOPD charges adjusted to cost. To the extent that there is a difference in the cost 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 has indicated that such data should not be used to develop an ASC-specific market basket. Instead, the industry has suggested that CMS could establish an HOPD market basket and use it to update payments in both the ASC payment system and the OPPS (Ambulatory Surgery Center Association 2024).

However, the Commission has asserted that the cost structures of ASCs and HOPDs are likely very 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 most 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 2025a, Medicare Payment Advisory Commission 2018). Therefore, using an HOPD-specific market basket for ASCs would likely result in inaccurate payments.

The Commission recognizes that ASCs are small facilities, 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 2025). The State of Pennsylvania has required ASCs to submit these data since at least 2005, and that has not appeared to be a barrier to the entry of additional ASCs in the state. From 2005 to 2018, the number of ASCs in Pennsylvania rose from 153 to 242 (an average increase of 3.6 percent per year). In 2024, there were 240 ASCs. ■

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/2024/10/MedPAC_Payment_Basics_25_ASC_FINAL_SEC.pdf.

2 Total knee arthroplasty (Current Procedural Terminology (CPT) Code 27447) was first covered under the ASC payment system in 2020. About 10,800 of these procedures were provided in ASCs to FFS Medicare beneficiaries in 2020. The number of these procedures rose to 49,258 in 2024. Total shoulder arthroplasty (CPT Code 23472) was first covered under the ASC payment system in 2024, and the number of these procedures was 11,047 in that same year.

3 By statute, coinsurance for a service paid under the OPPS cannot exceed the Medicare Part A inpatient hospital deductible ($1,736 in 2026). 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 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 2024 were total knee arthroplasty and total hip arthroplasty.

4 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 called the Total Cost of Care (TCOC) Model. Under the TCOC Model, hospital budgets are capped, and they receive no additional revenue if they exceed their budgets. If a Maryland hospital shifts a surgical procedure from the hospital to an ASC, the hospital would receive an increase in its revenue. However, the Maryland system reduces the hospital's global budget by 50 percent of the Medicare payment for those services, allowing the hospital to retain the other 50 percent as continued incentive to move care to the usually lower-cost ASC setting. A study has found that this system of sharing the revenue from a shift of services from HOPDs to ASCs has had little or no effect on the extent to which hospitals make these shifts relative to the system that preceded the TCOC under which hospitals did not share the revenue from shifting services from HOPDs to ASCs (Mathematica 2024).

5 We define "single-specialty ASCs" as having more than 67 percent of their FFS Medicare claims in one clinical specialty. We define "multispecialty ASCs" as having less than 67 percent of their FFS Medicare claims in one clinical specialty.

6 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 ($1,736 in 2026), while the ASC system does not have a limit on beneficiary cost sharing.

7 The 14 procedures that were removed from the IPO list but not added to the ASC CPL are anesthesia procedure codes that are excluded from ASC payment for CY 2026 (see Addendum EE of CY 2026 OPPS/ASC final rule).

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

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