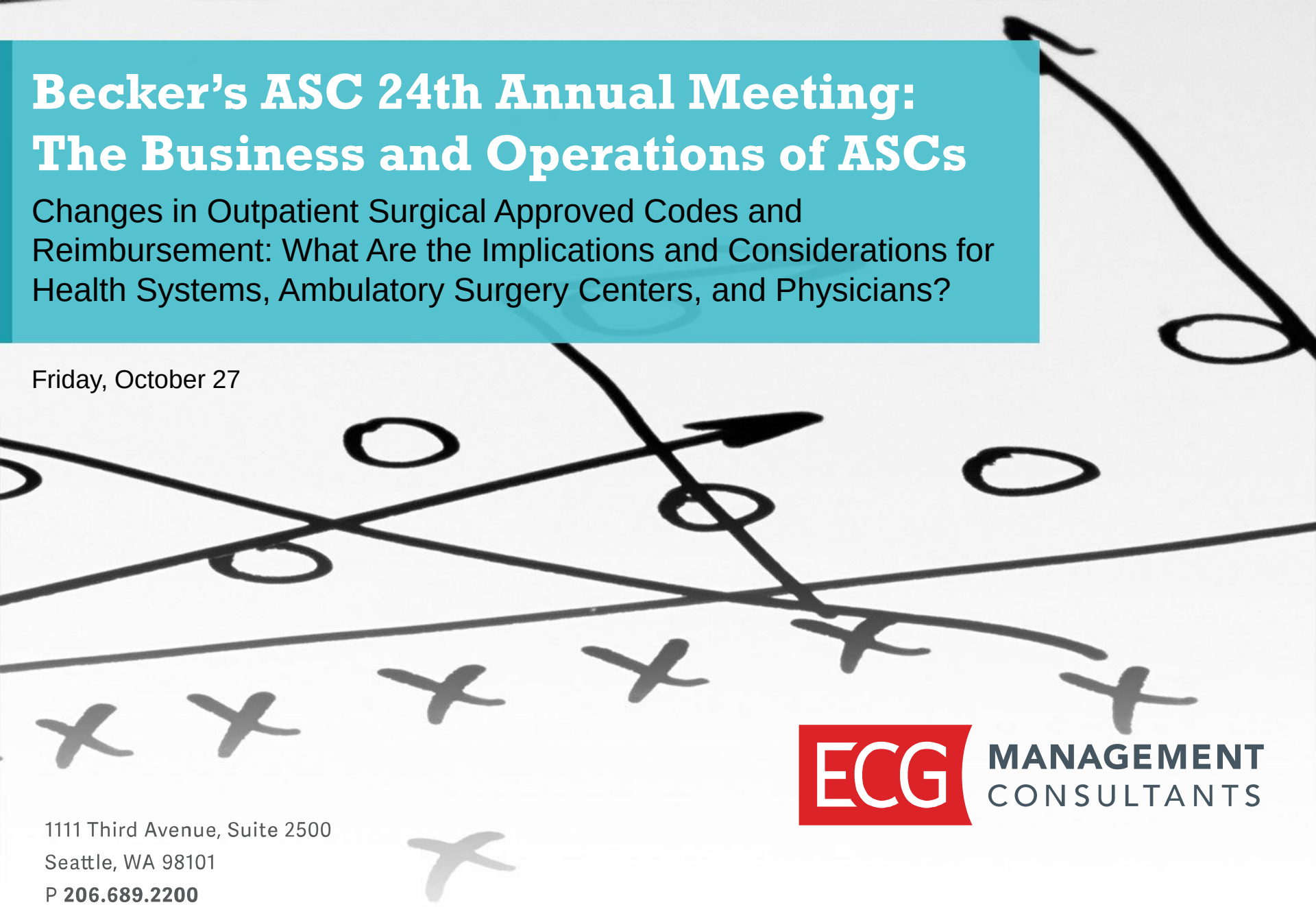
Becker's ASC 24th Annual Meeting: The Business and Operations of ASCs

Changes in Outpatient Surgical Approved Codes and Reimbursement: What Are the Implications and Considerations for Health Systems, Ambulatory Surgery Centers, and Physicians?

Friday, October 27



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Agenda

The goal of our presentation is to present you with food for thought regarding the expected changes in reimbursement for ambulatory surgery in various sites of service and the implications to health systems and physicians alike.

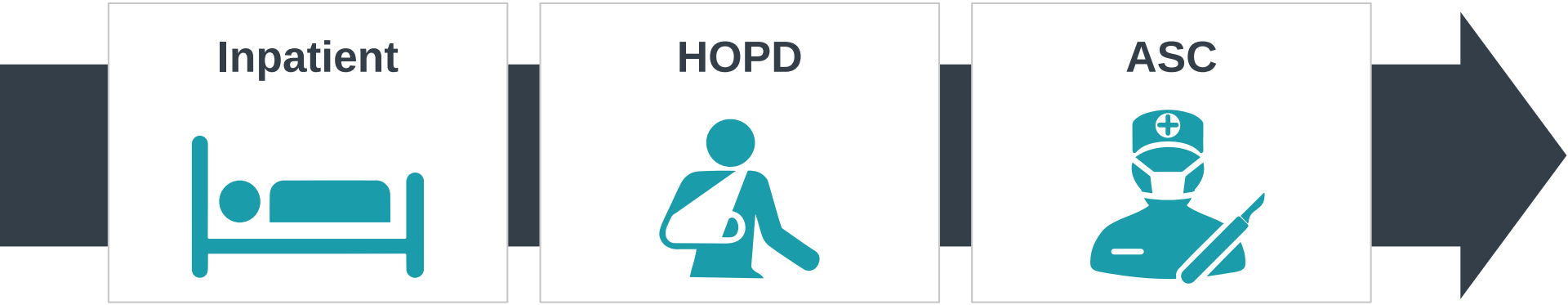
- The Changing Landscape
- The Value of Alignment
- Important Facts to Remember
- Questions and Discussion

We hope that you come out of this with one or two key strategies to contemplate as the changes take shape over the coming months.

The Changing Landscape

The Changing Landscape

Migration of Higher-Acuity Surgery



Key Drivers

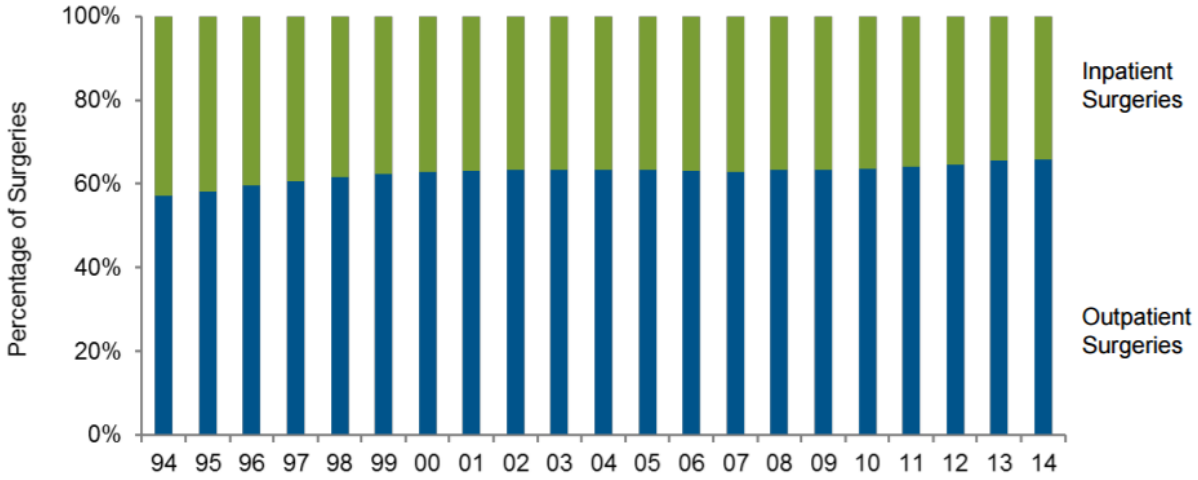
- Advancement of clinical technologies that allow smaller incisions and shorter stays, enabling higher-acuity cases to be performed safely in the ambulatory surgery center (ASC) setting
- Medicare and commercial payor cost pressures
- Physician motivation—finances and efficiency

The Changing Landscape

Shift from Inpatient to Outpatient

The demand for ASCs is expected to grow!

Percentage Share of Inpatient versus Outpatient Surgeries, 1994–2014



Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.
Previously Chart 3.14 in 2013 and earlier years' Chartbooks.

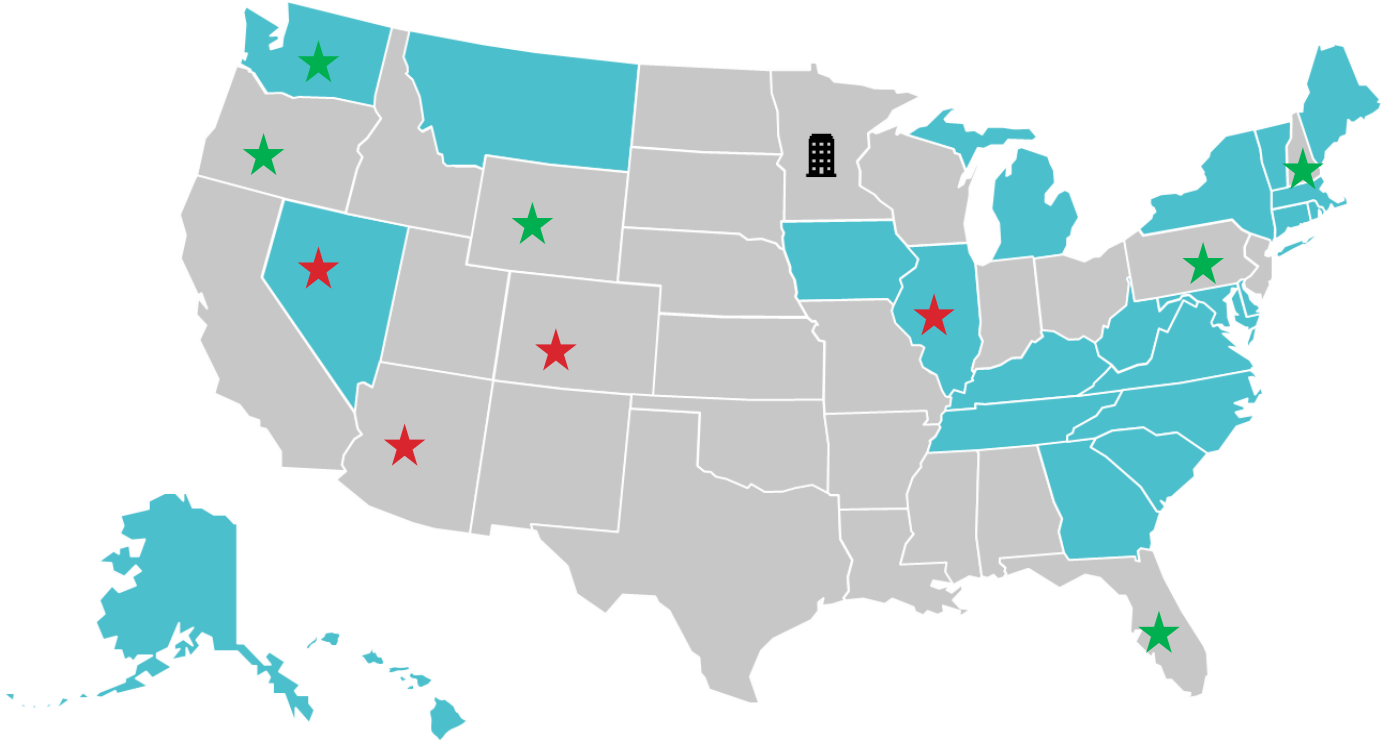
- Inpatient surgery migration to the outpatient setting is growing at a steady pace.
- California is one of the most progressive states in the country relative to case mix and migration of surgery to ASCs.
- ASCs play an important role in a payor's network and total cost of care.

Sources: http://www.aha.org/research/reports/tw/chartbook/2016/chart3-11.pdf and
http://www.modernhealthcare.com/article/20160604/MAGAZINE/306049986.

The Changing Landscape

CONs and Extended Recovery Care in ASCs

Of all ASCs, 37% are in the 24 states that have a CON. Four states have regulations for extended recovery care, enabling higher-acuity cases in ASCs.



★ States with regulations that allow extended recovery care.
★ States with a history of or active proposed legislation for extended recovery care.

Hotel associated with an ASC.

Source:
http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.

Examples of CON regulations:

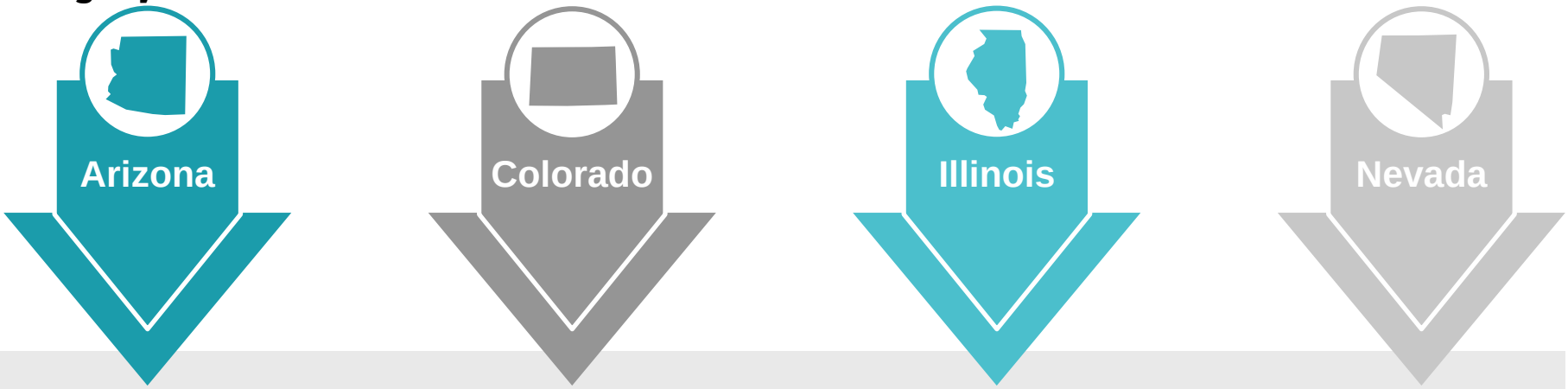
- In *Maryland*, a CON is only required for ASCs with more than one OR. As a result, the state is occupied by single-OR ASCs.
- In *Vermont*, CON requirements are so strict that there is only one ASC in the entire state.

CON states are AK, AL, CT, GA, HI, IA, IL, KY, ME, MD, MA, MI, MS, MT, NV, NY, NC, RI, SC, TN, VA, VT, WA, and WV.

The Changing Landscape

Extended Recovery Care

Extended stay licensure and regulations enable the migration of hospital-based surgery to ASCs.



- Federal Medicare reimbursement is generally limited to stays of no more than 23.59 hours in ASCs.
- Some states have a separate license for extended stay recovery care centers that allow patients to stay for longer than the ASC allowed time of 23.59 hours.
- Extended stay recovery care centers are typically part of an ASC with a separate license and are often allowed to keep patients for 72 hours.

NOTE: Extended stay license considered in 2015 legislative session: New Hampshire, Washington, and Wyoming.

Medicare does not allow or reimburse ASCs for extended recovery care in excess of 24 hours.

The Changing Landscape

2018 Medicare OPPS Proposed Rule Changes

IPO List

- CMS is soliciting commentary to remove total knee arthroplasty (TKA) from the IPO list as well as partial and total hip.
- CMS is soliciting commentary as to whether TKA and total and partial hip should be added to the ASC covered surgical list.

New Codes

- 22856 (Cerv artific diskectomy): device-intensive code
- 22858 (second level cer diskectomy): packaged and not separately payable
- 58572 (Tlh uterus over 250 g)

Cost Reporting

- CMS is requesting commentary on payment reform for ASCs to include cost data to support rate updates.
- CMS is interested in whether ASCs should submit cost data and how they would do so.

Rate Increases

- Average rate increase of 1.9%
- Payment increases to ASCs projected at $155 million compared to 2017

The Changing Landscape

OPPS Medicare Rule Changes: Implications on Total Joint Commercial Rates

Rate

- If approved by CMS, the final rate will be critical to the success of ASC migration.
- Commercial payors utilize Medicare to set the rate and justify rate changes; inadequate Medicare rates can have a negative impact on commercial rates.

Implants

- Total joints currently approved for ASCs are classified as device-intensive codes.
- Device-intensive codes are impacted by device/implant cost; however, they are included in the total reimbursement rate with no separate implant payment.

Volume

- The volume of Medicare ASC-eligible cases will be impacted by comorbidities.
- If Medicare approves, momentum for migration of volume is expected to accelerate, especially with access to extended recovery care.

Cost

- Success with migration will be highly impacted by total case cost relative to reimbursement.
- If reimbursement does not cover cost, ASCs may not take the cases.

The Changing Landscape

Medicare Total Joint Reimbursement Yearly Comparison

Trends in ASC Total Joint Reimbursement

2017 Changes

2016 CPT Code	2017 CPT Code	2017 Description	2016 Medicare ASC Rate	2017 Medicare ASC Rate	Difference (dollars)	Difference (percentage)
24361	24361	Reconstruct elbow joint	$7,886.65	$12,514.27	$4,627.62	58.7%
25446	25446	Wrist replacement	$7,886.65	$12,312.74	$4,426.09	56.1%
24363	24363	Replace elbow joint	$7,886.65	$12,122.48	$4,235.83	53.7%
25442	25442	Reconstruct wrist joint	$7,886.65	$12,106.58	$4,219.93	53.5%
24371	24371	Revise reconst elbow joint	$7,886.65	$11,683.64	$3,796.99	48.1%
23616	23616	Treat humerus fracture	$7,886.65	$11,357.49	$3,470.84	44.0%
27443	27443	Revision of knee joint	$3,532.70	$4,981.42	$1,448.72	41.0%
25443	25443	Reconstruct wrist joint	$2,486.22	$3,817.22	$1,331.00	53.5%
26531	26531	Revise knuckle with implant	$2,486.22	$3,683.89	$1,197.67	48.2%
25445	25445	Reconstruct wrist joint	$2,486.22	$3,609.13	$1,122.91	45.2%
25449	25449	Remove wrist joint implant	$2,486.22	$2,651.09	$164.87	6.6%
26536	26536	Revise/Implant finger joint	$2,486.22	$2,651.09	$164.87	6.6%
25332	25332	Revise wrist joint	$1,339.58	$1,219.54	$(120.04)	-9.0%
25447	25447	Repair wrist joints	$1,339.58	$1,219.54	$(120.04)	-9.0%
25441	25441	Reconstruct wrist joint	$7,886.65	$7,721.01	$(165.64)	-2.1%
25444	25444	Reconstruct wrist joint	$7,886.65	$7,575.44	$(311.21)	-3.9%
24366	24366	Reconstruct head of radius	$7,886.65	$7,464.57	$(422.08)	-5.4%
24587	24587	Treat elbow fracture	$7,886.65	$7,159.04	$(727.61)	-9.2%
27446	27446	Revision of knee joint	$7,886.65	$7,156.50	$(730.15)	-9.3%
24362	24362	Reconstruct elbow joint	$7,886.65	$7,138.73	$(747.92)	-9.5%
27442	27442	Revision of knee joint	$7,886.65	$7,117.15	$(769.50)	-9.8%
24370	24370	Revise reconst elbow joint	$7,886.65	$6,887.37	$(999.28)	-12.7%
27441	27441	Revision of knee joint	$7,886.65	$4,981.42	$(2,905.23)	-36.8%

The Changing Landscape

HOPD Comparison to ASC Total Joint Reimbursement

CPT/HCPCS Code	Description	ASC 2017 Payment Rate[1]	HOPD 2017 Payment Rate[2]	ASC Medicare Rate Percentage Difference from HOPD Rate
23616	Treat humerus fracture	$11,357.49	$14,704.13	29%
24361	Reconstruct elbow joint	$12,514.27	$14,704.13	17%
24362	Reconstruct elbow joint	$7,138.73	$9,561.23	34%
24363	Replace elbow joint	$12,122.48	$14,704.13	21%
24366	Reconstruct head of radius	$7,464.57	$9,561.23	28%
24370	Revise reconst elbow joint	$6,887.37	$9,561.23	39%
24371	Revise reconst elbow joint	$11,683.64	$14,704.13	26%
24587	Treat elbow fracture	$7,159.04	$9,561.23	34%
25332	Revise wrist joint	$1,219.54	$2,438.34	100%
25441	Reconstruct wrist joint	$7,721.01	$9,561.23	24%
25442	Reconstruct wrist joint	$12,106.58	$14,704.13	21%
25443	Reconstruct wrist joint	$3,817.22	$5,221.57	37%
25444	Reconstruct wrist joint	$7,575.44	$9,561.23	26%
25445	Reconstruct wrist joint	$3,609.13	$5,221.57	45%
25446	Wrist replacement	$12,312.74	$14,704.13	19%
25447	Repair wrist joints	$1,219.54	$2,438.34	100%
25449	Remove wrist joint implant	$2,651.09	$5,221.57	97%
26531	Revise knuckle with implant	$3,683.89	$5,221.57	42%
26536	Revise/implant finger joint	$2,651.09	$5,221.57	97%
27441	Revision of knee joint	$4,981.42	$9,561.23	92%
27442	Revision of knee joint	$7,117.15	$9,561.23	34%
27443	Revision of knee joint	$4,981.42	$9,561.23	92%
27446	Revision of knee joint	$7,156.50	$9,561.23	34%

1 ASC 2017 payment rate is the national unadjusted rate retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html.

2 HOPD 2017 payment rate is the national unadjusted rate retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

The Changing Landscape

Payor Demand for Cost Savings

How can ASCs be a solution for payors?

- Payors are focused on cost savings opportunities and implementation of benefit designs that direct volume to ASCs.
- Co-pays, deductibles, and co-insurance incentives are motivating consumers to select providers that utilize a lower-cost site of service.
- Large employer groups are concerned about cost and interested in a lower-cost setting and quicker recovery time, which places demands on the payors.
- Payors are creating incentives that reward physicians for behavior that results in high-quality services provided in lower-cost settings.
- Cases that can move to the ASC setting from the hospital can be identified to show value to payors.
- The savings to payors translates into meaningful losses to hospitals with the continued emphasis of migration of surgery to the ASC setting.

The Changing Landscape

Impact to Payors and Hospitals: Savings versus Losses

Scenario One: Total Joints	Scenario Two: Hospital-Based Orthopedic Surgery Volume
$40,000 Hospital Contract DRG Rate	**$6,000** Average Hospital Net Revenue per Case
100 cases per year Hospital Volume That Can Move to ASC	**1,000 cases per year** Hospital Volume That Can Move to ASC
$4 million Hospital Total Cost to Payor	**$6 million** Hospital Total Cost
$25,000 ASC Rate	**$4,000** ASC Average NR per Case
$2.5 million ASC Total Joint Projected Cost to Payor	**$4 million** Hospital ASC JV Total Cost to Payor
$1.5 million ASC Total Joint Savings = Loss to Hospital	**$2 million** ASC Savings = Loss to Hospital

The Changing Landscape

UnitedHealthcare Directing Cases to ASCs: Example

Overview

In an effort to minimize out-of-pocket costs for UnitedHealthcare members, improve cost-efficiencies for the overall health care system and help ensure access to medically necessary care, as required by our members' benefit plans, we are implementing new prior authorization requirements that take into account site of service for certain minor surgical procedures.

Encouraging these procedures to be performed in medically appropriate sites of service is another step we are taking toward achieving the Triple Aim to help improve care experiences and health outcomes for our members, in cost-effective ways. These prior authorization requirements apply to many UnitedHealthcare commercial plans and are supported by member benefit plan language that requires services to be medically necessary, including cost-effective.

Starting Oct. 1, 2015 (in most states), prior authorization is required for the following procedures if performed in an outpatient hospital setting. Prior authorization is not required if the procedures are performed at a participating network ambulatory surgery center.

Procedures & Services	Codes for UnitedHealthcare Commercial Plans			
Abdominal Paracentesis	49083			
Carpal Tunnel Surgery	64721			
Cataract Surgery	66821	66982	66984	
Hernia Repair	49585	49587	49650	49651
	49652	49653	49654	49655
Liver Biopsy	47000			
Tonsillectomy & Adenectomy	42821	42826		
Upper & Lower Gastrointestinal Endoscopy	43235	43239	43249	45378
	45380	45384	45385	
Urologic Procedures	50590	52000	52005	52204
	52224	52234	52235	52260
	52281	52310	52332	52351
	52352	52353	52356	57288

If the prior authorization process is not complete before performing a procedure in an outpatient hospital, claims will be administratively denied, and the member cannot be billed for the service. If the request for prior authorization is denied, members can be billed for the service to be performed in an outpatient hospital setting if the provider obtains adequate written consent from the member pursuant to UnitedHealthcare's protocols. For more information, please refer to the Administrative Guide at **UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Administrative Guides**.

We recognize that some patients require more complex care due to a variety of factors. When making coverage determinations related to site of service, pursuant to the terms of a member's benefit plan, we will consider factors such as the availability of a participating network facility, specialty requirements, physician privileges and whether a patient has an individual need for access to more intensive services. We encourage you to familiarize yourself with participating network ambulatory surgery centers in your area and obtain privileges to perform procedures in those centers, if you do not already have them.

Please reference the following frequently asked questions to learn more.

Q1. What UnitedHealthcare benefit plans are included?

A. The prior authorization requirement applies to commercial benefit plans including exchange benefit plans and the following plans:

- Golden Rule Insurance Company (group 902667)
- Mid-AtlanticMD Healthplan Individual Practice Association, Inc. ("M.D. IPA") or Optimum Choice, Inc. ("Optimum Choice") products
- Neighborhood Health Partnership
- UnitedHealthcare of the River Valley Health Plan
- UnitedHealthcare Oxford Health Plans*
- UnitedHealthcare
- UnitedHealthcare Life Insurance Company (group 755870)

*UnitedHealthcare Oxford Health Plans currently require prior authorization for these procedures when they are provided in a setting other than a physician's office. When prior authorization is requested, the site of service will now be reviewed to determine if the site of service is medically necessary, as part of the prior authorization review process.

Q2. When does the prior authorization requirement become effective?

A. The prior authorization requirement becomes effective in most states for dates of service on or after Oct. 1, 2015 except that the following states have different effective dates:

- Dates of service on or after **Nov. 1, 2015** for providers in **Colorado**
- Dates of service on or after **Dec. 1, 2015** for providers in **Illinois**

Q3. Why did UnitedHealthcare choose these particular procedures?

A. We conducted careful clinical reviews to determine which procedures are clinically appropriate to be performed at a participating network ambulatory surgery center for most patients, taking into consideration the terms of our members' benefit plans and significant out-of-pocket costs to UnitedHealthcare members when these procedures are done in a hospital setting.

Q4. What happens if one of these procedures has already been scheduled to be performed in an outpatient hospital setting after the effective date?

A. If one of these procedures is already scheduled to be performed on or after the effective date, you will need to request prior authorization. In some cases, this may mean you and your patient decide to move procedures to a participating network ambulatory surgery center to align with the coverage determination. Our review process will take into account the terms of the member's benefit plan, the availability of a participating facility, specialty requirements, physician privileges and whether a

The Changing Landscape

Key Anecdotes Becoming Trends

- In a Western market, a health plan has agreed to pay an orthopedic group double-digit rate increases for several years, contingent upon the group moving total joint replacements out of the hospital and into its ASC.
- The hospital is not aware of this agreement.

- A major national payor contacts patients before authorizing a surgery to educate them on the benefits of ASCs and out-of-pocket expense differentials.
- UnitedHealthcare is redirecting surgery to ASCs, including endoscopy, cystoscopy, carpal tunnel repairs, and cataract surgery. HOPDs will not be paid without prior authorization.

The Value of Alignment

The Value of Alignment

ASC Implications for Health Systems: Future Considerations

Health system ASC strategies are mandatory and critical to success!

Health systems and hospitals are feeling pressure from payors and their communities to reduce costs. In addition, both changes in government regulations and commercial payors reward providers for migrating high-acuity surgery to the ASC setting, which poses a financial threat to health systems due to the significance of surgical revenue. This motivates the demand for ASCs and the need for an ASC strategy. Retention of equity for hospital partners is expected to grow as higher-valued surgery shifts to a lower-cost setting. Health systems are expected to capitalize on their value relative to their equity position and increase alignment with physicians via ASC JVs.

The Value of Alignment

Hospital Outpatient Surgery Strategies

Health systems are evaluating conversion of HOPDs versus ASCs, which is highly dependent upon the market and access to rates.

Why are hospitals looking for an ASC strategy?

- Site-of-service rate differentials are narrowing.
- Hospitals' freestanding HOPDs that are more than 250 yards from the hospital campus no longer have access to HOPD reimbursement.
- Increased physician alignment and access to lost volume presents accretive value.
- ASCs are capturing high-dollar volume from hospitals.
- A focus on total cost of care and value-based pricing is becoming more prevalent.
- Hospital ORs are full; ASCs offer access and efficiency.

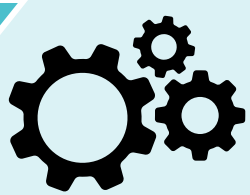
When are hospitals maintaining HOPDs?

- HOPDs are more advantageous on rate.
- ASC market is too competitive and rate differentials are significant.
- Hospital ORs are not full; volume should be retained on campus.
- Physician alignment is in HOPDs via comanagement agreements.

The Value of Alignment

Why Is There an Increased Demand for Hospital ASC JVs?

Operations and CMS Changes



- Efficiency equals reduced cost.
- Physicians want access to incremental income.
- There is desire for physician management control.
- ASCs must know their cost!
- Payors see the opportunity for savings.
- There is increased commercial payor acceptance of approval of codes beyond the Medicare list.
- CMS has closed the gap on HOPD- and ASC-approved CPT codes on the ambulatory payment classification (APC) list.
- There are implications of APC bundling logic and device-intensive procedures.

Surgery Pricing and Transparency

- ASCs typically represent 30% or more in savings to payors.
- ASC pricing can be 50% less than a hospital.
- Charge transparency is trending toward mandatory.
- Payor, employer, and consumer perspective is important for competitive pricing of outpatient surgery.
- Value-based pricing/gainsharing arrangements exist.
- Will there be bundled payments in ASCs?

The Value of Alignment

Preliminary Strategic Rationale Example

Any alignment between a health system and a group of physicians must begin with a shared purpose.

- Capture growth of market share for musculoskeletal (MSK) services.
- Mitigate financial pressures associated with shifting care from an inpatient to outpatient site of service.

- Partner with a preferred health system to lower the total cost of care for MSK services in the geographic area.
- Upgrade existing spaces to state-of-the-art facilities.
- Create an opportunity for economic investment in real estate and clinical service ventures.

Shared Goals

- Establish a destination center to provide low-cost, high-quality, comprehensive MSK services to the region.
- Create an environment that fosters collaboration to manage the total cost of care.
- Align the strategic, operational, and financial interests of all parties through innovative and contemporary structures.

The Value of Alignment

Conceptual Model Overview: Core Services

Consideration with respect to the scope of services and type of ambulatory destination must be made at the outset.

ASC Only

- A freestanding ASC is developed on campus, and elective-based, outpatient MSK cases are moved to the new campus.
- A JV is formed for the new building and the ASC services.
- A separate medical hotel may be established to accommodate cases that require an overnight stay.

Ambulatory MSK Care Center

- Building off of the ASC concept, a more comprehensive ambulatory care center is developed that includes physician office space and ancillary services.
- All services on campus could be provided via a JV between the participating entities.

Comprehensive MSK Institute

- In order to position the health system and/or providers to assume risk for MSK procedures, all elective-based inpatient and outpatient care is relocated to the new campus.
- Inpatient beds and operating rooms would require a separate facility.
- A SNF and/or other extended-care options may be required to control costs in a risk-based reimbursement model.

Low Complexity → **High Complexity**

The Value of Alignment

Conceptual Model: Array of Business Arrangements

An array of business models maybe be combined in various ways to achieve the goals and objectives to ensure strategic, operational, and financial goals are achieved.

	JV ASC	Professional Services Agreement	Comanagement Agreement	Bundled Payment	Under-Arrangement
Ambulatory Surgery	✓	✓	✓	✓	✓
MOB		✓	✓	✓	
Diagnostic imaging	✓		✓	✓	
MSK Urgent Care	✓	✓	✓	✓	
Other Therapy	✓	✓	✓	✓	
Other Ancillaries	✓	✓	✓	✓	
Inpatient Beds/ORs			✓	✓	
Inpatient Rehab			✓	✓	✓
Extended Stay	✓		✓	✓	

The Value of Alignment

Ambulatory Care Center Example

A 66,000-square-foot state-of-the-art facility that opened in 2013 was structured as a JV, involving ambulatory services such as surgery, diagnostic imaging, physician clinics, and therapy.

Real Estate

- A real estate management company was formed between the health system, an imaging provider, and physicians, including orthopedic surgeons, anesthesiologists, and radiologists.
- The company owns the land and the building.

Clinical Comanagement

- In addition, a management company was formed between the same entitles to manage the services provided in the new facility.
- Physicians are compensated for their time and the performance of key indicators over a three-year period.

The Value of Alignment

Comprehensive MSK Institute Example

The orthopedic specialty hospital below has 30 beds and is operated by a health system; it represents an example of a single campus that offers a comprehensive set of MSK services.

Physician Group Practice

Orthopedic Specialty Hospital

- The specialty hospital is owned and operated by the health system; however, the land and the building were initially owned by the physician group practice and leased to the health system.
- The physician group practice owns and operates the MOB, which houses ancillary services (e.g, PT, diagnostic imaging, DME, pharmacy) and an ASC.

The two organizations continue to discuss alignment opportunities with respect to the JV of the ASC, BPs, and CAs.

Important Facts to Remember

Important Facts to Remember

- Surgery migration from inpatient sites and HOPDs to ASCs is expected to continue to grow as payors are striving to reduce cost with higher-acuity cases targeted for savings by Medicare and commercial payors.
- An ASC strategy can enable opportunity for increased access to physicians and patients in secondary markets.
- Health system ASC strategies vary, offering proactive opportunities for physician alignment and mitigation of losses that are expected due to the market and payor demands to reduce cost.
- Analyzing reimbursement methodologies relative to the cost of services and case mix, and with consideration of payor mix, is critical to an ASC's success.
- Partnering with ASCs will create accretive value to a hospital if it presents access to new or historically lost volume.
- Hospital equity position should be carefully considered with respect to volume for potential migration and the financial impact to the hospital; the value of the hospital partner; and implications on reimbursement that can be impacted by equity position.
- CMS levels the playing field for payment methodology and logic with the implementation of OPPS and APCs for ASCs and HOPDs.
- Operating margins of a well-run ASC are 25% to more than 50%; health systems can create opportunity to increase value with effective structures and a defined strategy.

Questions & Discussion

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