ASCs at a Tipping Point: The New Reality of Surgical Services for Health Systems
INTRODUCTION

For decades, surgeries performed in hospital operating rooms (ORs) have been among the most profitable services in healthcare. As a result, most hospitals regard inpatient (IP) surgery as their crown jewel. It makes money, and hospitals without high surgical volumes have struggled financially. Attracting busy surgeons has been a mainstay strategy, and at times it has seemed as if hospitals’ business development efforts have been geared primarily toward securing surgery volumes. Neurosurgery, cardiac surgery, and orthopedics have traditionally been the most prestigious and profitable programs at hospitals.

In contrast, health systems have had a love-hate relationship with ambulatory surgery centers (ASCs). Only when push came to shove—when facing the catastrophic loss of hundreds of cases, or a medical staff rebellion—have most hospitals been willing to consider joint ventures with surgeons interested in ASCs. Many other hospitals watched helplessly as “their” cases left for ASCs in which they had no ownership interest.

ASCs are not a new idea—they have been with us for over 40 years—but interest in them is escalating. There are over 5,000 Medicare-certified ASCs in the United States, and the number continues to grow, as do their service capabilities. Consider the following developments:

- In early 2017, UnitedHealth Group announced a $2.3 billion acquisition of Surgical Care Affiliates.
- In 2015, Tenet Health formed a $2.6 billion joint venture with USPI.
- A northeastern health system intends to develop a network of more than 30 ASCs.
- A southwestern health system has plans to develop more than 20 ASCs, with an in-house ASC management company to support the network.
- A southeastern health system is seeking to develop or acquire more than 10 centers in its market area.

Clearly, the IP-dominated paradigm for surgery is evolving rapidly, with some of the most profitable cases transitioning to ASCs. Forward-looking health systems are investing heavily in this shift—in some cases strategically reducing IP revenue to better position their systems for the future. Dozens of health systems have already made this change, and many more are in the process. We believe that ASCs are at a tipping point in the evolution of health care delivery, and hospitals without a comprehensive ambulatory surgery strategy are putting their institutions at great risk.

In this paper, we will describe the forces that are changing surgery and outline strategic considerations for navigating this fundamental shift in a crucial business.
DRIVING CHANGE IN THE SURGERY LANDSCAPE

First we will focus on the five main drivers of the changing surgery landscape and movement toward the ASC model: the shift to value-based care; reimbursement changes for ASCs; the accelerating transition to outpatient (OP) care; and both the superior patient and physician experience offered by ASCs.

Shift to Value

The shift to value is requiring health system leaders to rethink many of their tried-and-true strategies, and providers are being pushed to reduce costs, improve quality, and enhance patient satisfaction and convenience. Further, commercial and governmental payors are seeking more transparency regarding site of service on reimbursement rates. With these factors in mind, many health system leaders are directing surgical services out of the hospital IP setting and into the OP setting.

Under the evolving paradigm for surgery, IP ORs are a cost center and, like other expenses, are a target for evaluation and reduction. The historic protective impulse to keep volume in the hospital is giving way to a greater focus on transitioning care to lower-cost settings. Migration of surgical services from IP to hospital OP departments (HOPDs) and ultimately to ASCs is highly motivated by the significant opportunity for cost savings.
Reimbursement Changes: Payment Rates Are Impacting Migration Across Sites of Service

CMS implemented the Outpatient Prospective Payment System (OPPS) for HOPDs in 2000 and for ASCs in 2004. Since that time, Medicare has been seeking to level the playing field for payment methodologies between hospitals and ASCs. In 2017, the dollar value of Medicare HOPD rates compared to ASC rates is approximately 55% for all approved ASC services, so ASCs represent a meaningful savings to CMS and commercial payors. In 2017, CMS approved meaningful rate increases for several total joint procedures, ranging from 45.2% to 58.7% (see exhibit I), which enables migration to the ASC model. Medicare is clearly motivated to identify opportunities for added savings, both by increasing the number and type of ASC-eligible cases and by providing incentives for ASC operators to perform them.

Commercial payors nationwide have also migrated to the APC (or APC-like) payment methodology in many markets. These payors are aligning payment systems in hospital payor contracts with ASC payor contracts. Therefore, when CMS modifies payment systems, it sets the stage for the commercial payors to adopt the same or a modified version of the Medicare methodologies as a platform for ASC reimbursement. Commercial payors are implementing aggressive contracting initiatives and are commonly moving hospital OP surgery reimbursement to ASC reimbursement methodologies with differentials that are closing the gap between ASC and hospital reimbursement rates.

### Exhibit I—ASC Total Joint Medicare Rate Increases, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2016 Medicare ASC Rate</th>
<th>2017 Medicare ASC Rate</th>
<th>Difference ($)</th>
<th>Difference (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>24361</td>
<td>Reconstruct Elbow Joint</td>
<td>$7,887</td>
<td>$12,514</td>
<td>$4,628</td>
<td>58.7%</td>
</tr>
<tr>
<td>25446</td>
<td>Wrist Replacement</td>
<td>$7,887</td>
<td>$12,313</td>
<td>$4,426</td>
<td>56.1%</td>
</tr>
<tr>
<td>24363</td>
<td>Replace Elbow Joint</td>
<td>$7,887</td>
<td>$12,122</td>
<td>$4,236</td>
<td>53.7%</td>
</tr>
<tr>
<td>25442</td>
<td>Reconstruct Wrist Joint</td>
<td>$7,887</td>
<td>$12,107</td>
<td>$4,220</td>
<td>53.5%</td>
</tr>
<tr>
<td>24371</td>
<td>Revise Reconstruct Elbow Joint</td>
<td>$7,887</td>
<td>$11,684</td>
<td>$3,797</td>
<td>48.1%</td>
</tr>
<tr>
<td>23616</td>
<td>Treat Humerus Fracture</td>
<td>$7,887</td>
<td>$11,357</td>
<td>$3,471</td>
<td>44.0%</td>
</tr>
<tr>
<td>27443</td>
<td>Revision of Knee Joint</td>
<td>$3,533</td>
<td>$4,981</td>
<td>$1,449</td>
<td>41.0%</td>
</tr>
<tr>
<td>25443</td>
<td>Reconstruct Wrist Joint</td>
<td>$2,486</td>
<td>$3,817</td>
<td>$1,331</td>
<td>53.5%</td>
</tr>
<tr>
<td>26531</td>
<td>Revise Knuckle with Implant</td>
<td>$2,486</td>
<td>$3,684</td>
<td>$1,198</td>
<td>48.2%</td>
</tr>
<tr>
<td>25445</td>
<td>Reconstruct Wrist Joint</td>
<td>$2,486</td>
<td>$3,609</td>
<td>$1,123</td>
<td>45.2%</td>
</tr>
</tbody>
</table>

The Shift to OP Care: More High-Acuity Cases Are Coming to an ASC Near You

Advances in technology, smaller incision sites, and OP anesthesia and pain management are only some of the contributing factors that have enabled the migration of surgery from the IP setting first to an HOPD and then to an ASC (see exhibit II). Several states, including Colorado, Nevada, and Illinois, have extended stay recovery laws that allow patients to recover in ASCs for more than 24 hours and up to 72 hours or greater. Extended recovery care licensure is expected to continue to grow as many states, including Florida and Oregon, have proposed legislation and/or are actively pursuing bills for extended recovery care.

Surgery migration to the OP setting is accelerating, with CPT codes that have traditionally been designated as hospital IP—only being approved first for HOPDs and subsequently for the ASC setting. Over the past several years, CMS has added total joint codes and several high-value spine codes, including laminectomy, anterior cervical fusion, and posterior lumbar fusion procedures, to the ASC approved list. As quickly as Medicare is moving, however, they may actually be lagging commercial payors in this area. We often see medical directors for health plans gaining comfort with the cost, quality, and service advantages of migrating cases to ASCs, and many are approving codes for ASCs for complex procedures in total joints, spine surgery, and hysterectomies—ahead of CMS. This has set the stage for further promoting the migration of ambulatory surgery from the hospital to the ASC setting.

CMS’s evolving position on total knee arthroplasty (TKA) makes an interesting case study. TKA surgery has been increasingly performed safely and effectively in ASCs on non-Medicare patients. A conservative count of 200 to 300 ASCs nationwide are performing TKAs. In proposing that this code, 27447, be removed from the IP-only list, CMS praised the “innovations” in TKA care [that] include minimally invasive techniques, improved perioperative anesthesia, alternative postoperative pain management,
and expedited rehabilitation protocols,” which made it possible for this procedure to be performed in the OP setting. CMS recognizes the benefits of performing TKAs in the OP setting, including “a likelihood of fewer complications, fewer surgical site infections, more rapid recovery, increased patient satisfaction, recovery at home with the assistance of family members, and a likelihood of overall improved outcomes.”

Commercial payors seem to agree. Since ASCs present savings opportunities, health plans are increasingly implementing policies that redirect volume out of hospitals and into the ASC setting. In October of 2016, UnitedHealthcare announced a policy that prohibits designated OP surgery procedures from being performed in the HOPD setting without authorization. If these select procedures are performed in the HOPD without authorization, the HOPD will not be reimbursed and is not allowed to seek payment from the patient. ECG has also seen payor arrangements that directly reward physicians for aggressively moving cases away from hospitals and into ASCs.

### A Better Experience for Patients

Patients are also realizing the benefits of the shift to OP surgery.

#### Pricing Transparency and Consumer Demands

With the rise of high-deductible plans and health savings accounts, consumers are more price sensitive than ever, and demand for pricing transparency is on the rise. ASCs charge patients based on a flat fee for all surgical services, inclusive of supplies, incidentals, and often implants. Hospitals typically charge patients based on itemized fees for these items, frequently causing confusion. In some cases, we have evaluated HOPD charges for OP surgeries that are 5 to 10 times greater than those of a competing ASC. With increased pressure to be price competitive, HOPDs are being challenged and many must revisit their pricing methodologies or cede these cases to competitors.

#### Patient Experience and Quality

Patients have a strong preference for the convenience of OP facilities with easy parking, line of sight to the front door, and uncrowded spaces. In ASCs, nurse-to-patient ratios are higher—commonly at 2:1—often resulting in higher levels of patient satisfaction and quality of care. ASCs also have lower rates of nosocomial infection than other sites, and patients recover more quickly under the care of anesthesiologists who are highly skilled in OP cases.

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Physician Satisfaction and Alignment

The culture and philosophy of an ASC are often very appealing to surgeons (see exhibit III). ASCs offer increased efficiency in OR turnover time, effective management of block time scheduling, and employees with a positive, can-do attitude, creating high levels of employee and physician satisfaction. OR turnover time is normally far shorter than it is in hospitals, and on-time starts are the “rule” rather than the “exception.” For example, an average ASC OR turnover time may be 10 to 20 minutes for cases with general anesthesia (and less with a local anesthetic or sedation), while a hospital often requires 30 to 45 minutes or more. It is not uncommon for ASCs to enable surgeons to increase their case volume by 25% to 50% per day, which substantially benefits their productivity and professional compensation. With physician compensation under siege across a variety of fronts, we expect this advantage to become even more important over time, even for health systems that employ surgeons.

Since physician investments in ASCs are allowed under federal regulation, surgeon equity in ASCs is the norm. While owning less than 100% of an ASC will reduce the financial return to the hospital and other investors, physician engagement in the volume and profitability of an ASC is critical to its success. Progressive health systems view shared ownership as an opportunity to integrate with hard-to-align surgical specialties such as orthopedics, gastroenterology, and otorhinolaryngology.

Exhibit III—ASC Culture and Philosophy

The Patient as the Customer
- State licensure, Medicare certification, and accreditation = quality assurance
- Smaller setting = direct access and communication with leadership
- Patient satisfaction surveys: internally and externally administered
- Lower costs

The Physician as the Customer
- Better control and flexibility over scheduling
- Flat organizational structure
- Efficiency
- Involvement in purchasing and expenditure

Efficiency
- Turnaround times of 10 to 20 minutes based on case types
- On-time case starts and block utilization monitored and reported; MEC and governing body support

Can-Do Attitude
- The ASC culture is about “getting it done” without the bureaucracy in hospitals that requires multiple committees’ reviews and layers of approvals
SURGERY CENTER STRATEGY: THREE HIGH-LEVEL OPTIONS TO CONSIDER

So what do you do when your core product—hospital-based surgery—is threatened by a combination of regulatory, financial, and competitive forces? We see three strategic options:

1. Hunker down

In this option, a hospital will resist the transition of surgical cases, relying on its brand power, physician loyalty, and potentially its influence with health plans to fight the battle with ASCs. Moves by surgeons or other competitors to transfer volumes to ASCs will be met with threats to hire competing physicians or direct referrals from employed physicians elsewhere. This option is appealing in the short term, since it enables maximum retention of hospital volume and revenue across a short-term decision time frame such as an annual budgeting period.

Prognosis: While satisfying in the short term, the hospital is susceptible to ongoing pressure from physicians, payors, and patients; it is also vulnerable to competition from a superior business model for surgery.
2. Manage the transition, limit the risk

In this option, a hospital will pursue investments in ASCs but only when forced to do so and the risk of volume loss is imminent. Investment decisions will be made based on a calculus of ability to retain volumes in an HOPD setting and potential to backfill lost volumes (see exhibit IV). Where the analysis dictates, tactically deciding to join an ASC joint venture will be preferred over potentially losing all volume. In these cases, sizing the ASC investment and managing which cases to transition will be critical variables for minimizing losses.

**Prognosis:** While this option has the potential to optimize returns to the hospital, it also delays the building of core expertise in ambulatory surgery and leaves the hospital vulnerable to efficient new entrants.

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**Exhibit IV—Risk Scenarios Tied to Case Volume Shift From Hospital to ASC**

ECG recently developed a surgery strategy for a health system that considered current case volumes and specialty mix, the possibility of relaxed certificate-of-need regulations, and the cases a local medical group could plausibly move to a new ASC. We crafted a series of scenarios that illustrated the risk of various outcomes, including, at the extreme, the possibility of losing over $30 million in revenue if all ASC-eligible cases left the system. Armed with this information, the system is evaluating the opportunity to approach the group with a limited-scope ASC joint venture that would meet the group's financial needs, promote physician-health system alignment, and retain critical high-margin services in the hospital.
3. Be a player in OP surgery—“disrupt yourself.”

In this option, the hospital aggressively pursues an ASC-based surgery strategy as a core business line, actively seeking to partner with existing centers and pursuing de novo sites where market conditions indicate. The health system makes a strategic decision to invest in ASCs similar to its commitments to other lines of business such as primary care, home health, or a health plan. A distinct ASC management structure is established with dedicated leadership, infrastructure, and business development functions. This strategy may be executed in partnership with a for-profit ASC management company or by hiring external expertise and seasoned surgery center operators.

Prognosis: This option is likely to produce short-term financial pain as volumes are aggressively channeled to partially owned centers, but if managed skillfully, it will lead the health system to superior long-term positioning in a value-based healthcare world.
**FINAL THOUGHTS**

The current payor environment, technological advances, movement of surgery from the hospital to the ASC setting, diminishing physician compensation, demand for physician alignment, and site-of-service payment neutrality all pose significant risk to hospitals and health systems that do not have a comprehensive ASC strategy. ASCs present a significant opportunity for hospitals to align with physicians, address value-based initiatives, and meet the demands from patients for cost-effective, high-quality care. We expect continued migration to the ASC setting, which indicates an ASC strategy is critical to the long-term success of hospitals and health systems.

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