



Ambulatory surgery center payment models: current trends and future directions

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The total health care expenditure in 2017 was \$3.5 trillion dollars—an increase of 3.9% over the previous year and up from \$2.6 trillion in 2010 (1,2). With these numbers predicted to grow at an annual rate of 5.5%, the Centers for Medicare and Medicaid Services (CMS) have been piloting new programs and payment systems to reduce costs and incentivize physicians and healthcare organizations to provide cost-effective care (2-4). In 1983, Medicare introduced the inpatient prospective payment system in the hopes that hospitals and physicians would start to provide more patient care in the outpatient setting. Since then, the number of surgeries performed as outpatient procedures has increased dramatically from 3.7 million in 1981 to over 32.0 million in 2005 (5). In 2017, more than 50% of all outpatient surgeries were conducted in ambulatory surgery centers (ASCs)—a market which is projected to reach \$40 billion in 2020 (6).

At the center of this massive growth are ASCs. ASCs exclusively provide outpatient surgeries (same-day or 23-h stay) which typically focus on a small subset of routine procedures and treatments. This approach allows ASCs to reduce the overall perioperative costs of surgery—largely those associated with post-operative care—while still being able to produce equivalent outcomes and maintain a high rate of patient satisfaction (2,5-7). Between 1996 and 2008, there was a massive growth of ASCs because reimbursement rates were slightly higher when compared to those received by hospitals. However, since the adoption of the Affordable Care Act (ACA), reimbursements to ASCs have become approximately 42% less when compared to hospitals for the same procedure—a phenomenon which has blunted the growth and widespread use of ASCs (2,5-8). Despite

this change, the ASC industry still reports revenues of approximately \$24 billion, with an annual growth rate of 5%—a financial opportunity which many large practices, companies, and hospital systems have recognized in recent years (7).

The ASCs specifically operated by larger hospitals are referred to as hospital outpatient departments (HOPDs). The distinction between an ASC and an HOPD is important due to different payment systems that are used by CMS for reimbursement. The HOPD reimbursement rates are in part determined by the hospital market basket, whereas the ASC reimbursement rates are subject to the consumer price index (CPI) (2). The difference in these payment metrics creates a disparity in the compensation for similar services because the CPI is a poor proxy for the inflation that the healthcare sector experiences. This is largely because the CPI considers the prices that all consumers pay for goods, 42% of which comes from real estate, whereas the hospital market basket focuses on goods purchased by hospitals—60% of which comes from wages and benefits (2). This discrepancy resulted in an ASC reimbursement rate of 56% of that paid to HOPDs (2). In 2019, CMS has updated the payment factors for ASCs to utilize the hospital market basket index instead of the CPI, which should begin to equalize the payments between the HOPDs and ASCs and move towards site-neutral payments (9). It is important to note that when CMS was asked how the gap between ASC and HOPD payments should be expected to close, the organization admitted the HOPD rate would most likely drop to match the ASC rate, and not the reverse (9). That being said, for device-intensive procedures where use of the device may be 30% or more of the overall procedure costs, CMS will make

special considerations. This insight is especially important for reimbursement rates for HOPDs, where many of these procedures are performed (10).

Spine surgery specifically represents an area of tremendous growth and potential in the ASC environment. Spine procedures often represent 20% to 25% of orthopedic procedures but contribute more than 50% to the profit (7). Therefore, the combination of high revenues per procedure observed in spine surgery with an ASC's ability to reduce operating room and post-operative costs—approximately 60% cost savings during spine procedures—represents a unique opportunity to achieve extremely favorable profit margins. In practice, this has resulted in one of the highest operating room profit margins (7). Although high profits justify performing more spine surgeries at ASCs, it is essential to determine which of these procedures can be safely and effectively performed in these environments (7). By and large, a patient's preoperative risk factors—including age greater than 80 years, body mass index (BMI) over 25, chronic obstructive pulmonary disease, obstructive sleep apnea, history of transient ischemic attack or stroke, hypertension, and previous cardiac surgery—have the most significant impact on the safety of ambulatory procedures. Patients with these types of co-morbidities are typically treated in an inpatient setting for postoperative monitoring and so that any potential postoperative complications—which may contribute to the overall higher cost of spine procedures typically observed in the hospital setting—may be properly managed (7). Studies have shown that performing cervical spine procedures—including anterior cervical discectomy and fusion procedures, cervical disc replacements, and posterior laminoforaminotomies—at ASCs is relatively safe with most patient reporting good or excellent results (7).

In terms of lumbar surgery, single level lumbar decompression is the single most common spinal procedure performed at ASCs and has shown to be effective and safe when compared to inpatient surgery. On the other hand, lumbar fusions performed in the ambulatory setting have been associated with relatively high hospital re-admittance and emergency room visit rates (15%) compared to analogous procedures performed in the hospital setting (4%) (7).

Currently, the predominant payment model for spine surgery—and healthcare in the United States as a whole—is the fee-for-service (FFS) model: providers are reimbursed for every component of care provided regardless of cost, quality, or the outcome. This model provides a significant amount of financial stability for providers as they treat

patients; however, this system typically incentivizes providers to over-utilize the system and over-treat (4,11). On the opposite end of the spectrum is the global payment model, a type of capitation system in which a flat fee is paid to providers for the total management of a patient population throughout a year; additional interventions do not result in extra reimbursements in this system. As each procedure represents a cost to the provider, this model may incentivize providers to not only minimize overall costs, but to also reduce the volume of procedures—many of which may be expensive and burdensome to the patient (4,11). Lastly, episode-based, or “bundled” payments represent a middle ground between the FFS model and global payment model. In this model, there is a single reimbursement per episode of care (4,11). This single payment is expected to cover all aspects of care in a given episode, placing the responsibility on providers to disperse the funds for the various services required in that particular treatment course. Bundled payments provide an incentive for providers to lower the costs of management for each particular episode of care and improve outcomes; however, since payments are still made for each episode of care encountered, providers are not necessarily encouraged to reduce the total number of patients whom they treat (4,11-13). Overall, the bundled payments model has shown to improve continuity and coordination of care, thereby reducing overutilization of the health system by 5–15% and healthcare spending by 10% (14,15). *Table 1* compares the current ASC payment models in effect.

Currently, the FFS model is the dominant payment model in spine surgery; however, many orthopedic care organizations expect 30–45% of patients to be covered under bundled payments in the coming years (11). In particular, spinal procedures that have well defined post-operative courses and lead to minimal complications are ideally suited for the bundled payment model. The cost-saving ability of ASCs combined with the structure of the bundled payments model should serve to reduce overall healthcare spending, while simultaneously improving patient continuity of care and profit margins for outpatient centers. For ASCs to fully capitalize on the financial opportunities presented by bundled payments, they must preoperatively stratify patients by taking into account patient demographics, comorbidities, social determinants of health, as well as anticipate postoperative complications (2,3,7,12,14-17).

Bundled payment contracts have been shown to increase patient volume from large-scale employers, like Walmart;

Table 1 Comparison of payment models

| Payment model | Fee-for-service | Episodic care (bundled payments) | Global payment |
|--------------------------|--|---|---|
| Overview | Each service rendered is reimbursed individually | Physician/group is given a single comprehensive payment for the complete care of the episode. | Physician/group receives a single payment to care for a population of payments, irrespective of actual services rendered. |
| Physician incentive | Higher case and procedure Volume | Higher case volume and cost saving | Low utilization of resources |
| Physician financial risk | Low | Medium | High |

thus, ASCs are in a prime position to capitalize on this larger volume of patients due to increased procedural capacity and more efficient operating rooms (5,16,18). However, without effective risk stratification of patients, the bundled payment model may in fact saddle ASCs with higher episodic costs. With CMS continually reforming healthcare payment models, bundled payments should be expected to grow in popularity as they provide an excellent compromise between incentivizing providers to render cost-effective, high-quality care, while still maintaining surgeon case volume.

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Footnote

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