SECTION 2F

Assessing payment adequacy and updating payments for ambulatory surgical center services

RECOMMENDATIONS

2F-1 The Secretary should expedite collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system.

***YES: 16 • NO: 0 • NOT VOTING: 0 • ABSENT: 1**

2F-2 The Congress should eliminate the update to payment rates for ASC services for fiscal year 2004.

YES: 15 • NO: 0 • NOT VOTING: 1 • ABSENT: 1

2F-3 Until the Secretary implements a revised ASC payment system, the Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures, after accounting for differences in the bundle of services covered.

YES: 15 • NO: 0 • NOT VOTING: 1 • ABSENT: 1

***COMMISSIONERS' VOTING RESULTS**

SECTION 2F

Section 2F: Assessing payment adequacy and updating payments for ambulatory surgical center services

In this section

- Collecting recent ASC cost data
- Assessing payment adequacy
- Accounting for cost changes in the coming year
- Update recommendation
- Variations in payment for ambulatory surgical procedures by setting

An ambulatory surgical center (ASC) is a distinct entity that exclusively furnishes outpatient surgical services. The most recent data on the cost of providing ASC services to Medicare beneficiaries are from a 1994 survey by CMS of ASCs' costs and charges. Because we lack recent data on ASCs' costs, our analysis of the adequacy of current Medicare payments for ASC services is based only on market factors, such as entry and exit of providers, changes in the volume of services, and providers' access to capital. Through our analysis of these factors, we find that current payments for ASC services are more than adequate. There has been rapid growth in the number of ASCs; between 1991 and 2001, the number of Medicare-certified ASCs more than doubled. The volume of procedures provided by ASCs to beneficiaries increased by over 60 percent between 1997 and 2001. In addition, ASCs have sufficient access to capital. We estimate that ASCs' per-service costs will increase during the coming year at the rate of inflation in input prices, less an adjustment for expected productivity growth. Current Medicare payments for ASC services are at least adequate to cover this estimated increase in unit cost. The Commission is concerned that the existence of ASC payment rates that exceed hospital outpatient department rates for the same procedures could create financial incentives to shift services between settings.

Background

Since 1982, Medicare has covered the facility costs of certain surgical procedures provided in freestanding or hospital owned and operated ambulatory surgical centers (ASCs). An ASC is a distinct entity that exclusively furnishes outpatient surgical services. The procedures that are eligible for Medicare payment when provided in an ASC are also furnished to Medicare beneficiaries in inpatient and outpatient hospital settings, and sometimes in physician offices. In 2001, ASCs provided almost 3 million surgical procedures to Medicare beneficiaries and received about $1.6 billion in related payments. Medicare accounts for 20 to 30 percent of revenues received by the largest for-profit ASC chains.

To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage for ASCs, which require compliance with state licensure law and specify minimum standards for: administration of anesthesia, quality evaluation, operating and recovery rooms, the medical staff, nursing services, and other areas. ASCs are deemed to be in compliance with the conditions of coverage if they are licensed by a state agency or accredited by a private accreditation body.[1] Most Medicare-certified ASCs are for-profit, freestanding (as opposed to hospital owned and operated) facilities located in urban areas (Table 2F-1). Almost 40 percent of Medicare-certified ASCs are concentrated in four states that account for 25 percent of beneficiaries: California, Florida, Maryland, and Texas (Figure 2F-1).

ASC procedures eligible for Medicare payment

The Centers for Medicare & Medicaid Services maintains a list of surgical procedures eligible for Medicare facility payment when performed in an ASC. CMS is required by law to update the list every two years in consultation with appropriate medical organizations. Since 1995, however, with the exception of updates resulting from coding changes, the list has not been modified. The most common categories of procedures furnished to Medicare beneficiaries in ASCs in 2001 were cataract removal/lens insertion, colonoscopy, and other eye procedures (Table 2F-2, p. 138).[2]

Surgical procedures must meet several criteria to be added to the list of procedures eligible for Medicare payment when performed in an ASC:

- **Site-of-service volume.** Procedures must meet two site-of-service volume standards to be added to the list: (1) The procedure must be performed in hospital inpatient settings at least 20 percent of the time but can also be

TABLE 2F-1

Characteristics of Medicare-certified ambulatory surgical centers, 1991–2001

	1991	1996	1997	1998	1999	2000	2001
Number of facilities	1,460	2,265	2,462	2,644	2,786	3,028	3,371
New facilities			237	228	162	295	446
Exiting and merged facilities			40	46	20	53	103
Net percent growth from previous year			8.7%	7.4%	5.4%	8.7%	11.3%
	Percent of all centers						
For profit	94%	93%	93%	94%	94%	94%	94%
Nonprofit	6	6	6	6	6	6	5
Freestanding	99	99	99	99	99	99	99
Hospital owned and operated	1	1	1	1	1	1	1
Urban, in MSA	88	90	90	89	89	88	88
Rural	12	10	10	11	11	12	12

Note: MSA (metropolitan statistical area, as defined by the Office of Management and Budget).

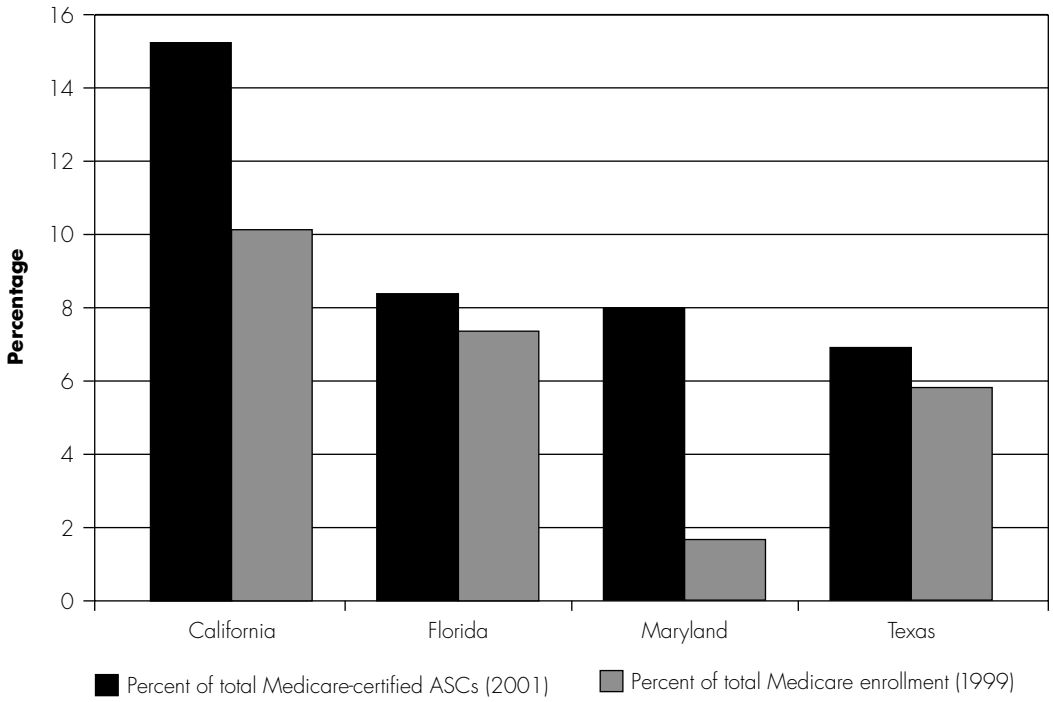
Source: MedPAC analysis of provider of services file from CMS.

1 If an ASC is privately accredited, it must still comply with state licensure requirements. The Centers for Medicare & Medicaid Services has approved four private accreditors: the American Association for Accreditation of Ambulatory Surgical Facilities, the Accreditation Association for Ambulatory Health Care, the American Osteopathic Association, and the Joint Commission on Accreditation of Healthcare Organizations.

2 These procedure categories are based on CMS's Berenson-Eggers Type of Service classification scheme, which groups several related procedures in each category. The category of other eye procedures includes after cataract laser surgery (Healthcare Common Procedure Coding System (HCPCS) code 66821).

FIGURE 2F-1

States with the most Medicare-certified ASCs, 2001



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of provider of services file from CMS and Health Care Financing Administration, Department of Health and Human Services. Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2000. Baltimore (MD), HCFA. June 2001.

safely performed in outpatient facilities. (2) The procedure can not be performed more than 50 percent of the time in physician offices (procedures usually provided in physician offices are generally assumed not to require the more elaborate facilities of an ASC).[3]

- **Time needed to perform procedure.** To be payable by Medicare in an ASC, a procedure must not exceed 90 minutes of surgery or 4 hours of recovery time; anesthesia for the procedure cannot last longer than 90 minutes.
- **Clinical criteria.** A procedure is excluded from Medicare payment in an ASC if it (1) generally results in extensive blood loss, (2) requires major or prolonged invasion of body cavities, (3) directly involves major blood vessels, or (4) is generally emergent or life-threatening in nature.

In 1998, CMS proposed revising its criteria for determining which procedures are eligible for Medicare facility payment when provided in an ASC and expanding the list of procedures approved for payment (Health Care Financing Administration 1998). CMS proposed eliminating the surgery, anesthesia, and recovery time limits but continuing to use specific clinical standards for determining whether a procedure could safely be performed in an ASC. CMS also proposed eliminating site-of-service volume as a principal criterion of approval for the ASC list but proposed continuing to consider it as one of the factors in the approval process. This change would have allowed procedures that are frequently performed in physician offices to be considered for addition to the ASC list. Thus, it could have led to the shift of some procedures to ASCs from the physician office setting, where the practice expense fee is generally less than the ASC facility fee. CMS has been planning to release a partial final rule that would update the ASC list (but not modify the criteria for determining eligibility for the list) in early 2003 (Scully 2002). Expanding the list of procedures payable by Medicare in ASCs would likely increase the volume of procedures provided to beneficiaries in ASCs.

3 There are different site-of-service criteria applied to procedures that are already on the list of services eligible for Medicare payment. To remain on the list, procedures must have combined inpatient, hospital outpatient, and ASC volume greater than 46 percent, physician office volume of less than 50 percent, and inpatient hospital volume of greater than 10 percent (Health Care Financing Administration 1998).

TABLE 2F-2

Most common categories of procedures provided to Medicare beneficiaries in ASCs, 2001

Procedure category	Volume (as percent of total)	Medicare payments (as percent of total)	Medicare payments (millions)
Cataract removal/lens insertion	29.1%	49.5%	$799
Colonoscopy	18.0	13.4	217
Other eye procedures	12.0	9.7	156
Upper gastrointestinal endoscopy	10.1	6.6	106
Minor procedures—musculoskeletal	10.1	5.2	84
Other ambulatory procedures	4.5	3.0	48
Ambulatory procedures—musculoskeletal	3.5	2.8	42
Cystoscopy	3.1	2.0	32
Arthroscopy	1.9	1.7	27
Ambulatory procedures—skin	1.8	1.3	21
Total	94.1	95.2	$1,532

Note: ASC (ambulatory surgical center). Each category includes several procedure codes. Table does not include all procedures provided to beneficiaries in ASCs.
Other eye procedures include after cataract laser surgery.
Minor procedures—musculoskeletal include interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, tumor excision, and closed treatment of certain fractures.
Other ambulatory procedures include services such as breast biopsy, nasal polyp excision, abscess drainage, dilation of esophagus, and septoplasty.
Ambulatory procedures—musculoskeletal include services such as hammertoe operation, tendon sheath incision for finger, arthrotomy, tenotomy, and tendon repair.
Ambulatory procedures—skin include services such as skin debridement, excision of lesion, wound repair, and skin graft.

Source: MedPAC analysis of the 5 percent Standard Analytical File of ASC facility claims, 2001, and the Berenson-Eggers Type of Service classification scheme from CMS.

ASC payment system

Medicare uses a fee schedule to pay for facility services provided in an ASC, such as nursing, recovery care, anesthetics, and supplies (see Appendix A for more information on the ASC payment system). The ASC fee schedule divides procedures into nine payment groups based on similar costs.[4] For fiscal year 2003, the payment rates for these groups range from $333 to $1,399. Medicare pays for related physician services separately under the physician fee schedule.

CMS is statutorily required to conduct a survey of costs and charges for individual procedures from a sample of ASCs every five years. These data are used to revise ASC payment rates. Although the most recent cost survey was conducted in 1994, the payment rates based on this survey were never implemented because of legislative action (see discussion below). Thus, current payment rates are based on a 1986 cost survey and are probably no longer consistent with ASC costs.

Between revisions to the payment system, the payment rates generally are required to be updated annually using the consumer price index for all urban consumers (CPI–U). From fiscal year 1998 through fiscal year 2002, however, the Balanced Budget Act of 1997 (BBA) limited annual updates to the CPI–U minus 2 percentage points (but not less than zero).[5] ASC rates were updated by 3 percent for fiscal year 2003.

In 1998, CMS proposed restructuring the ASC payment system to make it more consistent with the outpatient hospital prospective payment system (PPS), which was then under development. The agency proposed replacing the 8 ASC payment groups with 105 ambulatory payment categories (APCs) that classified procedures based on cost and clinical characteristics.[6] The payment rates for the APCs would have been based on data from the 1994 cost survey.

In response to CMS's proposed rule, the Congress included a provision in the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 that required CMS to do the following:

- delay implementing the new payment system until 2002;
- phase in the payment system over four years; and
- base payment rates on cost survey data from 1999 or later.[7]

4 The highest payment group ($1,399) currently has only one code (HCPCS code 50590, Extracorporeal Shock Wave Lithotripsy). Payments have not yet been made for this procedure due to a court order (*American Lithotripsy Society v. Sullivan*) that required CMS to reconsider the payment rate. CMS is planning to add several procedures to the ASC list that will be placed in this payment group (CMS 2002).

5 The Omnibus Budget Reconciliation Act of 1993 had eliminated the annual CPI–U update for 1994 and 1995.

6 The APCs proposed for the ASC payment system were those included in the outpatient payment system proposed in 1998. Subsequently, CMS modified the APC definitions for the outpatient PPS and expanded the number of APCs.

7 In the first year of the new payment system's implementation, 25 percent of the payment would be based on the new system and 75 percent on the current system. The proportion of the payment from the new payment system would increase to 50 percent in the 2nd year of implementation, 75 percent in the 3rd year, and 100 percent in the 4th year.

As of early 2003, CMS has not conducted the new cost survey that is needed to revise the ASC payment system.

Trends in Medicare payments for ASC services

Between 1996 and 2001, Medicare payments (program spending and beneficiary cost sharing) for ASC facility services doubled while payments to physicians increased by 25 percent and payments to outpatient departments grew by 17 percent. Medicare payments to ASCs more than quadrupled between 1991 and 2001, increasing from $375 million to $1.6 billion (Figure 2F-2). Payments to ASCs are projected to increase at an average annual rate of 11 to 12 percent between 2002 and 2007.[8] Payments to ASCs were less than 1 percent of total Medicare spending in 2001.

Factors affecting growth of ASC services

In addition to Medicare payment policy (discussed in the next section), several other factors have influenced the rapid growth in Medicare payments for ASC services:

Shift of services from inpatient settings to ambulatory care settings

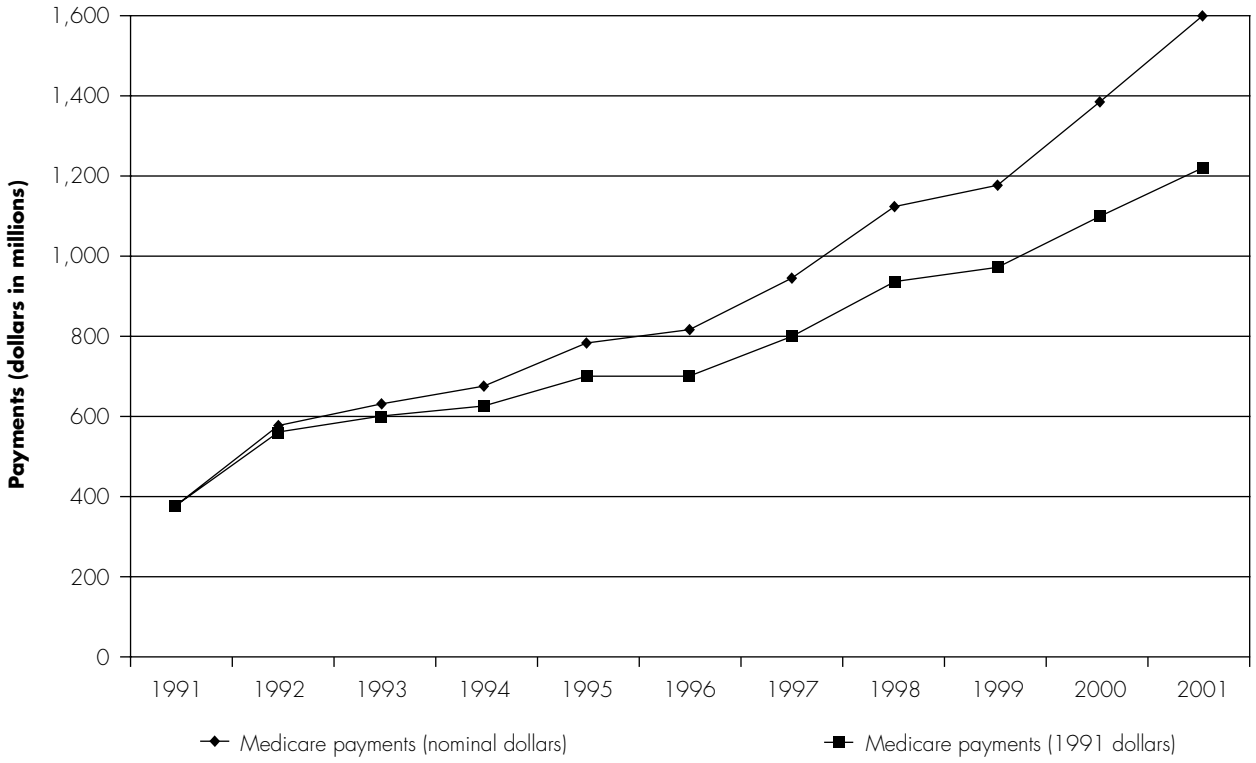
To some extent, the growth in ASC services is part of the general shift of services from inpatient hospital to ambulatory care settings. Between 1994 and 1998, several high-volume procedures that can be provided in multiple settings—such as upper gastrointestinal (GI) endoscopy, colorectal endoscopy, and arthroscopy—migrated from the inpatient setting to one or more ambulatory care settings (MedPAC 2000).

Growth in ASCs' share of ambulatory services

ASCs' share of certain ambulatory surgical procedures has been increasing in comparison to that of hospital outpatient departments and physician offices. For example, our analysis of Medicare claims data found that between 1997 and 2000,

FIGURE 2F-2

Growth in total Medicare payments for ASC services, 1991–2001



Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Average annual growth of nominal payments (1991–2001) = 15.6 percent. Average annual growth of payments in 1991 dollars (1991–2001) = 12.5 percent.

Source: CMS, Office of the Actuary.

8 This estimate is based on projections from the Congressional Budget Office's March 2002 baseline and the 2002 annual report of the Boards of Trustees of the Medicare trust funds.

ASCs' share of cataract removal/lens insertion procedures increased from 37 percent to 42 percent. ASCs' share of colonoscopies, upper GI endoscopies, and other eye procedures (such as after cataract laser surgery) also grew.

Changes in practice patterns and medical technology

Changes in clinical practice and health care technology have expanded the use of ambulatory procedures. For example, colonoscopy and upper GI endoscopic procedures, which together account for 20 percent of Medicare payments to ASCs (Table 2F-2, p. 138), have increased because of the development of flexible fiberoptic scopes and expanded Medicare coverage of colon cancer screening. The growth in cataract lens replacement, which accounts for about half of Medicare payments to ASCs, has been spurred by advances in microsurgery and ultrasound techniques and the aging of the population (MedPAC 2000).

Benefits to patients

An ASC may offer patients more convenient locations, shorter wait times, and lower coinsurance than a hospital outpatient department (20 percent in an ASC compared with up to 55 percent in an outpatient department).

Benefits to physicians

Because ASCs are specialized settings for ambulatory surgery, physicians may be able to perform procedures more efficiently than in a hospital outpatient department. For example, the surgical environment in an ASC is often customized for a specific procedure, such as cataract lens replacement. In addition, it may be easier for physicians to reserve surgical time in an ASC than an outpatient department that may be subject to unpredictable demands.

Physicians also may be able to increase their revenues by investing in ASCs. There are fewer legal restrictions on physician ownership of ASCs than on other types of health care facilities, such as clinical laboratories. The laws prohibiting physicians' referral to health care entities with which they have financial relationships (Section 1877 of the Social Security Act) do not apply to surgical services provided in an ASC (Health Care Financing Administration 2001). In addition, the Department of Health and Human Services Office of Inspector General has published safe harbor regulations that protect physicians who invest in ASCs from prosecution under the anti-kickback statute, if certain conditions are met.[9] Among other conditions, the safe harbor regulations generally protect physician investors for whom the ASC is an extension of their office practice (Office of Inspector General 1999). Physicians who invest in an ASC can receive a share of the ASC's profits that is related to their portion of the investment. The CEO of a large ASC chain has claimed that a physician's ASC revenues can "replace . . . the decline in his or her professional fee that has occurred in the last three to five years because of pressure from managed care, insurance companies, and Medicare" (Physician Compensation Report 2002).[10] However, data on the relative profitability of ASCs and the extent of physician ownership of ASCs are difficult to obtain.

Collecting recent ASC cost data

As discussed earlier, CMS is statutorily required to conduct a survey of ASCs' costs and charges every five years. These data are used to revise the ASC payment rates. However, CMS has not conducted a new cost survey since 1994. The collection of recent ASC cost data would allow the Congress and CMS to evaluate current ASC payment rates and to revise the ASC payment system. Once they are collected, MedPAC would use recent cost data to assess the adequacy of ASC payment rates.

RECOMMENDATION 2F-1

The Secretary should expedite collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system.

IMPLICATIONS 2F-1

Spending

- The collection of ASC charge and cost data would not affect Medicare benefits spending. However, the revision of ASC payment rates based on recent data would probably affect Medicare spending. Until new rates are developed, however, we are unable to project whether they would increase or decrease spending.

Beneficiary and provider

- The collection of recent charge and cost data should not affect beneficiaries. There could be small administrative costs for ASCs to provide the data to CMS.

Assessing payment adequacy

The first question in applying MedPAC's approach to evaluating payment adequacy is whether the current level of Medicare's payments for ASC services is adequate relative to providers' costs. However, there is no recent information on the cost of ASC services that would allow us to compare Medicare's payments to ASCs' costs. The revised ASC payment rates

9 The anti-kickback statute prohibits health care providers from receiving or paying anything of value to influence the referral of services covered by Federal health programs.

10 The Medicare payment changes to which this statement refers may include the phase-in of the resource-based practice expense relative value units, which ended in 2002 and reduced payment rates for surgical services, on average, and the 5.4 percent cut in physician payment rates in 2002.

proposed by CMS in 1998 (which were based on data from the 1994 ASC cost survey) would have reduced 1998 payment rates for high-volume services such as cataract-related procedures and gastrointestinal endoscopies, which suggests that 1998 payments exceeded costs for these procedures.[11] Although we lack recent data on ASC costs, information on market factors allows us to judge the adequacy of Medicare payments for ASC services. Rapid growth in the number of ASCs and the volume of procedures they provide to beneficiaries, together with ASCs' sufficient access to capital, lead us to conclude that current Medicare payments to ASCs are more than adequate.

Entry and exit of providers

Rapid growth in the number of providers furnishing services to beneficiaries may indicate that Medicare's payment rates are at least adequate and potentially too high. Conversely, rapid provider withdrawals from Medicare could suggest that rates are too low.

The number of Medicare-certified ASCs more than doubled between 1991 and 2001, from 1,460 to 3,371 (Table 2F-1, p. 136). After slowing down in 1998 and 1999, growth in the number of facilities accelerated in 2000 and 2001. Each year from 1997 through 2001, an average of over 270 new facilities entered the market, while an average of only 52 closed or merged with other facilities. Most of the new and existing ASCs are for-profit entities.

Changes in the volume of services

Large increases in the volume of services provided could indicate that payment rates are at least adequate and potentially too high, and small increases could signal unfavorable rates. The volume of procedures provided by ASCs to Medicare beneficiaries increased by over 60 percent between 1997 and 2001. This growth occurred despite annual updates to ASC payment rates of less than 1 percent between 1998 and 2002, as mandated by the BBA.

The growth in the volume of ASC procedures has paralleled increases in the number of ASCs (Figure 2F-3, p. 142). The growth in the number of facilities, volume of procedures, and Medicare payments to ASCs appears to be accelerating.

Beneficiaries' access to care

Although ASCs are growing in number, they are not available in all areas. Beneficiaries who are unable to access an ASC may receive ambulatory surgical services in a hospital outpatient department, and, in some cases, a physician's office. Thus, even though some beneficiaries do not have access to surgical services in an ASC, they can receive the same services in other settings.

Providers' access to capital

Rapid growth in the number of both independently-owned ASCs and ASCs that are part of investor-owned chains implies that they have sufficient access to capital. The relatively small start-up costs of ASCs and their quick returns on investment have made them attractive to physicians and other investors (Versel 2002).

Several ASCs acquire capital, as well as management expertise, by partnering with for-profit ASC chains. Companies that invest in or manage ASCs have increased their acquisition of new facilities and experienced strong revenue and earnings growth in the last few years. The four largest investor-owned ASC chains had a financial stake in about 13 percent of all ASC facilities in 2001. New ASC chains have recently entered the market and others are poised to follow. The stock value of at least two large chains has been growing faster than that of the overall health care industry (Borden 2002).

Although the stock value of the largest owner of ASCs has recently fallen because of factors unrelated to its ASC line of business, other ASC firms have received positive investment ratings by financial analysts over the past year.

Accounting for cost changes in the coming year

Given the information about the adequacy of the current level of Medicare payments, the next step in determining payment updates is to ask how much providers' unit costs will change in the coming year. Several factors will affect the change in the unit cost of ASC services.

The most important factor that will affect the cost of ASC services is inflation in input prices. Medicare's payment system for ASCs uses the CPI–U to approximate changes in input prices per unit of service faced by ASCs. Currently, CMS projects that the CPI–U will increase by 2.7 percent in fiscal year 2004.[12]

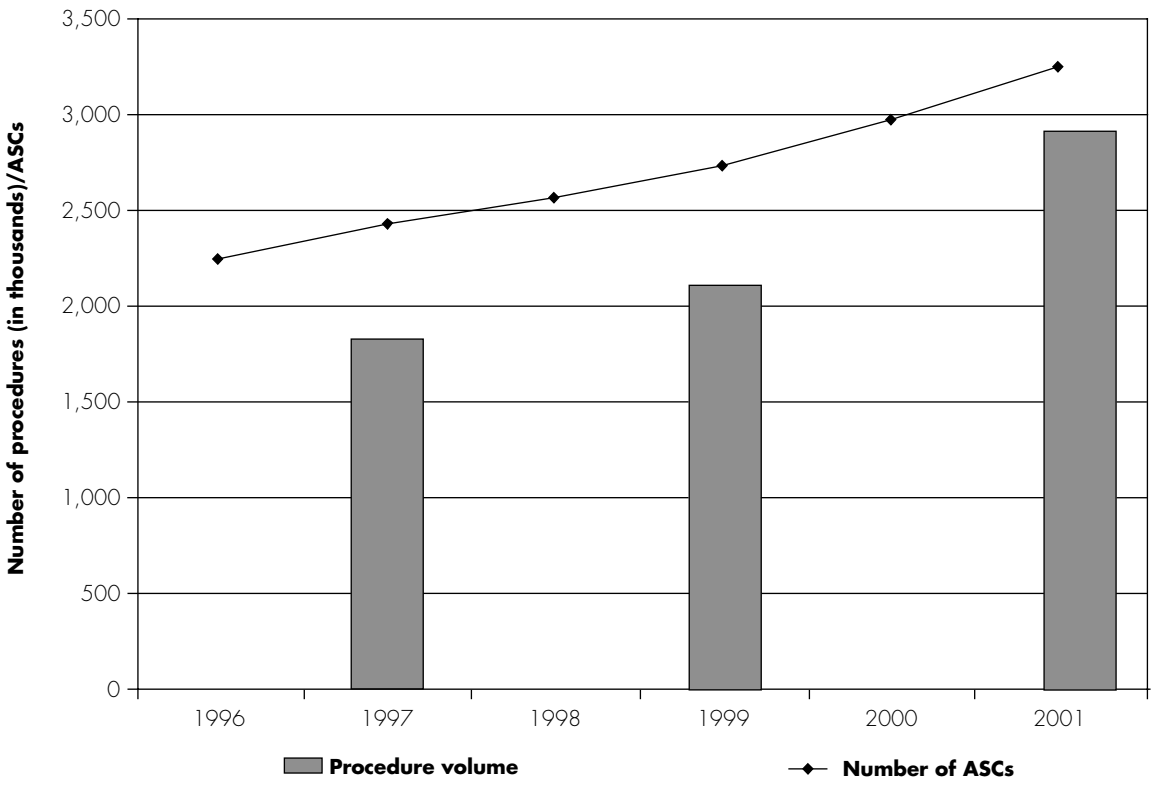
ASC costs also may increase because of scientific and technological advances that enhance the quality of care but also raise costs. The ASC payment system, unlike the hospital outpatient PPS, has no pass-through payment mechanism to account for the cost of new technologies. However, among procedures eligible for Medicare payment in an ASC, we lack evidence that the ASC payment system has created barriers to the use of new technologies. For example, procedures that use new technologies have not experienced reductions in the volume of services provided to beneficiaries. Thus, we do not make an allotment for cost increases due to scientific and technological advances when estimating ASC cost changes in the coming year. We plan to continue monitoring changes in the volume of ASC procedures associated with new technologies to ensure that

11 The revised 1998 payment rates proposed by CMS would have increased payments for several lower-volume procedures, such as arthroscopic surgery and hernia repair, which suggests that actual 1998 payment rates were less than the costs of these services.

12 This estimate is subject to revision by CMS as more recent CPI–U data become available.

FIGURE 2F-3

Growth in the number of ASCs and volume of procedures provided to Medicare beneficiaries in ASCs, 1996–2001



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of provider of services file and 5 percent Standard Analytical File of ASC facility claims from CMS.

payments are adequate to cover the cost of new technologies that enhance quality.

Productivity growth (the ratio of growth in outputs to growth in inputs) should reduce the cost of ASC services. Measuring productivity growth requires detailed information on the personnel, facilities, and other inputs used and on the quantity, quality, and mix of services (outputs) produced. Because such data are generally not available, MedPAC has adopted a policy standard for expected productivity growth that is based on growth in multifactor productivity in the national economy. The current estimate of growth in multifactor productivity from the Bureau of Labor Statistics is 0.9 percent.

By subtracting productivity growth from input price inflation (2.7 percent), it appears that the unit cost of ASC services will increase by about 1.8 percent during the coming year. We believe that current payments for ASC services are at least adequate to cover this cost increase.[13]

Update recommendation

RECOMMENDATION 2F-2

The Congress should eliminate the update to payment rates for ASC services for fiscal year 2004.

Under current law, CMS will update ASC payment rates for fiscal year 2004 by the projected increase in the CPI–U. Our analysis of ASC market factors suggests that current Medicare payments for ASC services are more than adequate and should be at least adequate to cover the expected increase in ASC costs in fiscal year 2004. Thus, we conclude that no update to ASC payment rates is necessary for next year.

IMPLICATIONS 2F-2

Spending

- Because this recommendation would eliminate the current law update to ASC payment rates for fiscal year 2004, we estimate that it would reduce payments by less than $50

13 Even if we were to assume that ASCs' input prices per unit of service will increase by the hospital market basket (projected to increase by 3.5 percent in fiscal year 2004), we believe that current payments for ASC services are at least adequate to cover this cost increase.

million in the first year and by less than $250 million over 5 years.

Beneficiary and provider

- Because current Medicare payments for ASC services are more than adequate, we do not expect that this recommendation would reduce ASCs' ability to provide ambulatory surgical services to beneficiaries.

Variations in payment for ambulatory surgical procedures by setting

Procedures payable by Medicare when provided in ASCs are also performed in hospital outpatient departments and, in some cases, physician offices. As discussed in the accompanying text box, many other ambulatory services can be provided in multiple settings (see text box, p. 144). Generally, Medicare facility payment rates for the same surgical procedure vary depending on the site of care. For example, ASCs and hospital outpatient departments receive different payment rates for the same surgical procedures. The 2003 ASC payment rate exceeds the 2003 outpatient department rate for 13 percent of the procedure codes for which ASCs received Medicare payments in 2001.[14] These codes accounted for 35 percent of Medicare payments to ASCs in 2001. ASC rates are higher than outpatient department rates for 8 of the 10 procedure codes with the highest share of Medicare payments to ASCs (Table 2F-3). However, the ASC rate is lower than the hospital outpatient rate for cataract removal/lens insertion, the procedure that accounted for the largest share (half) of Medicare payment to ASCs in 2001.

Payment differences may reflect underlying cost differences among settings, such as levels of staffing or the mix of patients, or they may be due to the historical development of each payment system. If payment variations are due to factors other than differences in underlying costs, there could be financial incentives to shift services between settings, which might increase costs to the program and beneficiaries.

Although ASCs receive higher payment rates than outpatient departments for certain procedures, it does not appear that ASCs incur higher costs, on average, than outpatient departments for these procedures. In fact, outpatient departments are probably more costly than ASCs for similar procedures because they must meet additional regulatory requirements and treat patients who are more medically complex. Unlike ASCs, hospitals are subject to the Emergency Medical Treatment and Active Labor Act, which requires outpatient departments to stabilize and transfer patients who believe they are experiencing a medical emergency, regardless of their ability to pay. In addition, Medicare's conditions of participation for hospitals require them to comply with patients' rights requirements, such as establishing a patient complaint process, and to implement quality improvement programs (CMS 2003). Medicare's conditions of coverage for ASCs, which have not been updated since

TABLE 2F-3

Hospital outpatient department and ASC payment rates for ambulatory surgery services, 2003

Procedure code	Description	Hospital outpatient rate	ASC rate	Percent difference	Share of Medicare payments to ASCs, 2001
66984	Cataract removal/lens insertion	$1,160	$973	–19%	49%
66821	After cataract laser surgery	246	446	81	7
45378	Colonoscopy, diagnostic	413	446	8	5
43239	Upper gastrointestinal endoscopy, biopsy	387	446	15	5
45385	Colonoscopy with removal of lesion by snare	413	446	8	3
62311	Epidural injection, lumbar or sacral	250	333	33	3
45380	Colonoscopy with biopsy	413	446	8	2
45384	Colonoscopy with removal of lesion by forceps	413	446	8	2
43235	Upper gastrointestinal endoscopy, diagnostic	387	333	–14	1
52000	Cystoscopy	329	333	1	1

Note: ASC (ambulatory surgical center). Procedures are arranged by share of Medicare payments to ASCs in 2001, from highest to lowest.

Source: CMS, program memo on update of rates and wage index for ambulatory surgical center payments effective October 1, 2002 (AB–02–124); CMS, Final rule: Medicare program; changes to the hospital outpatient prospective payment system and calendar year 2003 payment rates (CMS–1206–FC).

14 These figures are based on MedPAC's analysis of 2003 ASC and hospital outpatient payment rates and the 5 percent Standard Analytical File of ASC facility claims, 2001, from CMS.

Medicare payments for services provided in multiple settings: a larger issue

In addition to ambulatory surgical services, many other ambulatory services—including clinic visits, many diagnostic tests, and some therapies—can also be provided in multiple settings. The proliferation of settings that provide similar services can improve access to care for beneficiaries. Medicare should strive to ensure that clinical considerations, rather than financial incentives, drive decisions about the setting in which care is delivered.

What are some payment differences by setting?
Medicare payment differences by setting do not consistently favor one setting over another. For example, in 2002, the practice expense payment to a physician for a magnetic resonance imaging (MRI) of the brain was $403, whereas a hospital outpatient department was paid $365 for the same service.[1] In 2002, the practice expense payment for a low-level clinic visit in a physician's office was $25, while the hospital outpatient department facility fee for the same visit was $54.[2] Hospital outpatient department payment rates for chemotherapy drugs, which are based on hospitals' reported costs, are lower than payment rates for chemotherapy drugs delivered in physician offices and clinics (which are based on 95 percent of the drug's average wholesale price).

Do payment policies influence the setting and organization of care?
Payment differences may affect providers' decisions regarding which organizational structures to adopt and which services to provide in a given setting. Differences in payment that are driven by differences in the cost of providing a service should not influence these decisions. However, differences in payment that affect the profitability of providing a specific service in one setting versus another may do so. Fully assessing the impact of payment differences on how care is organized and where it is delivered requires a better understanding of the costs of providing care in each setting, the types of patients who receive care in each setting, and how physicians and beneficiaries decide where care is received.

How is the provision of services changing?
In recent years, settings that specialize in certain services have grown. For example:

- The number of ambulatory surgical centers, which often specialize in particular surgical procedures, doubled between 1991 and 2001 (MedPAC analysis of provider of services file from CMS).

- Single-speciality hospitals, which provide both inpatient and outpatient care, are emerging for cardiac care, orthopedics, and cancer care (Hospitals and Health Networks 2002).

- Providers are also developing specialized ambulatory facilities for oncology and cardiac care (Devers et al. 2001).

The growth of specialized settings could be driven by the higher profitability of certain services in one setting versus another or by providers' desire to specialize in higher profit services within a setting (such as cardiac care in an inpatient hospital). Particular services have shifted from one setting to another. For example, a recent MedPAC analysis shows that a number of more sophisticated services, including MRI, radiation therapy, and many cardiac services, are increasingly provided in physicians' offices or clinics rather than hospitals' outpatient departments.[3]

What are the implications for patient care?
A better understanding of the quality of care provided in alternative settings—including safety, regulatory oversight, and clinical considerations—is needed. Existing clinical guidelines typically do not address the site of care. Original research is required to develop the tools necessary to determine what impact the setting of care may have on quality and outcomes. ■

1 The practice expense payment accounts for the cost of office-based resources used in providing the service.

2 These are payments for Healthcare Common Procedure Coding System (HCPCS) code 70551, MRI of brain without contrast, and HCPCS code 99213, office/outpatient visit, established patient.

3 MedPAC analysis of the 5 percent Standard Analytical File, 1999 and 2000, from CMS.

1982, do not contain these requirements (Office of Inspector General 2002).[15]

By comparing the characteristics of patients who received similar procedures in ASCs or hospital outpatient departments, we found that outpatient departments serve patients who are more medically complex than ASCs. It is probably more costly to provide surgical procedures to patients with more health problems. For example, patients in worse health may require additional monitoring during the surgery and recovery period. We first compared the average risk scores of patients who received similar procedures in an ASC or outpatient department in 1999.[16] The risk scores represent beneficiaries' expected service use given their health status, relative to that of the national average beneficiary. Expected use is based on the beneficiary's risk category, which reflects age, sex, and diagnoses from hospital inpatient, hospital outpatient, and physician visits during the previous year (1998), and on the national average historical spending per beneficiary in each risk category.

Because outpatient departments are more likely than ASCs to perform services such as cardiovascular procedures that are associated with higher-risk patients, it is important to control for the type of surgical procedure provided when comparing risk scores between settings. Thus, we calculated average risk scores for patients who received similar types of procedures, such as cataract removal or colonoscopy. For the 10 categories of procedures with the highest share of Medicare payments to ASCs, patients who were treated in outpatient departments had somewhat higher average risk scores than ASC patients (Table 2F-4).

We also compared average total Medicare payments for all services for beneficiaries who received similar procedures in ASCs and hospital outpatient departments in 1999. Total payments represent health care use and could reflect beneficiaries' health status: Use of services should increase as health status declines.

TABLE 2F-4

Average risk scores for Medicare beneficiaries receiving surgical procedures in ASCs and outpatient departments, 1999

Procedure category	Average risk score for beneficiaries in ASCs	Average risk score for beneficiaries in Outpatient departments	Percent difference	Share of Medicare payments to ASCs, 1999
Cataract removal/lens insertion	1.25	1.28	2%	54%
Other eye procedures	1.31	1.37	5	11
Colonoscopy	1.15	1.22	6	11
Other ambulatory procedures	1.33	1.38	4	7
Upper gastrointestinal endoscopy	1.32	1.44	9	6
Ambulatory procedures—musculoskeletal	1.09	1.22	12	3
Cystoscopy	1.43	1.50	5	2
Ambulatory procedures—skin	1.45	2.26	56	1
Arthroscopy	0.90	0.99	10	1
Minor procedures—other	1.58	1.73	9	1

Note: ASCs (ambulatory surgical centers). Procedure categories are based on CMS's Berenson-Eggers Type of Service classification scheme.
Each category includes several procedure codes. This table includes the 10 procedure categories with the highest share of Medicare payments to ASCs in 1999. These categories accounted for 97 percent of payments to ASCs in 1999. This analysis includes only procedures that were payable by Medicare in ASCs in 1999.
Risk scores are based on the hierarchical condition category risk adjustment model, which predicts beneficiaries' expected service use in 1999, given their health status, relative to that of the average beneficiary. Expected use is based on each beneficiary's age, sex, and diagnoses from inpatient, outpatient, and physician visits in 1998. The risk score differences between settings are statistically significant (1 percent level). The average risk score across all Medicare beneficiaries is 1.0.
Other eye procedures include after cataract laser surgery.
Other ambulatory procedures include interventional pain management procedures (such as epidural injection and facet joint block), dilation of esophagus, and septoplasty.
Ambulatory procedures—musculoskeletal include services such as hammertoe operation, tendon sheath incision for finger, arthrotomy, tenotomy, and tendon repair.
Ambulatory procedures—skin include services such as skin debridement, excision of lesion, wound repair, and skin graft.
Minor procedures—other include certain nasal, oral, urological, and nerve procedures.

Source: MedPAC analysis of the 5 percent Standard Analytic File of Medicare claims, 1998 and 1999, from CMS, and CMS's Berenson-Eggers Type of Service classification scheme.

15 Medicare's conditions of coverage for ASCs require them to assess and maintain the quality of care they provide, which is less stringent than the requirement for hospitals to conduct specific performance improvement projects.

16 The risk scores were derived from the hierarchical condition category risk adjustment model.

However, health care use also could be affected by other factors, such as variations in supplemental coverage, access to providers, and regional practice patterns. Total Medicare payments include both Medicare spending and beneficiary cost sharing for all services used by the beneficiary, including inpatient, ambulatory, and post-acute care. We controlled for geographic adjustments to payment rates by using nationally standardized rates. As with our analysis of risk scores, we controlled for the different mix of services in each setting by separately calculating average total payments for beneficiaries who received services in each category of procedures.

For each of the 10 categories of procedures with the highest share of Medicare payments to ASCs, beneficiaries who received care in outpatient departments had substantially higher total service use than patients who were treated in ASCs (Table 2F-5). These results are consistent with the results of our analysis of beneficiaries' average risk scores in each setting. Together, these studies indicate that, compared to ASCs, outpatient departments serve patients who are more medically complex.

Our comparison of regulatory requirements and patient characteristics in ASCs and outpatient departments indicates that outpatient departments are probably the more costly setting. Thus, the existence of ASC rates that are higher than hospital outpatient rates is probably not due to higher costs in the ASC setting but instead related to the separate development of the payment systems for each setting. The ASC payment system currently sets rates for 9 payment groups based on 1986 cost data, while the 2003 hospital outpatient PPS sets rates for 570 APC groups based on 2001 cost data. Because the higher payment rates for certain procedures performed in ASCs do not appear to be related to higher costs in the ASC setting, these payment variations could create financial incentives to inappropriately shift services from outpatient departments to ASCs.

RECOMMENDATION 2F-3

Until the Secretary implements a revised ASC payment system, the Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures, after accounting for differences in the bundle of services covered.

IMPLICATIONS 2F-3

Spending

- Because this recommendation would lower ASC payment rates for procedures in which the ASC rate currently exceeds the hospital outpatient PPS rate, after adjusting for differences in the bundle of services covered, we estimate that it

TABLE 2F-5

Average total Medicare payments for all services for beneficiaries receiving surgical procedures in ASCs and outpatient departments, 1999

Procedure category	Average total payments for beneficiaries in ASCs	Average total payments for beneficiaries in Outpatient departments	Percent difference	Share of Medicare payments to ASCs, 1999
Cataract removal/lens insertion	$6,948	$8,044	16%	54%
Other eye procedures	6,584	7,796	18	11
Colonoscopy	6,254	7,088	13	11
Other ambulatory procedures	8,494	11,033	30	7
Upper gastrointestinal endoscopy	8,672	10,784	24	6
Ambulatory procedures—musculoskeletal	6,236	9,410	51	3
Cystoscopy	9,508	11,194	18	2
Ambulatory procedures—skin	9,759	24,990	156	1
Arthroscopy	5,539	8,109	46	1
Minor procedures—other	10,035	12,600	26	1

Note: ASCs (ambulatory surgical centers). Procedure categories are based on CMS's Berenson-Eggers Type of Service classification scheme.
Each category includes several procedure codes. This table includes the 10 procedure categories with the highest share of Medicare payments to ASCs in 1999. These categories accounted for 97 percent of payments to ASCs in 1999. This analysis includes only procedures that were payable by Medicare in ASCs in 1999.
Total payments include both Medicare spending and beneficiary cost sharing for all services used by beneficiaries, including inpatient, physician, ambulatory, and post-acute care.
Medicare payments are based on nationally standardized payment rates.
The differences in average total payments between settings are statistically significant (1 percent level).
Other eye procedures include after cataract laser surgery.
Other ambulatory procedures include interventional pain management procedures (such as epidural injection and facet joint block), dilation of esophagus, and septoplasty.
Ambulatory procedures—musculoskeletal include services such as hammertoe operation, tendon sheath incision for finger, arthrotomy, tenotomy, and tendon repair.
Ambulatory procedures—skin include services such as skin debridement, excision of lesion, wound repair, and skin graft.
Minor procedures—other include certain nasal, oral, urological, and nerve procedures.

Source: MedPAC analysis of the 5 percent Standard Analytic File of Medicare claims, 1999, from CMS, and CMS's Berenson-Eggers Type of Service classification scheme.

TABLE 2F-6

Estimated impact of limiting ASC payment rates to hospital outpatient rates, by procedure category

Procedure category	Estimated percent reduction in 2003 ASC payments	Share of Medicare payments to ASCs, 2001	Average 2003 ASC rate (current law)	Average 2003 ASC rate (if rates limited)
Cataract removal/lens insertion	0%	50%	$971	$971
Colonoscopy	8	13	446	411
Other eye procedures	29	10	493	351
Upper gastrointestinal endoscopy	11	7	425	377
Minor procedures—musculoskeletal	19	5	335	273
Other ambulatory procedures	2	3	435	425
Ambulatory procedures—musculoskeletal	1	3	505	501
Cystoscopy	2	2	390	382
Arthroscopy	0	2	604	603
Ambulatory procedures—skin	15	1	480	410
Average across all procedures	7			

Note: ASC (ambulatory surgical center). Procedure categories are based on CMS's Berenson-Eggers Type of Service classification scheme. Each category includes several procedure codes. This table includes the 10 procedure categories with the highest share of Medicare payments to ASCs in 2001. These categories accounted for 95 percent of payments to ASCs in 2001. Average ASC rates are the average of the rates for the procedure codes in each category, weighted by each code's service volume. The estimated reductions in 2003 ASC payments assume that ASC payment rates would not exceed hospital outpatient base rates for the same procedure. The estimates do not include adjustments to account for differences in the bundle of services covered in each setting or changes in the provision of ASC services that might result from payment rate changes.
Other eye procedures include after cataract laser surgery.
Minor procedures—musculoskeletal include interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, tumor excision, and closed treatment of certain fractures.
Other ambulatory procedures include services such as breast biopsy, nasal polyp excision, abscess drainage, dilation of esophagus, and septoplasty.
Ambulatory procedures—musculoskeletal include services such as hammertoe operation, tendon sheath incision for finger, arthrotomy, tenotomy, and tendon repair.
Ambulatory procedures—skin include services such as skin debridement, excision of lesion, wound repair, and skin graft.

Source: MedPAC model based on 2003 ASC and hospital outpatient payment rates and 2001 volume of ASC services from 5 percent Standard Analytic File of ASC facility claims, 2001, from CMS.

would reduce Medicare payments by between $50 million and $200 million in the first year and between $250 million and $1 billion over 5 years. These estimates are based on comparisons of the ASC and outpatient base rates for the same procedures. They do not include adjustments to account for differences in the bundle of services covered in each setting or changes in the provision of ASC services that might result from payment rate changes.[17]

Beneficiary and provider

- We estimate that this recommendation would lower rates for about half of ASC services (weighted by the volume of services provided to beneficiaries in 2001). These procedures, which account for about 35 percent of Medicare payments to ASCs, would experience average payment reductions of 20 percent. Overall, ASC payments would be reduced by about 7 percent.
- The impact of this recommendation on individual ASCs would vary by the services offered by the facility. Table 2F-6 shows the payment impact of implementing this recommendation by procedure category. Each category includes several procedure codes. Although payments for cataract removal/lens insertion (the highest-volume category of ASC services) would not be affected, payments for other eye procedures (primarily after cataract laser surgery) would be reduced by almost 30 percent. Almost half of ASCs provide ophthalmology procedures (Table 2F-7, p. 148). Payments for gastrointestinal procedures would be reduced by about 8 to 11 percent. About 40 percent of ASCs furnish these procedures. Single-specialty ASCs providing a limited range of services for which payments are reduced would be disproportionately affected compared to multispecialty ASCs, which could spread payment reductions across a broader service

17 The estimates are from a model of ASC payments that is based on 2003 ASC and hospital outpatient PPS payment rates and 2001 ASC service volume.

line. Single-specialty and multispecialty facilities each account for roughly half of all ASCs (Federated Ambulatory Surgery Association 2002).

- Based on our analysis of payment adequacy, we do not expect ASCs to provide fewer procedures as a result of this recommendation. However, even if ASCs provide fewer ambulatory surgical services, we do not expect beneficiaries' access to these services to be reduced because they can be received in alternative settings. Reductions to ASC payment rates also would lower beneficiary cost sharing.

This recommendation refers to the total Medicare payment received by ASCs and hospital outpatient departments (the program's portion of the payment plus the beneficiary's cost sharing). Because different payment systems apply to ASCs and outpatient departments, the service bundle for the same procedure may not be equivalent in each setting. Differences in the bundle of services should be taken into account when comparing ASC and outpatient hospital payments for the same procedure. For example, if a surgical procedure does not normally require an imaging or radiology service, the procedure's payment rate in each setting will not reflect the cost of this additional service. In some cases, however, the physician performing the procedure may decide that it is clinically important to use an imaging service (such as using fluoroscopy to enhance the surgeon's field of vision). Although an outpatient department could bill Medicare for both the surgical procedure and the imaging service, an ASC is not permitted to bill separately for ancillary services, such as imaging or radiology services. Thus, an ASC that provided an imaging service in conjunction with a surgical procedure would not be separately reimbursed for its cost. Payments for services that are sometimes provided in connection with a surgical procedure but are not part of the procedure payment rate should be accounted for when comparing payment rates in ASCs and outpatient departments.

Another issue that affects the comparability of payment rates between settings is whether the cost of drugs or devices used in a procedure is part of the payment bundle. Outpatient departments may receive pass-through payments for certain new technology items, such as drugs and devices, that are used in the delivery of services (see Appendix A).[18] Pass-through payments are provided in addition to the service's base payment. ASCs do not receive pass-through payments. To the extent that new technology items are used for procedures provided in ASCs, their costs are included in the procedure payment rate and not reimbursed separately. On the other hand, ASCs can receive separate payments for prosthetic devices used in conjunction with surgical procedures, whereas outpatient departments cannot. The cost of prosthetic devices is included in the outpatient PPS base payment rate. Separate payments for items used in connection with a surgical procedure should be considered when comparing ASC and outpatient rates.

TABLE 2F-7

Distribution of ambulatory surgical centers by specialty type, 2001

Specialty type	Percent of ASCs
Ophthalmology	48%
Plastic surgery	45
Gastroenterology	40
Orthopedic	38
General surgery	35
Gynecology	35
Otolaryngology	35
Podiatry	35
Urology	28
Pain management	22

Note: ASC (ambulatory surgical center). ASCs may offer services in more than one specialty. Data include both Medicare-certified and non-Medicare-certified ASCs.

Source: SMG Marketing Group, Inc., 2002.

Because the outpatient PPS is relatively new and its payment rates have fluctuated in the last few years, there could be a concern with using these rates to set a ceiling for ASC payment rates. However, outpatient rates have recently fluctuated due to technical reasons and we expect rates to stabilize in future years.[19] The use of cost data from hospitals operating under the outpatient PPS to set outpatient rates, which was done for the first time for 2003 rates, also should enhance the stability of the system. Previously, outpatient PPS rates were based on cost data from hospitals operating under the prior, cost-based, payment system. ■

18 Most of the payments for pass-through items have been incorporated into the outpatient PPS base rates for 2003.

19 In 2002, price information from manufacturers was used to incorporate some pass-through costs into base APC rates. In 2003, hospital cost data was used to calculate all payment rates. This change in methodology generally led to lower payment rates for services using pass-through items in 2003 than in 2002. CMS took steps to limit the change in payment from 2002 to 2003.

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