

CHAPTER

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**Ambulatory surgical centers**

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

- 5** The Congress should implement a 0.5 percent increase in payment rates for ambulatory surgical center services in calendar year 2012 concurrent with requiring ambulatory surgical centers to submit cost and quality data.

**COMMISSIONER VOTES: YES 15 • NO 1 • NOT VOTING 0 • ABSENT 1**

# Ambulatory surgical centers

## Chapter summary

Ambulatory surgical centers (ASCs) furnish outpatient surgical services to patients not requiring hospitalization and for whom an overnight stay is not expected after surgery. In 2009,

- ASCs served 3.3 million fee-for-service (FFS) Medicare beneficiaries, an increase of 1.2 percent over 2008;
- there were 5,260 Medicare-certified ASCs, an increase of 2.1 percent (109 ASCs) over 2008; and
- Medicare combined program and beneficiary spending on ASC services was \$3.2 billion, an increase of 5.1 percent per FFS beneficiary over 2008.

## Assessment of payment adequacy

Most of the available indicators of payment adequacy for ASC services, discussed below, are positive and exhibit little change from 2008. The Patient Protection and Affordable Care Act of 2010 did not change the basic structure of the ASC payment system, and Medicare still does not require ASCs to submit cost or quality data.

**Beneficiaries' access to care**—Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC care has generally been adequate.

## In this chapter

- Are Medicare payments adequate in 2011?  
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- How should Medicare payments change in 2012?  
.....

- ***Capacity and supply of providers***—From 2004 through 2009, the number of Medicare-certified ASCs grew by an average annual rate of 5.1 percent. However, the growth slowed to 2.1 percent in 2009. The slower growth in 2009 may reflect the downturn in the U.S. economy. Also, the ASC payment system underwent a substantial revision in 2008 (see online Appendix A from Chapter 2C of our March 2010 report at [http://medpac.gov/chapters/Mar10\\_Ch02C\\_APPENDIX.pdf](http://medpac.gov/chapters/Mar10_Ch02C_APPENDIX.pdf)), and investors may be responding to the large change in payment rates that occurred under that revision.
- ***Volume of services***—From 2004 through 2009, the volume of services per beneficiary grew by an average annual rate of 8.1 percent; in 2009, volume increased by 3.4 percent.

***Quality of care***—CMS does not require ASCs to submit data on the quality of care they provide. Consequently, we do not have sufficient data to assess ASCs' quality of care.

***Providers' access to capital***—ASCs' access to capital appears to be adequate as the number of ASCs has continued to increase.

***Medicare payments and providers' costs***—From 2004 through 2009, ASCs' Medicare revenue increased from \$2.5 billion to \$3.2 billion. Also, from 2004 through 2008, Medicare payments per FFS beneficiary increased at an average annual rate of 7.2 percent and in 2009 by 5.1 percent. ASCs do not submit data on the cost of care they provide to the Medicare program. Therefore, we cannot calculate a margin as we do in other sectors to assist in assessing payment adequacy. ■

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## Background

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An ambulatory surgical center (ASC) is a distinct entity that furnishes outpatient surgical procedures to patients who do not require an overnight stay following the procedure. Most ASCs are freestanding facilities rather than part of a larger facility, such as a hospital. About one-quarter of ASCs in 2008 were jointly owned by physicians and hospitals (Medical Group Management Association 2009). In addition to receiving ambulatory surgical procedures in ASCs, beneficiaries may also receive such procedures in hospital outpatient departments (HOPDs) and, in some cases, physicians' offices.

Since 1982, Medicare has made payments for surgical procedures provided in ASCs. Physicians who perform procedures in ASCs or in other facilities receive separate payments for their professional services. In addition, about 90 percent of ASCs have at least one physician owner (Ambulatory Surgery Center Association 2008). Physicians who perform surgery in an ASC that they own receive a share of the ASC's facility fees in addition to their professional fees.

To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage for ASCs, which specify standards for administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, nursing services, and other areas.

Medicare pays for a bundle of facility services provided by ASCs, such as nursing, recovery care, anesthetics, and supplies. This payment system underwent substantial revisions in 2008 (see online Appendix A from Chapter 2C of our March 2010 report at [http://medpac.gov/chapters/Mar10\\_Ch02C\\_APPENDIX.pdf](http://medpac.gov/chapters/Mar10_Ch02C_APPENDIX.pdf)). The most significant changes included a substantial increase in the number of surgical procedures covered under the ASC payment system, allowing ASCs to bill separately for certain ancillary services, and large changes in payment rates for many procedures. To help ASCs adjust to the changes in payment rates, CMS phased in the new payment system over four years, from 2008 through 2011; 2011 is the first year ASC payment rates will be based entirely on the revised rates. Beneficiaries are responsible for paying 20 percent of the ASC payment rate.

Medicare covers about 3,500 surgical procedures under the ASC payment system. For most covered surgical procedures, the relative weight is based on its relative weight under the outpatient prospective payment system (PPS)—

the system Medicare uses to set payments for most services furnished in HOPDs. This linkage to the outpatient PPS is consistent with a previous Commission recommendation to align the relative weights in the outpatient PPS with the ASC payment system (Medicare Payment Advisory Commission 2004). For most covered surgical procedures, the payment rate is the product of its relative weight and a conversion factor set at \$41.94 in 2011. Because the outpatient PPS conversion factor for 2011 is \$68.88, payment rates are lower in ASCs than in HOPDs.

The reason for the difference in conversion factors is that CMS set the ASC conversion factor so that total ASC payments in 2008 would equal what the program spent on ASC services in 2007, the year before CMS implemented the revised ASC payment system. In the outpatient PPS, CMS sets the conversion factor so that payments in that system equal what the program spent on hospital outpatient services the year before CMS implemented the outpatient PPS. CMS updates both the ASC and outpatient PPS conversion factors over time to reflect changes in input prices. Because of the lower payment rates in ASCs, movement of surgical services from HOPDs to ASCs can reduce aggregate program spending and beneficiary cost sharing provided that the growth of ASCs does not result in an increase in the overall number of surgical services.

Lower payment rates for ASCs relative to HOPDs are appropriate because, according to prior Commission analysis, ASCs likely incur lower costs than HOPDs, as HOPDs must meet additional regulatory requirements and treat patients who are more medically complex (Medicare Payment Advisory Commission 2003, Medicare Payment Advisory Commission 2004). 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 the patients' ability to pay. In addition, patients treated in HOPDs are, on average, more medically complex than patients treated in ASCs, and these more complex patients are likely more costly (Medicare Payment Advisory Commission 2003). A comparison of ASC costs and HOPD costs by the Government Accountability Office confirmed that ASC costs are, on average, lower than HOPD costs (Government Accountability Office 2006). However, it is not clear how much lower ASC payment rates should be relative to HOPD rates because we lack adequate cost data from ASCs to make that determination.

An important exception to the link between the relative weights in ASCs and HOPDs is the procedures that are

performed predominantly in physicians' offices and that were first covered under the ASC payment system in 2008 or later. In ASCs, payment for these "office-based" procedures is the lesser of the amount derived from the outpatient PPS relative weights or the nonfacility practice expense amount from the Medicare physician fee schedule (MPFS). CMS set this limit on the rate for office-based procedures to prevent migration of these services from physicians' offices to ASCs for financial reasons. Because CMS updates payment rates in the outpatient PPS and the MPFS independently of each other, it is possible for the ASC payment rate for an office-based procedure to be based on the outpatient PPS rate in one year and on the MPFS rate the next year (or vice versa).

The ASC payment system generally parallels the outpatient PPS in terms of which ancillary services are paid separately and which are packaged into the payment of the associated surgical procedure. Starting in 2008, ASCs receive separate payment for these ancillary services:

- radiology services that are integral to a covered surgical procedure if separate payment is made for the radiology service in the outpatient PPS,
- brachytherapy sources implanted during a surgical procedure,
- all pass-through and non-pass-through drugs that are paid separately under the outpatient PPS when provided as part of a covered surgical procedure, and
- devices with pass-through status under the outpatient PPS.

The links between the ASC payment system, the outpatient PPS, and the MPFS raise broader questions about how Medicare should pay for the same services that are provided in different settings. Should Medicare pay the same amount regardless of where a service is delivered? If so, how should that amount be determined? Alternatively, should the payment vary based on the cost of efficient providers in each setting, with an adjustment for the quality performance of providers? The current ASC payment system exhibits elements of each approach. Payments for many office-based procedures performed in ASCs are equal to the nonfacility practice expense amount in the MPFS, and ASCs and HOPDs receive the same amount for pass-through drugs and devices. In contrast, payments for most ASC services are less than the comparable payment under the outpatient PPS.

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## Are Medicare payments adequate in 2011?

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To address whether payments for the current year (2011) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2012), we examine several measures of payment adequacy. We assess beneficiaries' access to care by examining the supply of ASC facilities and changes over time in the volume of services provided, providers' access to capital, and change in revenue from the Medicare program. Unlike our assessments of other provider types, we could not use quality data in our analysis because CMS does not require ASCs to submit data on quality measures. Likewise, we cannot examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.<sup>1</sup> Finally, we caution that the effect of Medicare payments on the financial health of ASCs is limited because, on average, Medicare spending accounts for only about 17 percent of an ASC's overall revenue (Medical Group Management Association 2009).<sup>2</sup>

Our results show that beneficiaries have at least adequate access to care in ASCs, although there is some variation among subgroups of beneficiaries (see text box). In addition, ASCs have adequate access to capital, and Medicare payments to ASCs have grown strongly. Together, these measures suggest that payment rates have been at least adequate.

### **Beneficiaries' access to care: Supply of ASCs and volume growth indicate access is adequate**

Increases in the number of Medicare-certified facilities and volume of services provided to Medicare beneficiaries suggest growing access to ASCs. This growth may be beneficial to patients and physicians because ASCs can offer them convenience and efficiency relative to HOPDs—the sector with the greatest overlap of surgical services with ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs; for physicians, ASCs may offer more control over their work environment, customized surgical environments, and specialized staff. In addition, Medicare has lower payment rates and beneficiaries generally face lower coinsurance in ASCs than in HOPDs. Therefore, as long as this growth in ASCs does not lead to inappropriate use of services, the Commission recognizes the benefits that ASCs offer.

## Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments

There is evidence that ambulatory surgical centers (ASCs) treat different types of patients than hospital outpatient departments (HOPDs). ASCs are less likely than HOPDs to serve medically complex patients, Medicaid patients, African Americans, and Medicare beneficiaries who are older or eligible for Medicare because of disability.

Our analysis of Medicare claims from 2009 found that the following groups are less likely to receive care in ASCs than in HOPDs: Medicare beneficiaries who also have Medicaid coverage (dual eligibles), African Americans (who are more likely to be dual eligibles), beneficiaries who are eligible because of disability (under age 65), and beneficiaries who are age 85 or older (Table 5-1).<sup>3,4</sup> The smaller share of disabled and older beneficiaries treated in ASCs may reflect the healthier profile of ASC patients relative to HOPD patients. In addition, the smaller share of African American patients in ASCs relative to HOPDs may be linked to where ASCs and hospitals are located.

Research by the Commission has shown that compared with HOPDs, ASCs treat Medicare patients who are less medically complex, as measured by differences in average risk scores (Medicare Payment Advisory Commission 2003).<sup>5</sup> Under a contract with the Commission, RAND Health compared the characteristics of Medicare beneficiaries who had cataract surgery or a colonoscopy in an ASC with beneficiaries who received these procedures in an

**TABLE 5-1**

### Medicare patients treated in ASCs differ from patients treated in HOPDs, 2009

Characteristic	Percentage of beneficiaries	
	ASC	HOPD
Medicaid status		
Not Medicaid	86.7%	78.0%
Medicaid	13.3	22.0
Race/ethnicity		
White	88.8	84.9
African American	6.6	10.0
Other	4.6	5.1
Age (in years)		
Under 65	13.3	20.8
65 to 84	79.2	68.4
85 or older	7.5	10.8
Sex		
Male	41.8	43.4
Female	58.2	56.6

Note: ASC (ambulatory surgical center), HOPD (hospital outpatient department). All of the differences between ASC and HOPD beneficiaries are statistically significant ( $p < 0.05$ ). The analysis excludes beneficiaries who received services that are not covered in the ASC payment system.

Source: MedPAC analysis of 5 percent carrier and outpatient standard analytic claims files, 2009.

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From 2004 through 2008, the number of Medicare-certified ASCs increased by 5.8 percent per year. However, the growth rate slowed to 2.1 percent in 2009. This slow growth continued into 2010, as the number of ASCs increased by 0.6 percent to 5,291 during the first three quarters of 2010 (an annual growth rate of 0.8 percent). The relatively slow growth in 2009 and the first three quarters of 2010 may reflect the downturn in the economy that occurred in 2008 and 2009 and the relatively slow recovery from that downturn. The substantial changes to the ASC payment system that occurred in 2008 also may

have contributed to the slower growth, as investors may have waited to see how the new system affected the overall ASC market before deciding to open new facilities.

### Capacity and supply of providers: Number of ASCs grew rapidly over last several years, but growth has slowed

The number of Medicare-certified ASCs has increased substantially over the last several years. From 2004 through 2009, an average of 307 new facilities entered the program each year, while an average of 66 closed

## Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments (cont.)

HOPD. RAND found that ASC patients were less likely to have certain comorbidities, such as dementia and chronic obstructive pulmonary disease (Sloss et al. 2006). Sicker patients may be treated in HOPDs instead of ASCs because hospitals offer emergency services and access to onsite specialists if complications arise.

According to data from Pennsylvania on all patients, ASCs are less likely than HOPDs to serve Medicaid patients. In 2009, Medicaid patients accounted for 4.1 percent of diagnostic and surgical procedures in ASCs in Pennsylvania, compared with 11.0 percent of procedures in HOPDs (Pennsylvania Health Care Cost Containment Council 2010) (Figure 5-1).<sup>6</sup> Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (87.6 percent vs. 79.5 percent). Although the Pennsylvania data may not be nationally

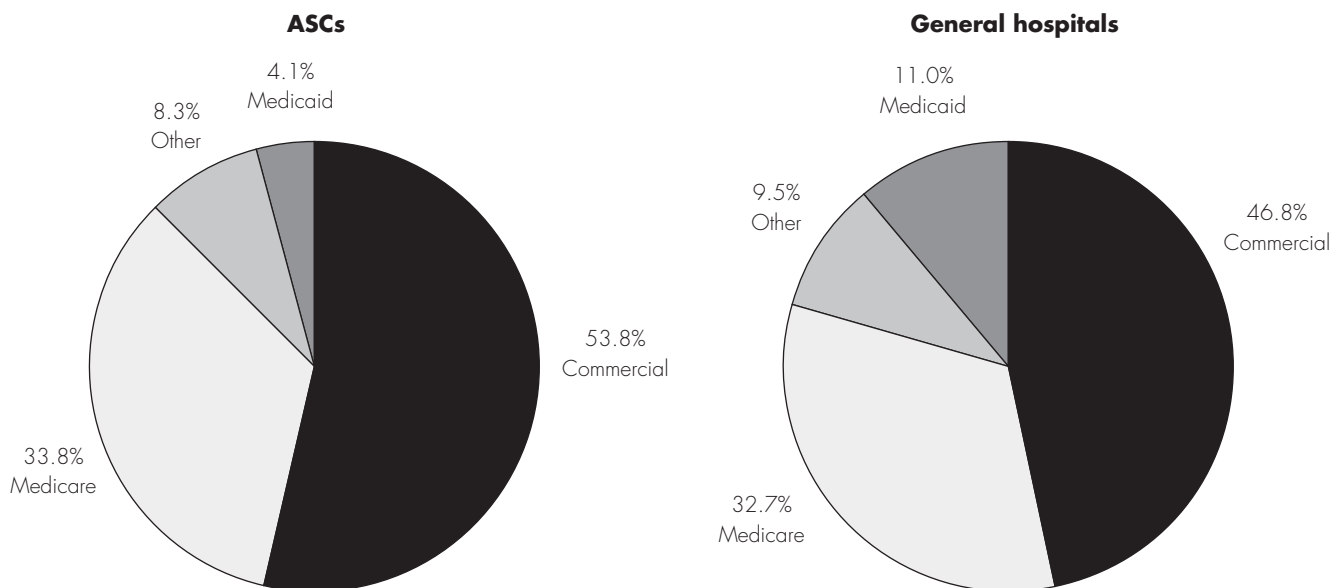
representative, national estimates from the National Survey of Ambulatory Surgery (NSAS), conducted by the Centers for Disease Control and Prevention (CDC), also show that ASCs treat a smaller share of Medicaid patients than hospitals. According to NSAS data compiled for the Commission by CDC, ambulatory surgery visits by Medicaid patients accounted for 3.9 percent of total visits to freestanding ASCs in 2006, compared with 8.1 percent of total visits to hospital-based surgery centers.<sup>7</sup>

Several factors could explain why ASCs treat a smaller share of Medicaid patients (including dual eligibles) than HOPDs. A study by Gabel and colleagues suggests that physicians refer their more lucrative patients to ASCs and the less lucrative ones to hospitals (Gabel et al. 2008). This study examined referral patterns for physicians in Pennsylvania who sent most of their

*(continued next page)*

**FIGURE 5-1**

**Distribution of outpatient procedures by payer at ASCs and general acute care hospitals in Pennsylvania, fiscal year 2009**



Note: ASC (ambulatory surgical center). Outpatient procedures include diagnostic and surgical services. Other payers include auto insurance, workers' compensation, and other government programs.

Source: Pennsylvania Health Care Cost Containment Council 2010.



## Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments (cont.)

patients to physician-owned ASCs rather than HOPDs. These physicians were much more likely to refer their commercially insured and Medicare patients than their Medicaid patients to a physician-owned ASC. They sent more than 90 percent of their commercial and Medicare patients—but only 55 percent of their Medicaid patients—to an ASC instead of a hospital. ASCs' location decisions may also result in a smaller share of Medicaid patients; for example, they may

choose to locate in areas with a high proportion of commercially insured patients. In addition, many state Medicaid programs do not pay Medicare's cost sharing for dual eligibles if the Medicare rate for a service minus the cost sharing is higher than the Medicaid rate for the service (Medicare Payment Advisory Commission 2010a). If states do not pay the cost sharing for ASC services used by dual eligibles, ASCs could be discouraged from treating these patients. ■

or merged with other facilities (Table 5-2). The average annual growth rate during this period was 5.1 percent.

To provide a more complete picture of capacity in ASCs, we also examined the change in the number of operating rooms. From 2003 through 2009, the mean number of operating rooms per ASC increased slightly from 2.5 to 2.6, although the median number of operating rooms remained the same at 2. This finding indicates that the growth in the number of operating rooms has been similar to the growth in the number of ASCs.

Our analysis also indicates that ASCs are concentrated geographically. As of 2009, Arizona had the most ASCs per beneficiary followed by Washington, Idaho, and Maryland, with each state having more than 30 ASCs per 100,000 beneficiaries. Meanwhile New York had the fewest ASCs per beneficiary, followed by Vermont and West Virginia, with each state having fewer than 5 per 100,000. In addition, in 2009, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not

changed over time (Table 5-3, p. 108). Beneficiaries who do not have access to an ASC may receive ambulatory surgical services in HOPDs and, in some cases, in physicians' offices. In addition, beneficiaries who live in rural areas may travel to urban areas to receive care in ASCs.

Steady growth in the number of Medicare-certified ASCs may indicate that Medicare's payment rates have been at least adequate, despite the fact that there were no positive updates to ASC payment rates from 2004 through 2009. However, Medicare payments are not a substantial source of revenue for ASCs. According to a survey conducted by the Medical Group Management Association, Medicare accounted for only 17 percent of ASC revenue, on average, in 2008 (Medical Group Management Association 2009). In addition, other factors have likely influenced the growth in the number of Medicare-certified ASCs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings.

**TABLE  
5-2**

**Number of Medicare-certified ASCs has grown by 28 percent, 2004-2009**

	2004	2005	2006	2007	2008	2009
Number of centers	4,106	4,404	4,654	4,932	5,151	5,260
New centers	369	355	332	347	273	164
Exiting centers	77	57	82	69	54	55
Net percent growth in number of centers from previous year	7.7%	7.3%	5.7%	6.0%	4.4%	2.1%

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2009.

**TABLE  
5-3****Most Medicare-certified ASCs  
are urban and for profit**

ASC type	2004	2009
Urban	87%	88%
Rural	13	12
For profit	96	96
Nonprofit	4	3

Note: ASC (ambulatory surgical center). Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS, 2009.

- Medicare began covering colonoscopy for colorectal cancer screening in 1998, increasing beneficiary use of the service in ASCs (and other settings).
- ASCs may offer patients greater convenience than HOPDs in terms of better locations, the ability to schedule surgery more quickly, and shorter waiting times.
- For most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs.<sup>8</sup>
- Physicians may find it more efficient to perform procedures in ASCs because they often have customized surgical environments and specialized staffing.
- Physicians who invest in ASCs can increase their revenue by receiving ASC facility payments. The federal anti-self-referral law (also known as the Stark Law) does not apply to surgical services provided in ASCs.
- Because physicians can probably perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more professional fees.

**Number of services grew during 2004–2009; newly covered services contributed to growth in number of services during 2007–2009**

Our examination of growth in service volume in ASCs focused on the number of surgical services provided per FFS beneficiary. We used this measure rather than aggregate service volume because enrollment in FFS Medicare has been declining in recent years due to large

increases in Medicare Advantage enrollment. We believe that growth in aggregate service volume would understate the extent to which FFS beneficiaries are receiving care in ASCs. Also, our analysis includes only surgical procedures that are covered under the ASC payment system, even though the ASC payment system now provides separate payment for some radiology services. We limited the analysis to surgical services because before 2008 the ASC payment system provided separate payment only for surgical procedures. From 2004 through 2009, the volume of surgical services per FFS beneficiary increased by an average of 8.1 percent per year (47 percent overall), including a 3.4 percent increase in 2009 over 2008 (Table 5-4).

The 2008 revision to the ASC payment system substantially increased the number of covered services, and these newly covered services contributed 41 percent of the overall volume growth from 2007 through 2009. We evaluated the effect of the increased number of covered services by breaking down the growth in service volume from 2007 through 2009 into two parts: the portion due to surgical services newly covered after 2007 (that is, Medicare began paying for these services in ASCs in 2008 or 2009) and the portion due to surgical services covered in both 2007 and 2009. Our analysis indicates that ASC service volume per FFS beneficiary increased by 6.6 percent per year from 2007 through 2009 (Table 5-4).<sup>9</sup> Services newly covered in 2008 or 2009 accounted for 2.7 percentage points of the increase in service volume per

**TABLE  
5-4****Volume of ASC services per FFS  
beneficiary has continued to grow**

Time period	Average annual volume growth per FFS beneficiary
2004 to 2009	8.1%
2007 to 2009	6.6
2008 to 2009	3.4
Services covered in 2007	2.4
Services newly covered in 2008 and 2009	23.7

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

Source: MedPAC analysis of 5 percent carrier standard analytic claims files, 2004, 2007, 2008, and 2009.

**TABLE  
5-5**

**Most frequently provided ASC services in 2009 were similar in 2007**

Surgical service	2007		2009	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	19.9%	1	18.1%	1
Upper GI endoscopy, biopsy	7.9	2	8.0	2
Diagnostic colonoscopy	5.9	3	4.6	4
Colonoscopy and biopsy	5.5	4	5.5	3
After cataract laser surgery	5.4	5	4.4	5
Lesion removal colonoscopy	4.8	6	4.4	6
Injection spine: lumbar, sacral (caudal)	4.3	7	3.6	7
Inject foramen epidural: lumbar, sacral	3.1	8	3.6	8
Inject paravertebral: lumbar, sacral add on	2.9	9	2.8	9
Inject paravertebral: lumbar, sacral	1.9	10	1.9	11
Lesion remove colonoscopy	1.7	11	1.3	15
Colon cancer screen, not high-risk individual	1.7	12	1.3	16
Inject foramen epidural add on	1.6	13	2.0	10
Upper GI endoscopy, diagnosis	1.5	14	1.3	14
Colorectal screen, high-risk individual	1.4	15	1.6	12
Cystoscopy	1.3	16	1.2	17
Destruction paravertebral nerve, add on	1.1	17	1.4	13
Revision of upper eyelid	0.9	18	1.0	19
Cataract surgery, complex	0.9	19	1.2	18
Inject spine, cervical or thoracic	0.8	20	0.9	21
Total	74.6		70.0	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal).

Source: MedPAC analysis of 5 percent carrier standard analytic claims files, 2007 and 2009.

FFS beneficiary, while services covered in both 2007 and 2009 accounted for the remaining 3.8 percentage points.<sup>10</sup> Moreover, the volume of surgical services newly covered in 2008 or 2009 increased by 23.7 percent in 2009, but these services were still a small share—5.3 percent—of total ASC volume in 2009.

Although newly covered services contributed much of the growth in service volume after 2007, the services that have historically contributed the most to overall volume continued to comprise a large share of the total in 2009. For example, cataract removal with intraocular lens insertion had the largest volume in both 2007 and 2009, accounting for 20 percent of volume in 2007 and 18 percent of volume in 2009. Moreover, 19 of the 20 most frequently provided services in 2007 were among the 20 most frequently provided in 2009 (Table 5-5). For these 20 services, service volume per FFS beneficiary

increased by 3.2 percent per year from 2007 through 2009. However, these 20 services accounted for a smaller share of total volume in 2009 than in 2007: 70.0 percent versus 74.6 percent. The fact that the most frequently provided services make up a smaller share of the total than previously may indicate that ASCs are diversifying their operations in response to the payment and coverage revisions made in 2008.

**Evidence that surgical services have migrated from HOPDs to ASCs**

The growth in service volume provided in ASCs may reflect, in part, migration of services from HOPDs to ASCs. We compared volume growth for services provided in ASCs with the growth of ASC-covered services provided in HOPDs. We limited this analysis to services that were covered in the ASC payment system in 2004, as the inclusion of services covered in the outpatient

**TABLE  
5-6**

**Volume of surgical services grew faster in ASCs than in HOPDs, 2004-2009**

Measure	Average annual percent change, 2004-2009	
	ASCs	HOPDs
Number of services per FFS beneficiary	6.8%	0.1%
Number of beneficiaries served	3.6	-1.7
Services per beneficiary served	3.1	1.8

Note: ASC (ambulatory surgical center), HOPD (hospital outpatient department), FFS (fee-for-service). To ensure comparability across sectors, the services analyzed consist of the same set of ambulatory surgical services. This set consists of services that were payable by Medicare when provided in an ASC in 2004.

Source: MedPAC analysis of 5 percent carrier and outpatient standard analytic claims files, 2004 and 2009.

PPS in 2004 that became covered in the ASC payment system after 2004 would have biased the results. From 2004 through 2009, the number of ASC-covered surgical services per FFS beneficiary grew by 6.8 percent per year in ASCs but by only 0.1 percent per year in HOPDs, which suggests that these surgical services may have migrated from HOPDs to ASCs during that period (Table 5-6). However, the difference in the rate of growth between ASCs and HOPDs narrowed in 2009: Surgical services per FFS beneficiary grew by 2.4 percent in ASCs compared with 1.1 percent in HOPDs. Therefore, the pace of migration of services from HOPDs to ASCs may be slowing.

Other data also suggest a shift in surgical services to ASCs. In Pennsylvania, ASCs' share of outpatient diagnostic and surgical procedures performed on all patients rose from 10 percent to 33 percent between 2000 and 2009. Moreover, most of the growth in outpatient diagnostic and surgical procedures during those years occurred in ASCs (Pennsylvania Health Care Cost Containment Council 2010).

However, factors other than migration to ASCs may have contributed to the relatively slow growth of surgical services in HOPDs. First, some HOPD services may have migrated to physicians' offices. Second, HOPDs may have found that services not covered under the ASC payment system, such as diagnostic imaging, are more profitable than surgical services. From 2004 through 2009, volume per FFS beneficiary of services not covered under the ASC payment system grew by 4.5 percent annually in HOPDs, compared with only 0.1 percent growth in ASC-covered services in HOPDs.<sup>11</sup>

Assuming there is no change in aggregate service volume, a shift in surgical services from HOPDs to ASCs would slow the growth of program spending because (starting in 2008) the payment rates for all surgical services are lower in the ASC payment system than in the outpatient PPS.<sup>12</sup> Our analysis comparing the number of cataract surgeries with intraocular lens insertion provided in ASCs with those in HOPDs illustrates this point. We found that, from 2004 through 2009, the proportion of these procedures provided in ASCs increased from 59 percent to 69 percent. Meanwhile, the payment rate for these procedures in 2009 was \$965 in ASCs compared with \$1,605 in HOPDs.

Most ASCs have some degree of physician ownership; physicians' investment in ASCs could give them an incentive to perform more surgical services than they would if they provided outpatient surgery only in HOPDs. This additional volume could partially offset the effect of comparatively lower ASC rates on Medicare spending. Recent studies offer limited evidence that physicians with an ownership stake in an ASC perform a higher volume of certain procedures than nonowning physicians (Hollingsworth et al. 2010, Mitchell 2010, Strobe et al. 2009). One study, using a proxy measure of physician ownership of ASCs in Florida, found that physicians who invested in ASCs increased their volume of four common surgical procedures in all settings more rapidly than nonowning physicians (Hollingsworth et al. 2010).<sup>13</sup> Although this study had limitations (it was based on a single state, used a proxy measure of physician ownership, and did not examine whether the additional procedures were inappropriate), it does suggest that the growth in ASCs may have resulted in greater overall volume of surgical procedures and not simply a migration of services

**TABLE  
5-7****Medicare payments to ASCs have grown, 2004-2009**

	2004	2005	2006	2007	2008	2009
Medicare payments (billions of dollars)	\$2.5	\$2.7	\$2.8	\$2.9	\$3.1	\$3.2
Medicare payments per FFS beneficiary	\$73	\$78	\$85	\$90	\$97	\$102
Percent change per FFS beneficiary	10.9%	6.8%	8.5%	5.6%	8.1%	5.1%

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

Source: CMS, Office of the Actuary.

from one setting to another. Consequently, the reductions in Medicare spending due to lower payment rates in ASCs could be partially offset by a higher overall number of procedures.

Moreover, there is evidence that physician-owned specialty hospitals are associated with higher volume in a market. The Commission found that the entrance of a cardiac hospital in a market was associated with a greater increase in coronary artery bypass graft surgeries than would be expected (Medicare Payment Advisory Commission 2006). Specialty hospitals and ASCs are different, but the relationship between physician ownership and volume of services in specialty hospitals may be similar for ASCs. Because it is probably easier to generate demand for some of the low-risk procedures typically provided in ASCs than for the higher risk procedures furnished in specialty hospitals, the influence of physician ownership on volume may be stronger in ASCs than in specialty hospitals.

### **Providers' access to capital: Growth in number of ASCs and ASCs' financial performance suggest adequate access**

Owners of ASCs require capital to establish new facilities and upgrade existing ones. The change in the number of ASCs is the best indicator available of ASCs' ability to obtain capital. The number of ASCs continued to increase in 2009, although at a slower rate than in prior years (Table 5-2, p. 107). The downturn in credit markets that occurred in the latter part of 2008, the economic slowdown that occurred in 2008 and 2009, and the sluggish pace of the economic recovery likely reduced providers' access to capital and may have had a role in slowing the growth in the number of new ASCs. Because these economic changes were unrelated to changes in Medicare payments, changes in access to capital in 2009 may not be a good indicator of Medicare payment adequacy. In addition,

Medicare accounts for a relatively small share of ASCs' overall revenue, and thus other factors may have a larger impact on access to capital for this sector.

Data on the financial performance of publicly traded ASCs also provide evidence of the sector's access to capital. From 2009 through 2010, earnings per share (EPS) of stock were expected to be largely unchanged for one of the two publicly traded ASC chains (Deutsche Bank 2010a). EPS for the other publicly traded chain was projected to fall by 8 percent from 2009 through 2010, but it is expected to increase by 11 percent in 2012 (Deutsche Bank 2010b). The earnings produced by these ASCs are one source of capital they can use to establish new facilities or expand existing ones. We caution, however, that the publicly traded ASC chains represent only 4 percent of all Medicare-certified ASCs, so their growth in earnings may not be indicative of the ASC industry.

### **Medicare payments: Payments have increased rapidly**

In 2009, ASCs received about \$3.2 billion in payments from Medicare and beneficiaries' cost sharing (Table 5-7). From 2004 through 2008, spending per FFS beneficiary increased by an average of 7.2 percent per year and by 5.1 percent in 2009. From 2007 through 2009, spending per FFS beneficiary increased by 6.6 percent per year, with services newly covered after 2007 accounting for 2.4 percentage points of that increase; services covered in both 2007 and 2009 accounted for the remaining 4.2 percentage points.

Earlier, we showed that services newly covered after 2007 accounted for 41 percent of the service volume growth from 2007 through 2009. Some may be concerned that payment rates for these newly covered services are inadequate when they are equivalent to the nonfacility practice expense amount from the MPFS. However, the

growth in spending and volume in 2009 suggests that ASC payment rates for these newly covered services were at least adequate. It is plausible that ASCs will furnish more of the newly covered services in succeeding years as more ASCs modify their operations to furnish those services. As evidence, the volume of services that were newly covered after 2007 increased by 23.7 percent in 2009 (these services still represented a small share—5.3 percent—of total ASC volume in 2009).

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## How should Medicare payments change in 2012?

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Our payment adequacy analysis indicates that the supply of Medicare-certified ASCs has increased, beneficiaries' use of ASCs has increased, and access to capital has been adequate. In addition, CMS increased the ASC conversion factor by 1.2 percent in 2010 and by 0.2 percent in 2011. The update for 2011 was based on a 1.5 percent increase in the consumer price index for all urban consumers (CPI-U), which CMS uses to update ASC rates, minus a 1.3 percent deduction for multifactor productivity growth, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA). However, our information for assessing payment adequacy is limited because, unlike other facilities, Medicare does not require ASCs to submit cost or quality data.

### Update recommendation

As the Commission considers an update to the ASC conversion factor for 2012, several goals should be balanced:

- Maintain beneficiaries' access to ASC services.
- Pay providers adequately.
- Hold down the burden on the beneficiaries, workers, and firms who finance Medicare.
- Maintain the sustainability of the Medicare program by appropriately restraining spending in the ASC sector.
- Keep providers under financial pressure to constrain costs.
- Require ASCs to submit cost and quality data.

Ensuring payment adequacy for ASCs is important to Medicare. The providers with the greatest overlap of surgical services with ASCs are HOPDs, and ASCs can offer advantages over HOPDs that are beneficial to maintain. Medicare's cost per service is lower in ASCs, and beneficiaries generally have lower coinsurance in ASCs than in HOPDs for each procedure covered under the ASC payment system (Government Accountability Office 2006). Also, ASCs likely offer efficiencies to beneficiaries and physicians that are not available in HOPDs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling; for physicians, they can offer customized surgical environments and specialized staffing. Thus, it is vital that ASCs be paid adequately to ensure that beneficiaries have this option available.

ASCs may still be in the process of adjusting to the revised payment system that CMS implemented in 2008. However, indications based on data from 2008 and 2009 suggest that the revised payment system is not detrimental and may be beneficial to ASCs' long-term future:

- ASCs' revenue and volume from Medicare-covered services increased from 2007 through 2009, and much of this growth was from services newly covered after 2007.
- The volume of services that were newly covered under the revised payment system increased by 23.7 percent in 2009, but we caution that these services made up only 5.3 percent of total surgical volume in ASCs in 2009.
- The number of ASCs increased in 2008, 2009, and the first three quarters of 2010 despite an economic slowdown and sluggish recovery.

However, to fully assess the effects of the revised payment system and make informed decisions about the ASC update, we need cost and quality data. Cost data are also needed to examine whether an alternative input price index would be an appropriate proxy for ASC costs or an ASC-specific market basket should be developed (Medicare Payment Advisory Commission 2010b). The Commission has previously expressed concern that the market basket index that CMS uses to update ASC payments (the CPI-U) may not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010b). Quality data would enable CMS to assess ASCs' performance and reward high-performing providers and allow beneficiaries to compare quality among providers.

## RECOMMENDATION 5

**The Congress should implement a 0.5 percent increase in payment rates for ambulatory surgical center services in calendar year 2012 concurrent with requiring ambulatory surgical centers to submit cost and quality data.**

## RATIONALE 5

On the basis of our payment adequacy indicators, the lack of data on the cost and quality of ASC services, and our concerns about the potential effect of ASC growth on overall program spending, we believe that a moderate update of 0.5 percent is warranted for 2012. The Commission does not support a positive update for ASC services unless the Congress requires ASCs to submit cost and quality data to CMS.

A number of factors indicate that Medicare payments to ASCs have been at least adequate. The Commission has found continued growth in the number of Medicare-certified ASCs as well as fairly strong growth in the volume of services to Medicare beneficiaries, number of beneficiaries receiving care in ASCs, and number of services per beneficiary treated in ASCs. This growth occurred despite no positive updates to ASC payment rates from 2004 through 2009. In addition, the number of services covered under the ASC payment system increased substantially in 2008, providing ASCs with an opportunity to enhance their Medicare revenue. Data suggest that ASCs are adapting to the opportunities presented by the increase in covered services. From 2007 through 2009, the newly covered services contributed 41 percent of the growth in service volume and 37 percent of the growth in spending. Moreover, in 2009, the volume per beneficiary of these newly covered services increased by 23.7 percent. Finally, the growth in the number of ASCs indicates they have at least adequate access to capital. Therefore, although we lack cost and quality data, the indicators we do have suggest that payments have been adequate.

It is vital that CMS begin collecting cost and quality data from ASCs without further delay. The lack of cost and quality data for ASCs is a major reason why our recommended update for ASCs is lower than that of the other two sectors that perform ambulatory surgeries—physicians' offices and HOPDs. Cost data from ASCs would enable analysts to determine the costs of an efficient provider, which would help inform decisions about the ASC update. All else being equal, continued growth in the volume of Medicare services, number of beneficiaries treated in ASCs, and number of Medicare-certified ASCs signal that payments are at least adequate. However, data

Medicare does not require ASCs to submit cost or quality data despite the Commission's recommendations in previous reports that ASCs submit such data to CMS (Medicare Payment Advisory Commission 2004, Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2010b). Although CMS has the authority to require ASCs to submit quality data and to reduce the annual update by 2.0 percentage points for ASCs that fail to do so, the agency has decided to postpone collection of those data to allow ASCs time to adjust to the revised payment system and give CMS time to identify the most appropriate quality measures. CMS has also raised concerns about its resource constraints. We are encouraged, however, that CMS intends to propose an ASC quality measure reporting program in the 2012 proposed rule for HOPDs and ASCs (Centers for Medicare & Medicaid Services 2010).

Those who argue against ASCs submitting cost data contend that ASCs typically are relatively small facilities and have limited resources for supplying the data. The Commission maintains, however, that ASCs are businesses, and businesses typically keep records of their costs for purposes such as filing taxes. Moreover, other small providers, such as home health agencies and hospices, are required to submit cost data to CMS. Because collecting and vetting cost reports from the more than 5,000 Medicare-certified ASCs would be burdensome for CMS and because total Medicare spending on ASCs is small relative to other sectors (\$3.2 billion), CMS should streamline the collection of cost data relative to other sectors.

One data collection mechanism could be an annual survey of a random sample of ASCs—for example, a randomly selected set of facilities (with mandatory response). Advantages of a random sample are that all ASCs would not have to furnish data each year and that CMS would have to process data from only a fraction of them. A second mechanism could be cost reports from all ASCs that are more streamlined than hospital cost reports but still have enough information to fully assess the adequacy of ASC payment rates and develop an ASC market basket. An advantage of a streamlined cost report is that ASCs would not face the uncertainty presented by a random sample; each ASC would know that it has to submit a cost report each year. In addition, a complete set of cost data would be available for assessing payment adequacy and developing a market basket. The burden on CMS from auditing cost reports could be reduced by randomly selecting a fraction of all cost reports to audit.

on the financial performance of ASCs are important to give the Congress a more complete picture of payment adequacy. Cost data are also needed to examine whether an alternative input price index would be an appropriate proxy for ASC costs or whether an ASC-specific market basket should be developed. Not all ASCs would be required to submit cost information if CMS decided to collect cost data by surveying a random sample of ASCs.

Quality data from ASCs would enable CMS to assess performance and reward providers through payment adjustments based on quality and allow beneficiaries to compare providers and sites of care on the basis of quality. Because CMS will require time to develop a method for collecting cost and quality data and to select quality measures, we recognize that ASCs may not begin submitting data during 2012. However, the Congress should require ASCs to submit these data as soon as possible so that CMS can begin preparing to collect the data. We are encouraged that CMS intends to propose an ASC quality measure reporting program in the 2012 proposed rule for HOPDs and ASCs (Centers for Medicare & Medicaid Services 2010).

We believe that a 0.5 percent increase in ASC payments for 2012 will enable ASCs to continue furnishing services to beneficiaries, thereby maintaining beneficiaries' access to ASC care. Under current law established in PPACA, the update in 2012 for ASCs would be the currently projected increase in the CPI-U of 2.1 percent less the currently forecast multifactor productivity growth of 1.3 percent, for a net update of 0.8 percent (IHS Global Insight 2010).

In developing this recommendation, we considered the advantages that ASCs offer relative to HOPDs. Specifically, ASCs can offer greater efficiency and convenience to patients and providers. In addition, program spending and beneficiary cost sharing are generally lower in ASCs than in HOPDs on a per service basis. Therefore, migration of surgical services from HOPDs to ASCs could reduce aggregate program spending and beneficiary cost sharing.

However, such an impact on aggregate spending and cost sharing is not certain. If ASCs are drawing services away from settings where payment rates typically are lower, such as physicians' offices, the expansion in the number of ASCs would increase Medicare spending. In addition, HOPDs may be increasing their provision of nonsurgical services to offset the migration of surgical procedures to ASCs. Finally, the prevalence of physician ownership

of ASCs may give physicians an incentive to perform more surgical services than they would if they provided outpatient surgical services only in HOPDs. Recent studies offer limited evidence that physicians with an ownership stake in an ASC perform a higher volume of certain procedures than nonowning physicians. To the extent that physicians act on this financial incentive, a higher overall number of procedures could offset some of the reductions in program spending and beneficiary cost sharing that result from ASCs' lower payment rates and coinsurance.

## IMPLICATIONS 5

### Spending

- Because the projected update under current law for 2012 would be 0.8 percent, our recommended update of 0.5 percent would decrease federal spending by less than \$50 million in the first year and by less than \$1 billion over five years.

### Beneficiary and provider

- Because of the growth in the number of Medicare-certified ASCs and the number of beneficiaries treated in ASCs, we do not anticipate that this recommendation will diminish beneficiaries' access to ASC services or providers' willingness or ability to provide those services.
- ASCs will incur some administrative costs to submit cost and quality data. ■



## Endnotes

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- 1 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated a requirement that the Secretary collect cost data from ASCs every five years.
- 2 Medicare's share of total ASC revenue varies by type of ASC, ranging from 7 percent for ASCs that specialize in orthopedic procedures to 43 percent for ASCs that specialize in ophthalmology cases (Medical Group Management Association 2009).
- 3 Because ASCs are disproportionately located in some states (such as California, Florida, Georgia, Maryland, and Texas), we weighted beneficiaries so that in each state the percentage of beneficiaries receiving care in ASCs matched the national percentage. This process prevented idiosyncrasies in states that have high concentrations of ASCs from biasing the results. The analysis excluded beneficiaries who received services that are not payable by Medicare in ASCs.
- 4 Some of the discrepancies we see between the profile of ASC patients and the profile of HOPD patients are not as large as they appear because of interactions with other variables. For example, Medicare patients who also have Medicaid coverage (dual eligibles) are less likely to receive care in ASCs than in HOPDs. The smaller share of African Americans treated in ASCs is influenced by the fact that they are more likely than other races and ethnicities to be dual eligibles. If we control for differences in the percent of dual eligibles in ASCs and HOPDs, the share of African Americans treated in ASCs rises from 6.6 percent to 7.6 percent, compared with 10.0 percent in HOPDs.
- 5 Risk scores represent beneficiaries' expected service use given their health status relative to that of the national average beneficiary. For the 10 categories of procedures with the highest share of Medicare payments to ASCs, patients treated in ASCs in 1999 had somewhat lower average risk scores than HOPD patients.
- 6 These data are based on 262 ASCs and 171 hospitals.
- 7 The sample of freestanding ASCs in the NSAS includes facilities listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database and Medicare-certified ASCs from CMS's Provider of Services file (Cullen et al. 2009). Thus, at least some of the ASCs in the sample may not be Medicare-certified ASCs.
- 8 By statute, coinsurance for a service paid under the outpatient PPS cannot exceed the hospital inpatient deductible (\$1,132 in 2011). The ASC payment system does not have the same limitation on coinsurance, and for a few services the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the outpatient PPS coinsurance.
- 9 Our analysis of service volume in 2009 included surgical procedures only, as nearly all these procedures had Current Procedural Terminology codes in the range 10000–69999. Our analysis of 2009 service volume did not include nonsurgical services, such as radiology services, brachytherapy sources, drugs, and pass-through devices. In addition, it did not include services that are packaged in 2009.
- 10 Office-based procedures accounted for most of the growth from newly covered services. These procedures accounted for 2.4 percentage points of the average annual volume increase from 2007 through 2009.
- 11 In Chapter 3 of this report, we report an average annual growth rate for hospital outpatient services from 2004 through 2009 of 4.3 percent. The growth rate of 0.1 percent for HOPD services that we report in this chapter is much lower because it refers to growth in surgical services covered in the ASC payment system as of 2004. The growth rate reported in Chapter 3 is for all surgical services and all nonsurgical services provided in HOPDs. Surgical services covered in the ASC payment system in 2004 make up only 5.6 percent of total volume in HOPDs.
- 12 Before 2008, ASC rates could be above, below, or equal to HOPD rates.
- 13 This study assumed that physicians who performed at least 30 percent of their outpatient surgeries at a given ASC within a year were ASC owners. The four procedures for which there was a significant relationship between ASC ownership and volume in the time series analysis were carpal tunnel release, cataract excision, colonoscopy, and knee arthroscopy. There was no significant relationship for myringotomy with tube placement.

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