

CHAPTER

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**Ambulatory surgical  
center services**

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

- 5-1** The Congress should update the payment rates for ambulatory surgical centers by 0.5 percent for calendar year 2013. The Congress should also require ambulatory surgical centers to submit cost data.

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

- .....
- 5-2** The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016.

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

# Ambulatory surgical center services

## 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 2010,

- ASCs served 3.3 million fee-for-service (FFS) Medicare beneficiaries, an increase of 0.9 percent from 2009;
- there were 5,316 Medicare-certified ASCs, an increase of 1.9 percent (99 ASCs) from 2009; and
- Medicare combined program and beneficiary spending on ASC services was \$3.4 billion, an increase from 2009 of 2.6 percent per FFS beneficiary.

## Assessment of payment adequacy

Our results indicate that beneficiaries' access to ASC services is at least adequate, as most of the available indicators of payment adequacy for ASC services, discussed below, are positive. However, our results also indicate slower growth in the number of ASCs and volume of services in 2010 than in previous years.

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

## In this chapter

- Are Medicare payments adequate in 2012?
- How should Medicare payments change in 2013?
- Using quality data from ASCs to reward high-performing and penalize low-performing providers

- **Capacity and supply of providers**—From 2005 through 2009, the number of Medicare-certified ASCs grew by an average annual rate of 4.6 percent. However, the growth slowed to 1.9 percent in 2010. The relatively slow growth in 2010 may reflect the sluggish recovery from the financial crisis that peaked in 2008 and substantial revisions to the ASC payment system that same year (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)). In addition, Medicare payment rates for most ambulatory surgical services have become much higher in hospital outpatient departments (OPDs) than in ASCs—for 2012, Medicare rates are 74 percent higher in OPDs than in ASCs. This payment gap may have influenced some ASC owners to sell their facilities to hospitals.
- **Volume of services**—From 2005 through 2009, the volume of services per FFS beneficiary grew by an average annual rate of 7.6 percent; in 2010, volume increased by 1.6 percent.

**Quality of care**—Although CMS has established a program for ASCs to submit data on quality of care, ASCs will not begin submitting these data until October 2012. Consequently, we do not have data to assess ASCs’ quality of care.

**Providers’ access to capital**—ASCs appear to have adequate access to capital, as the number of ASCs has continued to increase.

**Medicare payments and providers’ costs**—From 2005 through 2009, Medicare payments for ACS services per FFS beneficiary increased at an average annual rate of 6.8 percent, but the rate slowed to 2.6 percent in 2010. 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 in other sectors to assist in assessing payment adequacy.

### **Using quality data from ASCs to reward high-performing and penalize low-performing providers**

To improve the quality of care provided to beneficiaries in ASCs, CMS should use ASC quality data to reward high-performing and penalize low-performing providers. CMS should also publicly report quality measurement results to help consumers compare quality among facilities. CMS recently established a Quality Reporting Program for ASCs that requires them to submit quality data beginning in 2012; ASCs that do not submit data would have their annual payment update reduced in 2014. However, Medicare payments to ASCs would not be adjusted based on the provider’s actual performance on quality measures. CMS lacks the statutory authority to implement a value-based purchasing (VBP) program for ASCs.

The Commission supports the Quality Reporting Program for ASCs but believes that, eventually, 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 VBP programs in Medicare, a VBP program for ASCs should include a relatively small set of measures that primarily focus on clinical outcomes, with some process, structural, and patient experience measures. Several of these measures will be reported through the ASC Quality Reporting Program, but other measures need to be developed. An ASC VBP program should reward ASCs for improving care and exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services. ■



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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 after 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). ASCs are not the only provider of outpatient surgical procedures; they are also provided in hospital outpatient departments (OPDs) 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 payments for their professional services that are separate from fees the facility receives for the procedures. About 90 percent of ASCs have at least one physician owner (Ambulatory Surgery Center Association 2008). Physicians who perform surgeries in ASCs 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 ASCs for a bundle of facility services, such as nursing, recovery care, anesthetics, and supplies (a more detailed description of the ASC payment system can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_11\\_ASC.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_ASC.pdf)). 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.

Medicare covers about 3,500 surgical procedures under the ASC payment system. For most covered surgical procedures, the relative weight is based on the procedure's relative weight under the outpatient prospective payment system (OPPS)—the system Medicare uses to set payments for most services furnished in OPDs. This linkage to the OPSS is consistent with a previous Commission recommendation to align the relative weights

in the OPSS with the ASC payment system (Medicare Payment Advisory Commission 2004). For most covered surgical procedures, the payment rate is the product of the procedure's relative weight and a conversion factor set at \$42.63 in 2012. In contrast, the OPSS conversion factor for 2012 is \$70.12, making payment rates lower for ASCs than for OPDs.

The conversion factors for the ASC payment system and the OPSS differ for the following reasons. First, CMS set the initial ASC conversion factor for 2008 so that total ASC payments under the revised payment system would equal what they would have been under the payment system in effect before 2008. By comparison, CMS set the initial OPSS conversion factor for 2000 so that payments under the new prospective payment system would equal what total payments would have been under the prior cost-based payment system for outpatient services in effect before 2000. Second, CMS uses different update factors to account for changes in input prices for ASCs and OPDs. CMS uses the consumer price index for all urban consumers (CPI-U) as the basis for updating the ASC conversion factor and the hospital market basket as the basis for updating the OPSS conversion factor.

Payment rates for procedures that are performed predominantly in physicians' offices and that were first covered under the ASC payment system in 2008 or later are determined by a different method. In ASCs, payment for these "office-based" procedures is the lesser of the amount derived from the OPSS relative weight or the nonfacility practice expense amount from the Medicare physician fee schedule (PFS). 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 OPSS and the PFS independently of each other, it is possible for the ASC payment rate for an office-based procedure to be based on the OPSS rate one year and on the PFS rate the next year (or vice versa).

Because Medicare pays ASCs less than OPDs for most services, movement of surgical procedures from OPDs to ASCs can reduce aggregate program spending and beneficiary cost sharing. However, reduced Medicare spending due to lower payment rates could be partially offset by a higher overall number of procedures if physician ownership of ASCs leads to higher volume.

It is appropriate to pay OPDs more than ASCs because OPDs treat patients who are more medically complex on average than ASCs, and OPDs on the same campus as the

main hospital are able to offer emergency services and access to onsite specialists if complications arise during a procedure (Medicare Payment Advisory Commission 2003, Medicare Payment Advisory Commission 2004, Wynn et al. 2011) (see the text box). There are likely additional costs associated with treating sicker patients and maintaining emergency standby capacity. By contrast, ASCs treat healthier patients on average and do not maintain the same capacity as hospitals to treat emergencies. These factors, in addition to the specialized staffing and customized surgical environments of ASCs, probably contribute to the shorter time and lower cost of ASC procedures relative to OPD services. RAND Health analyzed time data from the National Survey of Ambulatory Surgery and found that average surgery time in ASCs is nearly 40 percent less than in OPDs (Wynn et al. 2011). A comparison of ASC costs and OPD costs by the Government Accountability Office (GAO) found that ASC costs are, on average, lower than OPD costs (Government Accountability Office 2006).<sup>1</sup> However, we are not able to isolate the impact of various factors on the time and cost differences between settings.

The ASC payment system generally parallels the OPPS 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 have received 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 OPPS,
- brachytherapy sources implanted during a surgical procedure,
- all pass-through and non-pass-through drugs that are paid separately under the OPPS when provided as part of a covered surgical procedure, and
- devices with pass-through status under the OPPS.

The links between the ASC payment system, the OPPS, and the PFS raise broader questions about how Medicare should pay for the same services 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 adjustments for the quality performance of providers, differences in patient severity, and additional costs incurred by hospitals to be available for emergency care 24 hours a

day? 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 PFS, and ASCs and OPDs receive the same amount for pass-through drugs and devices. In contrast, payments for ASC surgical services are less than the comparable payment under the OPPS. The Commission has begun investigating payment rate differences for services delivered in multiple ambulatory settings, such as evaluation and management services provided in OPDs and physicians' offices (see Chapter 3).

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## Are Medicare payments adequate in 2012?

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To address whether payments for 2012 are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2013), 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 furnished, providers' access to capital, and revenue from the Medicare program. Unlike our assessments of other provider types, however, we do not assess quality of care because ASCs do not yet submit data on quality measures, although CMS has established a program for ASCs to submit quality data beginning in October 2012. Also, we do not examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.<sup>2</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>3</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). ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow. These measures suggest that payment rates were at least adequate through 2010.

### **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 can be



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

There is evidence of differences in the patient populations of ambulatory surgical centers (ASCs) and hospital outpatient departments (OPDs). ASCs are less likely than OPDs 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 2010 found that the following groups are less likely to receive care in ASCs than in OPDs: 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>4</sup> The smaller share of disabled, older, and dual-eligible beneficiaries treated in ASCs may reflect the healthier profile of ASC patients relative to OPD patients. The smaller share of African American patients in ASCs relative to OPDs may be linked to differences in the geographic locations of ASCs and hospitals and the fact that African Americans in fee-for-service Medicare are less likely than other beneficiaries to have supplemental coverage. In addition, hospitals receive reimbursement from Medicare for 70 percent of the copayments they are unable to collect from beneficiaries (bad debt). ASCs receive no reimbursement for Medicare beneficiaries' bad debt. This difference in bad debt policy between hospitals and ASCs may contribute to the higher share of African Americans treated in OPDs.

**TABLE 5-1**

### Medicare patients treated in ASCs differ from patients treated in OPDs, 2010

Characteristic	Percentage of Medicare patients	
	ASC	OPD
Medicaid status		
Not Medicaid	86.0%	76.9%
Medicaid	14.0	23.1
Race/ethnicity		
White	88.1	84.2
African American	6.8	10.4
Other	5.1	5.4
Age (in years)		
Under 65	14.0	21.4
65 to 84	78.6	67.7
85 or older	7.4	10.9
Sex		
Male	42.1	43.5
Female	57.9	56.5

Note: ASC (ambulatory surgical center), OPD (hospital outpatient department). All of the differences between ASC and OPD 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, 2010.

(continued next page)

beneficial to patients and physicians because ASCs can offer them convenience and efficiency relative to OPDs—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 OPDs; for physicians, ASCs may offer more control over their work environment and specialized staff. In addition, Medicare has lower payment rates and beneficiaries generally face lower coinsurance in ASCs than in OPDs. However, 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 OPDs. 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). 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.

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

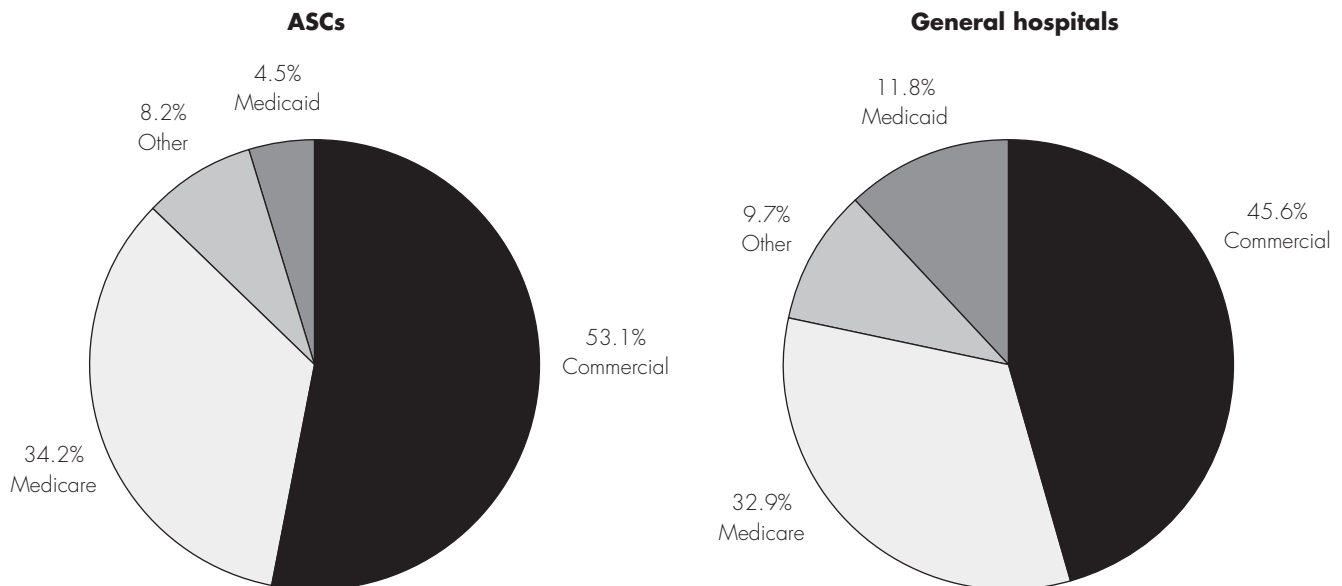
Research by the Commission found that, compared with OPDs, ASCs treat Medicare patients who are less medically complex, as measured by differences in average risk scores (Medicare Payment Advisory Commission 2003). Risk scores represent beneficiaries' expected service use given their health status relative to that of the national average beneficiary.<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 OPD. RAND found that ASC patients were less likely to have certain comorbidities, such as dementia and chronic obstructive pulmonary disease (Sloss et al. 2006). One explanation for why OPDs treat comparatively sicker patients is that hospitals offer emergency services and access to onsite specialists if complications arise.

According to data from Pennsylvania on Medicare and non-Medicare patients, ASCs are less likely than OPDs to serve Medicaid patients. In 2010, Medicaid patients accounted for 4.5 percent of diagnostic and surgical procedures in ASCs in Pennsylvania, compared with 11.8 percent of procedures in OPDs (Pennsylvania Health Care Cost Containment Council 2011) (Figure 5-1).<sup>6</sup> Commercially insured and Medicare patients represented a higher share of ASC procedures than OPD procedures (87.3 percent vs. 78.5 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, Medicaid patients accounted for 3.9 percent of ambulatory

*(continued next page)*

**FIGURE 5-1**

**Distribution of outpatient procedures by payer at ASCs and general acute care hospitals in Pennsylvania, fiscal year 2010**



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 2011.

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

surgery visits to freestanding ASCs in 2006 compared with 8.1 percent of these 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 OPDs. 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 patients to physician-owned ASCs rather than OPDs. 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' locations 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. In contrast, hospitals in states where Medicaid does not pay Medicare's cost sharing can be compensated for 70 percent of the bad debt incurred by dual-eligible beneficiaries. ■

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

The number of Medicare-certified ASCs increased substantially over the past several years, growing by 4.6 percent per year from 2005 through 2009 and by 1.9 percent in 2010. During this period, an average of 279 new facilities entered the program each year, while an average of 71 closed or merged with other facilities (Table 5-2).

From 2005 through 2008, the number of Medicare-certified ASCs increased from 4,362 to 5,095, an average annual increase of 5.3 percent. However, the growth rate decelerated to 2.4 percent in 2009 and 1.9 percent in 2010. This slow growth continued into 2011, as the number of ASCs increased by 1.0 percent to 5,368 during the

first three quarters of 2011 (an annual growth rate of 1.3 percent). Several factors might explain the relatively slow growth from 2009 through the first three quarters of 2011:

- The economy is experiencing a sluggish recovery from the financial crisis that peaked in 2008, which has dampened demand for elective services (Johnson et al. 2010, Kaiser Family Foundation 2011).
- The ASC payment system underwent a substantial revision in 2008, and investors may be responding to the large change in payment rates that occurred under that revision.
- Payment rates for most ambulatory surgical services are 74 percent higher in the OPPS than in the ASC payment system, which has led some ASC owners to

**TABLE  
5-2**

**Number of Medicare-certified ASCs has grown by 22 percent, 2005-2010**

	2005	2006	2007	2008	2009	2010
Number of centers	4,362	4,608	4,879	5,095	5,217	5,316
New centers	354	331	344	281	213	152
Exiting centers	59	85	73	65	91	53
Net percent growth in number of centers from previous year	7.3%	5.6%	5.9%	4.4%	2.4%	1.9%

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2010.

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

ASC type	2005	2010
Urban	87%	88%
Rural	13	12
For profit	96	97
Nonprofit	4	3

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2010.

sell their facilities to hospitals and caused some health care systems to expand OPDs rather than establish new ASCs (North Carolina Department of Health and Human Services 2008, State of Connecticut 2011).

- There may be limited opportunities to develop new facilities because most physicians who perform procedures in ASCs are already affiliated with an ASC (Cain Brothers 2011). This factor leads some analysts to predict weak growth in the number of ASCs in the near future.

To provide a more complete picture of capacity in ASCs, we also examined the change in the number of operating rooms. From 2005 through 2010, the mean number of operating rooms per ASC increased slightly from 2.5 to 2.7, although the median number of operating rooms remained the same at 2. This finding indicates that growth in the total number of operating rooms has been similar to growth in the number of ASCs and that new ASCs are roughly the same size as existing ones.

ASCs are concentrated geographically. As of 2010, Maryland had the most ASCs per fee-for-service (FFS) beneficiary, followed by Washington, Idaho, and Georgia, with each state having more than 30 ASCs per 100,000 beneficiaries. Meanwhile, Vermont had the fewest ASCs per FFS beneficiary, followed by West Virginia, New York, and Kentucky, with each state having fewer than 6 ASCs per 100,000 beneficiaries.<sup>8</sup> In addition, in 2010, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time (Table 5-3). Beneficiaries who do not live near an ASC may receive ambulatory surgical services in OPDs 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). Other factors have also 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.
- 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 OPDs 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 OPDs.<sup>9</sup>
- Physicians have greater autonomy in ASCs than in OPDs, which enables them to design customized surgical environments and hire specialized staff.
- 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 OPDs in the same amount of time, they can earn more professional fees.

**Number of ASC services grew from 2005 to 2010; newly covered services contributed to growth in number of services from 2007 to 2010**

We examined growth in the number of ASC surgical services provided per FFS beneficiary.<sup>10</sup> The volume of surgical services per FFS beneficiary increased by an



average of 7.6 percent per year from 2005 through 2009 and by 1.6 percent in 2010 (Table 5-4).

The 2008 revision to the ASC payment system substantially increased the number of covered services, and these newly covered services contributed 39 percent of the overall volume growth from 2007 through 2010. We evaluated the effect of the increased number of covered services by breaking down the growth in service volume from 2009 through 2010 into two parts: the portion attributable to surgical services newly covered after 2007 and the portion attributable to surgical services covered in both 2007 and 2010. Our analysis indicates that services newly covered after 2007 grew by 3.6 percent in 2010 and services covered in both 2007 and 2010 grew by 1.5 percent in 2010 (Table 5-4).<sup>11</sup>

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 compose a large share of the total in 2010. For example, cataract removal with intraocular lens insertion had the largest volume in both 2007 and 2010, accounting for 19.9 percent of volume in 2007 and 17.6 percent of volume in 2010. Moreover, 19 of the 20 most frequently provided services in 2007 were among the 20 most frequently provided in 2010 (Table 5-5, p. 126). For these 20 services, volume per FFS beneficiary increased by 1.9 percent per year from 2007 through 2010. However, these 20 services accounted for a smaller share of total volume in 2010 than in 2007: 68.0 percent versus 74.6 percent. The fact that the most frequently provided services made up a smaller share of the total in 2010 than in 2007 indicates that the ASC industry is diversifying the surgical services it provides.

**Surgical services have migrated from OPDs to ASCs but rate of migration appears to have slowed**

The growth in service volume provided in ASCs may reflect, in part, migration of services from OPDs to ASCs. We compared volume growth of services provided in ASCs with the growth of ASC-covered services provided in OPDs. We limited this analysis to services that were covered in the ASC payment system in 2005, as the inclusion of services covered in the OPDS in 2005 that became covered in the ASC payment system after 2005 would have biased the results. From 2005 through 2009, the number of ASC-covered surgical services per FFS beneficiary grew by 6.1 percent per year in ASCs but was virtually unchanged in OPDs, which suggests that

**TABLE 5-4**

**Volume of ASC services per FFS beneficiary has continued to grow**

Time period	Average annual volume growth per FFS beneficiary
2005 to 2009	7.6%
2009 to 2010	1.6
Services covered in both 2007 and 2010	1.5
Services newly covered after 2007	3.6

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

Source: MedPAC analysis of 5 percent carrier standard analytic claims files, 2005, 2007, 2009, and 2010.

these surgical services may have migrated from OPDs to ASCs during that period (Table 5-6, p. 127). However, the migration from OPDs to ASCs appears to have slowed, as the volume of these services grew at the same rate (1.0 percent) in ASCs and OPDs in 2010. Factors that have likely contributed to narrowing the difference between ASCs and OPDs are higher Medicare payment rates in OPDs relative to ASCs and increased employment of physicians by hospitals, which we discuss in detail in Chapter 3 of this report.

Other data also suggest slowing migration from OPDs to ASCs. In Pennsylvania, ASCs' share of outpatient diagnostic and surgical procedures performed on all patients increased from 10.2 percent in 2000 to 32.5 percent in 2009 but showed only a small increase to 32.6 percent in 2010 (Pennsylvania Health Care Cost Containment Council 2011).

We believe it is desirable to maintain beneficiaries' access to ASCs, as Medicare payment rates for surgical services are lower in ASCs than in OPDs. Our analysis comparing the number of cataract surgeries with intraocular lens insertion provided in ASCs with those in OPDs illustrates this point. We found that, from 2005 through 2010, the proportion of these procedures provided in ASCs increased from 62 percent to 70 percent; the payment rate for these procedures in 2010 was \$962 in ASCs compared with \$1,633 in OPDs. Moreover, ASCs can offer patients advantages over OPDs such as more convenient locations and shorter waiting times.

**TABLE  
5-5**

**Highest volume ASC services in 2007 and 2010**

Surgical service	2007		2010	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	19.9%	1	17.6%	1
Upper GI endoscopy, biopsy	7.9	2	8.0	2
Diagnostic colonoscopy	5.9	3	4.2	5
Colonoscopy and biopsy	5.5	4	5.6	3
After cataract laser surgery	5.4	5	4.0	6
Lesion removal colonoscopy, snare technique	4.8	6	4.3	4
Injection spine: lumbar, sacral (caudal)	4.3	7	3.5	8
Injection foramen epidural: lumbar, sacral	3.1	8	3.8	7
Injection paravertebral: lumbar, sacral add on*	2.9	9	1.9	11
Injection paravertebral: lumbar, sacral*	1.9	10	2.1	9
Lesion removal colonoscopy, by biopsy forceps or bipolar cautery	1.7	11	1.1	17
Colon cancer screen, not high-risk individual	1.7	12	1.3	15
Injection foramen epidural add on	1.6	13	2.0	10
Upper GI endoscopy, diagnosis	1.5	14	1.3	16
Colorectal screen, high-risk individual	1.4	15	1.7	12
Cystoscopy	1.3	16	1.1	19
Destruction paravertebral nerve, add on	1.1	17	1.5	13
Revision of upper eyelid	0.9	18	1.0	20
Cataract surgery, complex	0.9	19	1.3	14
Injection spine: cervical or thoracic	0.8	20	0.8	26
Total	74.6		68.0	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal).  
\*The description of these services changed in 2010 to include imaging guidance.

Source: MedPAC analysis of 5 percent carrier standard analytic claims files, 2007 and 2010.

However, we must be attentive to the fact that most ASCs have some degree of physician ownership, and this ownership could give physicians an incentive to perform more surgical services than if they provided outpatient surgery only in OPDs. This additional volume could partially offset the effect of comparatively lower 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>12</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 suggests that the growth in ASCs may have resulted in greater overall volume of surgical procedures. Another study that focused on a single state found that the rates of colonoscopy and upper gastrointestinal tract endoscopy in ambulatory settings increased faster in health care markets where an ASC entered than in markets that had no ASC entry (Hollingsworth et al. 2011). Based on these studies, it is plausible that 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

**TABLE  
5-6**

**Volume of surgical services grew faster in ASCs than in OPDs from 2005 to 2009, but growth was equal in 2010**

Measure	Average annual percent change, 2005-2009		Percent change, 2010	
	ASCs	OPDs	ASCs	OPDs
Number of services per FFS beneficiary	6.1%	0.0%	1.0%	1.0%
Number of beneficiaries served	3.8	-1.3	-0.6	0.2
Services per beneficiary served	2.2	1.3	1.6	0.8

Note: ASC (ambulatory surgical center), OPD (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 are payable by Medicare when provided in an ASC. In addition, the surgical services included in the 2010 volume were limited to those that were covered in 2005.

Source: MedPAC analysis of 5 percent carrier and outpatient standard analytic claims files, 2005 and 2010.

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 their ability to obtain capital. The number of ASCs continued to increase in 2010, although at a slower rate than in prior years (Table 5-2, p. 123). This slowing growth rate may reflect the sluggish recovery from the financial crisis that peaked in 2008 and substantial revisions to the ASC payment system that same year, the small number of physicians who are currently unaffiliated with an ASC who can be recruited to a new ASC, and the widening difference between payment rates in the ASC payment system and the OPDS. In 2008, the average payment rate for services provided in ASCs was 62.6 percent of what would have been paid in OPDs. This number fell to 58.2 percent in 2010. However, Medicare accounts for a relatively small share of ASCs' overall revenue, so other factors may have a larger effect on access to capital for this sector.

Data on the financial performance of the only publicly traded ASC chain also provide evidence of the sector's access to capital. Earnings per share of stock for this chain are expected to increase by 2 percent from 2010 to 2011 and by 22 percent from 2011 to 2012, with the large increase in 2012 mostly related to the acquisition of new facilities (Deutsche Bank 2011). The earnings produced by this ASC chain are one source of capital it can use to establish new facilities or expand existing ones. We caution, however, that this chain represents only 4 percent of all Medicare-certified ASCs, so its earnings growth may not be indicative of the entire ASC industry.

**Medicare payments: Payments have increased rapidly**

In 2010, ASCs received about \$3.4 billion in payments from Medicare and beneficiaries' cost sharing (Table 5-7, p. 128). Payments per FFS beneficiary increased by an average of 6.8 percent per year from 2005 through 2009 and by 2.6 percent in 2010. From 2007 through 2010, per capita payments increased by 5.3 percent per year, with services newly covered after 2007 accounting for 1.7 percentage points of that increase; services covered in both 2007 and 2010 accounted for the rest.

Industry observers may be concerned that payment rates for the newly covered services, which accounted for 39 percent of the volume growth from 2007 through 2010, are inadequate. However, the growth in volume and payments in 2010 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 provide those services.

**TABLE  
5-7****Medicare payments to ASCs have grown, 2005-2010**

	2005	2006	2007	2008	2009	2010
Medicare payments (billions of dollars)	\$2.7	\$2.8	\$2.9	\$3.1	\$3.2	\$3.4
Medicare payments per FFS beneficiary						
Payments	\$78	\$85	\$90	\$97	\$102	\$105
Percent change	6.8%	8.5%	5.6%	8.1%	5.2%	2.6%

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.

## How should Medicare payments change in 2013?

Our payment adequacy analysis for the period reviewed indicates that the number of Medicare-certified ASCs has increased, beneficiaries' use of ASC services has grown, and access to capital has been adequate. However, our information for assessing payment adequacy is limited because we lack quality-of-care and cost data on ASCs (see discussion below). On the basis of evidence from the available indicators, we conclude that ASC payments are at least adequate.

CMS recently established a Quality Reporting Program for ASCs under which facilities will begin reporting quality data in October 2012. Until such data are collected and publicly released, we will not be able to assess ASCs' quality. The Commission has recommended in several previous reports that ASCs submit cost data to CMS (Medicare Payment Advisory Commission 2004, Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2010b, Medicare Payment Advisory Commission 2011). Cost data would enable analysts to determine the costs of an efficient provider, which would help inform decisions about the ASC update. Cost data would also help determine whether an alternative input price index would be an appropriate proxy for ASC costs or whether an ASC-specific market basket should be developed. As discussed in the text box (p. 130), the Commission 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).

We understand CMS's concern that requiring ASCs to submit cost data may impose a burden on ASCs (Centers for Medicare & Medicaid Services 2011). Although ASCs are generally small facilities that may have limited resources for collecting cost data, such businesses typically keep records of their costs for filing taxes and other purposes. Moreover, other small providers, such as home health agencies and hospices, submit cost data to CMS. To minimize the burden on CMS and ASCs, CMS should create a streamlined process for ASCs to track and submit cost data. One such mechanism could be annual surveys of a random sample of ASCs (with mandatory response). Another approach would be cost reports from all ASCs that are more streamlined than hospital cost reports but have sufficient information to assess the adequacy of ASC payments and develop an ASC market basket.

CMS increased the ASC conversion factor by 0.2 percent in 2011 and by 1.6 percent in 2012. The update for 2012 was based on a projected 2.7 percent increase in the CPI-U, minus a 1.1 percent deduction for multifactor productivity growth, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA). We project that the update for 2013 will be 1.2 percent: the currently projected increase in the CPI-U of 2.1 percent less the currently forecasted multifactor productivity growth of 0.9 percent (IHS Global Insight 2011).

### Update recommendation

As the Commission considers an update to the ASC conversion factor for 2013, 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 data.

In balancing these goals, the Commission concludes that ASCs should receive a modest positive update in 2013 and that the Congress should require them to submit cost data.

### RECOMMENDATION 5-1

**The Congress should update the payment rates for ambulatory surgical centers by 0.5 percent for calendar year 2013. The Congress should also require ambulatory surgical centers to submit cost data.**

### RATIONALE 5-1

On the basis of our payment adequacy indicators, the lack of ASC cost data, and our concerns about the potential effect of ASC growth on overall program spending, we believe a moderate update of 0.5 percent is warranted for 2013. The indicators of payment adequacy for which we have information are positive: There has been continued growth in the number of Medicare-certified ASCs and beneficiaries' use of ASC services, and ASCs have adequate access to capital. Therefore, although we lack cost and quality data, the indicators we have suggest that payments have been at least adequate. It is vital that CMS begin collecting cost data from ASCs without further delay. The lack of such data for ASCs is a major reason why our recommended update for ASCs is lower than that for OPDs in Chapter 3 of this report (1.0 percent for 2013). Cost data from ASCs would enable analysts to determine the costs of an efficient provider, which would help inform decisions about the ASC update. Such 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.

### IMPLICATIONS 5-1

#### Spending

- The currently projected ASC update for 2013 is 1.2 percent. However, we recommend that payment

rates be increased by 0.5 percent. Therefore, relative to current law, our recommended update for 2013 would decrease federal spending by less than \$50 million in the first year and by less than \$1 billion over five years. The spending implication of this recommendation is based on Medicare spending projections that were made prior to a sequester, as the recommendation was developed and voted on before the sequester was triggered and became current law. If a Medicare sequester does occur, it will change the spending implication of the recommendation.

#### 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 data.

### Using quality data from ASCs to reward high-performing and penalize low-performing providers

To improve the quality of care provided to beneficiaries in ASCs, CMS should use ASC quality data to reward high-performing and penalize low-performing providers. CMS should also publicly report quality measurement results to help consumers compare quality among facilities. CMS recently established a Quality Reporting Program for ASCs that requires them to submit quality data beginning in 2012; ASCs that do not submit data would have their annual payment update reduced in 2014 (Centers for Medicare & Medicaid Services 2011). However, Medicare payments to ASCs would not be adjusted based on the provider's actual performance on quality measures. Although the Secretary recently submitted a plan to the Congress to implement a value-based purchasing program (VBP) for ASCs that would reward high-performing facilities, the agency lacks the statutory authority to establish such a program (Department of Health and Human Services 2011).

The Commission supports the Quality Reporting Program for ASCs but believes that, eventually, high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system.

## Revisiting the market basket for ambulatory surgical centers

**B**ecause of our concerns that the market basket index CMS uses to update ambulatory surgical center (ASC) payments (the consumer price index for all urban consumers (CPI-U)) may not reflect ASCs' cost structure, we examined whether an alternative market basket index would better measure changes in ASCs' input costs (Medicare Payment Advisory Commission 2010b). 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 and found that ASCs' cost structure differs from that of hospitals and physician offices.

Although CMS has historically used the CPI-U as the basis for Medicare's annual updates to ASC payments, the mix of goods and services in this price index probably does not reflect ASC inputs. The CPI-U is based on a sample of prices for a broad mix of goods and services, including food, housing, apparel, transportation, medical care, recreation, personal care, education, and energy (IHS Global Insight 2011). The weight of each item is based on spending for that item by a sample of urban consumers during the survey period. Although ASCs probably use some of these items, their share of spending on each item is likely very different from the CPI-U weight. For example, housing accounts for 43.4 percent of the entire CPI-U (Bureau of Labor Statistics 2009).

Because CMS currently lacks data on ASCs' input costs, we explored whether one of two existing Medicare indexes would be an appropriate proxy for ASC input costs: the hospital market basket, which is used to update payments for inpatient and outpatient hospital services, and the practice expense component of the Medicare Economic Index (MEI), which measures changes in physicians' practice expenses. It is reasonable to expect that ASCs have many of the same types of costs as hospitals and physicians' offices, such as medical equipment, medical supplies, building-

related expenses, clinical staff, administrative staff, and malpractice insurance.

We used 2004 ASC cost data from a GAO survey to compare the distribution of ASC costs with the distribution of hospital costs (derived from the hospital market basket) and physician practice expenses (derived from the practice expense portion of the MEI). (See our March 2010 report for more details on the method (Medicare Payment Advisory Commission 2010b).) Although the GAO data are not sufficient for comparing each category of costs across settings, they suggest that ASCs have a different cost structure from hospitals and physicians' offices. ASCs appear to have a much higher share of expenses related to 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 physicians' offices. ASCs' comparatively larger share of costs for medical supplies and drugs could be related to their high volume of cataract removal and lens insertion procedures. These procedures use intraocular lenses, which are included in the medical supplies category and are relatively expensive. Another factor could be that ASCs furnish primarily surgical procedures, whereas hospitals and physicians provide a significant number of evaluation and management services, which probably have lower supply costs than surgical procedures.

The ASC cost data used in our comparative analysis are eight years old and do not contain information on several types of costs. Therefore, the Congress should require ASCs to submit new cost data to CMS. CMS should use this information 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 market basket could include the same types of costs that appear in the hospital market basket or MEI but with different cost weights that reflect the unique structure of ASC costs. ■

The current quality reporting program could lay the foundation for such a VBP program, which was the case for the Medicare hospital inpatient VBP program. Other ambulatory care providers—physicians and OPDs—already have quality reporting programs, and the

Commission has recommended that Medicare adopt VBP (also known as pay-for-performance) programs for these sectors (Medicare Payment Advisory Commission 2005, Medicare Payment Advisory Commission 2007a).

Consistent with the Commission's overall position on pay-for-performance programs in Medicare, a VBP program for ASCs should include a relatively small set of measures that primarily focus on clinical outcomes and some process, structural, and patient experience measures. Several of these measures will be reported through the ASC Quality Reporting Program but other measures need to be developed. An ASC VBP program should reward ASCs for improving care and exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services.

### Criteria for measures

The Commission has outlined the following general criteria for performance measures for any Medicare pay-for-performance program (Medicare Payment Advisory Commission 2005, Medicare Payment Advisory Commission 2007b):

- Measures should be evidence based and accepted by independent quality experts, private and public sector purchasers, providers, and consumer organizations.
- Collecting and analyzing measurement data should not be unduly burdensome for either the provider or the Medicare program.
- Incentives should not discourage providers from accepting riskier or more complex patients.
- Most providers should be able to improve on the available measures. Aspects of care being measured should be within the control of the provider, there should be room for improvement in the quality of care being measured, and the measure set should include measures that apply to all patients, such as safe practices and patient perceptions of care.
- The performance measures selected for all of Medicare's VBP programs should send consistent signals about Medicare's expectations for quality and efficiency across different types of providers and care settings. To that end, quality measures should be aligned across settings such as ASCs, OPDs, and physicians' offices for services that are performed in all those settings.

An ASC VBP program should include a relatively small set of measures to reduce the administrative burden on ASCs and CMS, and the measure set should primarily focus on clinical outcomes, as Medicare's central concern

should be improving outcomes across all ASCs and over time. The program should also include some clinical process, structural, and patient experience measures. Because the program should minimize the data collection burden on providers, CMS should avoid or minimize the use of measures that require providers to extract data from a sample of patients' medical charts.

### Outcome measures

CMS should consider incorporating the following outcome measures into an ASC VBP program:

- patient fall in the ASC;
- patient burn;
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant;
- hospital transfer or admission after an ASC procedure, whether the patient is transferred directly to the hospital from the ASC or admitted to the hospital after returning home from an ASC procedure; and
- surgical site infection.

The first three outcome measures listed above are patient safety indicators identified by the National Quality Forum (NQF) as "serious reportable events," which are defined as errors in medical care that are clearly identifiable and measurable, are usually preventable, are serious in their consequences for patients, and indicate a problem in a health care facility's safety systems. These indicators do not require risk adjustment because they measure events that are usually preventable and should not be affected by patients' severity of illness or health status. These measures can also apply to multiple types of procedures and ASCs. The ASC versions of these measures were developed by the industry-sponsored ASC Quality Collaboration and have been endorsed for ASC use by the NQF. Given that these measures were developed by a coalition of ASC groups, it should be technically feasible for ASCs to report these indicators without undue administrative burden. Under the new ASC Quality Reporting Program, ASCs will begin reporting these measures on claims in October 2012.

Under this program, ASCs will also begin reporting a claims-based measure tracking whether patients are transferred or admitted directly to a hospital (including a hospital emergency room) upon discharge from an ASC, which can indicate a potentially preventable complication,

serious medical error, or other unplanned negative outcome. An ASC with a high rate of transfers or inpatient admissions may be providing suboptimal care or may be performing procedures on patients who should not be treated in an ambulatory surgical setting. This measure—which was endorsed in its current form by the NQF—should be expanded to include patients who return home after the ASC procedure but who are admitted to a hospital shortly thereafter because of a problem related to the procedure. Including these patients in the measure would enable CMS to more comprehensively track patients who experience serious complications or medical errors related to an ASC procedure. Because some patients are admitted to the hospital after returning home from an ASC, CMS could analyze claims data to look for hospital admissions for adverse events related to an ASC procedure that occur within a certain number of days of a procedure.

Another important outcome measure is the rate of surgical site infections (SSIs) in ASCs. Researchers have found that lapses in infection control practices were common among a sample of ASCs in three states (Schaefer et al. 2010). Problems with infection control could increase the rate of SSIs. Therefore, CMS should develop an SSI measure that applies to common ASC procedures. CMS should consider using the same measures to track infection rates for ambulatory surgeries for both OPDs and ASCs. Measuring SSI rates could be a way to encourage providers to collaborate and better coordinate care for ambulatory surgery patients. Because SSIs often do not appear until after a patient has been discharged from an ASC and because ASCs typically do not have an ongoing relationship with patients, CMS could instruct ASCs to conduct a follow-up phone call with patients, their caregivers, or their physicians within an appropriate time period after the procedure to identify patients who have developed SSIs. ASCs could include this information in the patient's medical record and submit it to CMS.

Although the ASC Quality Reporting Program does not yet include an SSI measure, CMS will consider proposing one in the future after the agency has identified an appropriate set of outpatient procedures for an SSI measure and developed a protocol for facilities to track and report SSIs (Centers for Medicare & Medicaid Services 2011). CMS will also consider including an SSI measure in the hospital outpatient Quality Reporting Program. The hospital inpatient Quality Reporting Program includes an SSI measure that applies primarily to inpatient procedures.

## **Process measures**

In addition to outcome measures, an ASC VBP program should also initially include one or more infection control process measures, given existing concerns about infection control practices in ASCs (Schaefer et al. 2010). CMS should eventually phase out the process measures once the agency adopts an SSI outcome measure that applies to a large number of ASC procedures. One potential process measure is prophylactic intravenous (IV) antibiotic timing, which assesses the rate of ASC patients who received IV antibiotics to prevent an SSI on time (within one or two hours before the incision). Timely administration of IV antibiotics is effective in reducing the risk of developing an SSI. This indicator is part of the ASC Quality Reporting Program and is also used in the Quality Reporting Programs for hospital inpatient and outpatient settings and in the Physician Quality Reporting System (PQRS). Another potential infection control process measure is discontinuation of prophylactic antibiotics, which measures the percent of patients who received a prophylactic antibiotic who had an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time; this measure is currently used in PQRS. CMS could also consider including a third PQRS process measure related to preventing another type of serious surgical complication: venous thromboembolism (VTE) prophylaxis when indicated in all patients.<sup>13</sup>

## **Structural and patient experience measures**

The ASC VBP program should also include structural and patient experience measures. Structural measures are designed to ensure that a facility is capable of providing high-quality care. The ASC and hospital outpatient Quality Reporting Programs include a structural measure that assesses whether ASCs are using a safe surgery checklist. A safe surgery checklist helps ensure that safe practices are performed before administration of anesthesia, before incision, and before the patient leaves the operating room. The use of such checklists has been associated with significant reductions in surgical complications and mortality (de Vries et al. 2010). Because ASCs will report whether they used a safe surgery checklist to CMS through the QualityNet website, the data reporting burden should be minimal. Hospitals currently report structural measures through QualityNet under the inpatient and outpatient Quality Reporting Programs.

Because measures of patient experience provide information on patients' perceptions of access to care and how well their providers communicate with them,



the Commission supports the development of a survey to measure patients' perceptions of their ASC care. Such a survey could be modeled after the existing Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician and Group Survey and the CAHPS Surgical Care Survey. CMS has indicated that a patient experience measure could be included in the ASC Quality Reporting Program in the future (Centers for Medicare & Medicaid Services 2011). When the Commission recommended a VBP program for physicians, we suggested that a patient experience measure could become part of such a program (Medicare Payment Advisory Commission 2005).

### **CMS should incorporate quality measures over time that use data from patient registries and electronic health records**

We encourage CMS to consider incorporating quality measures that use data from patient registries into the ASC VBP program over time, when it is clinically appropriate and administratively feasible to do so. The Commission has found that claims-based process measures provide important but limited information about quality of care and are the least burdensome approach to collecting quality information. However, patient registries that can aggregate and report more detailed clinical data from a provider's entire patient population also have value for quality improvement. Registries can be used to analyze providers' adherence to evidence-based process measures and track patients' health outcomes over time. We note that PQRS includes two registry-based measures that relate to outcomes of cataract surgery, which is a common ASC service.<sup>14</sup> CMS could consider adapting these registry-based measures for ASCs. Providers can also use registries to track patients who are treated with a particular drug or device, information that could be used for postmarket surveillance of clinical outcomes associated with the use of that product.

The Commission strongly supports the use of electronic health records (EHRs) and other health information technology, such as computerized provider order entry and clinical decision support, as tools that can improve the quality and reduce the cost of care (Medicare Payment Advisory Commission 2005). EHRs may reduce the administrative burden of collecting and reporting clinical data that are not readily available from claims, such as diagnostic test results. As EHRs become more widespread, CMS should consider adding more clinically detailed measures to the ASC VBP program as well as using

EHR data to refine risk-adjustment methods for outcome measures that are adjusted for patients' health status.

### **CMS should address statistical issues related to performance measures that have a small number of cases**

Certain ASCs—including those with relatively low volumes of Medicare patients—may report small numbers of cases for the calculation of some performance measures, especially measures of low-frequency and high-cost events, such as serious reportable events and other patient safety incidents. The rates reported for these providers could vary substantially from one observation period to the next based solely on random statistical variation, which in effect would reward or penalize providers for fluctuations in their performance scores that are unrelated to their actual quality of care.

To address these cases, CMS could consider the use of composite measures that would aggregate the rates for several measures of rare events into a single rate, or consider alternative ways to calculate scores on these kinds of measures, such as using performance data from multiple years. The trade-off for the increased statistical reliability in both approaches is that the reported rates become less actionable for providers. In the case of a composite measure, the result is the sum or average of several different measures that may have varying rates of performance, making it hard for a provider to know where to focus quality improvement efforts. In the case of a multiyear measure, the results may capture performance from past years that no longer reflect current practices, making it difficult to show improvement quickly and create momentum for more rapid change. CMS should keep this trade-off in mind as it balances the need for statistically reliable measures that also yield actionable quality information for providers and beneficiaries.

### **Medicare should reward ASCs for improving care and exceeding quality benchmarks**

The goal of a VBP program is to improve care for as many beneficiaries as possible. Thus, it is important to reward providers who attain certain thresholds of quality as well as lower performing providers who improve their quality over time. Consistent with the Commission's design criteria for VBP programs and the inpatient hospital VBP program, ASCs should be rewarded either for attaining high thresholds of quality performance or for significantly improving their own prior year performance (Medicare Payment Advisory Commission 2005, Medicare Payment Advisory Commission 2007b). It is reasonable to expect

that, over time, these thresholds will converge as more facilities raise their performance to the national attainment benchmark.

### **Funding for VBP program should come from existing ASC spending**

Funding for the pool of incentive payments in the VBP program 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. As in the inpatient hospital VBP program, the size of this pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program. Because aggregate ASC payments would be reduced to fund the program, and money from the resulting pool of funds would be distributed to facilities based on their performance, high-performing or consistently improving ASCs would receive higher payments than under current law while low-performing ASCs would receive lower payments. This policy should encourage facilities to improve their performance so they can receive additional payments or avoid payment reductions.

#### **RECOMMENDATION 5-2**

**The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016.**

#### **RATIONALE 5-2**

To improve the quality of care for beneficiaries in ASCs, Medicare's payment system should reward high-performing facilities and penalize low-performing facilities. The Commission has also recommended that Medicare adopt VBP programs for the other providers of ambulatory surgery—physicians and OPDs. The VBP program for ASCs should include a relatively small set of measures that primarily focus on clinical outcomes and some process, structural, and patient experience measures.

Several of these measures will be reported through the ASC Quality Reporting Program but other measures need to be developed. The program should reward ASCs for improving care and exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services.

Requiring the VBP program to begin in 2016 would give CMS sufficient time to develop additional quality measures, design a method for scoring measures, and determine whether ASCs attained high thresholds of quality performance or improved their own prior year performance.

#### **IMPLICATIONS 5-2**

##### **Spending**

- Because funding for the pool of incentive payments in the VBP program should come from existing Medicare spending for ASC services, this recommendation would not increase Medicare spending. The Congress or CMS could design the program to create small savings. For example, penalties for ASCs that have excessive rates of hospital transfers or admissions may be implemented in a non-budget-neutral manner, similar to the policy in PPACA that reduces payments to hospitals with a high rate of readmissions.

##### **Beneficiary and provider**

- This recommendation should increase the quality of care provided to beneficiaries in ASCs.
- ASCs will incur some administrative costs to submit quality data. Because aggregate ASC payments would be reduced to fund the program, and money from the resulting pool of funds would be distributed to facilities based on their performance, high-performing or consistently improving ASCs would receive higher payments than under current law while low-performing ASCs would receive lower payments. ■

## Endnotes

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- 1 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004; they received reliable cost data from 290 facilities.
- 2 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated a requirement that the Secretary collect cost data from ASCs every five years.
- 3 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).
- 4 Because ASCs are disproportionately located in some states (Maryland, Washington, Idaho, and Georgia), 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.
- 5 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 OPD patients.
- 6 These data are based on 266 ASCs and 165 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 Vermont, West Virginia, New York, and Kentucky all have certificate-of-need laws for ASCs, which may help explain the relatively low number of ASCs in those states.
- 9 By statute, coinsurance for a service paid under the OPPTS cannot exceed the hospital inpatient deductible (\$1,156 in 2012). 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 OPPTS coinsurance.
- 10 Our analysis excluded radiology services provided in ASCs because the ASC payment system did not pay separately for radiology services before 2008.
- 11 Our analysis of service volume in 2010 included surgical procedures only, as nearly all these procedures had Current Procedural Terminology codes in the range 10000–69999. Our analysis of 2010 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 2010.
- 12 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.
- 13 This indicator measures the percent of patients undergoing procedures for which VTE prophylaxis is indicated in all patients and who had an order for low molecular weight heparin, low-dose unfractionated heparin, adjusted-dose warfarin, fondaparinux, or mechanical prophylaxis to be given within 24 hours before incision time or within 24 hours after surgery end time.
- 14 The first indicator measures the percent of patients who had visual acuity of 20/40 or better within 90 days after the cataract surgery. The second indicator measures the percent of patients who had major complications related to cataract surgery within 30 days after the surgery.

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