

The Current State of Ambulatory Surgery Centers and Future Trends

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Surgical volumes continue to shift from inpatient and hospital outpatient departments to independent and co-owned Ambulatory Surgery Centers (ASCs). Consumer preferences, payer pressure, lower cost, possibility of site-neutral payments, equivalent safety, and clinical innovation have caused this outmigration. Physicians have embraced the shift due to dissatisfaction with current employment models, more professional autonomy, a sense of purpose, the ability to drive efficiency and quality of care, and the option to invest and benefit financially. Vascular surgeons can utilize their existing experience delivering outpatient care to grow their practices. The unique challenges and business structure of this care model, regulatory roadblocks, arbitrary reimbursement adjustments, and new corporate entrants to ASCs need to be understood. New models of outpatient care will likely include shifting higher-acuity procedures to ASCs. The care will be delivered by independent vascular surgeons or through alignment between physicians and hospital systems to provide optimal care to patients in convenient, secure, and cost-effective settings.

INTRODUCTION

Only 4 decades ago, most diagnostic and surgical procedures were performed in hospitals because of concerns about patient safety. As safety concerns were alleviated, efficiency and cost savings led to the development of stand-alone outpatient surgery centers called Ambulatory Surgery Centers (ASCs). The outmigration of care from hospitals was largely propelled by advances in technology, leading to an increase in minimally invasive procedures, a decrease in hospital stays, and allowing people to recover at home and return to work more quickly.

Today, ASCs are broadly accepted by patients, employers, insurers, and physicians as delivering safe, efficient, and cost-effective care for an increasing number of procedures.^{1,2}

WHY ASCS

A combination of safe delivery of care at lower cost and better patient experience driven by innovation and technology have led to the outmigration of procedures from hospitals to ASCs.¹ Patient satisfaction is also higher because ASCs usually offer convenient

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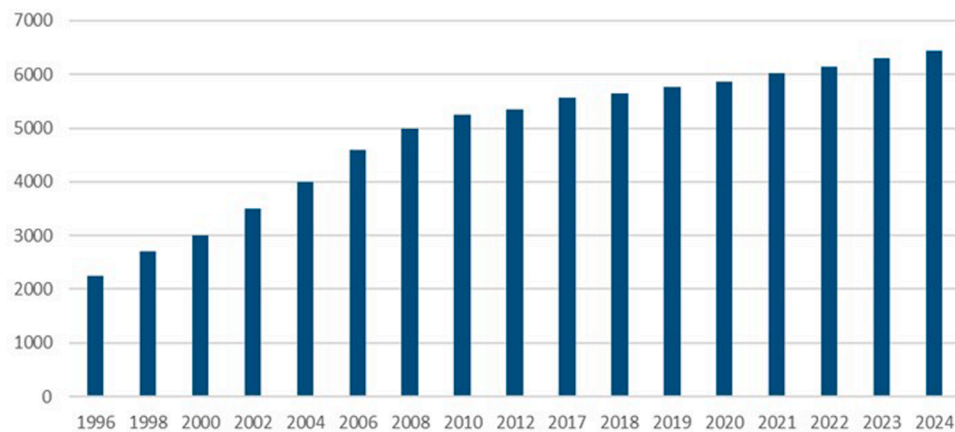


Fig. 1. ASCs ambulatory surgery centers.

locations, shorter wait times, lower cost-sharing, and easier scheduling compared to hospital outpatient departments (HOPDs).³ It is anticipated, based upon 2019 reimbursement rates, that this shift may lead to an annual reduction of \$114 billion to \$148 billion in overall healthcare spending.⁴

ASCs offer several benefits for surgeons, primarily professional autonomy and the ability to control their own schedule. Typically, physicians like professional autonomy and responsibility for providing high-quality care in the ASC.⁵ They can design and customize the facilities, hire the best staff, and modify and control all aspects of patient care to achieve optimal outcomes and efficiencies. Since operating time and room turnover are considered proxies for efficiency, ASCs can perform more procedures per room compared to HOPDs and therefore collect more revenue. After controlling for several variables like the number and type of procedures and patient demographics, procedures performed in ASCs on average took 31.8 minutes fewer than those performed in hospitals—a 25% difference relative to the mean procedure time.⁶

There are other benefits to ASCs. Surgeons appreciate that scheduled procedures cannot be “bumped” for emergencies, as they would at a hospital. Surgeons can invest in an ASC either alone, with other surgeons, or through a joint venture with a hospital.

For Medicare beneficiaries, ASCs offer patient-centered, efficient, and cost-effective care with equivalent outcomes.⁷ (As noted above, operative times are generally shorter compared to HOPDs.⁸ The Medicare payment rates to ASCs are, on average, 40–50% lower than the HOPD payment rates for all services that are covered in both

settings.⁹ The cost to beneficiaries (via cost sharing) is lower, as is the cost to the Medicare program and taxpayers.²

GROWTH

The first ASC was opened in Phoenix, Arizona, in 1970.¹⁰ In 1971, the American Medical Association (AMA) endorsed the American Society of Anesthesiologists (ASA) “Guidelines for Ambulatory Surgical Facilities,” including the concept of outpatient surgery under general or local anesthesia for selected procedures and patients.¹⁰ In a major step forward, Medicare approved reimbursements for ASCs for over 200 procedures in 1982. The list soon expanded to 1,535 procedures in 1985 and to 23 million annually by 2011.^{5,11} The number of Medicare-certified ASCs increased from over 5,300 in 2011 to 6,300 in 2023 (Fig. 1).^{2,11}

In terms of spending, the ASC market in 2020 was estimated at \$84 billion, with a projected compound annual growth rate (CAGR) of 3.9%, to \$131 billion by 2031.¹¹ Over the next decade, the demand for outpatient care is forecasted to outpace the United States population growth, 17% *versus* 13%, respectively.¹² The outpatient cardiovascular service line growth in the next decade is projected to exceed the inpatient service line growth, 25% *versus* 8%, respectively. The growth in the ASC industry is driven by numerous factors, but primarily by a shift toward lower costs of procedures. A 2021 report from United-Health Group showed that ASCs reduced the cost of orthopedic procedures, a major growth area, by 17% to 43%, saving patients an average of \$684 per procedure in an ASC compared to a HOPD.¹³

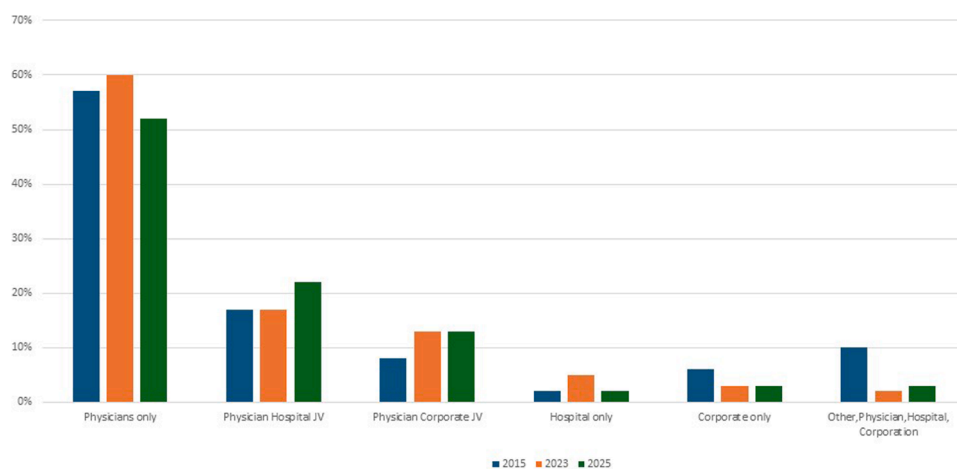


Fig. 2. Ownership structure of ambulatory surgery centers by years 2015, 2023, and 2025.

ASC STRUCTURE & OWNERSHIP

Surgeons can structure their outpatient procedure practices as Office-based Labs (OBLs), ASCs, or a hybrid. Different rules govern OBLs and ASCs. Both OBLs and ASCs have several ownership configuration options and can be single or multispecialty, including vascular surgery, cardiology, interventional radiology, and other nonvascular services.¹⁴

About 68% of ASCs operated independently in 2023.¹⁵ In a recent report to Congress, MedPAC reported that although physicians still held majority stakes, corporate ownership of ASCs between 2018 and 2013 rose slowly, from 20% to 21.1%.⁹ Although most ASCs are at least partially owned by physicians, only about one-third of the employed physicians are permitted to invest in ASCs.¹⁶ This portion was the lowest seen in several years and may be related to hospitals' desire to avoid risk (Fig. 2).^{16–18}

For surgeons, CMS continues to push reimbursement rates down for services, making it impossible for them to cover their rising practice overhead expenses solely through professional reimbursement. However, with “site-neutral” payments, narrowing the remuneration between HOPDs and ASCs, being pushed forward by CMS, more qualified surgeons are operating and owning ASCs, hoping to share in some of the technical fees.

Just like physicians, hospitals, or health systems can independently own the ASC, have a co-management arrangement with the physician(s) or have a joint venture (JV). In collaborating with hospitals, physicians may perceive certain advantages depending on the ownership structure. Hospitals

possess the financial “heft”, that is, access to capital, allowing the ASC to implement and/or update technology, including electronic medical records, artificial intelligence, and equipment. Future expansion, new service lines, and mergers and acquisitions (M&A) will be advantageous with their experience. Hospitals also have an established presence in the quality-of-care space and experience in human resources, payer contracts, advertising, and accreditation processes.

Initially, hospitals were reluctant to own or invest in ASCs, concerned that moving higher-reimbursed inpatient procedures to the lower-reimbursed outpatient setting would harm their bottom lines. Their other concern was that their average reimbursement for procedures would drop, causing short-term losses and affecting their credit ratings. Reports projecting significant growth in volumes of 15%–46% for specialties like orthopedics, spine, and cardiology changed their strategy.¹⁸ The growth of vascular services in ASCs between 2023 and 2028 is anticipated to be 16.7%.¹⁸ Hospitals, health systems, and corporations have now increasingly invested in ambulatory care, either alone or (more likely) as a joint venture with physicians, as part of their physician integration strategy. In a survey of hospital executives, 60% of “leaders were considering pursuing outpatient surgery joint ventures (JV) in 2024, the highest area of interest of any potential specialty partnerships.”¹⁹

SPECIALTIES

Most ASCs are either single specialty (52%) or include 2 specialties (13%).²⁰ From a Medicare-

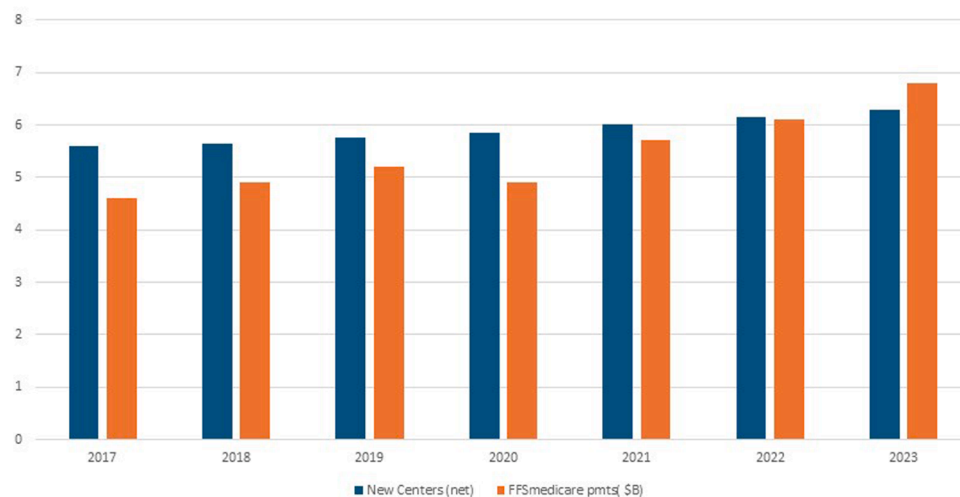


Fig. 3. FFS (Fee for service) in billions; includes Medicare spending & beneficiary cost sharing, Medicare Certified Centers (Net = total – closed) in thousands.

only perspective, 2023 billing data showed that 68% of ASCs had a single clinical emphasis.² Orthopedics, Pain, and Ophthalmology constitute most single specialty ASCs, whereas the “other” category (40%) includes multispecialty ASCs (General Surgery, Cardiology, Vascular Surgery, Trauma, Neurosurgery, Urology, and others.)² The shift of vascular surgery procedures to ASCs has accelerated with the aging population, changes in anesthetic techniques, the advent of minimally invasive technology and techniques, and basic procedures such as peripheral or coronary angiography costing much less in an ASC than in HOPDs. Many elective vascular surgical procedures, such as diagnostic arteriography, balloon angioplasty, atherectomy, stenting, venous ablation and stripping, vena cava filter insertion and removal, and hemodialysis access procedures can now be safely performed in an ASC.¹⁸

Shifting higher-acuity procedures from inpatient or HOPD settings to ASCs has continued to grow. Three service lines—orthopedics (joint replacement and hand), urology (prostate), and general surgery (hernia)—have grown outpatient volume more than the loss in inpatient volume.²⁰ The procedure list is likely to grow with better reimbursement.²¹ In November 2025, CMS started to phase out the Inpatient-Only List over 3 years and finalized its rule for the removal of 285 mostly musculoskeletal procedures and the addition of 573 codes to the ASC Covered Procedures List for 2026.²² Furthermore, the Consolidated Appropriations Act that was signed into law in February 2026 requires hospitals to obtain and use separate National Provider Identifiers (NPIs) for each off-campus HOPD by

2028, setting the scene for the enactment of site-neutral payment policies.²³

COST

Of the \$4.9 trillion spent on healthcare in the United States in 2023, private payers or commercial insurance were the single largest payer, accounting for 30% of all expenses.²⁴ Therefore, it is relevant that costs were reduced by more than \$38 billion annually due to outpatient care provided in ASCs.²⁵ Because of lower reimbursement for procedures performed in the ASC compared to the HOPD, patients benefited from lower deductibles and coinsurance payments totaling \$5 billion in annual savings.²⁵ Furthermore, in a study of commercial medical-claims data, the authors estimated that up to \$55 billion could be saved annually, depending on the number of procedures moving to ASCs.²⁵ ASCs manage to realize these savings for payers, with efficiencies focused on leaner staffing, and surgical specialty individualized operations, while not sacrificing patient safety or outcomes.²⁶

Medicare and Medicaid spending constitute about 21% and 18% of total national health expenditures, respectively. The fee-for-service Medicare program and its beneficiaries spent approximately \$6.8 billion on ASC services in 2023 (Fig. 3).⁹ Savings to Medicare and beneficiaries have been documented in procedures varying from cataracts to colonoscopies.²⁵ Part of the savings may be derived from regulatory relief. Unlike HOPDs, which are part of a hospital, ASCs are not required to comply

with the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). Despite MedPAC recommendations, ASCs are not required to submit annual cost reports to CMS, and their payment rates may not reflect actual costs, making cost comparison difficult.²⁷

PAYMENT

For fee-for-service Medicare reimbursements, CMS calculates payment rates for most ASC services by multiplying the Medicare Outpatient Prospective Payment System (OPPS) relative weights by the ASC conversion factor, which in 2025 was \$54.895.² Since the ASC conversion factor is much smaller than the OPPS conversion factor (\$89.169), ASC payment rates are 46% lower than OPPS payment rates.⁹ As a result of these conversion factor differences, a significant disparity has existed between payments for procedures performed in ASCs and HOPDs.²⁸ This payment advantage has, until recently, accelerated consolidation in hospital systems, without a proven improvement in quality of care or a decrease in price or cost.²⁹ Studies have shown that a “site-neutral” payment policy may save \$471 billion over the next decade for the Medicare program and Medicare enrollees and another \$107 billion for private insurers.³⁰

QUALITY OF CARE AND PATIENT EXPERIENCE

While there is general agreement that low-risk, minimally invasive procedures in most patients, even in elderly patients, appear to be safe in ASCs, there is more data needed to determine the safety of complex procedures migrating each year to ASCs. Most reports comparing ASCs and HOPDs show either better outcomes for the former or no significant difference. A retrospective study of Medicare beneficiaries undergoing outpatient surgery to assess the impact of ASCs on rates of hospital-based outpatient procedures showed no adverse events.³¹ Another retrospective report of elderly patients undergoing laparoscopic cholecystectomy showed no differences in mortality or morbidity between HOPDs or ASCs.³² An analysis by the California Ambulatory Surgery Association involving over one million ASC surgeries found that surgical site infection rates in ASCs were 6 times lower than in HOPDs.³³ Only one infection occurred per 1,000 ASC surgical cases, even with higher-risk specialty ASCs. Although the

Table I. Anticipated outpatient demand for selected surgical services

Volume growth		
Services	%	Years
Orthopedics	12%	2023–2028
Spine	17%	2023–2028
Cardiology	14%–25%	2023–2035
Vascular Services	14%–37%	2019–2029

Colliers U.S. Research report (<https://www.colliers.com/download-article?itemId=4e51a2da-908d-4947-8587-b89ad6c80af7>); Bain & Company (<https://www.bain.com/insights/ambulatory-surgery-center-growth-accelerates-is-medtech-ready/>); SG2 https://vascular.org/sites/files/2022-02/Sg2-SVS_Value%20of%20Vascular%20Surgery_Summary.pdf.

CDC estimates that hospitals have an infection rate of around 1%, they found the infection rate in ASCs to be about 0.1%.³⁴ This may be because specialty-focused ASCs did not operate on high-risk patients and those with multiple comorbidities. Better patient experiences in ASCs are purported to be an advantage over HOPDs.³⁵ A recent analysis by Press Ganey indicated that patient experience in ASCs reached a 5-year high in 2023.³⁶ Patients were likely to recommend the “provider” in about 85% and 84% of ambulatory surgery and medical practice settings, respectively. Vascular Surgery as a specialty was not mentioned specifically, but some surgery subspecialties received high patient experience scores, such as Cardiac Surgery (79%), OB-GYN (76%), Neurosurgery (76%), and Orthopedics (75%).

FUTURE TRENDS

A “macro-outlook” for ASCs estimates a “21% increase in volume over the next decade, compared to a 17% rise for outpatient volumes overall.”³⁷ The authors project a gain of only 3% in inpatient volumes, and a 13% increase in HOPDs. It is therefore clear that for the reasons outlined, outpatient care and ASCs will continue to grow (Table I).^{38–40} The ASC market is now competitive, with over 6,500 Medicare-certified ASCs in 2025 in the United States.¹⁰ Entrance of corporations, including private equity (PE), are all competing for the anticipated outmigration of in-hospital procedures and large revenue opportunities each year. The consolidation fervor is also likely to impact independent ASCs. Physicians will have a choice depending on their career stage and entrepreneurial spirit, whether to be owners and manage their ASC with other physician partners, jointly own an ASC with a hospital, be

hospital-employed, or work with corporate entities as a partner. Some risk-averse physicians may consider a JV a good alternative because hospitals are better able to leverage their reimbursement contracts and management experience, as well as reduced supply chain costs, in exchange for autonomy in operations.

With increasing use of technology and predictive Artificial Intelligence, cost may also be a factor driving independent physicians to pursue partnerships with other groups in the same specialty, hospitals, or corporate interests. Partnerships with management groups offer the infrastructure and experience in forming coalitions of independent ASCs and physician-owned facilities that bundle risk, administrative assistance, and finance are also a choice.⁴¹ Finally, an alternative option is joining an independent practice association (IPA) formed just for ASCs to assist with contract negotiations, efficiencies, and building value in a growing market.⁴¹

The stiffest competition for physician-owned ASCs is either large hospital systems or corporate/PE ownership. Hospitals are justifiably concerned about the increasing migration of procedures to outpatient facilities and the loss of inpatient revenue, impacting the bottom line.⁴² Consequently, hospital ownership of ASCs has surged. Hospitals are joining the competition, that is, independent physicians, with 75% of their ASCs organized as outpatient JVs in view of inpatient higher acuity procedures possibly moving to ASCs, lower cost, competitive quality of care, and advances in clinical and technological areas.¹¹ They can leverage their established supply chains, staffing models, and time-tested best practice policies. Given consumer demand and payer pressure, over 80% of hospitals and health systems in 2024 owned at least one surgery center, a significant increase from 41% in 2019.⁴³

There are some warning signs for independent ASCs. The number of ASCs operated by national operators in partnership has increased from 1,339 in 2011 to 1,941 in 2023.⁴⁴ In 2025, there were reports of several closures of ASCs for some of the reasons described below.⁴⁵

Financial Challenges

Managing finances while facing cutbacks in federal and state spending, stagnant reimbursement models, and rising operational costs is a challenge. Operating budgets have increased from 32% in 2022 to 43% in 2023, mostly due to labor costs.⁴⁶ A few insurers have announced a plan to cap Certified Registered Nurse Anesthetists reimbursement rates at 85% of the Physician Fee Schedule (PFS).⁴⁷

Workforce Shortages, Recruiting, and Retention Remain Challenging

A changing landscape of 77% of physicians (particularly recent trainees) moving from independent practice to hospital or corporate employment, burnout, and early retirement creates a difficult environment for ASCs.⁴⁶ Shortage of other clinical staff resulting in high turnover may sacrifice efficiency and result in increased expenses if staffing agencies are utilized. However, the same challenges may work in ASCs' favor as less labor-intensive settings with no call hours become more attractive for employees.

Clinician shortages also put upward pressure on compensation to match the salaries and benefits of large health systems. A continuing shortage of anesthesiologists, a necessity for ASCs, has resulted in demands for a stipend or a minimum daily payment for their services.

Increasing Comorbidity

Although recent studies have shown equivalent outcomes between patients treated in HOPDs and ASCs, sicker patients are now being seen in the latter.⁴⁶ The increased comorbidity of the previously inpatient population migrating to ASCs could translate to worse outcomes. It will take physicians to be proactive in adhering to and enforcing strict guidelines to deal with these risks. The safety net provided by hospitals may be at risk if the quality of care in ASCs is suboptimal.

The good news is that CMS continues to expand ASC-eligible CPT codes and move toward site cost-neutrality. At the state level, Certificate of Need (CON) laws are being relaxed, further enabling growth. ASC operators are responding with renewed focus on optimizing existing centers, investing in technologies, and expanding new or existing pipelines that improve surgical efficiency, increase fiscal value, and optimize outcomes. Cost savings, operational efficiencies, and high patient satisfaction all remain positive features. And yet, although 45% of hospital executives describe an improvement in patient outcomes, and 37% noted better patient experience in value-based care (VBC) at ASCs, only 29% saw significant cost savings from value-based models.⁴⁷

CONCLUSIONS

ASCs will continue to evolve, expand, and integrate, fueled by advanced technology, payer incentives, consumer choice, case migration, and positive outcomes. ASCs likely will become more subspecialty

specific (orthopedic, general surgery, urology, vascular, and cardiology) and may shift to overnight stays for some procedures, depending on patient acceptance, payors, and safety. Workforce challenges may lead to reduced capacity in acute care settings, diverting procedures to less labor-intensive settings such as an ASC, which can be more attractive for the workforce. Artificial intelligence, data analytics, and machine learning will streamline scheduling, inventory management, and clinical decision support. ASCs will probably compete for value-based care (VBC) and invest in postoperative follow-up and an emphasis on long-term outcomes and value.

Most importantly, it is compelling that more surgeons are recognizing the value of regaining autonomy in surgical care. In a recent survey, the average physician satisfaction in physician-led organizations is 70% to 90%, contrasted with 50% to 75% in health system-led practices.⁴⁸ The same survey showed 25% of hospital system-employed physicians are looking to change employers, with 37% favoring a physician-owned setting. By operating within ASCs, they can lead practices with a sense of purpose and take responsibility for the patient experience and outcomes in ways that are often not possible in hospital settings. Nevertheless, this also entails a responsibility for government agencies, hospital leaders, and professional societies to consider the viability of the entire care-delivery spectrum, not just the physician-owned segment.

Finally, there is an uncomfortable question for all of us. Has the financial incentive of ASC and OBL ownership led to “indication creep”? Following up on reports by professional societies and whistleblowers, the Health and Human Services (HHS) recently pointed to a significant increase in 2 procedures in 2023, with \$105 million of billing possibly unnecessary.⁴⁹ Vigilance, procedural restraint, and continued research are required from the vascular community to expose unethical actions.

CREDIT AUTHORSHIP CONTRIBUTION STATEMENT

Bhagwan Satiani: Writing – review & editing, Writing – original draft, Methodology, Data curation, Conceptualization. **Anil Hingorani:** Writing – review & editing, Formal analysis. **Jessica L. Bailey–Wheaton:** Writing – review & editing, Formal analysis. **Todd A. Zigrang:** Writing – review & editing. **Krishna Jain:** Writing – review & editing, Formal analysis, Conceptualization.

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