CHAPTER 10

Ambulatory surgical center services: Status report

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Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures to patients who do not require an overnight stay. In 2023, about 6,300 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries. FFS Medicare program and beneficiary spending on ASC services was about $6.8 billion. The volume of ASC surgical procedures per FFS beneficiary rose by 5.7 percent in 2023 and at an annual average rate of 0.6 percent from 2018 to 2022. Numerous factors have contributed to this sector's growth, including changes in clinical practice and health care technology that have expanded the provision of surgical procedures in ambulatory settings. For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to hospital outpatient departments. ASCs also offer physicians more specialized staff and control over their work environment.

Over 90 percent of ASCs are for profit and located in urban areas. The concentration of ASCs varies widely across states, ranging from 35 ASCs per 100,000 Part B beneficiaries (FFS and Medicare Advantage combined) in Maryland to 3 or fewer ASCs per 100,000 Part B beneficiaries in the District of Columbia, Kentucky, and Vermont. Relative to hospital outpatient departments (HOPDs), ASCs are less likely to provide surgical procedures to FFS Medicare beneficiaries who are disabled, have Medicaid

In this chapter

- Supply of ASCs and volume of services continued to grow in 2023
- Little change in ASC Quality Reporting Program measures
- Aggregate Medicare payments rose substantially in 2023, continuing a trend
- Ambulatory surgical centers should submit cost data

coverage, or are ages 85 or older. About 68 percent of ASCs that billed Medicare in 2023 specialized in a single clinical area, of which gastroenterology and ophthalmology were the most common. The remainder were multispecialty facilities, providing services in more than one clinical specialty, of which pain management and orthopedics were the most common. From 2018 to 2023, the specialties that grew most rapidly were pain management and cardiology.

The most common FFS Medicare procedure in ASCs in 2023 was extracapsular cataract removal with intraocular lens insertion, accounting for almost 19 percent of ASCs' FFS Medicare volume and 19 percent of spending. The 20 most common surgical procedures made up about 69 percent of ASCs' FFS Medicare volume in 2023, though questions have been raised about the value of some of these procedures.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 7.8 percent from 2018 through 2022 and by 15.4 percent in 2023. Because FFS Medicare payment rates are lower in ASCs than in HOPDs for all services that are covered in both settings, the cost to Medicare (and the taxpayers who fund the program) is lower if a surgical procedure is provided in an ASC rather than an HOPD. The beneficiary's cost-sharing liability is lower as well. However, it is possible that a shift of services from HOPDs to ASCs could increase the overall volume of surgical procedures, which would partially offset the reduction in total Medicare spending and beneficiaries' cost sharing.

Policymakers know little about the costs that ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its requirements for other types of facilities. As a result, it is not possible to properly evaluate the level of Medicare's payments relative to costs for ASCs. The Commission contends that ASCs could feasibly provide cost data, as other small providers such as home health agencies and hospices do. Beginning in 2010 through 2022, the Commission recommended that the Congress require ASCs to submit cost data and reiterated this recommendation in 2023 and 2024. In addition, we encourage CMS to synchronize the ASC Quality Reporting Program's measures with measures included in the Hospital Outpatient Quality Reporting Program to facilitate comparisons between ASCs and HOPDs. ■

An ambulatory surgical center (ASC) is a facility that primarily provides outpatient surgical procedures to patients who do not require an overnight stay. Outpatient surgical procedures are also provided in hospital outpatient departments (HOPDs) and, in some cases, physicians' offices. Fee-for-service (FFS) Medicare covers more than 3,700 surgical procedures in ASCs, though historically volume has been concentrated in a small number of procedures.

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 their professional services through the payment system for physicians and other health professionals, known as the physician fee schedule (PFS). For the facility portion, Medicare pays ASCs for a bundle of 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. For services that were first covered under the ASC payment system in 2008 or later and for which volume is greater in freestanding physician offices than in ASCs, the ASC payment rate is set to the lesser of the standard ASC payment rate or the nonfacility practice expense from the Medicare PFS. The rationale for this policy is to encourage provision of these services in the lowest-cost setting.

Payment rates in the ASC payment system are the product of a set of relative weights and a conversion factor (or base payment amount). The relative weights, which indicate each procedure's resource intensity relative to other procedures, used in the ASC payment system are the same as those in the OPPS. The ASC conversion factor ($54.90 in 2025) is less than that used in the OPPS ($89.17 in 2025), but since 2019, CMS updated the ASC conversion factor using the same method used to update the OPPS conversion factor: the hospital market basket index minus the multifactor productivity adjustment.[1]

For many years, the Commission reviewed available Medicare payment-adequacy indicators for ASCs to make recommendations on appropriate updates to the ASC payment system. Our payment-adequacy indicators pointed to a robust industry, with long-term growth in the number of ASCs, the volume of services provided to FFS Medicare beneficiaries, and total FFS Medicare payments. However, CMS has never required ASCs to submit cost data, and information about the quality of care has been of limited value. The Commission recommended that CMS require ASCs to submit cost data; in the absence of those data, the Commission has opted not to make an update recommendation since 2022. Instead, we provide a status report on ASCs, examining beneficiaries' access to ASC care, growth in the number of ASCs, growth in Medicare's payments to ASCs, and, to the extent possible, the quality of care provided in ASCs.

Supply of ASCs and volume of services continued to grow in 2023

The number of ASC facilities increased in 2023, as did the volume of ASC services provided to FFS Medicare beneficiaries. Access to ASCs may be preferable to patients and physicians compared with HOPDs, the provider type most like ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to HOPDs. ASCs provide physicians with specialized staff and more control over their work environment. However, these same qualities could lead to overuse of some surgical procedures.

The number of ASCs increased in 2023

From 2022 through 2023, the number of Medicare-certified ASCs rose 2.5 percent to 6,308 ASCs, compared with growth of 2.2 percent, on average, from 2018 through 2022 (Table 10-1, p. 302). During 2023, 250 new ASCs opened while 95 ASCs closed or merged with other facilities for a net increase of 155 facilities.

Numerous factors 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. This trend could continue as momentum grows for performing knee and hip arthroplasty (knee and hip replacement) as well as angioplasty in ambulatory settings.[2]

TABLE 10–1

Number of ASCs grew, 2018–2023

	2018	2022	2023	Average annual change 2018–2022
Total number of ASCs	5,650	6,153	6,308	2.2%
New	226	221	250	N/A
Closed or merged	136	93	95	N/A

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

Source: MedPAC analysis of Provider of Services file from CMS, 2024.

- ASCs can offer patients greater convenience than HOPDs, such as patients having less "nonoperative" time (the total time a patient spends in an operating room, minus the procedure time) in ASCs (Imran et al. 2019).
- For most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs.[3]
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff. These features of ASCs allow physicians to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees.
- Some states have eliminated or softened their certificate-of-need (CON) laws, such as South Carolina eliminating CON requirements for ASCs in 2023 and North Carolina eliminating CON requirements for ASCs located in counties with populations over 125,000.

TABLE 10–2

Most ASCs were for profit and located in urban areas, 2018 and 2023

	ASCs that were:		
Type of ASC	**Open in 2018**	**Open in 2023**	**New in 2023**
For profit	95.2%	95.3%	95.2%
Nonprofit	3.6	3.7	4.8
Government	1.2	1.0	0.0
Urban	93.4	93.8	96.8
Rural	6.6	6.2	3.2

Note: ASC (ambulatory surgical center). We defined "urban" as being in metropolitan statistical areas (MSAs) and "rural" as being outside MSAs. We calculated percentages using unrounded data.

Source: MedPAC analysis of CMS Provider of Services file, 2024.

TABLE 10–3 **FFS Medicare patients treated in ASCs differ from patients treated in HOPDs, 2023**

	Percentage of FFS Medicare patients that are in each category	
Characteristic	**ASC**	**HOPD**
Dual-eligibility status		
Not dually eligible	91.1%	85.0%
Dually eligible	8.9	15.0
Age		
< 65 (disabled)	5.9	9.8
65–84	88.6	81.5
85 +	5.5	8.7
Sex		
Male	43.8	46.5
Female	56.2	53.5

Note: FFS (fee-for-service), ASC (ambulatory surgical center), HOPD (hospital outpatient department). All differences between ASC and HOPD patients are statistically significant ($p < 0.05$). This analysis excludes beneficiaries who received services that are not covered under the ASC payment system.

Source: MedPAC analysis of carrier and outpatient standard analytic claims files for 2023 and the Common Medicare Environment file.

Most ASCs are for profit, and geographic distribution is uneven

Consistent with previous years, most ASCs in 2023 were for profit (95.3 percent) (Table 10-2). Because most ASCs are for-profit entities, they have an incentive to provide profitable services. As the number of ASCs grows, if ASCs act on this incentive, there is the potential for ASCs to account for an increasingly larger share of the profitable ambulatory procedures, leaving the less profitable ambulatory procedures to other settings, primarily HOPDs.

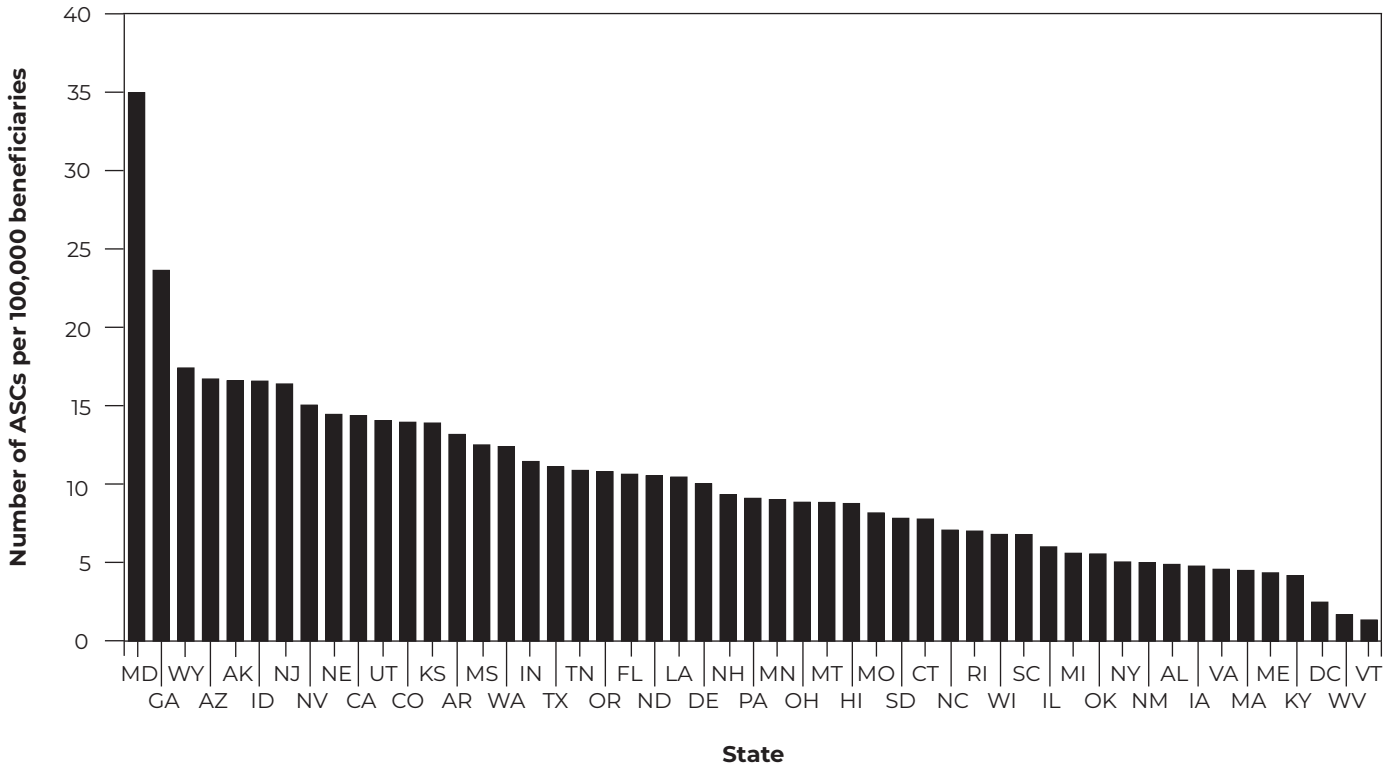
ASCs were also disproportionately located in urban areas in 2023 (93.8 percent) (Table 10-2). Stakeholders contend that rural areas typically lack the surgical specialists needed for ASCs and that the lower population density in rural areas makes them less viable locations for ASCs. Even though some areas have low ASC penetration, beneficiaries who do not live near an ASC can usually obtain ambulatory surgical services in HOPDs and, in some cases, physicians' offices. Beneficiaries who live in rural areas may travel to urban areas to receive care at ASCs.

We found that rural beneficiaries—defined as those who live outside metropolitan statistical areas (MSAs)—are less likely to receive care in ASCs than are urban beneficiaries, defined as those living in an MSA. In 2023, 8.6 percent of rural beneficiaries received care in an ASC compared with 12.6 percent of urban beneficiaries (data not shown). Moreover, the profile of FFS beneficiaries who receive their ambulatory surgeries in ASCs differs from those who receive their ambulatory surgeries in HOPDs. ASCs are less likely than HOPDs to serve Medicare beneficiaries who are dually eligible for Medicare and Medicaid, those who are ages 85 and older, and those who are under age 65 and eligible for Medicare because of disability (Table 10-3). Geographic areas that have high social risk factors have low ASC penetration, which helps to explain why ASCs have a relatively low share of FFS Medicare patients who are dually eligible or disabled (Medicare Payment Advisory Commission 2024). The low presence of FFS Medicare patients ages 85 and older may be due to physicians directing frail patients to HOPDs, where it may be safer to provide surgical services.

The concentration of ASCs varies widely across states. At the close of 2023, Maryland had the most ASCs per Medicare beneficiary (35 ASCs per 100,000 Part B beneficiaries (both FFS and Medicare Advantage)),

FIGURE 10–1

Number of ASCs per beneficiary varied widely by state, 2023



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2024 and the Common Medicare Environment file.

followed by Georgia, Wyoming, and Arizona (respectively, 24, 17, and 17 ASCs per 100,000 Part B beneficiaries) (Figure 10-1). Kentucky, the District of Columbia, West Virginia, and Vermont had the fewest ASCs per Part B beneficiary (4 or fewer ASCs per 100,000 Part B beneficiaries).[4]

Several factors contribute to variation in ASCs per Part B beneficiary among states. One factor that appears to have a strong effect is whether a state has a CON law for ASCs. However, even among the 22 states (plus the District of Columbia) that have CON laws, the stringency varies. For example, Nevada, which has a relatively weak CON law for ASCs, has one of the highest concentrations of ASCs per Medicare beneficiary; by contrast, Vermont has very strict CON laws and has by far the lowest number of ASCs per Medicare beneficiary. Moreover, some states have characteristics that appear to overwhelm the effects of having or not having a CON law. For example, Maryland has a strong CON law but has by far the most ASCs per Medicare beneficiary, likely due to the presence of an all-payer global-budget revenue model in the state that excludes care provided by ASCs. To help hospitals meet their budgets, it appears that they avoid providing many ambulatory surgical procedures in the hospitals, resulting in these procedures being provided in ASCs. New Mexico, by contrast, does not have a CON law for ASCs but has only about half as many ASCs per 100,000 Part B beneficiaries (5) as the average among all states (10), perhaps due to the large number of sparsely populated rural areas in the state.

According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2023, Ambulatory Surgery Center

Association 2021, Leapfrog 2019). Physician owners of ASCs receive additional income through distributions of facility profits according to their ownership interest. Other owners of ASCs include hospitals and corporate entities. One change that is occurring in the structure of ASC ownership is the extent of corporate involvement. In the ASC industry, five corporate entities are considered major holders of ASCs: United Surgical Partners International, AmSurg, Surgical Care Affiliates, HCA Healthcare, and Surgery Partners Holdings. From 2018 to 2023, the number of ASCs in which these five entities had some degree of ownership increased by 15.7 percent from 1,152 to 1,333, and the share of ASCs in which these entities had an ownership stake increased from 20.0 percent to 21.1 percent (Hawkins et al. 2023).

As noted above, ASCs offer several advantages for surgeons because they can customize their surgical environments and hire specialized staff, which allows them to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees. For beneficiaries, ASCs offer shorter nonoperative times than HOPDs (Imran et al. 2019). In addition, because Medicare payment rates are lower in ASCs than in HOPDs for all services that are covered in both settings (for most services, the ASC payment rates are 46 percent lower than the HOPD payment rates), the cost to beneficiaries (via cost sharing) is lower, as is the cost to the Medicare program (as well as taxpayers).[5]

Because of these advantages of ASCs, it could be beneficial for surgical procedures to migrate from the HOPD setting to ASCs. However, the low concentration of ASCs in many states and in rural areas limits the extent to which beneficiaries can access care in ASCs. Further, it is possible that shifting services from HOPDs to ASCs could increase the volume of surgical procedures, which would partially offset any associated reduction in total Medicare spending and beneficiaries' cost sharing.

Research indicates that when an ASC enters a market or a physician who performs surgical procedures in HOPDs and/or ASCs becomes an ASC owner, surgical procedures shift from HOPDs to ASCs and overall outpatient surgical volume in the market may slightly increase. Courtemanche and Plotzke found that the addition of an ASC to a hospital's market reduces a hospital's outpatient surgical volume by 2 percent to 4 percent if the facilities are within four miles of each other, but they found that this impact on HOPD surgical volume is unlikely to have a serious impact on the financial viability of a typical hospital (Courtemanche and Plotzke 2010). Hollenbeck and colleagues found that the entry of an ASC into a market that previously did not have any ASCs reduced outpatient surgical procedures provided in HOPDs by 7 percent. Within these markets, the volume of procedures provided in ASCs was greater than the decline in procedures provided in hospitals (Hollenbeck et al. 2015). Munnich and colleagues found that most physicians that provide surgical procedures in outpatient settings furnish those services in both ASCs and HOPDs (Munnich et al. 2021). They also found that two years after physicians obtained an ownership stake in an ASC, the share of the surgical procedures that those physicians provided in ASCs had increased by 22 percent, while the share they provided in HOPDs had decreased by about the same percentage. At the same time, the total number of outpatient surgical procedures they provided to both Medicare and non-Medicare patients increased by 9 percent. However, the total number of outpatient surgical procedures provided to FFS Medicare patients increased by a small amount, and this change was not statistically significant. In summary, research indicates that increased ASC presence in a market causes a shift of outpatient procedures from HOPDs to ASCs, and it might increase the total number of outpatient procedures by a small amount.

Specialization of ASCs largely unchanged; some growth in pain management and cardiology

In 2023, 68 percent of ASCs that billed Medicare specialized in a single clinical area. Gastroenterology and ophthalmology were the most common specialties, with each comprising about 20 percent of all ASCs that provided services to FFS Medicare beneficiaries. The remaining 32 percent of ASCs were multispecialty facilities, providing services in more than one clinical specialty (Table 10-4, p. 306).[6] In 2023, the most common multispecialty ASCs were those focusing on pain management and orthopedic services or gastroenterology and ophthalmology (combined, 8 percent of all ASCs were multispecialty and focusing on one of those two specialties).[7] From 2018 to 2023, the

TABLE 10–4

Specialization of ASCs billing Medicare in 2018 and 2023

	2018		2023	
Type of ASC	**Number of ASCs**	**Share of all ASCs**	**Number of ASCs**	**Share of all ASCs**
Single specialty	3,277	65%	3,917	68%
Gastroenterology	1,071	21	1,193	21
Ophthalmology	1,046	21	1,152	20
Pain management	612	12	800	14
Dermatology	197	4	197	3
Urology	127	3	152	3
Podiatry	87	2	62	1
Cardiology	55	1	221	4
Orthopedics/musculoskeletal	33	1	83	1
Respiratory	26	1	36	1
OB/GYN	14	<1	15	<1
Neurology	4	<1	5	<1
Other	5	<1	1	<1
Multispecialty	1,784	35	1,827	32
More than 2 specialties	1,313	26	1,345	23
Pain management and orthopedics	292	6	262	5
Gastroenterology and ophthalmology	179	4	220	4
Total	5,061	100	5,744	100

Note: ASC (ambulatory surgical center), OB/GYN (obstetrics and gynecology). We define a "single-specialty" ASC as one with more than 67 percent of its Medicare claims in one clinical specialty. We define a "multispecialty" ASC as one with less than 67 percent of its Medicare claims in one clinical specialty. The total number of ASCs in this table is less than the total number of ASCs listed in Table 10–1 (p. 302) because the ASCs included in this table are limited to those in the 50 states and the District of Columbia that had a paid Medicare claim, while the ASCs in Table 10–1 include all ASCs in the 50 states, the District of Columbia, and Puerto Rico. Columns containing the "shares of all ASCs" do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2018 and 2023.

number of ASCs specializing in pain management and cardiology services grew most rapidly.

Volume of services per beneficiary rose in 2023

For several years, aggregate volume of ASC services provided to Part B FFS beneficiaries declined as the number of beneficiaries in FFS Medicare decreased and the number in Medicare Advantage rose. That decline in the number of FFS beneficiaries was mitigated somewhat by a slow but steady increase in the number of services per Part B FFS beneficiary, which rose at an average annual rate of 0.6 percent from 2018 to 2022. However, in 2023, the number of services per Part B FFS beneficiary rose by 5.7 percent, causing an increase in aggregate ASC services provided to Part B FFS beneficiaries of 2.2 percent (Table 10-5).

The relatively strong volume growth in 2023 was driven by increased volume of the highest-volume procedures such as colonoscopies and cataract procedures as well as large percentage increases in the volume of total knee arthroplasty (33 percent) and total hip arthroplasty (34 percent) (data not shown).

TABLE 10–5

Volume of ASC services per FFS beneficiary rose in 2023

				Average annual change	
	2018	2022	2023	2018–2022	2022–2023
Volume of Medicare FFS services (in millions)	6.8	6.2	6.4	–2.3%	2.2%
Part B FFS beneficiaries (in millions)	33.3	29.6	28.7	–2.9	–3.3
Volume per 1,000 FFS beneficiaries	205.4	210.2	222.1	0.6	5.7

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

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2018–2023, and the 2024 Medicare Trustees' report.

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2023. For example, in both 2018 and 2023, extracapsular cataract removal with intraocular lens insertion had the highest volume, accounting for 18.6 percent of the total in 2018 and 18.5 percent in 2023 (Table 10-6, p. 308). Moreover, 18 of the 20 most frequently provided ASC services in 2018 were among the 20 most frequently provided in 2023. These services made up about 70 percent of ASC Medicare volume in 2018 and 69 percent in 2023.

Relative to the highest-volume surgical procedures, there was more change among the highest-revenue surgical procedures, reflecting a shift to higher-complexity services in ASCs. Two of the highest-revenue services in 2023—total knee arthroplasty and total hip arthroplasty—were not covered under the ASC payment system in 2018. For another high-revenue procedure in 2023—percutaneous laminotomy or laminectomy—revenue increased by a factor of 20 over the 2018 level.

A longstanding feature of the services provided in ASCs to FFS Medicare beneficiaries is that despite the ASC payment system covering over 3,700 procedures, the provision of ASC services has been concentrated in a relatively small number of procedures. Of the surgical procedures provided to FFS Medicare beneficiaries in ASCs, 75 percent of the volume was concentrated in 31 procedures, and 75 percent of the FFS Medicare revenue was concentrated in 59 procedures. A potential factor limiting the breadth of services provided by ASCs is the inpatient-only (IPO) list maintained by CMS, which is a list of services (including surgical procedures) that cannot be provided to Medicare beneficiaries anywhere but the hospital inpatient setting. The extent to which eliminating the IPO list would expand the services that ASCs provide is not clear.[8] CMS has steadily removed surgical procedures from the IPO list, but ASCs generally have provided low quantities of these procedures. Important exceptions include knee arthroplasty and hip arthroplasty, which have increased in ASC volume since CMS removed them from the IPO list in 2020 and made them services covered under the ASC payment system.

Another factor that may limit the breadth of ASC services is that 320 surgical procedures that are not on the IPO list are covered under the OPPS but not the ASC payment system. Because these procedures are provided in another ambulatory setting (HOPDs), coverage of these procedures under the ASC system could result in nontrivial provision in ASCs. However, most of these services are low volume in HOPDs, so it is likely that they would be low volume in ASCs.[9]

Little change in ASC Quality Reporting Program measures

CMS established the Ambulatory Surgical Center Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this

TABLE 10–6

For FFS beneficiaries, the 20 most frequently provided ASC services in 2018 were similar to those provided in 2023

	2018		2023	
Procedure name	**Percent of volume**	**Rank**	**Percent of volume**	**Rank**
Extracapsular cataract removal with IOL insert	18.6%	1	18.5%	1
Upper GI endoscopy, with biopsy: single or multiple	7.9	2	7.4	3
Colonoscopy and biopsy	6.9	3	6.7	4
Colonoscopy with lesion removal, snare technique	6.1	4	7.7	2
Injection transforaminal epidural: lumbar or sacral	4.7	5	4.2	5
After cataract laser surgery	4.1	6	3.7	6
Injection paravertebral facet joint: lumbar or sacral, single level	3.4	7	3.1	7
Injection interlaminar epidural: lumbar or sacral	2.7	8	1.9	9
Colorectal cancer screening, high-risk individual	2.1	9	2.4	8
Diagnostic colonoscopy	1.7	10	1.2	15
Destroy lumbar/sacral facet joint, single	1.7	11	1.9	10
Colorectal cancer screening, not high-risk individual	1.7	12	1.6	11
Injection procedure for sacroiliac joint, anesthesia	1.4	13	1.5	12
Extracapsular cataract removal complex without ECP	1.4	14	1.3	13
Cystourethroscopy	1.2	15	1.3	14
Injection paravertebral facet joint: cervical or thoracic, single level	1.1	16	1.1	16
Injection interlaminar epidural: cervical or thoracic	1.0	18	0.8	18
Upper GI endoscopy diagnostic brush wash	0.9	17	0.7	22
Blepharoplasty upper eyelid	0.9	19	1.0	17
Upper GI endoscopy, guide wire insertion	0.8	20	0.6	23
Total	70.2		68.6	

Note: FFS (fee-for-service), ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal), ECP (endoscopic cyclophotocoagulation). Percentages may not sum to totals due to rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from 2018 and 2023.

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 that CMS implement a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).

The ASCQR Program currently has four claims-based measures tied to unplanned hospitalizations for several important ASC specialties: gastrointestinal, orthopedics, urology, and general surgery (Table 10-7). CMS will add several measures for which ASCs will submit data from 2025 for ASC payment determination in 2027. However, we believe that CMS should implement additional quality measures to make the ASCQR Program more effective (see text box on CMS's new measures, pp. 310–311).

TABLE 10–7

ASCs' performance on quality measures improved on one measure, was unchanged on other measures, 2018–2023

Description of quality measure	Median 2018	2022	2023
ASC–12: Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy (per 1,000 colonoscopies)	12.2%	9.8%	9.8%*
ASC–17: Unplanned hospital visits within 7 days after orthopedic ASC procedure (per 1,000 procedures)	N/A	2.2	2.2
ASC–18: Unplanned hospital visits within 7 days of urology ASC procedure (per 1,000 procedures)	N/A	5.1	5.1
ASC–19: Facility-level 7-day hospital visit rate after general surgery procedures performed at ASCs (per 1,000 procedures)	N/A	1.0	1.0

Note: ASC (ambulatory surgical center), N/A (not applicable). "General surgery procedures" include abdominal, alimentary tract, breast, skin, wound, and varicose vein–stripping procedures.
* 2023 value is statistically different from 2018 value ($p < 0.05$).

Source: MedPAC analysis of data on quality measures for ambulatory surgical centers from CMS, 2018, 2022, and 2023.

From 2018 to 2023, ASCs statistically significantly improved their performance on ASC–12: Facility 7-day risk-standardized hospital visit rate after colonoscopy (Table 10-7). From 2022 to 2023, all four measure results were stable with no statistically significant changes.

Medicare beneficiaries can access the ASC-covered surgical procedures in HOPDs, so it is useful to compare the quality of care in ASCs to the quality in HOPDs. Only one quality measure listed in Table 10-7 is in the Outpatient Quality Reporting (OQR) Program: ASC–12, facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy. In 2022 (the most recent year for the OQR data), the median value in HOPDs for this measure was 13.1 (data not shown), worse than the ASC value of 9.8.

CMS will add several measures for which ASCs will submit data from 2025 for ASC payment determination in 2027. However, we believe that CMS should implement additional quality measures to make the ASCQR Program more effective (see text box on CMS's new measures, pp. 310–311).

Aggregate Medicare payments rose substantially in 2023, continuing a trend

In 2023, ASCs received $6.8 billion in FFS Medicare payments and beneficiaries' cost sharing (Table 10-9, p. 312). Spending by the FFS Medicare program was $5.4 billion, and beneficiary cost-sharing liability was $1.4 billion (data not shown).

Payments per FFS beneficiary rose at an average annual rate of 7.8 percent from 2018 through 2022 and by 15.4 percent in 2023 (Table 10-9, p. 312). The increase in 2023 reflects a 3.9 percent increase in the ASC conversion factor, a 5.7 percent increase in per capita volume, a 5.0 percent increase in the average relative weight of ASC services, and a 0.1 percent effect from an increase in spending from 2022 to 2023 on separately paid drugs provided to Medicare beneficiaries treated in ASCs.

Although the ASC payment system covers over 3,700 surgical procedures, the revenue that ASCs receive for providing services to FFS Medicare beneficiaries is concentrated in a relatively small number of

CMS is adding measures to the Ambulatory Surgical Center Quality Reporting Program, but further improvement is needed

CMS has been adding measures to the Ambulatory Surgical Center Quality Reporting (ASCQR) Program and has started collecting data on those measures (the data are not yet available). In 2024, CMS started collecting data on measures for four "never events," and in 2025, CMS will collect data on nine new measures (but three measures are voluntary in 2025) (Table 10-8).

The Commission asserts that CMS should continue to improve the ASCQR by moving toward outcome measures that apply to all ASCs. Although the ASCQR Program includes four measures that are claims based and measure clinical outcomes (ASC–12, ASC–17, ASC–18, and ASC–19; Table 10–7, p. 309), these measures exclude many services provided at ASCs, such as eye procedures and pain management. To improve the ASCQR Program, and consistent with MedPAC principles, it is important that the Secretary include more claims-based measures that assess clinical outcomes for the various specialties practiced at ASCs.

In addition, CMS should synchronize ASCQR measures with measures included in the Hospital Outpatient Quality Reporting (OQR) Program to facilitate comparisons between ASCs and hospital

(continued next page)

TABLE 10–8

Measures that CMS has recently added to the Medicare ASC Quality Reporting Program

Description of quality measure	First year of data collection
Patient burn	2024
Patient fall	2024
Wrong site, wrong side, wrong patient, wrong procedure, wrong implant	2024
All-cause hospital transfer/admission	2024
Facility commitment to health equity	2025
Screening for social determinants of health*	2025
Screen positive for social drivers of health*	2025
Five patient experience measures from the Outpatient and Ambulatory Survey of the Consumer Assessment of Healthcare Providers and Systems (CAHPS)	2025
About facilities and staff	
Communication about procedure	
Preparation for discharge and recovery	
Overall rating of facility	
Recommendation of facility	
Risk-standardized patient-reported outcome-based performance measure following elective primary total hip arthroplasty and/or total knee arthroplasty**	2025

Note: ASC (ambulatory surgical center).
* This measure will be voluntary for submission by facilities in 2025. It will become mandatory in 2026.
** This measure will be voluntary for submission by facilities in 2025, 2026, and 2027. It will become mandatory in 2028.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2025.

CMS is adding measures to the Ambulatory Surgical Center Quality Reporting Program, but further improvement is needed (cont.)

outpatient departments (HOPDs). Currently, the ASCQR and the OQR possess four common quality measures that pertain to cataract procedures, colonoscopy procedures, and patient assessments. CMS should consider expanding the overlap of the ASCQR and OQR, relying on either measures of general surgical procedures or measures of specific surgical procedures common to both settings. For example, CMS could consider including OQR measure OP–36 (the number of hospital visits after any outpatient surgery) in the ASCQR.

Because clinical outcomes can be effective measures of quality, CMS should also consider developing new ASC quality measures covering these three categories:

- ***Surgical-site infections (SSIs) occurring at ASCs.*** CMS has considered an SSI measure for ASCs in the past (Centers for Medicare & Medicaid Services 2011), but it is not currently working to develop one (Centers for Medicare & Medicaid Services 2016). In general, an SSI measure could be used to track infection rates for ASCs and identify quality improvement opportunities for ambulatory surgeries conducted in 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 whether services provided in ASCs are appropriate.*** While the ASCQR Program currently includes an ASC-reported colonoscopy measure that assesses 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).[10] Using these guidelines, a new measure could identify ASCs' share of colonoscopy cases for beneficiaries over age 85. CMS could consider similar measures for whether certain procedures that have become more common in ASCs in recent years are appropriate or for procedures that have drawn concern about appropriate use, such as spinal injections or certain orthopedic procedures (Chant et al. 2023, Ganguli et al. 2021).
- ***Claims-based outcome measure for cardiology services.*** Cardiology has become a growth area for ASCs as providers become more comfortable performing angiograms and angioplasties in ASCs. One projection predicts that by 2025, 33 percent of cardiology procedures will be provided in ASCs (Van Biesen and Johnson 2023). As cardiology procedures become more common in ASCs, it would be beneficial for CMS to add a claims-based measure to evaluate the quality of those procedures. ■

procedures. As noted above, in 2023, 59 procedures accounted for 75 percent of the Medicare revenue from surgical procedures (data not shown).

ASCs do not submit cost reports, so we cannot analyze the financial standing for all ASCs. However, the Pennsylvania Health Care Cost Containment Council (PHC4) collects total operating costs and total operating revenue from all ASCs in Pennsylvania, which allows for the calculation of operating margins for those ASCs. For 2023, the operating margin for the Pennsylvania ASCs was 24 percent, which is consistent with their historical operating margins of 23 percent to 25 percent from 2007 through 2022 (Pennsylvania Health Care Cost Containment Council 2024).[11] The data collected by PHC4 can be used to evaluate margins, but the data are somewhat limited and could not be used to create accurate ASC payment rates or an ASC-specific price index that could be used to update ASC payment rates.

TABLE 10–9

FFS Medicare payments to ASCs rose rapidly, 2018–2023

				Average annual percentage change	
	2018	2022	2023	2018–2022	2022–2023
FFS Medicare payments (billions)	$5.1	$6.1	$6.8	4.7%	11.6%
FFS Medicare payments per FFS beneficiary	$152	$205	$236	7.8%	15.4%

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

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

Ambulatory surgical centers should submit cost data

The Commission has frequently expressed concern that Medicare does not require ASCs to submit cost data, unlike other types of facilities. Every year from 2010 to 2022, the Commission recommended that the Congress require ASCs to submit cost data (Medicare Payment Advisory Commission 2010); the Commission reiterated this recommendation in 2023 and 2024. Cost data would enable policymakers to establish payment rates that accurately reflect ASC costs. Currently, ASC payment rates are not based on ASC cost data but instead are largely derived from the OPPS relative weights, which are based on HOPD charges adjusted to cost. To the extent that the cost structures of HOPDs and ASCs differ, ASC payment rates do not accurately reflect the cost of ASCs. Though some evidence suggests that FFS Medicare's payments for ASC services are higher than ASC costs on average, it is plausible that ASC payment rates are higher than ASC costs for some services and lower than ASC costs for others. This disparity would create incentives for ASCs to focus on providing high-margin services, which would narrow their scope of services relative to what they might offer if the payment rate for each service accurately reflected ASC costs.

Cost data are also needed to determine whether an alternative input price index would be an appropriate proxy for ASC costs. The Commission has previously expressed concern that the price index that CMS used to update the ASC conversion factor from 2010 through 2018 (the Consumer Price Index for All Urban Consumers) likely does not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010). Similarly, the price index that CMS has used to update the ASC conversion factor since 2019—the hospital market basket—likely does not reflect ASCs' cost structure.

CMS has shown some interest in collecting cost data to help determine ASC payment rates and has requested comments from stakeholders on whether the Secretary should collect cost data from ASCs. Most recently, the ASC industry has shown openness to submitting cost data but has indicated that such data should not be used to develop an ASC-specific market basket. Instead, the industry has suggested that CMS could establish an HOPD market basket and use it to update payments in both the ASC payment system and the OPPS (Ambulatory Surgery Center Association 2024).

However, the Commission has asserted that the cost structures of ASCs and HOPDs are likely very different. ASCs tend to be single specialty, for profit, and are not required to comply with the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), while HOPDs are multispecialty, typically nonprofit, and many of them must comply with EMTALA. In addition, relative to hospitals, ASCs are more urban, serve a different mix of patients demographically and by payer type, have a much higher share of

expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs (Medicare Payment Advisory Commission 2018). Therefore, using an HOPD-specific market basket for both settings would likely result in inaccurate ASC payments.

The Commission recognizes that ASCs are small facilities and requiring them to submit cost data would place a burden on them, but we have contended that it is feasible for ASCs to provide cost information. Small businesses like ASCs typically keep records of their costs for filing taxes and other purposes. In addition, all other facility providers submit cost data to CMS, including other small facilities such as rural health clinics, home health agencies, and hospices. 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 2024). The state of Pennsylvania has required ASCs to submit these data since at least 2005, with no apparent dampening effect on investor interest. From 2005 to 2018, the number of ASCs in Pennsylvania rose from 153 to 242 (an average of 3.6 percent per year). ■

Endnotes

1 The ASC payment system has several nuances that we have not discussed here. For a discussion of these nuances, see the Commission's *Payment Basics* for ambulatory surgical centers at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_ASC_FINAL_SEC.pdf.

2 Total knee arthroplasty (Current Procedural Terminology Code 27447) was first covered under the ASC payment system in 2020. About 10,800 of these procedures were provided in ASCs to FFS Medicare beneficiaries in 2020. The number of these procedures rose to 38,600 in 2023.

3 By statute, coinsurance for a service paid under the OPPS cannot exceed the Medicare Part A inpatient hospital deductible ($1,684 in 2025). The ASC payment system does not have the same limitation on coinsurance; for a small percentage of billing codes covered under the ASC payment system, beneficiary coinsurance exceeds the inpatient deductible. In these instances, coinsurance for an ASC-delivered procedure exceeds coinsurance for an HOPD-delivered procedure. Nearly all these services are "device-intensive" procedures, which are procedures in which the cost of a device is at least 30 percent of the ASC payment rate for the procedure. Of these procedures, the most frequently provided in 2023 were total knee arthroplasty and total hip arthroplasty.

4 The relatively high number of ASCs per Part B beneficiary in Maryland is due, at least in part, to a response to a Medicare waiver, which has resulted in Maryland hospitals operating under global budgets. Under this system, hospital budgets are capped, and they receive no additional revenue if they exceed their budgets. However, medical care received in ASCs falls outside the budgets, so there is an incentive for hospitals to shift outpatient surgical care to ASCs.

5 For some services, the OPPS cost sharing is lower than the ASC cost sharing because under the OPPS the cost sharing for a service cannot exceed the Medicare Part A inpatient hospital deductible ($1,684 in 2025), while the ASC system does not have a limit on beneficiary cost sharing. These services constituted 1.8 percent of ASC volume in 2023.

6 We define single-specialty ASCs as having more than 67 percent of their Medicare claims in one clinical specialty. We define multispecialty ASCs as having less than 67 percent of their Medicare claims in one clinical specialty.

7 The percentages for these two multispecialty categories in Table 10-4 (p. 306) add to 9 percent, but the unrounded percentages add to 8 percent.

8 The IPO list consists of Healthcare Common Procedure Coding System codes that are typically provided in an inpatient setting and cannot be paid under the ASC payment system or the OPPS. Throughout its rulemaking for the ASC payment system and the OPPS, CMS has received comments from stakeholders recommending that CMS eliminate the IPO list, while other stakeholders have recommended that CMS maintain the list (Centers for Medicare & Medicaid Services 2020).

9 Procedures covered under the ASC payment system are those that CMS determines are safe to provide in the ASC setting and lists in the ASC covered procedures list. CMS covers procedures under the OPPS that are not on the inpatient-only (IPO) list, which includes services that CMS deems unsafe to provide outside the inpatient setting. In 2021, CMS began a three-year phase-out of the IPO list that was slated for completion in 2023 (Centers for Medicare & Medicaid Services 2020). However, CMS paused this phase-out in 2022 and largely added back to the IPO list the services that had been removed from the IPO list in 2021 (Centers for Medicare & Medicaid Services 2021).

10 The American Cancer Society states that "people who are in good health and with a life expectancy of more than 10 years should continue regular colorectal cancer screening through the age of 75. For people ages 76 through 85, the decision to be screened should be based on a person's preferences, life expectancy, overall health, and prior screening history. People over 85 should no longer get colorectal cancer screening."

11 The margins for ASCs in Pennsylvania are different from the margins for other facilities because the margins for the ASCs do not include taxes or distributions to physician owners.

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