

CHAPTER

5

**Ambulatory surgical
center services**

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

5-1 The Secretary should require ambulatory surgical centers to report cost data.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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5-2 For calendar year 2021, in the absence of cost report data, the Congress should eliminate the update to the calendar year 2020 Medicare conversion factor for ambulatory surgical centers.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Ambulatory surgical center services

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay after the procedure. In 2018, the 5,717 ASCs certified by Medicare treated 3.5 million fee-for-service (FFS) Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$4.9 billion.

Assessment of payment adequacy

Our results indicate that beneficiaries' access to ASC services is adequate. The available indicators of payment adequacy for ASC services, discussed below, are positive.

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

- **Capacity and supply of providers**—From 2013 to 2017, the number of ASCs increased by an average annual rate of 1.5 percent. In 2018, the number of ASCs increased 2.6 percent. Most new ASCs in 2018 (93 percent) were for-profit facilities.
- **Volume of services**—From 2013 through 2017, the volume of services per beneficiary increased by an average annual rate of 1.5 percent. In 2018, volume increased by 2.2 percent.

In this chapter

- Are Medicare payments adequate in 2020?
- How should Medicare payments change in 2021?

Quality of care—The first five years of ASC-reported quality data show improvement in performance. Among the nine quality measures for which data were available through 2017, performance among the ASCs that reported data improved for most measures. CMS will be making several changes to the ASC Quality Reporting Program for 2019 and beyond. However, we remain concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems[®] measures and the lack of claims-based outcomes measures that apply to all ASCs. For example, CMS could add measures targeting the frequency of ASC patients receiving hospital care after ASC discharge.

Providers' access to capital—Because the number of ASCs has continued to increase and hospital systems and others have significantly incorporated ASCs into their business strategies, access to capital appears to be adequate.

Medicare payments and providers' costs—From 2013 through 2017, Medicare payments for ASC services per FFS beneficiary increased by an average annual rate of 4.9 percent. However, in 2018, growth in these payments increased by 7.4 percent. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to help assess payment adequacy.

The Commission believes cost data are vital for making informed decisions about updating ASC payment rates and for identifying an appropriate input price index for ASCs. Therefore, the Commission continues to recommend that the Secretary of Health and Human Services collect cost data from ASCs without further delay. Also, in the absence of cost report data, the Commission concludes that the positive payment adequacy measures indicate that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2021. ■

Background

An ambulatory surgical center (ASC) is a distinct entity that primarily provides outpatient surgical procedures to patients who do not require an overnight stay after the procedure. In addition to ASCs, hospital outpatient departments (HOPDs) and, in some cases, physicians' offices are locations where providers perform outpatient surgical procedures.

Since 1982, Medicare has covered and paid for surgical procedures provided in ASCs. Medicare covers surgical procedures represented in about 3,500 Healthcare Common Procedure Coding System (HCPCS) codes under the ASC payment system. However, ASC volume for services covered under Medicare is concentrated in a relatively small number of HCPCS codes. For example, in 2018, 28 HCPCS codes accounted for 75 percent of the ASC volume for surgical services provided to Medicare beneficiaries. For procedures performed in an ASC, Medicare makes two payments: one to the facility through the ASC payment system and the other to the physician for his or her professional services through the payment system for physicians and other health professionals known as the physician fee schedule (PFS). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2017, Leapfrog 2019). Physicians who perform surgeries in ASCs they own receive a share of the ASC's facility payment in addition to payment for their professional services. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify standards for administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, nursing services, and other aspects of care.

Medicare pays ASCs for a bundle of facility services and items—such as nursing, recovery care, anesthetics, and supplies—through a system that is linked primarily to the outpatient prospective payment system (OPPS), which Medicare uses to set payment rates for most services provided in HOPDs. The ASC payment system is also partly linked to the PFS. A more detailed description of the ASC payment system can be found online at http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_asc_final_sec.pdf?sfvrsn=0.

For most covered procedures, payment rates in the ASC payment system are the product of a relative weight and a conversion factor. The ASC relative weight, which indicates a procedure's resource intensity relative to other

procedures, is based on its relative weight under the OPPS. Although CMS links the ASC payment system to the OPPS, payment rates for all services covered under both systems are lower in ASCs for two reasons. First, CMS makes proportional adjustments to the relative weights of the OPPS because ASCs provide a different mix of services. Without a proportional adjustment to OPPS relative weights, Medicare program spending for ASC services would not be budget neutral from one year to the next. In 2020, this adjustment results in ASC relative weights that are 14.5 percent lower than the relative weights in the OPPS. Second, for most procedures covered under the ASC system, the payment rate is the product of its relative weight and an ASC conversion factor, set at \$47.75 for 2020, which is lower than the OPPS conversion factor of \$80.78 for 2020.

The ASC conversion factor is lower than the OPPS conversion factor because it started at a lower level in 2008 and (until 2019) has been updated at a lower rate than the OPPS conversion factor. CMS set the initial ASC conversion factor in 2008 such that total payments to ASCs under the revised payment system would equal what they would have been under the pre-2008 ASC payment system. From 2010 through 2018, CMS updated the ASC conversion factor based on the consumer price index for all urban consumers (CPI-U), while it used the hospital market basket (MB) index to update the OPPS conversion factor. The CPI-U has generally been lower than the hospital MB index. Therefore, before 2019, the ASC conversion factor was updated by smaller percentages than the OPPS conversion factor.

In a change of regulatory policy, CMS has instituted a policy of updating the ASC conversion factor using the hospital MB index from 2019 through 2023. Under this change, the updates to the ASC conversion factor will align with the updates to the OPPS conversion factor.

We are concerned that neither the CPI-U nor the hospital MB index reflects ASCs' cost structure (see text box, p. 161). The Commission has recommended that CMS collect cost data from ASCs to identify a price index that would be an appropriate proxy for ASC costs (Medicare Payment Advisory Commission 2010). However, the ASC industry has opposed the collection of cost data for this purpose (Ambulatory Surgery Center Association 2012), and CMS does not yet collect these data. In 2018, CMS requested comments from stakeholders on whether the Secretary should collect cost data from ASCs to use in determining ASC payment rates. Representatives

**TABLE
5-1**

Number of ASCs grew, 2013-2018

Type of ASC	2013	2017	2018	Average annual percent change	
				2013-2017	2017-2018
Total	5,253	5,571	5,717	1.5%	2.6%
New	179	215	224	N/A	N/A
Closed or merged	120	94	78	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable). The average annual percentage change data for the “new” and “closed or merged” categories are shown as “N/A” because they are outside the purpose of this table, which is to show the growth in the total number of ASCs.

Source: MedPAC analysis of Provider of Services file from CMS, 2019.

of individual ASCs provided comments that generally opposed a policy that would require ASCs to submit formal cost reports, but were willing to complete surveys on the condition that they would not be administratively burdensome (Centers for Medicare & Medicaid Services 2017). The Commission asserts, however, that all other institutional providers submit at least abbreviated versions of cost reports to CMS, including small entities such as hospices and home health agencies. Moreover, ASCs in Pennsylvania submit revenue and cost data each year to the Pennsylvania Health Care Cost Containment Council, so it is clear that submission of cost data is feasible for ASCs. Indeed, submitting revenue and cost data does not appear to adversely affect ASC participation, as in Pennsylvania there were six more ASCs in 2018 than in 2017.

CMS uses a different method from the one described above to determine payment rates for “office-based” procedures, which are procedures that are predominantly performed in physicians’ offices and were first covered under the ASC payment system in 2008 or later. Payment for office-based procedures is the lesser of the amount derived from the standard ASC method or the practice expense portion of the PFS rate that applies when the service is provided in a physician’s office (the nonfacility practice expense, which covers the equipment, supplies, nonphysician staff, and overhead costs of a service).¹ 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. Physicians who

provide office-based procedures in ASCs receive a separate payment under the PFS (the full facility payment rate).

The ASC payment system somewhat parallels the OPSS in terms of which ancillary items are paid separately and which are packaged into the payment of the associated surgical procedure. However, the connection between the ASC payment system and the OPSS has been declining as CMS has increased the number of services in comprehensive ambulatory payment classifications (C-APCs) in the OPSS, while CMS has not implemented C-APCs in the ASC system. C-APCs combine all hospital outpatient services reported on a claim that are covered under Medicare Part B into a single payment, with a few exceptions. CMS has not implemented C-APCs in the ASC system, stating that the system of processing ASC claims does not allow for the type of packaging of ancillary items necessary to create C-APCs. Therefore, the payment bundles for services in the C-APCs under the OPSS have greater packaging of ancillary items than the same services under the ASC payment system. Consequently, a disconnect exists between OPSS payment rates and ASC payment rates for the services that are in C-APCs under the OPSS, and this disconnect has grown over time as CMS has substantially expanded the number of C-APCs. Currently, about 72 percent of HCPCS codes for surgical procedures that are covered under the ASC payment system are in C-APCs under the OPSS. These procedures constituted 42 percent of ASC surgical volume in 2018. The Commission supports the use of C-APCs in

the OPPIs and encourages CMS to implement them in the ASC payment system because the greater packaging of ancillary items that occurs with C-APCs gives providers an incentive to furnish care more efficiently.

Although we do not have recent ASC cost data that would allow us to quantify cost differences between settings, some evidence suggests that ASCs are a lower cost setting than HOPDs. The Government Accountability Office (GAO) compared ASC cost data from 2004 with HOPD costs and found that costs were, on average, lower in ASCs than in HOPDs (Government Accountability Office 2006).² In addition, studies that used data from the National Survey of Ambulatory Surgery found that the average time for ambulatory surgical visits for Medicare patients was 25 percent to 39 percent lower in ASCs than in HOPDs, which likely contributes to lower costs in ASCs (Hair et al. 2012, Munnich and Parente 2014). An additional study using data from a facility that has both an ASC and a hospital found that surgeries took 17 percent less time in the ASC (Trentman et al. 2010). The 2010 Trentman study and the 2014 Munnich study estimated less time savings in ASCs than did the 2014 Hair study, likely because Trentman and Munnich accounted for differences in health status between patients treated in ASCs and those treated in HOPDs, while Hair did not. Beneficiaries who are sicker may require more time to treat. We have found that, on average, beneficiaries receiving surgical services in HOPDs are not as healthy as beneficiaries receiving those services in ASCs, as indicated by risk scores from the CMS hierarchical condition categories risk adjustment model.

Are Medicare payments adequate in 2020?

To address whether payments for the current year (2020) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2021), we examine several measures of payment adequacy. We evaluate 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 changes in ASC revenue from the Medicare program. However, our assessment of quality of care (another measure of payment adequacy) is limited and does not fully represent quality in ASCs. Our available indicators of payment adequacy are positive.

Beneficiaries' access to care: Supply of ASCs and volume of services indicate adequate access

Beneficiaries have adequate access to care in ASCs. The number of ASC facilities has increased, and the volume of services provided to Medicare beneficiaries in ASCs also has increased. Access to ASCs may be beneficial to patients and physicians compared with HOPDs, the provider type most similar to ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs. ASCs offer physicians more control over their work environment and specialized staff. In addition, Medicare's payment rates and beneficiaries' cost sharing are lower in ASCs than in HOPDs. However, these same qualities could lead to overuse of surgical procedures.

Capacity and supply of providers: Number of ASCs is increasing

From 2017 to 2018, the number of ASCs increased 2.6 percent to 5,717 ASCs (Table 5-1). This annual growth rate was faster than growth in the period from 2013 to 2017, when the number of ASCs increased, on average, 1.5 percent per year. In 2018, the number of new ASCs increased by 224, while 78 ASCs closed or merged with other facilities. The number of ASCs that closed or merged has declined each year from 2013 to 2018 and has been lower than the number of new ASCs each year. Finally, the number of ASCs that billed Medicare for at least one surgical service in 2018 was 5,063 (data not shown).

Two factors likely account for the slower growth from 2013 to 2017. First, from 2013 to 2016, to expand their outpatient surgery capacity, many hospitals acquired ASCs and made them hospital departments or developed new surgery centers that were part of the hospital. This approach limited the number of new freestanding ASCs (Jacobson 2014, Kochman 2014, Levingston 2014, Moody 2014, Sowa 2014). Hospitals' decisions to increase their outpatient surgery capacity may have been influenced by the higher rates Medicare pays for ambulatory surgical services provided in HOPDs relative to ASCs (in 2020, Medicare's rates are 98 percent higher in HOPDs than in ASCs). Second, during this period, the share of physicians employed by hospitals increased while the share in independent practice decreased (American Medical Association 2019, Berenson et al. 2012, Mathews 2012, Medicare Payment Advisory Commission 2013a, Merritt Hawkins 2014, Physicians Advocacy Institute 2019).

**TABLE
5-2****Most ASCs are for profit and urban**

ASCs that were:

Type of ASC	Open in 2013	Open in 2018	New in 2018
For profit	94.5%	94.6%	93.3%
Nonprofit	3.6	3.7	6.3
Government	1.9	1.7	0.4
Urban	92.6	93.3	98.2
Rural	7.4	6.7	1.8

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2019.

In general, these physicians are more likely to provide ambulatory procedures in the hospitals that employ them than in freestanding ASCs.

The relatively higher growth from 2017 to 2018 likely resulted from a change in payment policy for newly acquired ASCs under which hospital systems, such as Tenet and HCA, continued investments in outpatient surgical capacity. Hospital systems that acquire ASCs have the option of maintaining the facility as an ASC or converting it to an off-campus provider-based department (PBD) of a hospital (most likely an outpatient surgery department). However, in response to provisions in section 603 of the Bipartisan Budget Act of 2015, CMS in 2017 aligned payment rates for newly acquired facilities established as off-campus PBDs with PFS payment rates, which are typically lower than ASC rates. Therefore, beginning in 2017, there has been little incentive for a hospital system to acquire an ASC and convert it to an off-campus PBD. Instead, it is now more financially beneficial to maintain the facility as an ASC.

The number of operating rooms (ORs) in ASCs is also growing. In 2018, there were nearly 17,400 ORs in ASCs, or an average of 3.0 per facility. From 2013 to 2017, the total number of ASC ORs increased 0.9 percent per year, a slower rate than the growth in the number of ASCs over the same period (1.5 percent per year). However, from 2017 to 2018, the number of ORs in ASCs increased

by about 2.6 percent, the same as the growth rate in the number of ASCs during this period, which suggests the size of ASCs decreased from 2013 to 2017 but stayed at the same level from 2017 to 2018.

Consistent with previous years, most ASCs in 2018 were for profit (94.6 percent) and located in urban areas (93.3 percent) (Table 5-2). In contrast, 78.5 percent of HOPDs were in urban areas in 2018 (data not shown). ASCs that were new in 2018 were still likely to be for profit, but compared with existing ASCs, new ASCs were more likely to be nonprofit and urban (including urban and suburban areas). Beneficiaries who do not live near an ASC can obtain ambulatory surgical services in HOPDs and, in some cases, physicians' offices. Beneficiaries who live in rural areas can travel to urban areas to receive care in ASCs.

Geographic distribution of ASCs is uneven

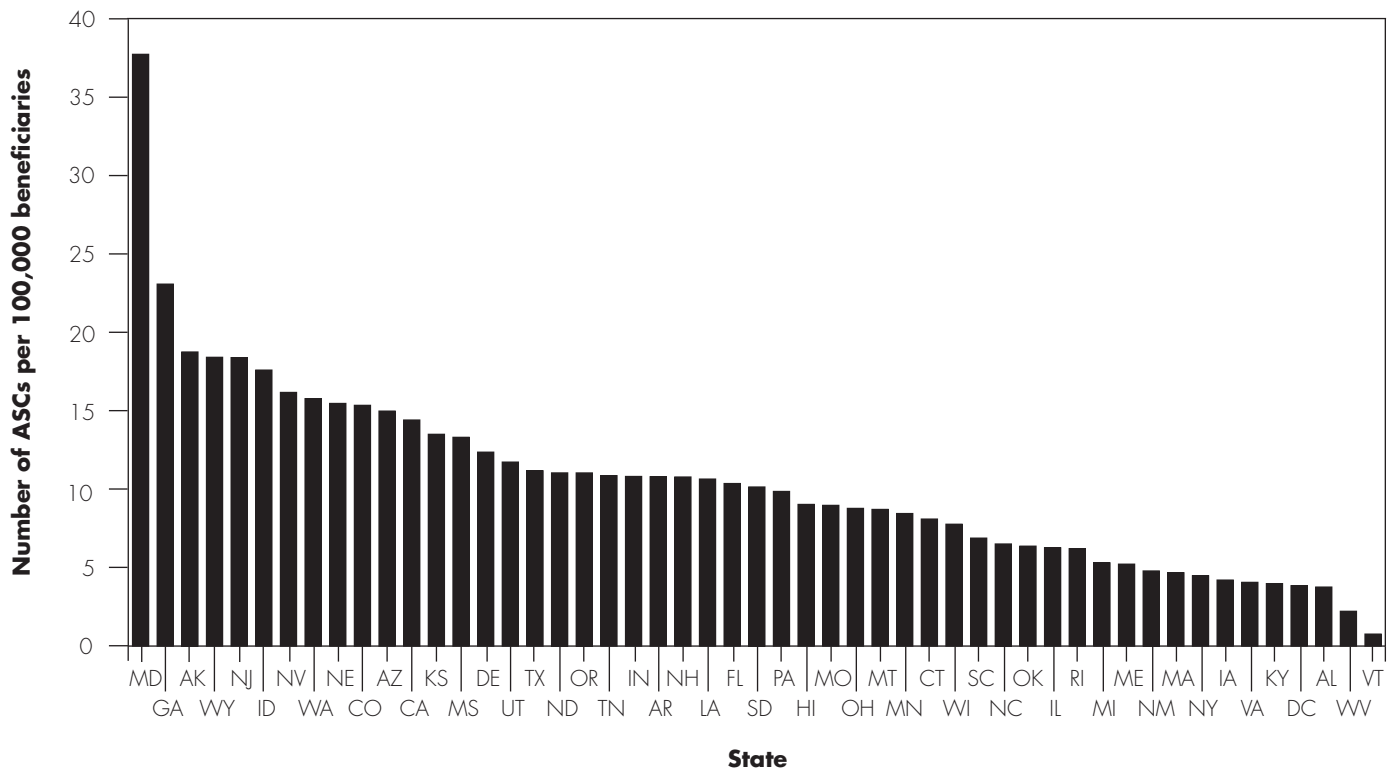
In addition to ASCs locating more in urban than rural areas, the concentration of ASCs varies widely among states. In 2018, Maryland had the most ASCs per Medicare beneficiary (38 ASCs per 100,000 Part B beneficiaries), followed by Georgia, Alaska, and Wyoming (18 to 23 ASCs per 100,000 beneficiaries) (Figure 5-1). Kentucky, the District of Columbia, Alabama, West Virginia, and Vermont had the fewest ASCs per beneficiary (fewer than 4 ASCs per 100,000 beneficiaries). Availability in Vermont was especially low, with less than 1 ASC per 100,000 beneficiaries and only 1 ASC in the entire state.³

Even though beneficiaries can largely receive the same services in HOPDs if an ASC is not located near them, the small number of ASCs in some states and rural areas raises concerns about beneficiaries' access to ambulatory surgical services in the context of site-neutral payments between ASCs and HOPDs. In its 2013 report, the Commission identified surgical services that are viable for site-neutral payments between the ASC payment system and the OPFS (Medicare Payment Advisory Commission 2013a). The impact of site-neutral payments between ASCs and HOPDs would be to lower payment for some services in HOPDs. Hospitals could respond by reducing the extent to which they provide these services. In areas that have low ASC concentration, site-neutral payments could make it more difficult for beneficiaries to access ambulatory surgical services.

We found that rural beneficiaries—defined as those who live outside metropolitan statistical areas (MSAs)—are less likely to receive care in an ASC than are urban

FIGURE 5-1

Number of ASCs per beneficiary varies widely by state, 2018



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2019.

beneficiaries—defined as those living in an MSA. In 2018, 7.2 percent of rural beneficiaries received care in an ASC versus 10.6 percent of urban beneficiaries.

Specialization of ASCs largely unchanged, some growth in pain management

In 2018, the majority of ASCs that billed Medicare specialized in a single clinical area, of which gastroenterology (21 percent of ASCs) and ophthalmology (21 percent of ASCs) were the most common. Overall, in 2018, 65 percent of ASCs were single-specialty facilities and 35 percent were multispecialty facilities, providing services in more than one clinical specialty (Table 5-3, p. 150).⁴ The most common multispecialty ASCs focused on two specialties; in 2018, those ASCs specialized in pain management and either ophthalmology or orthopedic services (6 percent of all ASCs). From 2015 to 2018,

ASCs specializing in pain management services grew most rapidly.

Continued growth in the number of ASCs suggests that Medicare’s payment rates have been adequate. Other factors also have likely influenced the long-term growth in the number of ASCs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings. There is potential for this trend to continue as momentum grows for knee and hip arthroplasty (knee and hip replacement) to be done in ambulatory settings.
- ASCs can offer patients greater convenience than HOPDs, such as the ability to schedule surgery more quickly.

**TABLE
5-3**

Specialization of ASCs billing Medicare in 2015 and 2018

Type of ASC	2015		2018	
	Number of ASCs	Share of all ASCs	Number of ASCs	Share of all ASCs
Single specialty	2,878	61%	3,277	65%
Gastroenterology	1,027	22	1,071	21
Ophthalmology	1,020	22	1,046	21
Pain management	355	8	612	12
Dermatology	191	4	197	4
Urology	124	3	127	3
Podiatry	95	2	87	2
Orthopedics/musculoskeletal	23	0	33	1
Respiratory	16	0	26	1
OB/GYN	9	0	14	0
Cardiology	10	0	55	0
Neurology	5	0	4	0
Other	3	0	5	0
Multispecialty	1,802	38	1,784	35
More than 2 specialties	1,421	30	1,313	26
Pain management and either ophthalmology or orthopedics	221	5	292	6
Gastroenterology and ophthalmology	160	3	179	4
Total	4,680	100	5,061	100

Note: ASC (ambulatory surgical center), OB/GYN (obstetrics and gynecology). A “single-specialty ASC” is defined as one with more than 67 percent of its Medicare claims in one clinical specialty. A “multispecialty ASC” is defined as one with less than 67 percent of its Medicare claims in one clinical specialty. ASCs included in this analysis are limited to those in the 50 states and the District of Columbia with a paid Medicare claim in 2018. Columns containing the share of all ASCs may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2018.

- For most procedures covered under the ASC payment system, beneficiaries’ coinsurance is lower in ASCs than in HOPDs.⁵
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff.
- Physicians who invest in ASCs and perform surgeries on their patients in those ASCs can increase their revenue by receiving a share of ASC facility payments. The federal anti-self-referral law (also known as the Stark Law) does not apply to ASC services.
- Because physicians are able to perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more revenue from professional fees.
- Increased interest across the health care industry in value-based care and the provision of care in lower cost settings has increased the strategic investment interest of hospital systems, insurers, and private equity firms in ASCs (Barclays 2018, Japsen 2018).

**TABLE
5-4**

Volume of ASC services per FFS beneficiary increased in 2018

Average annual change

	2013	2017	2018	2013-2017	2017-2018
Volume of services (in millions)	6.0	6.5	6.6	1.8%	1.4%
Volume per 1,000 FFS beneficiaries	182.3	193.3	197.6	1.5	2.2

Note: ASC (ambulatory surgical center), FFS (fee-for-service). The volume of services for 2013 and 2017 have been modified to reflect the volume of services covered under the ASC payment system in 2018 that was provided in those years. The amounts in the percent change columns were calculated before rounding, so some of the percent change values are not computable from the rounded figures.

Source: MedPAC analysis of physician/supplier standard analytic files from CMS, 2013-2018.

Number of beneficiaries treated and volume of services per beneficiary increased from 2017 to 2018

The volume of ASC surgical procedures per FFS beneficiary increased from 2017 to 2018. Also, the number of FFS beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary increased from 2017 to 2018. Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries who have Part B coverage. The volume of services per 1,000 FFS beneficiaries increased by an average of 1.5 percent per year from 2013 through 2017 and increased by 2.2 percent in 2018 (Table 5-4).

In addition, from 2013 through 2017, the number of FFS beneficiaries who received ASC services grew by an average 0.8 percent per year and by 0.9 percent in 2018 (data not shown). Also, the number of services per beneficiary receiving care in ASCs from 2013 through 2017 increased at an average annual rate of 0.9 percent and by 0.4 percent in 2018 (data not shown).

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2018. For example, the HCPCS code for cataract removal with intraocular lens insertion (HCPCS 66984) had the highest volume in both 2013 and 2018, accounting for 19.1 percent of the total in 2013 and 18.8 percent in 2018. Moreover, 19 of the 20 most frequently provided HCPCS codes in 2013 were among the 20 most frequently provided in 2018 (Table 5-5, p. 152). These services made up about 71 percent of ASC Medicare volume in 2013 and 70 percent in 2018.

A potential concern about the services most frequently provided in ASCs is the extent to which they are unnecessary or low value, such as spinal injections and other pain management services (Pinto et al. 2012). We have found that pain management services grew robustly from 2013 to 2018. Table 5-5 shows that during that period, strong growth occurred for injecting foramen epidural into either the lumbar or sacral area, injecting the paravertebral facet joint in the lumbar or sacral area, injecting an anesthetic into the sacroiliac joint, and destruction of nerves in the lumbar or sacral facet joint. Moreover, the volume of insertion or replacement of spinal neurostimulators increased sharply from about 2,100 in 2013 to 11,300 in 2018 (data not shown).

Volume of outpatient surgical procedures increased by similar percentages in ASCs and HOPDs in 2018

In 2018, volume per FFS beneficiary of surgical procedures covered under the ASC payment system increased by 2.2 percent in ASCs and by 2.0 percent in HOPDs. From 2013 through 2017, average annual growth in volume per FFS beneficiary of surgical services covered by the ASC payment system was 1.5 percent in ASCs compared with 0.3 percent in HOPDs.

Maintaining or expanding access to ASCs can be beneficial for patients and Medicare

Maintaining beneficiaries' access to ASCs has some benefits because services provided in this setting are less costly to Medicare and beneficiaries than services delivered in HOPDs.⁶ Medicare payment rates for surgical services performed in HOPDs are almost twice as high

**TABLE
5-5**

The 20 most frequently provided ASC services in 2018 were similar to those provided in 2013

Surgical service	2013		2018	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	19.1%	1	18.8%	1
Upper GI endoscopy, biopsy	8.7	2	7.9	2
Colonoscopy and biopsy	6.6	3	6.9	3
Lesion removal colonoscopy (snare technique)	5.2	4	6.2	4
After cataract laser surgery	4.5	5	4.2	6
Inject foramen epidural: lumbar, sacral	4.2	6	4.6	5
Injection spine: lumbar, sacral (caudal)	3.5	7	2.7	8
Diagnostic colonoscopy	2.8	8	1.7	10
Inject paravertebral: lumbar, sacral	2.6	9	3.4	7
Colorectal screen, high-risk individual	2.1	10	2.1	9
Colorectal screen, not high-risk individual	2.0	11	1.7	11
Cataract surgery, complex	1.6	12	1.4	14
Upper GI endoscopy, diagnosis	1.2	13	0.9	18
Revision of upper eyelid	1.1	14	0.9	19
Injection procedure for sacroiliac joint, anesthetic	1.1	15	1.4	13
Inject spine, cervical or thoracic	1.0	16	1.0	17
Cystoscopy	1.0	17	1.0	16
Lesion remove colonoscopy, hot biopsy forceps	0.9	18	0.5	30
Destroy lumbar/sacral facet joint	0.9	19	1.7	12
Inject paravertebral: cervical or thoracic	0.8	20	1.1	15
Total	71.1		70.0	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal). In both percentage columns, the numbers do not add to the "Total" because of rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from 2013 and 2018.

as in ASCs. For example, the payment rate in 2020 for cataract surgery with intraocular lens insertion (the service most frequently provided in ASCs) is \$2,022 in HOPDs compared with \$1,013 in ASCs. The lower payment rate in ASCs for this service has been financially beneficial to Medicare and beneficiaries. Other studies similarly find that ASCs are less costly than HOPDs in the Medicare and non-Medicare context and that price growth at ASCs has been slower than price growth at HOPDs (Carey 2015, Robinson et al. 2015).

Medicare program spending and overall beneficiary cost sharing could be reduced if medical professionals provide more surgical services in ASCs than HOPDs or

if Medicare reduces HOPD payment rates to the level of ASC payment rates. This issue is pertinent to the ASC sector because among even the most frequently provided services in ASCs, a substantial volume is provided in HOPDs. For example, medical professionals performed 421,000 Medicare-covered cataract surgeries with intraocular lens insertion in HOPDs in 2018, which was 25 percent of the total volume for this service.

However, most ASCs have some degree of physician ownership, and as owners of a business, these physicians have an incentive to perform more surgical services than if they provided outpatient surgery only in HOPDs they do not own. It is not clear whether the physician owners

of ASCs act on this incentive, but studies offer limited evidence that physicians who have an ownership stake in an ASC perform a higher volume of certain procedures than physicians who do not (Hollingsworth et al. 2010, Mitchell 2010, Strope et al. 2009).

Other studies suggest that the presence of an ASC in a market is associated with a higher volume of outpatient surgical procedures (Hollenbeck et al. 2015, Hollenbeck et al. 2014, Hollingsworth et al. 2011, Koenig and Gu 2013). Although none of these studies assessed the appropriateness of the additional procedures, they suggest that the presence of ASCs might increase overall surgical volume. Based on the results of these studies, it is plausible that reductions in Medicare spending due to lower payment rates for ASCs relative to HOPDs could be partially offset by a higher overall number of surgical procedures.

Research suggests that, in addition to the ASC sector, physician ownership has increased use in other health care sectors. Studies found that physician ownership of advanced imaging equipment has resulted in higher use of that equipment relative to physician nonowners (Hughes et al. 2011, Hughes et al. 2010, Shreibati and Baker 2011). However, another study refuted those results, finding that physician ownership of advanced imaging equipment had no effect on use of that equipment (Ohsfeldt et al. 2015). In addition, a study of physician-owned cardiac hospitals suggests that markets that had at least one of these hospitals had slightly higher growth rates in profitable cardiac surgeries relative to markets that did not have one of these hospitals (Stensland and Winter 2006).

Another setting that has a substantial overlap of services with ASCs is physician offices. In general, Medicare payment rates are higher in ASCs than in physician offices for the same procedure. Services that are frequently provided in both ASCs and physician offices include cystoscopy, pain management, and, to a lesser extent, cataract procedures. Cystoscopy is performed much more frequently in offices than in ASCs, pain management is about equally common in these two settings, and cataract procedures are done more frequently in ASCs than in offices.

Quality of care: ASC-reported quality data demonstrate modest improvement

ASC-reported quality data demonstrated modest improvement in recent years. CMS established the ASC

Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this system, ASCs that do not successfully submit quality measurement data have their payment update for that year reduced by 2 percentage points. Actual performance on these quality measures does not affect an ASC's payments; CMS requires ASCs only to submit the data to receive a full update. The Commission has recommended a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (see text box, p. 156).

The quality measures for which ASCs submit data continue to evolve. In the last two years, CMS made several revisions to the initial ASCQR measure set, which resulted in CMS measuring ASC quality based on nine measures (plus one voluntary measure) for 2020 and six measures (plus one voluntary measure) for 2022 (Table 5-6, p. 154). In recent years, CMS has chosen to discontinue or delay several measures that were considered "topped out" (meaning full or nearly full compliance with these measures has been reached), demonstrated less utility, or were not ready for use, including the discontinuation of the current adverse event measures (ASC-1 through ASC-4) and the delay of measures of patient experience.⁷ For 2022, CMS will implement two new claims-based measures: beneficiaries' visits to a hospital subsequent to an ASC orthopedic or urology procedure, respectively (ASC-17 and ASC-18).

Results from reported ASC quality data

Data reported by ASCs for five years (2013 to 2017) suggest improvement in ASC quality of care. Among the nine quality measures for which CMS made data available in 2017, performance improved for most measures. For the four adverse event measures, the data show consistently low levels of these events in each of the five years and gradual improvement (Table 5-7, p. 155). Specifically, the share of ASCs reporting zero adverse events increased over time. For example, from 2013 to 2017, the share of ASCs without any patient burns increased from 88 percent to 93 percent, and the share of ASCs without any patient falls increased from 91 percent to 95 percent (data not shown).

In addition to the adverse events measures, other ASCQR measures demonstrated improvement. For example, from 2014 to 2017, the share of ASCs reporting their staff received influenza vaccinations (ASC-8) increased from 74 percent to 78 percent. Also, measures of

**TABLE
5-6**

Quality measures used in the ASC Quality Reporting Program

Description of quality measure	Required in:	
	2020	2022
ASC-1: Patient burn	Yes ^a	No
ASC-2: Patient fall	Yes ^a	No
ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant	Yes ^a	No
ASC-4: Hospital transfer/admission	Yes ^a	No
ASC-9: Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients	Yes	Yes
ASC-10: Endoscopy/polyp surveillance: Colonoscopy interval for patients with a history of adenomatous polyps—avoid inappropriate use	Yes ^b	No
ASC-11: Cataracts: Improvement in patient’s visual function within 90 days following cataract surgery	Voluntary	Voluntary
ASC-12: Facility seven-day risk standardized hospital visit rate after outpatient colonoscopy	Yes	Yes
ASC-13: Normothermia outcome: Percentage of patients under anesthesia who are normothermic within 15 minutes of arrival in the post-anesthesia care unit	Yes	Yes
ASC-14: Unplanned anterior vitrectomy: Percentage of cataract surgery patients who have an unplanned removal of the vitreous	Yes	Yes
ASC-15: Five patient experience measures from the Outpatient and Ambulatory Survey Consumer Assessment of Healthcare Providers and Systems (CAHPS®):		
ASC-15a: About facilities and staff		
ASC-15b: Communication about procedure		
ASC-15c: Preparation for discharge and recovery		
ASC-15d: Overall rating of facility		
ASC-15e: Recommendation of facility	No ^c	No
ASC-17: Hospital visits after orthopedic ASC procedures	No ^d	Yes
ASC-18: Hospital visits after urology ASC procedures	No ^d	Yes

Note: ASC (ambulatory surgical center).

^aRetained in the ASC Quality Reporting (ASCQR) Program, but data collection is suspended by CMS starting in 2019.

^bDiscontinued by CMS from the ASCQR Program beginning in 2021.

^cCMS has delayed the implementation of this measure indefinitely.

^dCMS will require this measure in 2022.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system for 2020.

the surveillance and follow-up of patients treated for certain gastroenterology or cataract surgeries and the hospitalization rate within seven days of colonoscopy improved and had generally high levels of performance. Although room for improvement exists for five of these other measures (ASC-8, ASC-9, ASC-10, ASC-11, and ASC-12), these data appear to be trending in a positive direction.⁸

We also compared the performance of ASCs with the performance of HOPDs in 2017 on the four measures from the ASCQR Program (ASC-9, ASC-10, ASC-11, and ASC-12) that match with measures in the Hospital Outpatient Quality Reporting Program (OQR) (OP-29, OP-30, OP-31, and OP-32) (the data from the OQR are not shown). The data indicate that ASCs performed about the same or better, on average, on two measures:

**TABLE
5-7**

ASC quality measure levels, 2013-2017

ASC quality measure	Mean percent among ASCs				
	2013	2014	2015	2016	2017
ASC-1: Share of patients suffering burns	0.36%	0.25%	0.18%	0.18%	0.18%
ASC-2: Share of patients suffering falls	0.15	0.10	0.11	0.08	0.08
ASC-3: Share of patients suffering a "wrong" event	0.03	0.03	0.03	0.02	0.02
ASC-4: Share of patients transferred to a hospital	0.51	0.45	0.39	0.36	0.35
ASC-8: Share of ASC staff receiving an influenza vaccination		74	75	77	78
ASC-9: Share of average risk patients with appropriate endoscopy/polyp surveillance		76	80	81	83
ASC-10: Share of patients with polyp history with appropriate endoscopy/polyp surveillance		79	79	80	81
ASC-11: Share of patients with vision improvement 90 days after cataract surgery			96	96	96
ASC-12: 7-day risk standardized hospital visit rate after outpatient colonoscopy*				1.3	1.2

Note: ASC (ambulatory surgical center). For measures ASC-1, ASC-2, ASC-3, and ASC-4, we removed from this analysis ASCs that reported that more than 100 percent of patients had one of these events.
*CMS reports this measure as the rate per 1,000 colonoscopies, but we report this measure as a percentage (the rate per 100 colonoscopies).

Source: Medicare Hospital Compare data for ASCs, 2013-2017.

share of patients with vision improvement 90 days after cataract surgery (96 percent in ASCs versus 95 percent in HOPDs) and 7-day risk-standardized hospital visit rate after outpatient colonoscopy (1.2 percent in ASCs versus 1.5 percent in HOPDs). Conversely, HOPDs performed better on two measures: share of average-risk patients with appropriate endoscopy/polyp surveillance (87 percent in HOPDs vs. 83 percent in ASCs) and share of patients with polyp history with appropriate endoscopy/polyp surveillance (91 percent in HOPDs versus 81 percent in ASCs).

CMS should continue to refine ASC quality measures

The Commission asserts CMS should continue to improve the ASCQR Program by moving toward more CMS-calculated claims-based outcome measures that apply to all ASCs. In addition, CMS should synchronize ASCQR measures with measures included in the hospital OQR to facilitate comparisons between ASCs and HOPDs.

The Commission commends CMS on its decisions to discontinue a measure in 2021 (ASC-10: Endoscopy/polyp surveillance, colonoscopy interval for patients with a history of adenomatous polyps) because cost of collection exceeds the benefit and for adding the two claims-based unplanned hospitalization measures for 2022. However, the Commission maintains concern about three issues related to the ASCQR Program:

- The four ASCQR measures that are claims based and measure clinical outcomes (ASC-12, ASC-17, ASC-18, and ASC-19) may exclude many services provided at ASCs. Therefore, CMS could improve the ASCQR Program by including more claims-based measures that assess clinical outcomes that apply to the various specialties practiced at ASCs. CMS has made an improvement on this issue by adding a measure for payment determination in 2024, ASC-19: Facility-level seven-day hospital visits after general surgery procedures performed at ASCs. The general

Creating a value-based purchasing program for ambulatory surgical centers

In 2012, the Commission recommended that the Congress authorize and CMS implement a value-based purchasing (VBP) program for ambulatory surgical centers (ASCs). A VBP program would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).⁹

CMS established a quality reporting program for ASCs in 2012. However, Medicare payments to ASCs are not adjusted based on how they perform on quality measures, only on whether they report the measures. The Commission believes that high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system.

Consistent with the Commission's overall position on Medicare quality measurement, an ASC VBP program should incorporate measures that are patient oriented, encourage coordination across providers and time, and promote change in the delivery system. The ASC VBP program should include outcomes, patient experience, and value measures (which would address services that are costly but of low value). Also, quality measurement should not be burdensome for providers. ASCs can choose to use more granular measures to manage their own quality improvement.

An ASC VBP program should give rewards based on clear, absolute, and prospectively set performance targets (as opposed to "tournament models," which require that some providers gain while others lose). The Medicare program should take into account, as necessary, differences in a provider's population, including social risk factors. Because adjusting results for social risk factors can mask disparities in clinical performance, Medicare should account for social risk factors by directly adjusting payment through peer grouping, under which benchmarks for achievement are group specific, and each provider is compared with its peers (defined as providers whose patient populations are similar in terms of their social risk factors). In addition, funding for VBP incentive payments should come from existing Medicare spending for ASC services. Initially, funding for the incentive payments should be set at 1 percent to 2 percent of aggregate ASC payments. The size of this pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program. (Our March 2016 report to the Congress provides more detail about our recommendation to CMS about an ASC VBP program (Medicare Payment Advisory Commission 2016).) ■

surgery procedures included in this measure are abdominal, alimentary tract, skin/soft tissue, wound, and varicose vein stripping. We applaud CMS's decision to add this measure to the ASCQR. However, the procedures included in this measure accounted for just 3.3 percent of all ASC surgical procedures provided to FFS Medicare patients in 2018, so CMS may need to add more measures to further address this issue.

- CMS's delay of the Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) patient experience survey quality data excludes an important part of assessing quality of care.¹⁰ Among the Commission's quality measurement principles is that

quality programs include patient experience (Medicare Payment Advisory Commission 2018b). CAHPS is the only survey in the ASCQR Program that queries patients about their experience.

- ASCQR measures should be further synchronized with OQR measures to facilitate comparison across ASCs and HOPDs. For 2021, the ASCQR and the OQR possess four common quality measures that pertain to cataract procedures, colonoscopy procedures, and patient assessments. CMS should consider further expanding the overlap of the ASCQR and OQR, relying either on measures of general surgical procedures or measures of specific

surgical procedures common to both settings. For example, CMS could consider implementing OQR measure OP-36 (the number of hospital visits after any outpatient surgery) within the ASCQR, or implementing ASCQR measures ASC-17 and ASC-18 (the number of hospital visits following orthopedic and urology procedures, respectively) within the OQR. In addition, the aforementioned delay in implementing the CAHPS patient experience measures affects both the ASCQR and OQR and impedes the comparison of ASCs and HOPDs.

CMS should develop other quality measures

Because of the concerns cited above and the potential value of clinical outcome measures that apply to all ASCs, we believe CMS could consider developing new ASC quality measures covering any or all of the three following areas:

- ***The number of Medicare beneficiaries discharged from ASCs who have subsequent unplanned hospital visits.*** CMS has already begun to implement these measures for certain specialties through ASC-12, ASC-17, ASC-18, and ASC-19, but CMS has not developed these measures for some specialty areas or individual procedures that are common to ASCs such as pain management.
- ***Surgical site infections (SSIs) occurring at ASCs for the ASCQR Program.*** Researchers have found that lapses in infection control were common among a sample of ASCs in three states (Schaefer et al. 2010). The Hospital Inpatient Quality Reporting Program includes an SSI measure that applies primarily to inpatient procedures. Although CMS has considered an SSI measure for ASCs in the past, it has yet to implement one (Centers for Medicare & Medicaid Services 2011). In general, an SSI measure could be used to track infection rates for ASCs and identify quality improvement opportunities for ambulatory surgeries conducted in HOPDs and ASCs. In addition, measuring SSI rates could encourage providers to collaborate and better coordinate care for ambulatory surgery patients.
- ***Specialty-specific clinical guidelines to assess the appropriateness of specific services provided in ASCs.*** While the ASCQR currently includes two ASC-reported colonoscopy measures that assess appropriate

follow-up care, CMS could consider claims-based measures that assess appropriateness. For example, current American Cancer Society guidelines state that patients over the age of 85 should no longer receive colorectal cancer screening (American Cancer Society 2018). Using these guidelines, a new measure could identify ASCs' share of colonoscopy cases for beneficiaries over age 85. CMS could consider similar appropriateness measures for certain procedures that have become more common in ASCs in recent years or for which concerns about appropriate use have been suggested, such as spinal injections or certain orthopedic procedures.

Department of Health and Human Services will publicly report ASC-specific patient safety data

In response to the expanding scope of ASC services and the desire of ASCs to compare their performance with other ASCs, the Department of Health and Human Services, through the Agency for Healthcare Research and Quality (AHRQ), will collect and publicly report survey data on ASC-specific patient safety culture (Agency for Healthcare Research and Quality 2018, Dickson 2018a, Dickson 2018b). Similar to their hospital safety survey data, AHRQ will collect survey data from ASC staff regarding their perceptions of safety culture in their workplace. AHRQ will report this information on its website in a format permitting the individual identification of ASCs. AHRQ asserts that these data can be used by ASCs to improve their practices and by the public to inform decisions about where to receive care (Agency for Healthcare Research and Quality 2018).

ASCs' access to capital: Growth in number of ASCs suggests 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 available indicator of ASCs' ability to obtain capital. The number of ASCs increased in 2018 by 2.6 percent, faster than in previous years (Table 5-1, p. 146). However, Medicare accounts for a small share—perhaps 20 percent—of ASCs' overall revenue, so factors other than Medicare payments may have a larger effect on access to capital for this sector (Medical Group Management Association 2009).

From 2015 through 2017, hospital systems, private equity firms, and insurers made a number of acquisitions of and investments in businesses that own and operate

**TABLE
5-8**

Medicare payments to ASCs grew, 2013-2018

	2013	2017	2018	Average annual change	
				2013-2017	2017-2018
Medicare payments (in billions of dollars)	\$3.7	\$4.6	\$4.9	5.2%	6.4%
Medicare payments per FFS beneficiary	\$113	\$136	\$146	4.9	7.4

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

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

ASCs. More recently, these acquisitions and investments have slowed. Nevertheless, these organizations that have acquired ASCs continue to hold them and have continued to acquire more. For example, United Surgical Partners—which is largely owned by Tenet Healthcare Corporation—increased the number of ASCs under its control from 247 in 2017 to 255 in 2018. Also, Surgical Care Affiliates—which is owned by Optum—increased the number of ASCs that it holds from 190 to 210.

Finally, data from the annual analysis of Pennsylvania’s ASCs, conducted by the Pennsylvania Health Care Cost Containment Council (PHC4), indicate that ASCs are very profitable. PHC4 found that ASCs in Pennsylvania had an average total margin of 24 percent in 2018 (Pennsylvania Health Care Cost Containment Council 2019).¹¹

Although the various entities noted above appear to have adequate access to capital, we caution that these companies have ownership in a small share of the more than 5,700 ASCs. Consequently, the experience of these entities collectively may not reflect that of the entire ASC sector.

Medicare payments: Payments have steadily increased

In 2018, ASCs received \$4.9 billion in Medicare payments and beneficiaries’ cost sharing (Table 5-8). We estimate that spending by the Medicare program was \$3.9 billion and beneficiary cost sharing was \$1.0 billion (data not shown).

Spending per FFS beneficiary increased by an average annual rate of 4.9 percent from 2013 through 2017 and

by 7.4 percent in 2018 (Table 5-8). The increase in 2018 reflects a 1.2 percent increase in the ASC conversion factor, a 2.2 percent increase in per capita volume, a 4.4 percent increase in the average relative weight of ASC services, and a -0.4 percent effect from some frequently used drugs and devices being moved from separately payable status in 2017 to packaged status in 2018, plus a change in the use of some separately payable drugs. The high growth in the average relative weight (4.4 percent) was driven by increased volume of high-cost procedures, such as implantation of spinal neurostimulators, which may have resulted in lower volume for relatively low-cost injections for pain management.

How should Medicare payments change in 2021?

Our analysis indicates that the number of ASCs has increased, beneficiaries’ use of ASCs has increased, and access to capital has been adequate. Measures of ASC quality indicate improvement, although we have identified areas for improvement in ASC quality measurement. Our information for assessing payment adequacy, however, is limited because Medicare does not require ASCs to submit cost data, unlike other types of facilities. Since 2010, the Commission has recommended that the Congress require ASCs to submit cost data (Medicare Payment Advisory Commission 2010).

Cost data would enable the Commission to examine the growth of ASCs’ costs over time and analyze Medicare payments relative to the costs of efficient providers,

which would help inform our decisions about the ASC update. Cost data also are needed to examine whether an alternative input price index would be an appropriate proxy for ASC costs. As discussed in the text box on the ASC market basket index (p. 161), the Commission has previously expressed concern that the price index CMS used to update the ASC conversion factor from 2010 through 2018 (the CPI-U) likely does not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010). Also, the price index that CMS plans to use to update the ASC conversion factor from 2019 through 2023—the hospital market basket—does not reflect ASCs' cost structure.

CMS has concluded that it needs data on ASC input costs but to date has not required ASCs to submit cost data (Centers for Medicare & Medicaid Services 2012). However, CMS requested public comment on whether the agency should collect cost data from ASCs for use in determining ASC payment rates. ASC representatives commented that they oppose a requirement for ASCs to submit formal cost reports but expressed willingness to complete surveys if doing so is not administratively burdensome (Centers for Medicare & Medicaid Services 2017).

We contend it is feasible for ASCs to provide cost information. All other facility providers submit cost data to CMS. Indeed, ASCs in Pennsylvania submit cost and revenue data annually to a state agency that uses the data to estimate margins for those ASCs (Pennsylvania Health Care Cost Containment Council 2019). We recognize that ASCs are generally small facilities that may have limited resources for collecting cost data. However, such businesses typically keep records of their costs for filing taxes and other purposes, and other facility providers that are typically small, such as home health agencies and hospices, furnish cost data to CMS.

To minimize the burden on CMS and ASCs, CMS should create a streamlined process for ASCs to track and submit a limited amount of cost data. As it did in 1986 and 1994, CMS could annually conduct a survey of a random sample of ASCs, with mandatory response. CMS could also streamline ASC cost reporting by annually collecting a set of cost variables from all ASCs that is more limited than what is collected through formal cost reports, which would require less time for ASCs to complete. Alternatively, CMS could require ASCs to submit cost data from their existing cost accounting systems, provided the definitions of their reported cost variables are consistent with CMS's

definitions. The Commission does not believe that a streamlined process for collecting cost data would place a large burden on ASCs. After all, individual taxpayers are able to complete and submit lengthy income tax forms. Therefore, the Commission sees no reason why ASCs cannot submit at least minimal cost data.

For the Commission to determine the relationship between Medicare payments and the costs of efficient ASCs, ASCs would optimally submit the following information:

- total costs for the facility;
- Medicare unallowable costs, such as entertainment, promotion, and bad debt;
- the costs of clinical staff who bill Medicare separately, such as anesthesiologists and clinical nurse anesthetists (these costs would be excluded from the facility's costs because Medicare pays these clinicians separately);
- total charges across all payers and charges for Medicare patients (CMS could allocate total facility costs to Medicare based on Medicare's proportion of total charges); and
- total Medicare payments.

In addition, CMS would need to collect data on specific cost categories to determine an appropriate input price index for ASCs. For example, CMS would need data on the share of ASCs' costs related to employee compensation, medical supplies, medical equipment, building expenses, and other professional expenses (such as legal, accounting, and billing services). CMS could use this information to examine ASCs' cost structure and determine whether an existing Medicare price index is an appropriate proxy for ASC costs or whether an ASC-specific market basket should be developed.

CMS used the CPI-U to update the ASC conversion factor from 2010 through 2018. Using the CPI-U, CMS increased the ASC conversion factor by 0.3 percent in 2016, 1.9 percent in 2017, and 1.2 percent in 2018. However, CMS has indicated that the CPI-U does not reflect ASCs' input costs.

CMS made a significant regulatory change and decided to use the hospital market basket (MB) as the basis for updating the ASC conversion factor for a five-year period—2019 through 2023. In 2019, CMS used the

hospital MB to increase the ASC conversion factor by 2.1 percent. For 2020, the update to the ASC conversion factor is 2.6 percent, which is based on a projected 3.0 percent increase in the hospital MB minus a 0.4 percent reduction for multifactor productivity growth, as mandated by the Affordable Care Act of 2010. CMS based its decision to use the hospital MB in place of the CPI-U on concerns that the differences in payment rates between the ASC payment system and the OPSS has caused a shift of care from ASCs to HOPDs. CMS believes that using the same update mechanism for both ASCs and HOPDs could “encourage the migration of services from the hospital setting to the ASC setting and increase the presence of ASCs in health care markets or geographic areas where previously there were none or few, thus promoting better beneficiary access to care” (Centers for Medicare & Medicaid Services 2018). However, the growth in surgical volume per FFS beneficiary was higher in ASCs than in HOPDs in both 2017 and 2018, which suggests that services may have been shifting from HOPDs to ASCs without use of the hospital MB to update payments. This relatively high growth in ASCs may have been due to the provision in Section 603 of the Bipartisan Budget Act of 2015, which largely requires that ASCs acquired by hospitals will be paid at the relatively low payment rates in the PFS if the hospitals convert them to off-campus outpatient departments, while they would continue to be paid at the ASC rates if the hospitals keep them as ASCs.

During the five-year period of using the hospital MB, CMS states that it will:

- assess whether there is a migration of services from hospitals to ASCs and
- assess the possibility of working with stakeholders to collect cost data from ASCs in a minimally burdensome manner and could propose a plan to collect cost data (Centers for Medicare & Medicaid Services 2018).

Beginning with the Commission’s March 2010 report to the Congress, the Commission has stated for several years in comment letters and in published reports that the CPI-U does not likely reflect the current input costs of ASCs (Medicare Payment Advisory Commission 2010). However, the Commission does not support using the hospital MB index as an interim method for updating the ASC conversion factor because this index also does not accurately reflect ASCs’ costs (Medicare Payment Advisory Commission 2018a). CMS acknowledges that

the ASC and hospital cost structures are not identical because ASCs tend to be single specialty and for profit, and they are not required to comply with the Emergency Medical Treatment and Labor Act. The Commission concurs with these observations and adds that, relative to hospitals, ASCs are more urban, serve a different mix of patients, have a much higher share of expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs.

The Commission asserts that CMS should forgo the five-year period to assess the feasibility of ASC cost reporting and instead use its authority and resources to act quickly in gathering ASC cost data. ASCs are profitable organizations, and the number of ASCs and the volume of services continue to grow. Therefore, we believe it is unnecessary for CMS to spend five years assessing the feasibility of collecting cost data from ASCs.

Recommendation

In evaluating a need for an update to the ASC conversion factor for 2021, the Commission balanced the following objectives:

- maintain beneficiaries’ access to ASC services;
- pay providers adequately;
- maintain the sustainability of the Medicare program by appropriately restraining spending on ASC services;
- keep providers under financial pressure to constrain costs; and
- require ASCs to submit cost data.

In balancing these goals, the Commission concludes that the ASC update for 2021 should be eliminated and that the Secretary should collect cost data from ASCs.

RECOMMENDATION 5 - 1

The Secretary should require ambulatory surgical centers to report cost data.

RECOMMENDATION 5 - 2

For calendar year 2021, in the absence of cost report data, the Congress should eliminate the update to the calendar year 2020 Medicare conversion factor for ambulatory surgical centers.

Revisiting the ASC market basket index

From 2010 through 2018, CMS used the consumer price index for all urban consumers (CPI-U) as the market basket to update the conversion factor in the ambulatory surgical center (ASC) payment system. Because of our concern that the CPI-U likely does not reflect ASCs' cost structure, the Commission examined in 2010 whether an alternative market basket index would better measure changes in ASCs' input costs (Medicare Payment Advisory Commission 2010). Using data from a Government Accountability Office (GAO) survey of ASC costs in 2004, we compared the distribution of ASC costs with the distribution of hospital and physician practice costs. We found that ASCs' cost structure is different from that of hospitals and physician offices. ASCs have a much higher share of expenses for medical supplies and drugs than the other two settings, a much smaller share of employee compensation costs than hospitals, and a smaller share of all other costs (such as rent and capital costs) than physician offices. For more detail about our methods and findings, see Chapter 2C of our March 2010 report to the Congress (Medicare Payment Advisory Commission 2010).

Since our 2010 analysis, CMS has considered whether the hospital market basket or the practice expense component of the Medicare Economic Index (MEI) is a better proxy for ASC costs than the CPI-U (Centers for Medicare & Medicaid Services 2012). Most recently, CMS has decided to use the hospital market basket

(MB) as the basis for updating ASC payment rates from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). However, because of differences between the ASC and hospital cost structures, we find that the hospital MB is not an appropriate market basket for ASCs.

The ASC cost data from GAO used in our comparative analysis are 15 years old and do not contain information on several types of costs. Therefore, the Commission has recommended several times that the Congress require ASCs to submit new cost data to CMS (Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2018c, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010). In each of the last seven years, the Commission recommended eliminating the update to the ASC conversion factor, meaning the ASC conversion factor would not change from the previous year. CMS should use cost data to examine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. A new ASC MB could include the same types of costs that appear in the hospital MB or MEI but with different cost weights that reflect ASCs' unique cost structure. ■

RATIONALE 5-1 AND 5-2

The Commission has persistently recommended that the Secretary collect cost data from ASCs. Cost data would enable CMS and the Commission to examine the growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of an efficient provider, which would help inform decisions about the ASC payment update. Cost data are also needed to evaluate whether an alternative input price index would be an appropriate proxy for ASC costs.

We see no reason why ASCs should not be able to submit cost data. CMS collects cost data from all other institutional providers participating in the Medicare program. To date, the ASC industry has asserted that ASCs are small operations that lack the capacity and accounting expertise to enable them to complete cost reports. However, some of the sectors from which CMS collects cost data are predominantly small providers. Therefore, any ASC should be able to compile and submit a minimum set of cost data. Also, while the majority

of the ASC industry consists of freestanding facilities, hospital corporations and other large health care entities have entered the ASC industry in recent years and have the capacity and expertise to complete cost reports. CMS could limit the scope of the cost reporting system to minimize administrative burden on ASCs and the program. In addition, to implement this change, CMS should make cost reporting a condition of ASC participation in the Medicare program.

On the basis of our payment adequacy indicators, the importance of maintaining financial pressure on providers to constrain costs, and the absence of cost report data, we believe that the ASC conversion factor should not be increased for 2021. That is, the 2021 conversion factor in the ASC payment system should be the same as the conversion factor in 2020. Though we do not have cost data, and we have reservations about the measures used within the ASCQR Program, the indicators of payment adequacy for which we have information are positive: The volume of ASC services per beneficiary increased in 2018, the complexity of ASC services provided increased, and the number of ASCs increased. Also, ASCs appear to have adequate access to capital, ASC quality of care data have trended positive, and Medicare payments to ASCs have continued to grow.

Spending

- The Secretary has the authority to update the ASC conversion factor and has decided to use the hospital MB index as the basis for updating the conversion factor from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). The Affordable Care Act of 2010 requires that the update factor be reduced by a multifactor productivity measure. The currently projected hospital MB index increase for 2021 is 3.2 percent, and the forecast of productivity growth for 2021 is 0.4 percent, resulting in a projected update of 2.8 percent to the conversion factor for 2021. Relative to current Medicare law, our recommendations would decrease federal spending by between \$50 million to \$250 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 ASCs and the increase in ASCs' revenue from Medicare, we do not anticipate that these recommendations will diminish beneficiaries' access to ASC services or providers' willingness or ability to provide those services.
- ASCs may incur some minimal administrative costs to track and submit cost data, but we believe cost accounting is standard practice in the ASC industry, and ASCs should be able to draw cost data from that source. ■

Endnotes

- 1 CMS determines the payment rates in the ASC system independently from the payment rates in the PFS. Therefore, it is possible for an office-based procedure to have its payment rate based on the standard method in one year and on the PFS nonfacility rate the next year, or vice versa.
- 2 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004. They received reliable cost data from 290 facilities.
- 3 State certificate-of-need (CON) laws for ASCs appear to affect the number of ASCs in the state. Twenty-seven states and the District of Columbia have CON laws for ASCs. Nine of the 10 states with the fewest ASCs per capita have a CON law in place, while only 5 of the 10 states that have the most ASCs per capita have CON laws. Among these five states, Maryland and Georgia have exceptions in their CON requirements that make it easier to establish new ASCs.
- 4 We define *single-specialty* ASCs as those with more than 67 percent of their Medicare claims in one clinical specialty. We define *multispecialty* ASCs as those with less than 67 percent of their Medicare claims in one clinical specialty.
- 5 By statute, coinsurance for a service paid under the OPPI cannot exceed the hospital inpatient deductible (\$1,408 in 2020). The ASC payment system does not have the same limitation on coinsurance; for a small share of HCPCS codes covered under the ASC payment system, the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the OPPI coinsurance.
- 6 Cost sharing is lower under the ASC payment system for 96.7 percent of HCPCS codes that are covered under the ASC payment system.
- 7 Rather than a full discontinuation of measures ASC-1 through ASC-4, CMS has decided to suspend these four measures. Suspension means that ASCs are no longer required to report data on these measures, but CMS will retain them in the ASCQR Program for possible future use. Patient experience will be assessed using the Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) survey measures, but implementation of CAHPS measures has been delayed.
- 8 We did not include data for ASC-6 (safe surgery checklist) because ASC response rates were low, which we assume to be related to CMS discontinuing the measure for 2018.
- 9 The Commission also described its principles for a VBP program for ASCs in a letter to the Congress commenting on the Secretary's report to the Congress on a VBP program for ASCs (Medicare Payment Advisory Commission 2011a).
- 10 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. government agency.
- 11 The margins for ASCs have important differences from the margins in other sectors such as hospitals. In particular, the cost data used to determine margins for most ASCs do not include compensation for physician owners or the taxes paid on that compensation.

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