SECTION 3F

Ambulatory surgical center services

RECOMMENDATIONS

3F-1 There should be no update to payment rates for ASC services for fiscal year 2005.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

3F-2 The Secretary should revise the ASC payment system so that its relative weights and procedure groups are aligned with those in the outpatient prospective payment system. In addition:

- The Congress should require the Secretary to periodically collect ASC cost data at the procedure level to monitor the adequacy of ASC rates, refine the relative weights, and develop a conversion factor that reflects the cost of ASC services.
- The Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for the same procedures, accounting for differences in the bundle of services.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

3F-3 After the ASC payment system is revised, the Congress should direct the Secretary to replace the current list of approved ASC procedures with a list of procedures that are excluded from payment based on clinical safety standards and whether the service requires an overnight stay.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

SECTION 3F

Section 3F: Ambulatory surgical center services

In this section

- Are Medicare payments adequate in 2004?
- How should Medicare payments change in 2005?
- Update recommendation
- How should the payment system be revised?
- What procedures should Medicare pay for in ambulatory surgical centers?

Current Medicare payments for ambulatory surgical center (ASC) services are at least adequate to cover the projected increase in ASCs' per service costs in the coming year, less an adjustment for productivity growth. Beneficiaries have good access to ambulatory surgical services. The supply of ASCs and the volume of ASC services received by Medicare beneficiaries have increased significantly over the last several years. In addition, ASCs have sufficient access to capital.

Recent legislation requires the Secretary to revise the ASC payment system. The Secretary should align the ASC payment system with the outpatient prospective payment system and base the conversion factor on recent ASC cost data. If necessary, the Secretary should use such data to refine the relative weights for ASC services. Medicare should pay no more for the same service in an ASC than an outpatient department (accounting for differences in the bundle of services). Physicians and beneficiaries should have more choice over where to provide and receive an ambulatory surgical procedure. However, Medicare should only pay for ambulatory surgical procedures in an ASC when they are clinically appropriate for that setting.

Background

Since 1982, Medicare has paid a facility fee for certain surgical procedures provided in ASCs. An ASC is a distinct entity that exclusively furnishes outpatient surgical services not requiring an overnight stay; it can be either freestanding or hospital owned and operated. Beneficiaries can also receive surgical services in inpatient and outpatient hospital settings, and sometimes in physician offices.

To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage for ASCs, which specify minimum standards for: administration of anesthesia, quality evaluation, operating and recovery rooms, 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 an approved private accreditation body.[1]

Medicare uses a fee schedule to pay for a bundle of facility services provided in an ASC, such as nursing, recovery care, anesthetics, and supplies. The fee schedule divides procedures into nine payment groups. As of April 1, 2004, the rates for these groups will range from $333 to $1,339. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) eliminated future increases to ASC rates and made other changes to the payment system (see text box below).

CMS implemented the current ASC payment system in 1990. Payment rates are based on data from a 1986 survey of ASCs' costs and charges, updated periodically using the consumer price index for all urban consumers (CPI–U).[2] Because they are based on old cost data, these rates are probably no longer consistent with ASCs' costs.

In addition, most of the ASC payment groups include at least 100 services, which are often clinically unrelated. The use of such broad groups makes it difficult for CMS to classify new services and increases the likelihood that many services are over- or underpaid. Due in part to delays in revising the ASC payment system, there are significant disparities between ASC and hospital outpatient department rates for many services. For example, the ASC rate exceeds the outpatient department rate for 4 of the 10 highest-volume ASC procedures.

In 2002, ASCs furnished almost 3.5 million surgical procedures to Medicare beneficiaries and received about $1.9 billion in related payments (less than 1 percent of total Medicare spending). Medicare payments to ASCs (including program spending and beneficiary cost sharing) increased by almost 17 percent in 2002 and more than tripled between 1992 and 2002 (Figure 3F-1).

In addition to the adequacy of Medicare's payments for ASC services (discussed in the next section), many factors could have influenced this rapid spending growth. For example:

Changes to the ambulatory surgical center payment system in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

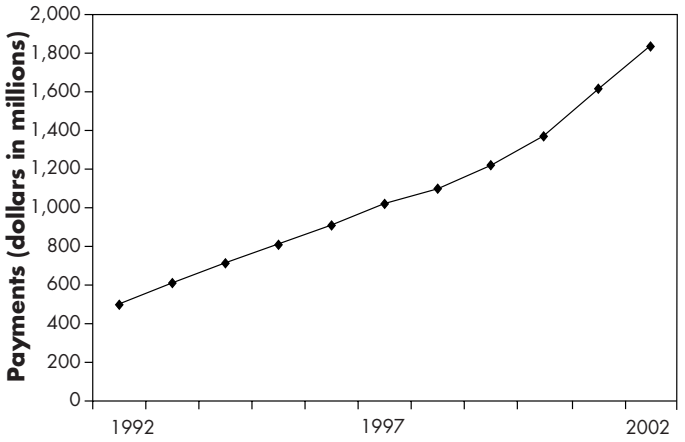
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) eliminated the payment update for ambulatory surgical center (ASC) services for fiscal year 2005, changed the update cycle to a calendar year, and eliminated the updates for calendar years 2006 through 2009. CMS had implemented a 2-percent increase to ASC payment rates for fiscal year 2004. The MMA eliminated this increase for the second half of 2004, thereby returning rates to their 2003 levels.

The MMA eliminated the provision that CMS survey ASCs' costs and charges every five years. It required the General Accounting Office (GAO) to study the relative costs of services in ASCs and hospital outpatient departments and whether the outpatient prospective payment system's (PPS's) procedure groups reflect ASC procedures. In examining these questions, the GAO should consider data submitted by ASCs. Based on its study, the GAO should recommend whether to use the outpatient PPS's procedure groups and relative weights as the basis for the ASC payment system.

The Secretary is required to implement a revised ASC payment system no earlier than January 2006 and no later than January 2008, taking into account the GAO's recommendations. Total payments under the new system should be equal to the total projected payments under the old system. ■

FIGURE 3F-1

Medicare payments to ASCs more than tripled, 1992–2002



Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing. Average annual growth of payments (1992–2002) equals 14 percent.

Source: CMS, Office of the Actuary.

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings (MedPAC 2000).
- Medicare began covering colonoscopy for colorectal cancer screening in 1998.
- ASCs may offer patients more convenient locations, the ability to schedule surgery more quickly, and shorter waiting times than hospital outpatient departments.
- Medicare beneficiaries' coinsurance is generally lower in ASCs than in outpatient departments (Table 3F-1).
- Physicians may be able to perform surgeries more efficiently in ASCs because they often have customized surgical environments and specialized staffing.
- Physicians who invest in ASCs can increase their practice revenue by receiving ASC facility payments. The federal anti-referral law does not apply to surgery services provided in ASCs, making it possible for physicians to own and provide care in these facilities (see text box, p. 200).

Are Medicare payments adequate in 2004?

We find that current Medicare payments for ASC services are at least adequate for 2004. Although we lack recent data on the cost of ASC services, we used various factors to assess the adequacy of payments: beneficiaries' access

TABLE 3F-1

ASCs have lower coinsurance than hospital outpatient departments for high-volume ambulatory surgical services, 2004

Procedure code	Description	Share of Medicare payments to ASCs, 2002	Hospital outpatient coinsurance	ASC coinsurance	Percent difference
66984	Cataract removal and lens insertion	46%	$496	$195	–61%
66821	After-cataract laser surgery	6	104	89	–15
45378	Colonoscopy, diagnostic	6	186	89	–52
43239	Upper gastrointestinal endoscopy, biopsy	5	143	89	–38
45385	Colonoscopy with removal of lesion by snare	4	186	89	–52
62311	Epidural injection, lumbar or sacral	3	76	67	–11
45380	Colonoscopy with biopsy	3	186	89	–52
45384	Colonoscopy with removal of lesion by forceps	2	186	89	–52
52000	Cystoscopy	1	105	67	–36
G0121	Colonoscopy, cancer screening	1	101	89	–12

Note: ASC (ambulatory surgical center). Procedures are arranged by share of Medicare payments to ASCs in 2002, from highest to lowest. Hospital outpatient coinsurance amounts shown here range from 25% to 41% of total payment rates under the outpatient prospective payment system; coinsurance will decline slowly over time until reaching 20% of total outpatient rates. ASC coinsurance amounts equal 20% of national average ASC rates, as of April 1, 2004. Beginning April 1, ASC rates will be reduced to fiscal year 2003 levels, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Source: CMS 2003a, CMS 2003b.

to care, changes in the supply of facilities, changes in the volume of services, and ASCs' access to capital. Medicare accounts for a relatively high share of overall volume for services in which many ASCs specialize (such as eye procedures and colonoscopy), and the volume of these services provided to beneficiaries has grown rapidly.

Beneficiaries' access to care

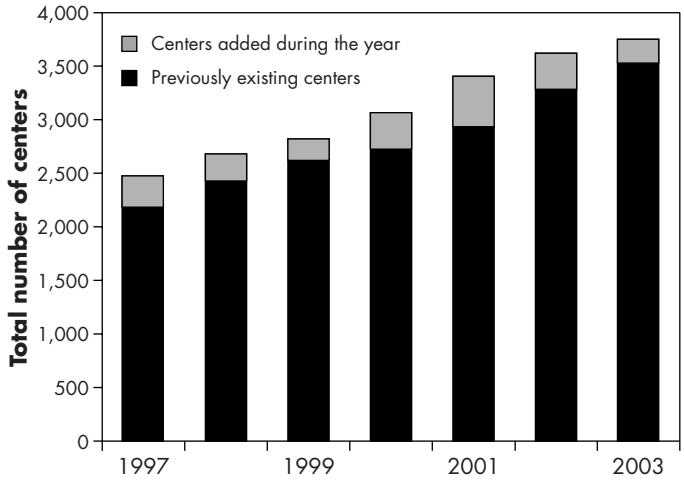
Beneficiaries have adequate access to ambulatory surgical services—whether in an ASC, hospital outpatient department, or physician office. Although we lack direct measures of beneficiaries' access to ASCs, indirect indicators, such as an increase in the number of facilities and the volume of services they provide, suggest that access to ASCs is growing. The number of ASCs has significantly expanded over the last several years (Figure 3F-2). In addition, the number of beneficiaries receiving ASC services increased by 14.5 percent per year, on average, between 1998 and 2002 (Table 3F-2). Despite this strong growth, ASCs tend to be concentrated in specific states and are not available in all areas (see discussion below). Beneficiaries who do not have access to an ASC may receive ambulatory surgical services in a hospital outpatient department and, in some cases, a physician office. Thus, even though some beneficiaries do not have access to surgical services in an ASC, they can obtain these services in other settings.

Changes in the supply of ASCs

The supply of ASCs has increased significantly over the last several years: Although the number of operating rooms per ASC stayed constant at 2.5 between 1997 and 2002, the number of ASCs grew rapidly. Rapid growth in the number of providers may indicate that Medicare's payment rates are at least adequate. However, Medicare is not the dominant payer for ASC services; according to a recent industry survey, Medicare payments account for 25 to 30 percent of revenue for the typical ASC (Federated Ambulatory Surgery Association 2003). On the other hand, Medicare accounts for a high share of overall volume for ASCs that specialize in ophthalmology services.

As of June 2003, 3,735 ASCs met Medicare's conditions of coverage.[3] The number of ASCs grew at an average annual rate of 8 percent from 1997 through the first half of 2003. Each year from 1997 through 2002, an average of 279 new Medicare-certified facilities entered the market, while an average of 58 closed or merged with other facilities. As of 2002, over 40 percent of ASCs were concentrated in five states—California, Maryland, Florida, Texas, and Washington—that accounted for 26 percent of beneficiaries.[4] Five states had fewer than 10 ASCs: Alaska, Hawaii, Rhode Island, Vermont, and West Virginia.

FIGURE 3F-2 **Number of Medicare-certified ASCs increased over 50 percent, 1997–2003**



Note: ASC (ambulatory surgical center). For 2003, data are through June. For all other years, data are through December.

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

TABLE 3F-2 **The volume of surgical services grew faster in ASCs than in hospital outpatient departments**

	Average annual change, 1998–2002	
Measure	**ASCs**	**Outpatient departments**
Number of services provided to Medicare beneficiaries	15.0%	1.7%
Number of beneficiaries served	14.5	4.8
Services per beneficiary	0.4	–3.0

Note: ASC (ambulatory surgical center). To ensure comparability, we analyzed the volume of the same set of ambulatory surgical services in each setting by selecting only those services that are payable by Medicare when provided in an ASC. Services per beneficiary is the change in the total number of ambulatory surgical services provided in each setting divided by the number of beneficiaries who received surgical services in each setting.

Source: MedPAC analysis of the 5 percent Standard Analytic files of ASC and hospital outpatient department claims from CMS.

TABLE 3F-3

Most ASCs are for profit, freestanding, and urban

ASC type	1998	2000	2002
For profit	94%	94%	95%
Nonprofit	6	6	5
Freestanding	99	99	99
Hospital owned and operated	1	1	1
Urban	89	88	87
Rural	11	12	13

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of the Provider of Services file from CMS.

TABLE 3F-4

Over half of Medicare-certified high-volume ASCs specialize in ophthalmology or gastroenterology procedures, 2002

Specialty type	Number of high-volume ASCs	Percent of high-volume ASCs	Percent of 2002 Medicare payments to all ASCs
Single-specialty			
Ophthalmology	393	34%	31%
Gastroenterology	212	18	9
Urology	23	2	1
Pain management	22	2	1
General	499	43	27
Total	1,149	100	68

Note: ASC (ambulatory surgical center). To select high-volume ASCs, we arrayed facilities by the number of claims they submitted in 2002. High-volume facilities are those in the top quartile of this distribution (submitted at least 1,000 claims). Except for pain management and general, specialty type is the specialty of the physicians who performed procedures accounting for at least 90 percent of Medicare payments to the ASC. For pain management ASCs, at least 90 percent of Medicare payments were for an interventional pain management procedure, such as epidural injection or facet joint block. General ASCs are all other high-volume ASCs.

Source: MedPAC analysis of the 5 percent Standard Analytic file of ASC and physician claims from CMS.

The composition of the ASC market has not changed over the last five years (Table 3F-3). Most Medicare-certified ASCs are for profit, freestanding (as opposed to hospital-owned and -operated) facilities and are located in urban areas.

Over half of high-volume, Medicare-certified ASCs specialized in a narrow range of procedures in 2002: About one-third specialized in ophthalmology services and almost 20 percent focused on gastroenterology services (Table 3F-4).[5] We lack data on changes in the number of single-specialty ASCs over time.

Does Medicare's share of overall facility volume vary by type of ASC? CMS's 1994 survey of ASCs' costs and charges is the most recent source of volume data at the procedure level for a representative sample of the market. Unfortunately, these data are old; but they indicate that Medicare accounted for a large share of the volume for several services in which ASCs specialize. Medicare accounted for about 75 percent of the overall volume of ophthalmology procedures, 45 percent of colonoscopy volume, and 40 percent of upper gastrointestinal endoscopy volume, compared to 40 percent of volume for all services payable by Medicare in an ASC.[6]

Changes in the volume of services

The volume of ASC services received by Medicare beneficiaries has grown rapidly over the last several years, which could indicate that payment rates are at least adequate. From 1998 to 2002, the number of procedures provided by ASCs increased by 75 percent (15 percent per year, on average), largely driven by growth in the number of beneficiaries served (Table 3F-2). This growth occurred despite increases to ASC rates of less than 1 percent per year during this period. The volume of ASC services grew by 18.2 percent from 2001 to 2002, with the following types of procedures experiencing the fastest growth: minor musculoskeletal procedures (28.9 percent), colonoscopy (27.8 percent), and upper gastrointestinal endoscopy (20.1 percent) (Table 3F-5, p. 190).[7]

Ambulatory surgical procedures have grown at a faster rate in ASCs than in outpatient departments. The number of surgical services provided by outpatient departments grew at an average annual rate of 1.7 percent from 1998 to 2002, while these services increased by 15.0 percent per year in ASCs over the same period (Table 3F-2).[8] As will be discussed later, there are significant disparities between ASC and outpatient department payment rates for many services.

ASCs' access to capital

Several indicators suggest that ASCs have sufficient access to capital. Owners of ASCs require capital to

TABLE 3F-5

Ophthalmology and gastroenterology procedures accounted for over two-thirds of ASC services provided to Medicare beneficiaries, 2002

Type of procedure	Medicare volume (as percent of total volume)	Medicare payments (as percent of total)	Medicare payments (millions)	Percent volume growth, 2001–2002
Cataract removal and lens insertion	27.4%	47.5%	$904	11.5%
Colonoscopy	19.5	14.8	282	27.8
Other eye procedures	11.3	9.3	176	10.9
Minor procedures–musculoskeletal	11.0	5.8	111	28.9
Upper gastrointestinal endoscopy	10.3	6.7	128	20.1
Other ambulatory procedures	4.5	3.0	56	17.9
Ambulatory procedures–musculoskeletal	3.5	2.6	50	18.8
Cystoscopy	2.8	1.9	36	9.6
Ambulatory procedures–skin	1.6	1.2	24	9.7
Arthroscopy	1.6	1.5	29	–0.2
Other services	6.5	5.6	106	29.0
Total	100.0	100.0	1,902	18.2

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing. Other eye procedures includes after-cataract laser surgery. Minor procedures–musculoskeletal includes interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision. Other ambulatory procedures includes breast biopsy, nasal polyp excision, abscess drainage, nerve graft, and ear surgery. Ambulatory procedures–musculoskeletal includes hammertoe operation, arthrotomy, tenotomy, and tendon repair. Ambulatory procedures–skin includes skin debridement, excision of lesion, wound repair, and skin graft.

Source: MedPAC analysis of the 5 percent Standard Analytic file of ASC claims from CMS, 2001 and 2002, and the Berenson-Eggers Type of Service classification scheme from CMS.

establish and upgrade their facilities. Because Medicare is not the dominant payer for ASC services, however, access to capital might not be a strong indicator of the adequacy of Medicare payments.

The best evidence of ASCs' access to capital is the rapid growth in the number of Medicare-certified centers over the last five years (Figure 3F-2). The ASC market is fragmented; according to an industry survey, about 12 percent of ASCs are owned or co-owned by the four largest companies (SMG Marketing Group, Inc. 2002). Most ASCs are independently owned by local investors who obtain capital through bank loans or by forming joint ventures with local physicians or hospitals. Some ASCs acquire capital and management expertise by partnering with larger, for-profit corporations. Although most corporations that own shares of ASCs also invest in hospitals and other health care facilities, some companies invest primarily in ASCs.

The financial performance of companies that own many ASCs provides additional evidence of ASCs' access to capital. Revenues for one of the large, publicly traded firms that specialize in ASCs grew by 24 percent during 2002 and were projected to grow 20 percent during 2003 (Standard & Poor's 2003). Medicare payments accounted for 40 percent of this company's revenue. This firm's stock price increased by over 90 percent during 2003, compared with 22 percent growth in the Standard & Poor's index of the 500 largest U.S. companies. Another large, investor-owned ASC chain experienced revenue growth of 40 percent during 2002; Medicare payments accounted for 10 percent of this firm's U.S. revenues (Standard & Poor's 2003). This firm's stock price increased by 120 percent during 2003.

How should Medicare payments change in 2005?

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' costs per unit of service (unit costs) will change in the coming year. The Commission concludes that Medicare payment rates for ASC services should stay the same for fiscal year 2005.

Factors for the update decision

Several factors could affect the change in the unit cost of ASC services:

- inflation in input prices,
- technological advances that enhance the quality of care and raise costs, and
- productivity growth.

Medicare's payment system for ASCs uses the CPI–U to estimate expected changes in input prices per unit of service that ASCs face. The CPI–U is currently projected to increase by 2.4 percent in fiscal year 2005.[9]

ASCs' costs also may increase if they adopt scientific and technological advances that enhance the quality of care but also raise costs. The ASC payment system, unlike the hospital outpatient prospective payment system (PPS), has no pass-through payment mechanism to explicitly cover the costs of new technologies (Section 3A provides more information on this feature of the outpatient PPS). However, the ASC payment system provides separate payments for some new devices:

- Medicare pays an additional amount to ASCs—currently $50—for new types of intraocular lenses that meet certain criteria. These lenses are used in cataract removal and lens insertion surgeries.
- ASCs can bill Medicare separately for the cost of some prosthetic devices—including some new devices—implanted during surgery.[10]

The volume of many procedures that are likely to incorporate new technologies (such as colonoscopy and cataract surgery) grew rapidly between 2001 and 2002 (Table 3F-5). This growth suggests that the ASC payment system does not inhibit the diffusion of new technologies. Thus, we do not make an allowance for cost increases due to technological advances when estimating ASC cost changes in the coming year.

The Commission believes that Medicare's payment systems should encourage efficiency and that providers should be able to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. MedPAC encourages efficiency primarily by including an adjustment for productivity when accounting for providers' cost changes in the coming year. MedPAC's productivity factor is a 10-year rolling average of the Bureau of Labor Statistics' estimate of economy-wide, multifactor productivity growth, which is currently estimated at 0.9 percent. Subtracting productivity growth from projected input price inflation results in a projected increase of 1.5 percent in the unit cost of ASC services during the coming year.

Update recommendation

RECOMMENDATION 3F-1

There should be no update to payment rates for ASC services for fiscal year 2005.

RATIONALE 3F-1

Based on the following evidence, we believe that current payments for ASC services are at least adequate to cover the projected 1.5 percent increase in ASCs' costs in 2005:

- Beneficiaries have good access to ambulatory surgical services.
- The number of ASCs has grown rapidly over the last five years.
- The volume of services provided by ASCs to beneficiaries increased by 75 percent from 1998 to 2002, despite annual payment rate updates of less than 1 percent during that period.
- ASCs have sufficient access to capital.

IMPLICATIONS 3F-1

Spending

Because this recommendation is consistent with current law, it would have no spending implications.

Beneficiary and provider

Because we conclude that current Medicare payments for ASC services are at least adequate to cover next year's projected increase in ASCs' costs, we do not expect that this recommendation would reduce ASCs' ability to provide services to beneficiaries.

How should the payment system be revised?

The Secretary should revise the current ASC payment system so that its relative weights and procedure groups

are aligned with those in the outpatient prospective payment system. The current ASC payment system has three major problems:

- It classifies procedures into only nine payment groups, which are not clinically coherent.
- It is not based on recent cost data.
- It produces payment rates that are not aligned with rates for ambulatory surgical services provided in other settings.

Create more payment groups

The ASC payment system categorizes services within nine payment groups based only on their cost similarity. By contrast, the outpatient PPS classifies services into about 700 payment groups based on both cost and clinical similarity. The number of services in each ASC group varies widely: 2 groups have 3 or fewer services, while 2 groups have more than 600 (the median group has 172). The payment rate for each ASC group is based on the median cost of the services in the group.

Using broad payment groups for most procedures means that many procedures are likely over- or underpaid, depending on the variation between their actual costs and the rate assigned to their group. Using more payment groups could minimize these variations between cost and payment. In addition, grouping services based on their clinical as well as cost similarity would improve the cohesiveness of the classification system.

Use more recent cost data

Current ASC payment rates are based on a 1986 cost survey and have been updated periodically using the CPI–U. Because they are based on old cost data, these rates probably no longer reflect ASCs' costs. Although the statute required CMS to conduct a survey of ASCs' costs and charges every five years, the agency has not collected data on the costs of ASC services since 1994.[11] The MMA eliminated this survey requirement (see text box, p. 186). Policymakers need timely data to adjust both the relative payment weights for different services and the average payment amount, as well as to assess the adequacy of overall Medicare payments. There are two alternatives for collecting cost data. CMS can:

- survey a sample of ASCs, or
- require all ASCs to submit cost reports.

CMS could supplement either approach by asking panels of experts to estimate the level of resources used for different services.

Survey a sample of facilities

Using the survey approach raises three issues: administrative burdens on ASCs and CMS, the representativeness of the sample, and the frequency of the survey. Collecting cost data from a sample of ASCs limits the burden of reporting data to those ASCs in the sample and limits the amount of data that CMS has to process and audit. However, CMS would have to obtain Executive Branch approval of the survey instrument and hire additional staff to oversee the survey process. If the survey is done periodically, as was the case until 1994, CMS would have to revise the instrument every few years and ASCs would have to learn how to respond to a new instrument.

A survey based on a sample of ASCs, moreover, might not provide adequate data on all the procedures they perform. For example, because of sample size limitations, CMS's 1994 survey did not provide reliable data to set relative weights for most of the payment groups that it proposed creating in 1998 (Health Care Financing Administration 1998). As with any sampling methodology, a sample of ASCs might not reflect the cost structure of all ASCs.

Under the previous survey requirement, CMS had to collect cost data every five years. Given the rapid pace of change in technology and clinical practice, however, data may need to be collected more frequently to accurately reflect changes in costs.

Collect cost reports

A requirement that each ASC must annually submit cost and charge data on procedures would have some advantages and disadvantages. Compared with a survey, annual cost reports would provide data on a broader set of ASCs and procedures. However, obtaining sufficient detail on the cost of individual procedures would require careful design and consideration of ASCs' accounting systems. Cost reports could also provide more timely data that better reflected the impact of clinical and technological changes on costs.

Annual cost reports would be more predictable and routine for ASCs than a periodic survey. On the other hand, a cost report requirement would apply to all ASCs, rather than a subset, and would require annual compliance. Many ASCs are small facilities with perhaps limited capacity to track

costs. However, CMS requires other small providers to submit cost reports, including home health agencies, hospices, and outpatient dialysis facilities. The forms used by these small providers could serve as a model for a limited ASC cost report.

Collecting annual cost reports would probably impose a larger administrative burden on CMS than conducting a survey:

- CMS would need to audit and analyze data from more facilities.
- CMS would have to develop a mechanism to process and audit the data. The CMS contractors who review ASC claims—carriers—do not currently handle cost reports. Perhaps ASC cost reports could be processed by fiscal intermediaries (FIs), which handle cost reports submitted by hospitals, skilled nursing facilities, and other providers. However, FIs would need added resources to carry out this new responsibility.

Estimate the level of resources used

In combination with either data collection option, CMS could convene panels of experts (such as physicians, nurses, and ASC administrators) to estimate the level of resources used for different procedures in ASCs. Such resources could include the type and mix of ASC staff, surgical supplies, equipment, and operating room and recovery time. CMS could use this information to review relative weights that are developed using cost report or survey data.

Align ASC rates with rates for services in other settings

CMS sets different payment rates for ambulatory surgical services based on the setting in which they are provided. A facility payment covers the overhead costs of surgical services when they are provided in an ASC or hospital outpatient department; the practice expense portion of the physician payment covers the overhead costs of services provided in a physician office.

The rate for a service in each setting usually differs. For example, the 2004 ASC facility rate for upper gastrointestinal endoscopy with biopsy is $446, compared with the outpatient PPS rate of $427 and the physician practice expense rate of $208 for an office procedure (Table 3F-6).[12]

Payment differences may reflect variations in the cost structure among settings, such as levels of staffing or the mix of patients, or they may be due to the historical

TABLE 3F-6

Hospital outpatient, ASC, and physician practice expense payment rates vary for high-volume ambulatory surgical services, 2004

			2004 payment rates		
Procedure code	Description	Share of Medicare payments to ASCs, 2002	Hospital outpatient	ASC	Physician practice expense
66984	Cataract removal and lens insertion	46%	$1,254	$973	$285
66821	After-cataract laser surgery	6	270	446	149
45378	Colonoscopy, diagnostic	6	453	446	226
43239	Upper gastrointestinal endoscopy, biopsy	5	427	446	208
45385	Colonoscopy with removal of lesion by snare	4	453	446	287
62311	Epidural injection, lumbar or sacral	3	288	333	183
45380	Colonoscopy with biopsy	3	453	446	264
45384	Colonoscopy with removal of lesion by forceps	2	453	446	250
52000	Cystoscopy	1	375	333	126
G0121	Colonoscopy, cancer screening	1	405	446	226

Note: ASC (ambulatory surgical center). Procedures are arranged by share of Medicare payments to ASCs in 2002, from highest to lowest. Payment rates shown here are the national average for each procedure. Physician practice expense rates are for services provided in the office setting. ASC rates are as of April 1, 2004, when rates will be reduced to fiscal year 2003 levels, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Physician practice expense rates reflect the 1.5% increase for 2004 required by the MMA.

Source: CMS 2004, CMS 2003a, CMS 2003b.

development of each payment system. If payment variations are unrelated to differences in underlying costs, there could be financial incentives to shift services to the most profitable setting, which would likely increase costs to the program and beneficiaries. The Commission has previously expressed its view that providers' decisions about site of care should be based on clinical, not financial, factors (MedPAC 2001).

How should Medicare better align ASC rates with rates for ambulatory surgical services offered in alternative settings? The options are to align ASC rates with outpatient department facility rates or with practice expense rates for physician office procedures. Although each of these settings has different capabilities and cost structures, ASCs are more like outpatient departments than physician offices. ASCs and outpatient departments are subject to more regulatory requirements (such as Medicare's conditions for participation) than physician offices and generally maintain additional infrastructure to support surgical procedures. In addition, outpatient departments are the dominant setting for ambulatory surgeries: They accounted for over half of the most common ambulatory surgical procedures in 2001 (Table 3F-7).

In 2004, the ASC payment rate exceeds the outpatient department rate for 13 percent of the surgical procedures that Medicare pays for in an ASC (315 codes out of 2,451), including 4 of the 10 highest-volume ASC services.[13] Table 3F-6 illustrates the variations in rates by setting for the 10 highest-volume ASC services. Procedures for which the ASC rate exceeds the outpatient department rate in 2004 accounted for 19 percent of Medicare payments to ASCs and 26 percent of ASC volume in 2002. ASC rates exceed outpatient rates for fewer services in 2004 than 2003 because outpatient rates increased faster than ASC rates in 2004 due to a higher outpatient update and changes to the outpatient weights.[14]

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. Because we lack data that would allow direct comparisons of costs between settings, we used indirect measures to compare costs.[15] In a previous report we considered two such indirect measures of relative costliness: regulatory burden and the mix of patients (MedPAC 2003). We found that outpatient departments are subject to additional regulatory

TABLE 3F-7

Over half of the most common ambulatory surgical procedures were performed in hospital outpatient departments, 2001

Procedure category	Share of ambulatory surgical volume, all settings	Share of volume, by setting		
		Outpatient departments	Physician offices	ASCs
Colonoscopy	16.0%	70.8%	4.3%	24.9%
Cataract removal and lens insertion	12.5	47.7	0.5	51.8
Minor procedures–musculoskeletal	10.7	48.1	31.1	20.8
Upper gastrointestinal endoscopy	9.5	72.0	4.5	23.5
Cystoscopy	9.0	28.7	63.8	7.5
Ambulatory procedures–skin	7.9	42.4	52.6	5.0
Other ambulatory procedures	7.3	69.8	16.5	13.8
Other eye procedures	6.9	27.5	33.6	39.0
Other minor procedures	5.0	30.1	63.3	6.5
Ambulatory procedures–musculoskeletal	3.4	59.8	17.4	22.9
Total	88.1	53.1	24.1	22.8

Note: ASC (ambulatory surgical center). Table only includes ambulatory surgical procedures that are on the list of services payable by Medicare when performed in an ASC. Procedure categories are arranged by their share of ambulatory surgical procedure volume across all settings, from highest to lowest. Minor procedures–musculoskeletal includes interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision. Ambulatory procedures–skin includes skin debridement, excision of lesion, wound repair, and skin graft. Other ambulatory procedures includes breast biopsy, nasal polyp excision, abscess drainage, and nerve graft. Other eye procedures includes after-cataract laser surgery. Other minor procedures includes nasal, oral, urological, and nerve procedures. Ambulatory procedures–musculoskeletal includes hammertoe operation, arthrotomy, tenotomy, and tendon repair.

Source: MedPAC and RAND analysis of the 5 percent Standard Analytic files of physician, outpatient department, and ASC claims from CMS, and the Berenson-Eggers Type of Service classification scheme from CMS.

requirements, which are likely to increase their overhead costs, and treat patients who are more medically complex.[16] Thus, outpatient departments probably incur higher costs than ASCs for similar procedures.

Unlike ASCs, hospitals are subject to the Emergency Medical Treatment and Active Labor Act, which requires outpatient departments that provide emergency services to screen, 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 safeguard patients' rights by establishing a patient complaint process and to have quality improvement programs (CMS 2003d). Medicare's conditions of coverage for ASCs, which have not been updated since 1982, do not contain these requirements.

We used Medicare beneficiaries' risk scores to compare the medical complexity of patients in ASCs and outpatient departments. The risk scores represent beneficiaries' expected costliness based on their age, sex, and diagnoses from hospital inpatient, outpatient, and physician visits during the previous year. We calculated average risk scores for patients who received similar types of procedures, such as cataract surgery or colonoscopy, in ASCs or outpatient departments.

For the 10 procedure categories that accounted for almost all Medicare payments to ASCs in 1999, patients who were treated in outpatient departments had higher average risk scores than ASC patients. These results indicate that outpatient departments provide care to beneficiaries who, on average, have somewhat higher medical complexity than patients who receive similar procedures in ASCs. It is probably more costly to treat surgical patients with more health problems. For example, patients with comorbidities could require additional time in the operating and recovery rooms and more sophisticated monitoring during surgery.

Because 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. Last year, the Commission recommended that, until the Secretary implements a revised ASC payment system, the Congress should ensure that payment rates for ASC services do not exceed hospital outpatient PPS rates for the same services, accounting for differences in the bundle of services covered by the base rate in each payment system (MedPAC 2003).

Base the payment system on the outpatient prospective payment system

Ideally, CMS would design a unique payment system for ASCs that classifies procedures into more payment groups, sets rates based on recent cost data that are aligned with rates in other settings, and is updated regularly. Due to competing priorities and congressional action, however, CMS has not implemented revisions to the ASC payment system since creating the current payment groups in 1990.[17] Given this experience, and the small size of the ASC sector compared with other provider types, it is probably more practical to link the ASC payment system to a system such as the outpatient PPS that sets rates for ambulatory surgical services, has many payment groups, and is revised regularly using recent data.

Basing the ASC payment system on the outpatient PPS would offer several advantages:

- Using a greater number of payment groups could enhance the accuracy of payments for individual ASC services.
- Linking the two payment systems would make it administratively easier for CMS to update ASC procedure groups and relative weights.
- Aligning the ASC and outpatient payment systems could reduce financial incentives to shift services between settings.

However, CMS would need to collect data on the cost of ASC services at the procedure level to monitor the adequacy of ASC rates, refine the ASC relative weights, and set a conversion factor that reflects the cost of ASC services. Policymakers would also need to address other differences in the payment systems that might cause payments to diverge.

As discussed earlier, the use of broad payment groups for most ASC procedures means that many of them are likely over- or underpaid, depending on the variation between their actual costs and the payment rate assigned to their group. Replacing the nine current ASC payment groups with the larger number of outpatient PPS groups could minimize these variations between cost and payment.

If the payment groups and relative weights used by the ASC payment system were based on those used by the outpatient PPS, CMS could update the ASC groups and

weights each year along with its annual revisions to the outpatient PPS. Easing the administrative burden for CMS should reduce or eliminate long delays in revising the ASC payment system.

Using similar procedure groups and relative weights in the ASC and outpatient payment systems would make it easier to align rates for the same services across settings. Although the actual rates might not be the same in each setting, the relative payment difference between a colonoscopy and upper gastrointestinal endoscopy, for example, would be similar in each site of care.

The ASC payment system should use a conversion factor, or average payment amount, to convert the relative weight for a service into a payment rate. The conversion factor should reflect the costs of efficient ASCs in providing care, unless ASCs incur higher costs than outpatient departments for similar services and patients (see discussion below). Thus, CMS would need to collect data on the cost of ASC services to develop a conversion factor. Such data would also be used to monitor the adequacy of Medicare payments to ASCs. As discussed earlier, there are two options for collecting these data.

Our analysis of indirect measures affecting the relative costliness of ASCs and outpatient departments suggests that ASCs are the lower-cost setting (see page 194). We expect that when ASC cost data are collected, they will confirm this assumption.

If, however, a direct comparison of ASC and outpatient department costs shows that ASCs incur higher average costs for surgical services, we would want to investigate whether this result is related to variations in patient severity, quality of care, and efficiency; the allocation of costs across different hospital service lines; or other factors. Medicare might want to base its rate for a service provided in multiple settings on the costs of the most efficient setting (the lowest-cost setting, controlling for patient mix and quality). This approach would produce a single rate for a service, regardless of where it is provided. It would encourage services to shift to the most efficient setting, while encouraging providers in other settings to become more efficient.

If ASC costs continue to exceed outpatient department costs after adjusting for these factors, should Medicare pay ASCs more than outpatient departments for similar services? Paying ASCs more might encourage the shift of surgical procedures from outpatient departments to ASCs. This migration would raise several issues, most notably the effect on the financial viability of general hospitals and the incentive for ASCs to build additional capacity when hospitals' current capacity for ambulatory surgical procedures may be sufficient. Thus, policymakers might want to pay no more for the same service in an ASC than an outpatient department.

It is possible that the outpatient PPS covers outpatient departments' costs for a broad mix of services even if the relative weights do not accurately reflect the relative costs of individual services. If true, this phenomenon would have less of an impact on outpatient departments, which can spread financial losses and gains from individual services across a broad service line, than ASCs, which often specialize in specific procedures. When applying the outpatient PPS weights to ASC services, CMS should periodically use data on the cost of specific ASC procedures to ensure that the weights reflect the relative costs of individual ASC services. If they do not, CMS should refine the weights to ensure that they cover the costs of specific ASC services.

Even if CMS were to align base payment rates for ASC and outpatient department services, other differences between the payment systems might cause payments to diverge. For example:

- The labor portion of the ASC rate, which is adjusted for geographic wage differences based on the location of the ASC, is currently 34.45 percent, compared with the hospital outpatient labor share of 60 percent. Variations in the labor share can affect payment rates for providers in locations with above- or below-average wages. In an area with below-average wages, for example, the share of the payment related to labor is reduced. If the labor share is higher, the payment reduction will be greater. The General Accounting Office's report on the ASC payment system will examine whether the current labor share of ASC payments is appropriate (see text box, p. 186).
- Each setting has different rules for whether the cost of drugs or devices used in a procedure is included in the base payment rate. Outpatient departments are eligible to receive pass-through payments for certain new technology items, such as drugs and devices, that are used in the delivery of services.[18] Pass-through payments are made in addition to the outpatient base payment. ASCs, however, do not receive pass-through payments; the cost of most new technology items used with procedures provided in ASCs is included in the

ASC base payment. On the other hand, ASCs may receive separate payments for some prosthetic devices that are implanted during surgical procedures, whereas payments for prosthetic devices are folded into outpatient PPS base rates.

- Outpatient departments are eligible to receive outlier payments; ASCs do not receive such payments (Section 3A provides more detail about outpatient PPS outlier payments).
- Outpatient departments are allowed to bill separately for radiology and imaging services that are ancillary to surgical procedures; ASCs are not. For example, if a procedure does not normally require a radiology or imaging service, the procedure's payment rate in each setting does 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 receive payment for both the surgical procedure and imaging service, an ASC could only receive payment for the surgical procedure.
- Under current law, annual updates to ASC rates are based on the increase in the CPI–U (with the exception of 2005 through 2009, when the update is eliminated); outpatient rates are updated using the hospital market basket.

Policymakers should address these differences if they decide to revise the ASC payment system based on the outpatient PPS.

RECOMMENDATION 3F-2

The Secretary should revise the ASC payment system so that its relative weights and procedure groups are aligned with those in the outpatient prospective payment system. In addition:

- **The Congress should require the Secretary to periodically collect ASC cost data at the procedure level to monitor the adequacy of ASC rates, refine the relative weights, and develop a conversion factor that reflects the cost of ASC services.**
- **The Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for the same procedures, accounting for differences in the bundle of services.**

RATIONALE 3F-2

The Secretary should base the ASC payment system on the outpatient PPS for the following reasons:

- Using a greater number of payment groups could enhance the accuracy of payments for individual ASC services.
- Linking the two payment systems would make it administratively easier for CMS to update ASC procedure groups and relative weights.
- Aligning the ASC and outpatient payment systems could minimize financial incentives to shift services between settings.

CMS should use data on the cost of ASC services at the procedure level to ensure that ASC weights cover the relative costs of individual services and to set the conversion factor. Even if cost data show that ASCs incur higher costs than outpatient departments, Medicare should pay no more for the same service in an ASC than an outpatient department (accounting for differences in the bundle of services covered by the base payment rates).

IMPLICATIONS 3F-2

Spending

- We are unable to estimate the spending implications of this recommendation. According to current law, total payments under the revised ASC payment system must be equal to the total projected payments under the old system; the conversion factor would be set at a level that maintains budget neutrality between the old and new payment systems. Under this recommendation, the conversion factor for the revised system would be based on recent ASC cost data. Thus, depending on the size of the conversion factor, total payments under the revised system could be higher or lower than total payments under the old system. Whether or not total payments rise or fall, some payment rates would probably increase while others would decline.

Beneficiary and provider

- This recommendation should not affect beneficiaries' access to care. As long as the payment rates cover ASCs' costs, ASCs should provide services to beneficiaries. This recommendation's effect on beneficiaries' cost sharing is unclear because we cannot project the magnitude of rate changes.

ASCs that specialize in services that are currently paid higher base rates in ASCs than outpatient departments, such as some endoscopy procedures, might experience payment reductions. However, ASCs that provide services now paid at much lower levels, such as some orthopedic procedures, might be paid more.

What procedures should Medicare pay for in ambulatory surgical centers?

After the ASC payment system is revised, CMS should eliminate its current list of procedures that Medicare will pay for in an ASC. Instead, it should pay for all ambulatory surgical procedures provided by ASCs that meet clinical safety standards and do not require an overnight stay. CMS is required by law to establish and update a list of procedures that are appropriately performed in inpatient hospital settings but may also be safely performed on an ambulatory basis in ASCs.[19] Only those procedures on the list are eligible for Medicare payment when performed in ASCs. CMS uses specific criteria for determining what procedures to include on this list. The current approach for deciding what ASC procedures are eligible for Medicare payment has the following problems:

- Long gaps between updates to the list of ASC procedures make it difficult for the list to keep up with changes in technology and clinical practice.
- Some of the criteria for adding procedures to the list may no longer be appropriate.

Problems with the current approach

CMS is required to update the list of approved ASC procedures every two years. Between 1995 and 2003, however, with the exception of updates due to coding changes, the list was not modified.[20] After 1995, changes in technology and clinical practice led to the development of additional procedures that could be safely performed in ASCs. Until the list was updated, however, ASCs could not receive payment for these procedures.

Surgical procedures must meet several criteria to be added to the list of services that Medicare will pay for in an ASC:

- **Site-of-service volume**. Procedures performed in hospital inpatient settings at least 20 percent of the time that can also be safely performed in outpatient facilities are eligible for the list; procedures performed in physician offices at least 50 percent of the time are excluded from the list.
- **Time needed to perform procedures.** A procedure must not generally exceed 90 minutes of surgery or 4 hours of recovery time; anesthesia for a covered procedure must last no longer than 90 minutes.
- **Clinical criteria.** A procedure is excluded from the ASC list 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 emergent or life-threatening in nature.

In 1998, CMS proposed revising its criteria for determining which procedures are eligible for payment, as well as expanding the list of services. The agency considered eliminating the surgery, anesthesia, and recovery time limits but retaining clinical standards for deciding whether a procedure could safely be performed in an ASC. CMS also proposed reducing the importance of site-of-service volume in the approval process.

In March 2003, CMS issued a final rule that updated the list of procedures, but it did not revise the criteria for determining eligibility for the list. The rule added almost 300 procedures to the list and deleted 140 procedures, bringing the total number of services on the list to about 2,400 (CMS 2003c).

Some of the criteria for adding procedures to the list, such as site-of-service volume and time limits, are probably no longer relevant for determining what services are clinically appropriate to perform in an ASC.

Site-of-service volume criteria

The Congress required that surgical procedures approved for payment in an ASC must also be performed in inpatient settings in order to encourage the migration of surgical services to ambulatory settings. Procedures such as cataract surgery were introduced in inpatient settings before shifting to ambulatory settings as technology and clinical practice developed.

This pattern has changed, however, and it no longer makes sense to consider inpatient volume when updating the ASC list. Today, new types of endoscopy and eye surgery are initially performed in ambulatory sites of care, bypassing the inpatient setting. In addition, many procedures, such as cataract removal and lens insertion, no longer meet the 20 percent inpatient volume requirement because of changes in site of care. CMS has created a

second set of standards to keep these procedures on the list.[21]

CMS should also consider dropping the requirement that procedures be performed less than 50 percent of the time in physician offices to be added to the list. This criterion was created to prevent the shift of procedures that are safely and routinely performed in physician offices to the more elaborate and costly ASC setting.[22] Even though physicians can safely perform many surgical procedures on healthy beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC or outpatient department. Physicians should have the discretion to decide which setting is most clinically appropriate for individual patients.

ASC payment rates usually exceed physician practice expense rates when the service is provided in an office (Table 3F-6, p. 193). The Commission is concerned that eliminating the physician office volume criterion might encourage the migration of procedures from physician offices to ASCs due to financial, rather than clinical, reasons. Thus, the Secretary should monitor ASC and physician office rates to ensure that they reflect the costs of efficient providers in each setting. The Secretary should also evaluate whether shifts of surgical services among ambulatory settings are related to clinical reasons, financial incentives, patient preferences, or other factors.

Time limit requirements

The time limit requirements for surgery, recovery, and anesthesia are unnecessarily rigid. CMS developed these criteria to ensure that only ambulatory procedures not requiring an overnight stay would be added to the list. CMS believed that procedures exceeding 90 minutes of surgery plus 4 hours of recovery, allowing time for potential delays and for patients to arrive at least 1 hour before the procedure begins, could not be completed at an ASC during an 8-hour day (HCFA 1995). Although the Commission agrees that procedures requiring an overnight stay should be performed only in an inpatient setting, CMS could accomplish this goal through less restrictive criteria. For example, CMS could exclude those procedures from payment that generally require an overnight stay, rather than specifying time limits for each portion of the procedure.

Use more reasonable criteria

When determining which services to reimburse in an ASC, CMS should focus primarily on whether it is clinically appropriate to provide a surgical procedure in an ASC. Procedures to exclude are those that usually require an inpatient admission or the additional resources of a hospital outpatient department, such as the availability of emergency backup and on-site specialists. Thus, CMS should continue to exclude those procedures that generally result in extensive blood loss, require major or prolonged invasion of body cavities, directly involve major blood vessels, or are life-threatening in nature. CMS also should exclude procedures that Medicare does not pay for in hospital outpatient departments because they require inpatient care.[23]

Create exclusionary list

Instead of requiring CMS to maintain a list of services that are eligible for payment when provided by an ASC, the Congress should consider authorizing CMS to create a list of services that are specifically excluded from payment. CMS would pay for any ambulatory surgical service not on such a list, as long as it is medically necessary.

An exclusionary list would make it easier for beneficiaries to receive new surgical procedures in ASCs. Under the current approach, a new procedure that is appropriate to provide in an ASC will not be reimbursed by Medicare until the ASC list is updated and the procedure is included. If the current list were replaced by an exclusionary list, Medicare could begin paying ASCs for the procedure at the same time it started paying for the procedure in other settings. Physicians would have greater discretion over where to provide a service. The burden would be on CMS to demonstrate that the ASC is an inappropriate setting for a given surgical procedure.

An exclusionary list carries certain risks, however. If CMS does not keep this list up to date, ASCs could begin performing services that are unsafe in that setting. Medical ethics principles and professional standards should reduce this risk. For example, the American Gastroenterological Association (AGA) recommends that physicians should not perform endoscopy on severely ill patients in an ASC or office setting (AGA 2001). In addition, ASCs have to meet minimal safety and quality standards to obtain Medicare certification and accreditation by private organizations. At least one accreditation group requires that an ASC's governing body determine what procedures are appropriate to perform in that facility and ensure that only qualified physicians are allowed to perform them (Accreditation Association for Ambulatory Health Care, Inc. 2003).

The Congress may wish to wait until CMS aligns the ASC payment system with the outpatient PPS before changing the process for approving ASC procedures. Otherwise, unwarranted disparities between ASC and outpatient rates could cause procedures to migrate to ASCs for financial, rather than clinical, reasons. In addition, CMS has had difficulty assigning newly eligible procedures to one of the nine current ASC payment groups due to the:

- absence of recent ASC cost data,
- lack of clinically homogeneous payment groups, and
- concern that some eligible procedures would have been reimbursed at much higher rates in an ASC than in an outpatient department (CMS 2003c).[24]

RECOMMENDATION 3F-3

After the ASC payment system is revised, the Congress should direct the Secretary to replace the current list of approved ASC procedures with a list of procedures that are excluded from payment based on clinical safety standards and whether the service requires an overnight stay.

RATIONALE 3F-3

Physicians and beneficiaries should have greater discretion over where to provide and receive an ambulatory surgical procedure. Thus, CMS should eliminate the use of rigid site-of-service volume standards and procedure time limits when deciding what procedures are eligible for payment in an ASC. Replacing the current list would make it easier for beneficiaries to receive new surgical procedures in ASCs. Medicare should only pay for ambulatory surgical procedures in an ASC when they are clinically safe for that setting. Thus, CMS should evaluate whether procedures meet clinical safety standards and require an overnight stay.

IMPLICATIONS 3F-3

Spending

- The spending implications of this recommendation are unknown. Expanding the number of ambulatory surgical procedures that may be performed in ASCs will probably lead to the migration of some services from outpatient departments and physician offices to ASCs. The increase in Medicare payments for services that shift from physician offices to ASCs (where rates are generally higher) might offset the decline in payments for services that move from outpatient departments to ASCs (where rates are generally lower). Medicare spending would increase if this recommendation increases the total volume of surgical procedures.

Beneficiary and provider

- ASCs would likely be able to provide a broader range of surgical services, offering beneficiaries an additional choice of setting. ASCs are now unlikely to provide procedures not payable by Medicare in an ASC. Beneficiaries who could receive services in an ASC instead of an outpatient department would likely have lower cost sharing (Table 3F-5, p. 190). ■

Legal context for physician ownership of ambulatory surgical centers

Section 1877 of the Social Security Act (the Stark self-referral law) prohibits physicians from making referrals for certain types of services to entities with which they have financial relationships. It also prohibits those entities from submitting claims to Medicare or Medicaid for those services. The law applies to several types of services, such as: clinical laboratory, radiology, physical therapy, and home health (HCFA 2001). However, it does not apply to surgical procedures provided in an ASC.

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. The 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. Among other requirements, the safe harbor regulations generally protect physician investors for whom the ASC is an extension of their office practice (Office of Inspector General 1999). In other words, the physician investors must be in a position to refer patients directly to the ASC and to perform the procedures themselves. The share of an ASC's profits received by physician investors must be related to their portion of the overall investment rather than their volume of referrals. ■

Endnotes

1 If an ambulatory surgical center (ASC) is deemed to be in compliance with the conditions of coverage through private accreditation, it must still comply with state licensure requirements.

2 The Balanced Budget Act of 1997 reduced annual updates to ASC rates by 2 percentage points between 1998 and 2002.

3 Most ASCs are certified by Medicare (SMG Marketing Group, Inc. 2002).

4 The following states experienced the greatest net growth in the number of ASCs between January 2002 and June 2003: Florida, California, Georgia, Texas, and New Jersey.

5 To select high-volume ASCs, we arrayed facilities by the number of Medicare claims they submitted in 2002. High-volume ASCs are those in the top quartile of this distribution (submitted at least 1,000 claims). These facilities accounted for 68 percent of total Medicare payments to ASCs and 66 percent of Medicare volume. We classified ASCs by specialty type based on the specialty of the physicians who performed procedures accounting for at least 90 percent of Medicare payments to the ASC.

6 Most of the volume data reported in the survey were from 1993. The survey sample included 295 ASCs, about 20 percent of all Medicare-certified ASCs in 1992.

7 Minor musculoskeletal procedures include interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision.

8 To ensure comparability, we analyzed changes in the volume of the same set of ambulatory surgical services in each setting by selecting only those services that are payable by Medicare when provided in an ASC. Thus, the data exclude surgical services provided in hospital outpatient departments that are not payable by Medicare when furnished by an ASC.

9 This projection is based on data from the fourth quarter of 2003 and is subject to change as more recent consumer price index data become available (Global Insight 2003).

10 Medicare pays for some prosthetic devices used in ASC procedures based on the durable medical equipment fee schedule. Such devices include implantable pain pumps and ocular implants.

11 In 1998, CMS proposed revising the ASC payment system based on data from a 1994 cost survey (Health Care Financing Administration 1998). However, the Congress required CMS to delay the new payment system and to base new payment rates on ASC cost survey data from 1999 or later (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000). In March 2003, CMS announced that it had developed a new cost survey instrument but had not yet fielded the survey (CMS 2003c).

12 The ASC rate will be effective April 1, 2004 (see text box, p. 186).

13 We compared calendar year 2004 outpatient department rates with the ASC rates that will be paid beginning April 1, 2004.

14 In 2003, the ASC payment rate exceeded the outpatient department rate for 15 percent of the procedures payable by Medicare when performed in an ASC (370 codes out of 2,451), including 9 of the 10 highest-volume ASC services. Procedures for which the ASC rate exceeded the outpatient department rate in 2003 accounted for 36 percent of Medicare payments to ASCs and 52 percent of ASC volume in 2002.

15 The upcoming General Accounting Office report on the ASC payment system may address whether outpatient departments have higher costs than ASCs (see text box, p. 186).

16 This issue is also discussed by A. Winter in Health Affairs (Winter 2003).

17 In 1998, CMS proposed revising the ASC payment system by creating 105 payment groups that were based on those included in the outpatient payment system proposed in the same year (Health Care Financing Administration 1998). However, this proposal was delayed by congressional action.

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

19 Section 1833(i) (1) of the Social Security Act (42 U.S.C. 1395).

20 In 1998, CMS proposed expanding the list of approved ASC procedures (Health Care Financing Administration 1998). However, this proposal was delayed by congressional action.

21 To remain on the ASC list, procedures must have combined inpatient, hospital outpatient, and ASC volume greater than 46 percent of volume across all settings and either physician office volume of less than 50 percent or inpatient hospital volume of greater than 10 percent (Health Care Financing Administration 1998).

22 CMS requires ASCs, unlike physician offices, to adhere to certain health and safety standards, such as maintaining designated operating and recovery rooms, that raise their overhead costs.

23 See CMS 2003a, p. 63465–63467.

24 To avoid encouraging the shift of procedures to ASCs for financial reasons, CMS decided to not add procedures to the list that would have been paid more in the lowest ASC group than in an outpatient department, even if the procedures met the eligibility criteria.

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