Stryker ASC – Module 4: Reimbursement in the ASC **Final: October 21, 2022**

OVERVIEW

As a result of health insurance plans and consumers becoming more astute to their options, more procedures continue to shift to ambulatory surgery centers (ASCs). Parties responsible for healthcare setting reimbursement rates also play a role in where procedures occur. Ultimately, this will lead to increased revenue in the ASC space. To make the best business decisions for their center(s), it is imperative that ASC leaders understand how they are being reimbursed for care.

OBJECTIVES

1. Identify current market dynamics leading to ASC expansion of care.
2. Explain care reimbursement and payer mix in the ASC.
3. Describe the role of the ASC leader in strategically maximizing reimbursement in the ASC.

INTRODUCTION

Ambulatory surgery centers (ASC) represent a rapidly expanding segment of healthcare in the United States. As additional procedures migrate to ASCs, continued growth is forecasted, especially for cardiac and orthopedic procedures.

For the same procedure in all markets, regardless of payer, ASC prices have generally been found to be significantly lower than hospital outpatient department (HOPD) prices. A review of commercial medical-claims data indicated that a $38 billion per year reduction in U.S. healthcare costs has occurred due to the availability of ASCs for outpatient procedures, more than $5 billion of which accrues to lower deductibles and coinsurance for the patient. Savings of as much as $55 billion per year could be realized if additional procedures were redirected to ASCs, depending on the mix of ASCs selected instead of HOPDs and the procedures that migrate.[1]

Current Overview of ASCs in the United States

Given their positive patient outcomes and significantly lower costs, ASCs have continued to experience growth. Business continues to boom through new outpatient cardiac and orthopedic procedures and, as technologies advance, hospital systems and physician-owners continue to seek ways to move more procedures to outpatient facilities.[2]

Forecasted Growth

The global markets indicate that the size of the ambulatory surgery center market exceeded $75 billion in 2020 and is expected to grow at over 6.1% compounded annual growth rate from 2021 to 2027.[2] Increasing healthcare costs, newer technologies allowing rapid recovery, and minimally invasive procedures have allowed hospitals to expand into hospital-owned ASCs, a market sector that was valued at 3.5 billion in 2020.[2] With a safer environment and lower rates of infection when compared to multi-specialty centers, the single-specialty segment of the market crossed the $45 billion mark in 2020 due to the growing number of single-specialty ASCs.[2]

Minimally invasive procedures and a growing demographic of aging people who deal with more complex chronic conditions that require effective management will both positively impact ASC market growth and expansion.[2] Performing surgical procedures for this aging population at ASCs allows for much lower costs than hospital settings, an appealing benefit to both insurance companies and healthcare managers.[3] Continued recruiting of qualified healthcare professionals at ASCs will also spur growth.[2]

Expansion of Procedures

Cardiology procedures, including angioplasties, loop recorder placement, catheterizations, and pacemaker insertions, are expanding into the outpatient arena. The ASC share of the cardiology market in 2015 was 4%. However, predictions indicate that will rise to 33% by the mid-2020s.[4]

New technologies are becoming available that allow surgeons to perform minimally invasive complex spine procedures. Some ASCs were already performing spinal fusions and disc decompressions, but procedures like single- and two-level 360-degree fusions are new to many ASCs.[4] Ambulatory surgery environments will also see growth as volume is expected to increase for total joint procedures including total shoulder, ankle, and elbow arthroplasty.[4]

With hospitals seeking growth by focusing on ASCs, many new procedures have migrated to the outpatient setting. Higher acuity procedures have also shifted from inpatient settings to outpatient settings. In 2020, CMS added 11 procedures to their ASC Covered Procedures List (ASC CPL), including total hip arthroplasty.[4]

As ASCs continue to recruit more physicians, build more ORs, expand service lines, and embrace new technologies, they will continue to expand and grow in many directions.[4]

ASC CURRENT MARKET DYNAMICS

Price variations exist between surgical procedures across geographic regions and surgical procedures.[5] Studies that delve into a correlation between the quality of healthcare services and the cost of healthcare services have produced inconsistent results. One study sought to determine if higher paid healthcare settings have higher quality outcomes than lower payment healthcare settings. For this study, inpatient commercial claims were analyzed using a brand name market scan research database to determine the association between hospital median payments for elective knee and hip procedures and three outcomes: complication rates, prolonged length of stay, and 30-day readmission rates. The study determined that higher payments cannot predict higher quality outcomes, a finding with implications for value-based insurance designs, high-value care provision strategies, consumer choices, and provider-payer negotiations.[5]

Value-based Care Shift

As the U.S. healthcare system seeks improvements in value-based care, there has been a shift to encourage surgical procedures to be performed in outpatient facilities. According to a demographic study of outpatient spine surgeries, patients who were self-pay or covered by private insurance had the highest proportion of outpatient spinal fusion surgeries throughout the study period. Self-pay patients who had ambulatory spinal fusion procedures increased from 16.12% to 20.28% from 2012 to 2014, and during the same timeframe private insurance patient procedures increased from 15.85% to 17.62%. The least common patient group was Medicare patients. Medicare beneficiaries who had ambulatory spinal fusions only increased from 4.62% to 4.84%. When compared with procedures done in an inpatient facility, there are multiple reports of decreased cost and higher patient satisfaction with outpatient spine surgeries done in an outpatient setting.[6]

Hospital and HOPD Surgical Volumes

A retrospective, population-based cohort study by Billig et al[7] used deidentified claims data from private employer-sponsored health insurance from 2009 to 2017. Data included patients older than 18 years who underwent trigger finger release, carpal tunnel release, excision of small hand masses, and wrist ganglion (N = 468,365). Of the 468,000+ procedures performed, about 61% were performed in HOPD settings, about 34% in ASC settings, and only 5% in office settings. The researchers reported that procedures performed in HOPDs cost an extra $1,216 in total payments and $115 in out of pocket (OOP) expenses when compared to office settings. Procedures performed in ASCs were also found to cost more than office settings with $709 more in total payments and $140 more in OOP expenses. See Table 1 for more detail found in the results of the study.

Table 1 - Detail from Retrospective Population-base Cohort Study

Total number of procedures: 468,365	***HOPD Setting 284,889 (60.8%)***	***ASC Setting 158,659 (33.9%)***	***Office Setting 24,817 (5.3%)***
Additional cost when compared to office setting	**Extra $1,216 in total payments*** **Added $115 in out-of-pocket (OOP expenses)**** * 95% CI, $1184-$1248 **95% CI, $109-$121	**Extra $709 in total payments*** **Added $140 in OOP expenses**** * 95% CI, $676-$741 **94% CI, $134-$146	
Reference Billig J, Nasser J, Chen JS, et al. Comparison of safety and insurance payments across operative settings. *JAMA Network Open*. 2020; 3(10):e2015951. Doi:10.1001/jamanetworkopen.202015951			

Historical Make-up vs. Current Trend[8]

Even before the pandemic, the hospital surgery market was shrinking. Trends indicate the best approach for hospital systems is to shift to a strategy that pivots focus to outpatient access, enhanced operational efficiencies, and enhanced patient experiences. The hospital share of the outpatient market has been shrinking due to the migration of outpatient procedures moving from inpatient settings to outpatient clinics over the last several years. In 2005, the hospital share was 59% of the outpatient market, compared to 40% more recently. High-revenue procedures that can only be performed in an inpatient OR have helped maintain some of the hospital share of this market. Higher reimbursement rates for ambulatory procedures performed in an HOPD have also helped hospitals stay in the outpatient market, but the pay differential continues to steadily decrease, and the decrease should continue as CMS continues to remove procedures from the inpatient only (IPO) list.

Insurance Health Plans

Due to continued high prices and a wide variation in prices, many insurers and employers have implemented creative insurance benefit designs. For example, reference pricing is a benefit design that directs patients to lower-price providers through targeted financial incentives. The California Public Employees' Retirement System used reference pricing models to incentivize members into choosing lower-priced ASCs over hospitals for procedures such as colonoscopies, arthroscopies, cataract procedures, and hip/knee replacement surgeries. The associated average per-procedure price reduction ranged between approximately $1700 and $2300 for colonoscopies, depending on model specification. Futures studies are needed to determine how reference pricing could be used for other medical procedures. More research is also necessary to determine how many more ASCs would be needed to meet potentially increased demands and the associated changes in negotiated prices due to a changing market structure.[9]

Impact of Value-based Payment Structures

As a means to improve patient care and reduce healthcare costs, bundled payments and value-based care initiatives have been gaining momentum in the ASC industry. Value-based care affords ASCs great potential, such as more patients due to better coverage, new revenue streams for ASCs, and more covered procedures.[10]

Consumer Cost Transparency

Consumer-based transparency tools are increasingly available to patients, thus allowing them to have access to healthcare charge data and reimbursement rates for select procedures. However, it isn't clear if patients rely on cost to determine quality of care when selecting their healthcare provider.[5]

Even within the same city and insurance network, healthcare prices vary dramatically. In Charleston, WV, healthcare prices for cataract surgery, including physician and anesthesiologist payments, were found to vary from $2,684 to $8,662 depending on the facility where the procedure was performed. This is a price variation of more than 300%

due in large part to the facility charges. The facility prices vary by almost 600%, more than 70% of all dollars spent on cataract surgery in the city. Facilities vary in their market power and offerings, which results in different negotiated rates with insurance companies. ASCs often offer fewer services than hospitals, giving them less negotiating leverage with commercial carriers. This often results in lower reimbursement rates than hospitals if the ASC wants to be part of insurance networks.[1]

Efficient for the Patient

Cost transparency gives patients the ability to know the cost of a healthcare service before receiving it. Facilities are required to provide accessible, clear pricing information about services provided as a machine-readable file listing all items and services in a consumer-friendly format that displays shoppable services. Access allows patients to shop and compare prices across healthcare facilities before they receive care.[11]

Cost Effective (Lower Co-pay)

Some commercial insurance companies offer advisors to help individuals as they consider treatment options. These advisors help consumers determine in-network providers and locate the best value using quality and cost comparisons for various medical procedures. Whether using advisors or online tools, patients can estimate out-of-pocket costs and, in some cases, even receive cash incentives from their insurance carrier for selecting lower-cost services, providers, or procedures when available. Some commercial insurance online tools also allow patients to comparison shop and make informed decisions specific to their particular coverage plan, with some benefit plans offering additional cash incentives just for shopping and comparing medical procedure costs.[12] Cost transparency empowers consumers to determine the out-of-pocket cost they are most comfortable with by allowing them to select a local facility with the lowest expenses.

Health System Partnerships with ASCs

Most ASCs are at least partially physician-owned, often with management companies or hospitals. Of the estimated 6,000 Medicare-licensed ASCs in the US in 2021, about 60% are fully physician-owned.[1] This ownership model has its benefit of maximum control. However, contracting and management challenges may be an issue. Joint ventures between ASC management companies, hospital systems, and physicians, or a combination thereof, may provide a better balance of physician influence and management expertise. Hospital-owned ASC ownerships are on the rise. These scenarios typically place physicians in co-management roles. As key players seek the right combination to maximize clinical success and efficiency, ASCs and alternative business models will continue to grow.[13]

Inpatient Only List (IPO)

The CMS inpatient only list defines the list of procedures, based on medical complexity, that Medicare will pay for when performed in the inpatient setting. After reviewing codes that meet current criteria for removal from the IPO list, CMS has proposed removing ten maxillofacial procedures from the IPO list for 2023.[14,15] When a procedure is removed from the IPO list, it does not automatically become eligible for coverage at an ASC. Initial removal from the IPO list only allows a procedure to be performed in an HOPD. These procedures cannot be performed in an ASC until they are added to the ASC covered procedures list (CPL). Only one procedure from the list has been added to the 2023 ASC CPL.

Total joint arthroplasty (TJA) was also removed in recent years from the Medicare inpatient-only list. In ASCs and hospitals, physician ownership and partnerships may help improve efficiency and cost containment. Arthroplasty surgeons may stop participating in Medicare payment reductions as Medicare reimbursements continue to steadily decrease. There is not a large difference between facility reimbursement rates for procedures with inpatient or outpatient procedure statuses, but there may be more significant differences from private insurers. Data indicates that facility fee differences for inpatient and outpatient TJA can be more than $15,000 in some private insurance bundles. This can add up if a facility performs thousands of these procedures each year.[16]

Pre-operative demand matching is one proposed method to benefit healthcare facilities and surgeons, maximize patient outcomes, and reduce payer costs. The appropriate facility need for a patient is determined through "demand" categories, including general health, weight, age, and expected activity. The appropriate operative facilities are determined based on an acuity level sliding scale, while post-operative facilities are selected using a rehabilitation requirement scale, with both using a sliding scale cost structure. A well-designed care navigation and stratification system must be in place to determine demand in a demand matching system. One such care navigation system implemented by the Rothman institute includes a pre-operative risk assessment survey using 58 yes/no questions, results of which auto-calculate risk assessment scores with pertinent positives to determine the best facility for care. When compared to traditional health system navigation, results of the Rothman Nurse Navigation system indicate that more than 90% of patients involved in ASC care were discharged to home, experienced per-case cost savings, improved patient quality, and decreased home health assistance utilization.[16]

As facility fees increase or remain steady, but professional fees go down, more surgeons may choose hospital employment, providing care for in-network patients, to maintain financial solvency. Healthcare facilities must adapt to ensure low cost to payers, quality patient care, and sustainable financial margins.[16]

CARE REIMBURSEMENT

Due to the lower costs for goods involved and reimbursement systems in place, the estimated overall cost of surgical procedures performed in ASCs is 53-55% less than the cost of performing the same procedure in a hospital. In 2003, Medicare paid hospitals 16% more than ASCs for the same procedure. As of 2019, Medicare paid hospitals an estimated 82% more than it paid ASCs for outpatient surgery. In 2019, the Centers for Medicare & Medicaid Services (CMS) was still using the hospital market basket to measure the cost of medical expenses to reimburse HOPDs and using the Consumer Price Index-Urban (CPI-U) to reimburse ASCs. The CPI-U is not only unrelated to medical costs, but historically the inflation update is also lower than the hospital market basket. This methodology led to significant cost savings, an estimated $37.8 billion, for procedures completed in the outpatient setting for the commercially insured U.S. population, with a greater potential for additional savings the more procedures move to ASCs.[13] In 2023, CMS will use the hospital market basket to reimburse both HOPDs and ASCs.

Payer Mix

Commercial

The average health insurance premium for employer-sponsored family coverage increased 61% from 2005 to 2015, a jump from $10,880 to $17,545 per year. Many employers have shifted these increased costs to the employees by adopting account-based or Consumer Driven Health Plans (CDHP). The average employee share of healthcare spending increased 81% during this same timeframe, from $2,713 to $4,955 annually. Cost transparency helps patients better identify in-network value providers and, therefore, lower costs for both employees and their employers.[1]

Percentage of ASC Mix

According to a 2022 multi-specialty ASC benchmarking study using 380 centers representing an aggregate surgical case volume of over two million, the average payer mix of total cases by percentage for ASCs is as follows:

- Commercial 44%
- Medicaid: 10%
- Medicare: 36%
- Self-pay: 5%
- Worker's Compensation: 5%
- Other: 14%[17]

Medicare

Medicare reimburses ASCs at 53% of the rate it reimburses HOPDs on average for the same procedures. Between 2007 and 2011, the payment gap between services delivered at ASCs instead of HOPDs reduced CMS costs by more than $7 billion. Less is known about the price differences and savings between ASC and HOPDs for commercial insurances, as they are not always disclosed to the public.[1]

CMS Reimbursement

Differences Between HOPD and ASC Rate of Reimbursement[1]

The average ASC price for knee arthroscopy in Charlotte, NC, was $6,118 while the average price of the same procedure in a HOPD was $12,493, an average savings of $6,375 when a patient chooses an ASC. If a patient has the Affordable Care Act Silver plan with a $2,700 deductible, 80% coinsurance, and $5,000 maximum out of pocket, they would save $1,275 and the payer would save the remaining $5,100. The same scenario would be $5,100 directly towards the bottom line for the employer in a self-funded employer-sponsored insurance plan. Using the same plan design for the Charleston, WV, cataract surgery scenario, a patient could save $566 by choosing an ASC instead of an HOPD. In an area where the per capita annual income is less than $35,000, this would be a significant savings. The payer would realize an additional savings of $2,264.

Hospital Outpatient Prospective Payment System (OPPS)

CMS proposed new Medicare payment rates on July 15, 2022 for ASC and HOPD services. These policies will affect approximately 5,500 ASCs and 3,411 hospitals. The rule is open for comment for 60 days, with a final ruling scheduled to be issued in November 2022. This year's rule includes payment rate proposals, advancing rural area health equity, and promoting effective, safe patient-centered care.[14]

Based on the projected hospital market basket percentage increase of 3.1% with a 0.4 percentage point productivity adjustment reduction, the proposal includes an update to the OPPS payment rates that meet applicable reporting requirements by 2.7%. According to CMS estimations, this will result in approximately $86.2 billion in payments to OPPS providers, $1.79 billion more than 2022.[18]

The CMS OPPS and ASC rate setting process uses the best available data to ensure payment rates reflect estimates of all costs associated with outpatient services. Typically, the best available data includes claims from the two years prior to setting the current proposed payment rates. The most recent available cost data report from 2021 includes overlap from 2020, which CMS does not believe to be the best overall approximation of outpatient hospital services because it would include data from the start of the pandemic. Therefore, the 2023 proposal for both OPPS and ASC payment system rates includes cost report data from the June 2020 Healthcare Cost Report Information System (HCRIS), which includes cost report data through 2019 before the pandemic, the same data used to set OPPS rates for 2022.[14]

Ambulatory Surgery Center Payment System

In the final 2019 rule, CMS applied the productivity-adjusted hospital market basket update to ASC payment system rates for an interim period of 5 years (2019-2023). Based on the same projected hospital market basket percentage increase of 3.1% reduced by 0.4 percentage points for the productive adjustment, the 2023 proposal includes a suggested ASC rate update of 2.7% for ASCs meeting relevant quality reporting requirements.[14] According to CMS estimations, this will result in approximately $5.4 billion in payments to ASC providers, which is $130 million more than in 2022.[18]

Factors Contributing to Differences in Payments Between HOPD and ASC[19]

The ASC industry in the U.S. was projected to grow at a 5.83% compounded annual growth rate from 2016 to 2022, a predicted growth faster than that of the overall U.S. economy. With a push towards value-based care and value-based payment contracts, ASCs are becoming more known for reducing payer costs by providing a more efficient

surgical setting. ASCs typically command lower rates than HOPDs. When outpatient surgeries shift from an HOPD to an ASC, the Medicare payment methodology changes from the OPPS to the ASC fee schedule. Although ASC fee schedules are linked to OPPS payments, the adjustments and inputs to the calculation are not the same. For example, in 2018, a diagnostic colonoscopy (CPT code 45378) would have an HOPD allowable payment rate of $709.98 and a freestanding ASC allowable payment rate of $369.84, 52% less than the HOPD rate.

Three main differences in payments between HOPDs and ASCs include:

- Relative weight: the CMS determined numerical value associated with the service provided. This value is multiplied by the conversion factor to determine the national Medicare allowable rate. Freestanding ASCs have a lower relative weight due to OPPSs proportional adjustments to relative weight to maintain budget neutrality, a method that, when compared with the HOPD relative weight, resulted in a 10.1% reduction to the ASC relative weight in 2018.
- Conversion factor: The ASC conversion factor is based on the hospital market basket. Changes in the basket encourage service migration from hospitals to ASCs and promote site neutrality between ASCs and hospitals. In 2019, the ASC conversion factor was $46.55 and the OPPS conversion factor, based on the hospital market basket as well, was $79.49, a difference of 59%.
- Wage index adjustment: The determined national Medicare allowable rate is further adjusted to include the geographical wage index for individual ASCs and HOPDs. This index is determined by calculating the average hourly wage ratio for a given labor market, usually the county level, to the national average hourly wage. This index adjustment varies for freestanding ASC and HOPD payments. Freestanding ASCs have 50% of the allowable rate adjusted while HOPDs have a 60% adjustment. Depending on the applied wage index, this methodology difference when weighing the labor portion of the payment can have a negative or positive impact on ASC payment rates when compared to OPPS rates.[19]

See Table 2 for a comparison of HOPD Conditions of Participation (CoP) and ASC Conditions of Coverage (CfC).

Table 2 - Comparison of HOPD Conditions of Participation (CoP) and ASC Conditions of Coverage (CfC)

Similarities		
	HOPD CoP	**ASC CfC**
		If an ASC has laboratory and radiologic services, they must also meet the same requirements as hospitals

Comments:
• Three condition categories are included in the hospital CoPs:
  ○ administration,
  ○ basic hospital functions, and
  ○ optional hospital services
• The same safeguards are in place for both HOPD CoPs and ASC CfCs, the condition names are even the same.
• Similar language exists for quality assessment and performance improvement (QAPI).
• Both ASCs and HOPDs must meet the life safety code Ambulatory Health Care Occupancy Provisions.
• Both facilities also require similar medical record information and have flexibility with the ability to determine when a physical assessment and medical history are required.		

Differences		
	HOPD CoP	**ASC CfC**
	Hospital must have policies and procedures in place establishing which outpatient departments, if any, are required to have a RN present.	Required to have a RN available for emergency treatment when there is a patient in the ASC.
	Patients' rights contain language regarding the use of restraint or seclusion.	Two sections address patient safety and respect and provide clear protections to ASC patients.
	The biggest difference is requirement of an antibiotic stewardship program.	No antibiotic stewardship program required since it is not routine to prescribe antimicrobial medications.
		More directives for emergency equipment, particularly who can operate emergency equipment.
	More information regarding emergency preparedness because that hospital requirements must be applicable for various departments.	
		No need for language regarding food and dietetic services because ASCs do not keep patients for long periods of time.
		Do not contain information regarding utilization review, however, the Medicare Claims Processing Manual includes language reminding facilities that procedures should be necessary and reasonable to the beneficiary in ASCs as well as all other covered services.
	Responsibilities address organ transplantation and procurement, neither of which apply to ASCs.	

Reference
Newbury K. ASCs versus HOPDs: How do federal regulations compare for these sites of services? *ASC Focus*. https://www.ascfocus.org/ascfocus/content/articles-content/articles/2021/digital-debut/ascs-versus-hopds. October 2021. Accessed August 6, 2022.

Implant reimbursement
With the shift of many inpatient surgical cases to the ASC arena, there is often little room for profit due to the substantial reimbursement reduction rates. Implant reimbursement is a big challenge for ASCs and, given the volume of procedures moving to this area, ASC leaders must ensure that commercial insurance contracts are well constructed to include payment for hardware and implants.[21]

Quality Reporting Requirements and Impact
The Ambulatory Surgical Center Quality Reporting (ASCQR) program, administered by CMS, is a pay-for reporting quality data program. To avoid penalties that may reduce their ASC annual payment rates, ASCs report quality of care data for standardized measures. This data allows CMS to develop a comprehensive set of quality measures that can be used to make informed decisions related to quality improvement in the ASC setting. Payment determinations use a variety of data sources to calculate the quality-of-care Medicare beneficiaries received within a given year, including measures reported by facilities or through Medicare claims information. CMS evaluates measures and uses this information to ensure quality of care. Their evaluation includes removing measures that are no longer needed and adding new measures if needed.[22]

ASC Covered Procedures List (CPL)
Each year, CMS determines which procedures should be added or removed from the ASC covered procedures list. Decisions are based on which procedures can be safely performed in an ASC. The 2023 ASC proposal includes adding one additional procedure to the ASC CPL, a lymph node biopsy or excision.[14]

ROLE OF THE ASC LEADER

Service Line Offerings
Successful ASC leaders embrace growth strategies, such as finding a way to add various types of surgeries that can be performed in their ASC. To ensure continued growth, ASC leaders must generate new revenue streams by continuing to add new services and new physicians. Revenue may be an obvious key to the success of an ASC, but ASC leaders must also continually carefully manage staffing, implant, drug, and supply costs as curtailing expenses is as important as generating new revenue. Competitive strength in the market comes from adding new service lines and demonstrating excellence delivering those services.[23] Opportunities to add new service lines may be the result of technological advances, Medicare and commercial carrier covering of added procedures, recruitment of physicians from other ASCs, or individual market reimbursement trends.[24]

Before considering a new service line, an ASC should assess the return on investment. This can be achieved by calculating revenue by procedure to project the expected net revenue for the new service line using the best estimate for the type and number of procedures for the year, calculating the net revenue based on best estimates of reimbursement, and then subtracting salary and other typical operating expenses (eg, supply, implant, rent, drugs, accounting, legal) to determine the best estimate of the net profit for the proposed new service. Estimated reimbursement versus expected discounts from payers should also be calculated. The addition of new service lines requires a team effort among all ASC stakeholders. New service lines have the best chance of success with proper planning and support.[23]

<u>Continual Review of Reimbursement</u>
Increased reimbursement has lent itself to several new ASC service line opportunities. For example, total joints, hips, knees, and hip arthroscopy have been added in the orthopedic area. New spine cases, such as laminectomies, ACDF fusions, and micro-discectomies have been added, along with vascular, radiologic, and interventional cardiology procedures approved by Medicare which, overall, will result in better reimbursement to ASCs who consider expanding into these specialty areas. Procedures such as graft and pain pumps, dialysis catheters, and peripheral artery disease procedures have also been added in some ASCs with success.[23]

Recruitment of New Service Line Offerings with Higher Reimbursement

If an ASC has physicians willing to do specific procedures, those procedures should be considered. Service lines may be good financial investments. However, without strong physician support, they may not be a good fit for a particular ASC. Before adding a new service line, leaders should also consider if the service will fit well within their market. Each year, as Medicare continues to add procedures to the ASC Covered Procedures list, ASCs have opportunity for growth.[23]

An essential part of planning and implementing a new service line is determining in- and out-of-network reimbursement rates. Medicare rates should be considered first as a base low rate of reimbursement, with commercial payer reimbursement information soon to follow. If a "new" service is not covered by a payer as an in-network procedure, leaders should try to negotiate the ability to offer it on an out-of-network reimbursement basis.[23]

Reimbursement and Competition Expertise

ASCs have opportunities to improve their financial performance due to changes in healthcare and the reimbursement arena. Knowledge of alternate payment models (i.e., shared savings, value-based purchasing), patient demographics and payer mix, and Medicaid Managed Care is crucial for ASC leaders. It is imperative that ASC leaders have an expertise in reimbursement trends, commercial payers, contracting opportunities, and value-based contract reimbursement factors.[25]

Using data from the Health Care Cost Institute (HCCI) that included claims and demographic data from three large payers, researchers identified 2008 to 2012 commercial insurance prices for outpatient procedures in 40 million individuals representing all 50 states, while accounting for 27% of the nonelderly population covered by commercial insurance. Data was used to construct year-level county price indices for outpatient procedures and ASC and HOPD price indices. These county price indices were matched to Medicare data year-level county market characteristics on ASC and hospital patient flow. Investigations included the number of ASCs available per capita, outpatient procedure prices, and market competitiveness measures.[26]

Results indicate that ASC availability keeps outpatient procedure prices down. From the bottom-quartile to the top-quartile, the average number of ASCs per capita in a geographic region was associated with a 3.6% decrease in outpatient procedure prices. Decreases in the inpatient HHI from the top-quartile to the bottom-quartile average is associated with an outpatient procedure price decrease of 9.9%, a result that stresses the importance of inpatient hospital competition. Competition among ASCs as well as competition between ASCs and HOPDs, was found to pay a significant role in the price determination process. From the top-quartile to the bottom-quartile average, decreases in the ASC Hirschman-Herfindahl Indices (HHIs) are associated with a statistically significant decrease of 7.7% in ASC prices. Results indicate that ASC competition is important not only because it limits prices charged by other ASCs, but also because it limits other HOPD and overall outpatient prices. Consumers benefit from ASC competition by paying lower prices for outpatient procedures.[26]

Negotiating Favorable Payer Contracts

Most ASCs have wrung out operating costs in purchased services, supplies, and implants to maximize profitability using group purchasing and vendor negotiations.[23] Medicare reimbursement policies are continually changing and that, coupled with the complexities of commercial payer contracts, makes payer contract negotiations difficult for ASCs. ASC leaders must be familiar with ASC rule changes and Medicare reimbursement. To ensure favorable payer contracts, payer negotiations must include a knowledge of current trends that allows an ASC to detail why it is beneficial to cover a particular service in their facility. For example, when CMS began separate reimbursement and coverage for a new, non-opioid postsurgical pain management local analgesic, ASC leaders gained some negotiation leverage which allowed them to address the following two priority strategies.

- Expand reimbursement by adding this type of non-opioid pain management and shifting cases to ASCs.
- Describe how the patient need for opioids would be reduced.

Both strategies should be very appealing to a payer. To validate the value of ASC care, ASCs should also be able to demonstrate to payers the payment gaps between HOPDs and ASCs when entering negotiations. For example, comparing Medicare reimbursement in an ASC versus an HOPD can be valuable because 100% of the Medicare HOPD payment may be enough to fully cover the case in an ASC setting.[27]

Contractual Language Expertise

Payment methodologies vary across the U.S. and by payer. It is important to understand ASC contract payment language to determine if current methodologies are too prohibitive. Expertise in contract language should be deep enough to include the most specific details, such as language regarding device-intensive procedures. For these types of procedures, contract language expertise must also include an understanding that the threshold for defining a procedure as device-intensive dropped from 40% to 30% in recent years, which expands the list of procedures that may qualify for additional reimbursement.[27]

Many payers have adopted unique, proprietary payment methodologies that are modified versions of current Medicare payment systems. ASCs may see commercial contracts that are based on Medicare percentages; however, the contract may not be based on the Medicare rules and rates for the current year. If an ASC doesn't have a management company to help with contracting, they must have an internal expert focused on understanding contract language, and they should also develop an organizational system that lists all contracts, expiration dates, and include a timeline for contract reviews. This list should be current and reviewed at least annually to ensure accuracy and efficiency. ASCs should regularly analyze their case mix and have supporting data on hand before entering contract negotiations.[27]

High-Volume CPT Codes to Negotiate Higher Reimbursement

With a reasonable approach and the right data, ASCs may be able to negotiate with payers for fairer payments and overcome some fee schedule inequities. Determining the most used CPT codes may lend to higher reimbursement. Data should include code frequency, top payers, fees for each code, and reimbursement rates per code that are calculated as a percentage of Medicare's reimbursement rates. Once this data is organized and analyzed, the codes with highest volume and dollar value can be determined. If one payer's plan rates are lower or if one code is paid at a much lower percentage of Medicare than others, this may be a good starting point for negotiations. Payers are unlikely to grant sweeping fee increases unless an ASC dominates a particular market. However, they may negotiate increases for individual services if the data analysis demonstrates inequities.[28]

Carve Out High-Impact CPT Codes

High-cost supplies implants, drugs, biologics, and surgical procedures may be "carved out" of a payer's payment methodology and paid at negotiated rates. Typically, carve outs are used for high-cost services, and any CPT codes corresponding to surgical procedures are ineligible for payment using the payer's standard payment methodology. Noncovered services such as implants, drugs, disposables, and biologics may be carved out. Contracts will usually identify these items in a carve-out list that includes corresponding CPT codes or applicable HCPCS codes.[29]

Insurance Verification

There are numerous steps to ensure an ASC is properly compensated, one of which is insurance verification.

Pre-authorization

Pre-authorization is the first step to optimizing reimbursement. Pre-authorization varies from payer to payer, and it is important to perform thorough payer benefit verification. ASCs should contact payers to verify benefits at least two days prior to a procedure, but not more than 14 days prior to a procedure, as benefits may change. Patients who are added on the day of procedure must be verified prior to the procedure time. Administrators should be immediately notified if a patient is ineligible for coverage or there is deviation in coverage such as non-participating contract or large deductible needing a payment plan. Pre-authorization is not a guarantee of payment, just that the payer agrees

the planned procedure is medically necessary. Coverage is depending on many things including copays, deductibles, eligibility, provider participation, in- and out-of-network benefits, timely submission of claims, and proper billing.[30]

Schedule Review Based on Anticipated Reimbursement

Medicare reimbursement schedules and managed care contracts may allow more than what some ASCs charge and, as such, ASCs may need to review their fee schedules. Also, if fees haven't been adjusted since an ASC opened, it may be time to do so. To remain compliant while increasing fees, ASCs should follow the following fee schedule best practices as summarized in Table 3.

Table 3 – Examples of Fee Schedule Best Practices

Audit Fees	• Check the most common procedures to ensure the profit margin forecast in the budget at least once or twice each year. • Consider creating a spreadsheet that shows prominent carrier and Medicare reimbursement rates compared to fee schedules and costs (direct and indirect). • Review equipment, implant, and supply lists needed for the most common procedures, paying close attention to a specialty to determine if profit margins are being met. If not, fees may need to be adjusted. • To prevent errors and ensure fee schedules remain compliant, limit fee changes to management (administrators, business office, and/or clinical director).
Increase Fees	• Determine whether the ASC is maintaining the necessary percentage above Medicare and primary contracted payer reimbursement rates, and if not adjust the fees. • Present fee schedule increases to the ASC's governing body.
Determine Minimum Baseline Fee	Government and private payers allocate much lower payments for some procedures than others. To determine an appropriate baseline • Review lowest fees and contract allowances. • Consider overhead costs and establish a minimum amount to charge for low-cost procedures. Minimum fees should include supply, salary, direct, indirect, and fixed costs. To remain compliant, ASCs must charge the same fee for each specific procedure to all third-party payers.
Document Fee Schedule Changes	Record any changes made to the fee schedule and how the change was determined.
Reference Serbin C. 4 ASC fee schedule best practices to know. https://www.linkedin.com/pulse/4-asc-fee-schedule-best-practices-know-caryl-serbin. December 19, 2017. Accessed August 6, 2022.	

Partner with Third-party Negotiation Specialists

While a lot of contract negotiations can be done in-house by an ASC, finding a third-party negotiation specialist may result in more favorable contracting. A negotiator can serve as an independent third-party mediator between an ASC and the payer, using their specialized experience to secure desired contracts. Often a lack of negotiation experience increases the length of negotiations, costing a center optimal reimbursement. Third-party negotiators are in the space on a regular basis, and therefore can usually get things done quickly, a time savings and financial benefit to an ASC. A successful negotiator should be equipped with all the data they need to form an evidence-based negotiation. With the data in hand, they should be able to objectively negotiate a timely and financially beneficial contract.[31]

SUMMARY

Reimbursement processes may be the key to ensure an ASC's financial stability. Over the last few years, there have been several changes to ASC reimbursement rates. These changes have challenged many ASCs to consider both the services they offer and how they manage reimbursement processes. ASC leaders must understand how they are being reimbursed to make the best business decisions. It is imperative that ASC leaders have a working knowledge of current market trends and an expertise in the reimbursement and payer arenas to strategically maximize ASC reimbursement.

NOTE: This content has been created for Stryker by an independent, third-party medical writer. This is evidence-based research and is not intended to be legal or consulting advice.

REFERENCES

1. Ambulatory Surgery Center Association. Healthcare Bluebook: Commercial insurance cost savings in ambulatory surgery centers. HealthSmart.
2. Global Market Insights. Ambulatory surgical centers market. 2020.
3. Outpatient Surgery Magazine. 2022 Special Edition: Outpatient surgery outlook: megatrends, influencers, and forecasts. December 2021.
4. Accelerated growth spurs innovation and change. *Outpatient Surg*. June 28, 2021.
5. Arenchild M, Offodile A, Revere L. Examining the relationship between payments and clinical outcomes in high-volume elective surgery in a commercially-insured population. *Inquiry*. 2020;57:1-11.
6. Beschloss A, Ishmael T, Dicindio C, et al. The expanding frontier of outpatient spine surgery. *Int J of Spine Surg*. 2021;15:266-273.
7. Billig J, Nasser J, Chen JS, et al. Comparison of safety and insurance payments across operative settings. *JAMA Network Open*. 2020; 3(10):e2015951. Doi:10.1001/jamanetworkopen.202015951.
8. Peters J. 3 ways hospitals need to pivot their OR strategy in the wake of COVID-19. Healthcare Financial Management Association. https://www.hfma.org/topics/financial-sustainability/article/3-ways-hospitals-need-to-pivot-their-or-strategy-in-the-wake-of-.html. December 17, 2020. Accessed August 6, 2022.
9. Aouad M, Brown T, Whaley C. Reference pricing: the case of screening colonoscopies. *J Health Econ*. 2019;65:246-259. Doi:10.1016/j.jhealeco.2019.03.002.
10. Newitt P. 9 updates on value-based care and ASCs 2022. *Becker's ASC Review*. https://www.beckersasc.com/asc-coding-billing-and-collections/9-updates-on-value-based-care-ascs-2022.html. January 24, 2022. Accessed August 6, 2022.
11. CMS.gov. Hospital price transparency. https://www.cms.gov/hospital-price-transparency. Accessed August 6, 2022.
12. Blue Cross Blue Shield of America. Consumers save money with cost transparency. https://www.bcbs.com/the-health-of-america/articles/consumers-save-money-cost-transparency-tools. July 5, 2022. Accessed August 6, 2022.
13. Badlani N. Ambulatory surgery center ownership models. *J Spine Surg*. 2019;5(Suppl 2):S195-S203.
14. CMS.gov. CY 2023 Medicare hospital outpatient prospective payment system and ambulatory surgical center payment system proposed rule (CMS 1772-P). https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center. Accessed August 6, 2022.
15. Ellison A. CMS pitches outpatient payment rule: 5 things to know. *Becker's Hospital CFO Report*. https://www.beckershospitalreview.com/finance/cms-pitches-outpatient-payment-rule-5-things-to-know.html. July 18, 2022. Accessed August 6, 2022.
16. Arshi A, Wellens B, Krueger C. How the shift in arthroplasty surgery location impacts relationship of private surgeons, hospitals, and ambulatory surgery centers. *Arthroplasty J*. 2021;1-4.

17. Hatton R. How payer mix for ASCs stacks up. *Becker's ASC Review*. https://www.beckersasc.com/asc-coding-billing-and-collections/how-payer-mix-for-ascs-stacks-up.html. March 7, 2022. Accessed August 6, 2022.
18. Franco M. CMS releases CY 2023 outpatient and ASC payment system proposed rule. https://www.hklaw.com/en/insights/publications/2022/07/cms-releases-cy-2023-outpatient-and-asc-payment-system-proposed-rule. July 21, 2022. Accessed August 6, 2022.
19. McMillan D, Long D, Payne A. HOPDs vs. ASC: Understanding payment differences. *HFMA*. https://www.hfma.org/topics/hfm/2019/april/hopds-vs--asc--understanding-payment-differences.html. April 1, 2019. Accessed August 6, 2022.
20. Newbury K. ASCs versus HOPDs: How do federal regulations compare for these sites of services? *ASC Focus*. https://www.ascfocus.org/ascfocus/content/articles-content/articles/2021/digital-debut/ascs-versus-hopds. October 2021. Accessed August 6, 2022.
21. Newitt P. Implant reimbursement vs ASCs: 5 leaders weigh in. *Beckers ASC Review*. https://www.beckersasc.com/asc-coding-billing-and-collections/implant-reimbursement-vs-ascs-5-leaders-weigh-in.html?oly_enc_id=3158I9926423G2B. May 5, 2021. Accessed August 6, 2022.
22. CMS.gov. ASC quality reporting. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting. Accessed August 6, 2022.
23. Zasa R. Successfully adding a new ASC service line. *Becker's ASC Review*. https://www.beckersasc.com/asc-news/successfully-adding-a-new-asc-service-line.html. October 2, 2018. Accessed August 6, 2022.
24. New ASC revenue sources via new reimbursement trends related to OBLS. *MedAxiom*. https://www.medaxiom.com/news/2020/10/04/partner-news/new-asc-revenue-sources-via-new-reimbursement-trends-related-to-obls/. October 4, 2020. Accessed August 6, 2022.
25. The ASC guide to navigating the future of reimbursement. https://go.beckershospitalreview.com/the-asc-guide-to-navigating-the-future-of-reimbursement. Accessed August 6, 2022.
26. Baker L, Bundorf MK, Kessler D. Competition in outpatient procedure markets. *Medical Care*. 2019;57(1):36-41.
27. Stewart A. 3 key strategies for ASCs to succeed in payer contract negotiations. *Becker's ASC Review*. https://www.beckersasc.com/asc-coding-billing-and-collections/3-key-strategies-for-ascs-to-succeed-in-payer-contract-negotiations.html. April 22, 2019. Accessed August 6, 2022.
28. Mertz G. Can you negotiate better reimbursement? *Fam Pract Manag*. 2004;11(9):31-34. https://www.aafp.org/pubs/fpm/issues/2004/1000/p31.html. Accessed August 6, 2022.
29. Ambulatory surgery center payer contract negotiation guide. https://www.exparel.com/hcp/ASC_Payer_Contract_Negotiation_Guide.pdf. Accessed August 6, 2022.
30. Serbin C. Improving ASC upfront collections: 5 fundamental steps in obtaining payer pre-authorization. *Becker's ASC Review*. https://www.beckersasc.com/asc-coding-billing-and-collections/improving-asc-upfront-collections-5-fundamental-steps-in-obtaining-payer-pre-authorization.html. November 27, 2017. Accessed August 6, 2022.
31. Pinnacle. Payor contracting negotiators yield tangible results for ASCs. https://www.pinnacleiii.com/payor-contracting-negotiators-tangible-results/. January 31, 2017. Accessed August 6, 2022.