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Ambulatory surgery center strategy for life sciences suppliers: shifting volume requires nuanced approach

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Overview

The migration of procedures from inpatient operating rooms to hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs) accelerated dramatically during the pandemic. As a result, life science and industry (LSI) firms must consider building an ASC strategy to partner with these outpatient sites.

After evaluating the shift, experts at Sg2®, a Vizient® company, determined that a one-size-fits-all approach was insufficient for LSIs seeking to build relationships with ASCs. As this report demonstrates, the shift to HOPDs and ASCs varies nationally by service line and even within service lines. In addition, each market and service line has varying forces at work that affect the pace of shift.

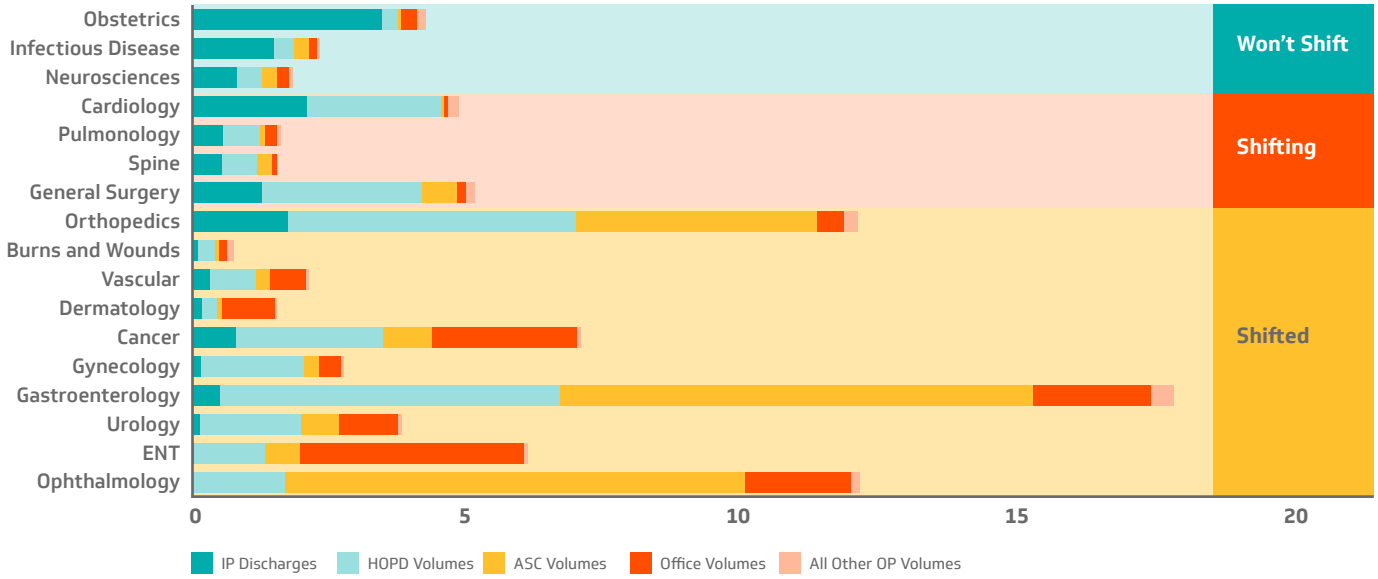
It's imperative for LSI organizations that provide products and services for shift-sensitive procedures to take a layered approach to strategy development. Such a strategy should begin by analyzing national trends and end with local market intelligence that will aid in the design of pace-related engagement approaches within each market type and service line.

Understand national trends

The pandemic accelerated the shift of several procedures from inpatient to outpatient sites of care, including ASCs — a shift that has since expanded to include additional service lines and procedures due to reimbursement changes (Figure 1).

Figure 1. Trends in outpatient shifts

2022 Procedure Volume by Service Line



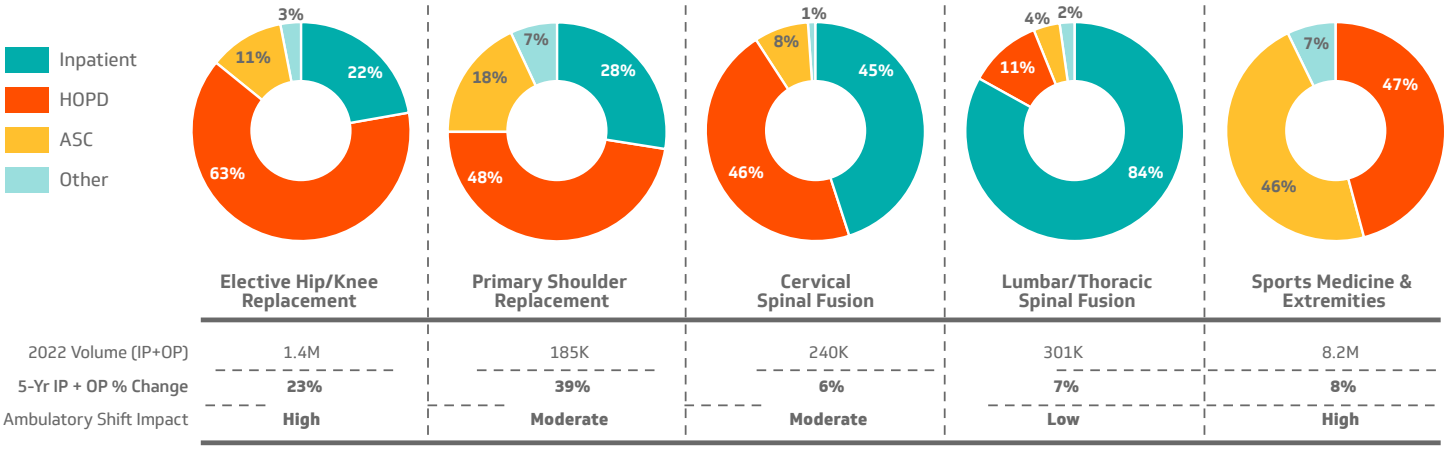
*Denotes 2020 release of the IoC forecast that includes impact of COVID-19 on service projections. This forecast uses baseline year 2019 and forecasts volumes through 2029. Note: IP procedures defined as all major therapeutic, all minor therapeutic, and diagnostics: brain biopsy and diagnostics: diagnostic catheterization. OP procedures defined as all major procedures, all endoscopy, and diagnostics: diagnostic catheterization. ENT = ear, nose and throat. Sources: Impact of Change®, 2018; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2015. Agency for Healthcare Research and Quality, Rockville, MD; OptumInsight, 2016; The following 2016 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2018; Sg2 Analysis, 2021.

Abbreviation: ENT = ear, nose and throat

Variation of procedure shift within service lines

In addition to understanding national trends around shifts from inpatient settings to ASCs, LSIs also should seek to understand how procedures within service lines are shifting to outpatient settings at different paces (Figure 2). Given the wide variation in reimbursement, payors often implement policies favoring ASCs, driving a faster pace for certain service lines (Figure 3).

Figure 2. Orthopedic and spine procedures demonstrate variation within service lines



	Elective Hip/Knee Replacement	Primary Shoulder Replacement	Cervical Spinal Fusion	Lumbar/Thoracic Spinal Fusion	Sports Medicine & Extremities
2022 Volume (IP+OP)	1.4M	185K	240K	301K	8.2M
5-Yr IP + OP % Change	**23%**	**39%**	**6%**	**7%**	**8%**
Ambulatory Shift Impact	**High**	**Moderate**	**Moderate**	**Low**	**High**

*National perspective, local considerations will impact market-level shift potential. Note: May not total 100% due to rounding; Analysis excludes 0-17 age group; Elective hip and knee replacement includes primary hip/knee replacement, and Osteoarthritis CARE Family only. Shoulder replacement includes orthopedics service line. Cervical fusion and lumbar fusion only include spine service line, all CARE Families. Sources: Impact of Change®, 2022; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2019; The following 2019 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2022; IQVIA; Sg2 Analysis, 2022. Sports Medicine is outpatient procedures only; MSKI and Concussion.

Abbreviations: ASC = ambulatory surgery center; HOPD = hospital outpatient department; IP = inpatient; OP = outpatient

Figure 3. Site of care reimbursement variation

Site of care reimbursements vary dramatically by procedure, and between sites of care (See Figure 3). For example, the reimbursement on a lumbar/thoracic spinal fusion conducted at an ASC is just over $6,000. The same procedure, conducted on an inpatient basis, yields $30,767, representing a variance of $24,545. Variances per procedure and site of care are outlined below. Suppliers should be cognizant of these variances when approaching health systems with an ownership stake in an ASC.

Procedures with highest site of care variance (office excluded)					
Procedure	**Proxy CARE family**	**ASC Reimbursement**	**HOPD Reimbursement**	**Inpatient Reimbursement Highest Variance**	**Highest Variance**
Lumbar/Thoracic Spinal Fusion	Degenerative Spine and Disc Injury	$6,222	$12,560	$30,767	$24,545
Primary Shoulder Replacement	Osteoarthritis	$1,441	$14,034	$15,745	$14,304
Vertebral Augmentation Procedures	Spinal fracture or dislocation	$3,228	$6,330	$14,259	$11,031
Cervical Spinal Fusion	Degenerative Spine and Disc Injury	$10,347	$14,148	$20,648	$10,301
Spinal Decompression/ Laminectomy	Degenerative Spine and Disc Injury	$4,013	$7,381	$14,003	$9,990
Pacemakers and Implantable Defibrillators	Dysrhythmia	$12,049	$15,331	$21,672	$9,623
Primary Knee Replacement	Osteoarthritis	$10,279	$13,907	$12,947	$3,628
Primary Hip Replacement	Osteoarthritis	$10,226	$13,746	$12,706	$3,620

Sources: Impact of Change®, 2021; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2021.

Abbreviations: ASC = ambulatory surgery center; HOPD = hospital outpatient department

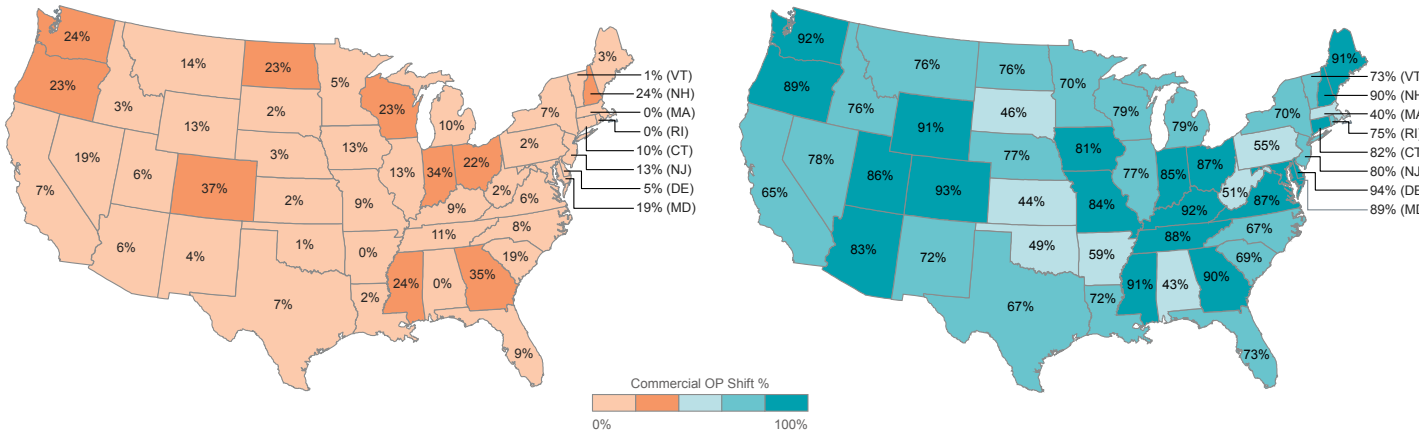
Variation within markets

The pace at which outpatient shifts occur depends greatly on the market dynamics affecting both the healthcare industry and specific procedures. Such factors include market size and projected procedure growth, payor and public policies and regulation and physician alignment. Figure 4 demonstrates the pace of acceleration that has occurred on certain procedures such as elective hip replacements due to changing patient preferences, payor requirements and regulations. (Figures 4, 5 and 6).

Figure 4. Outpatient shift accelerates dramatically in response to pandemic and after removal from the inpatient only list

Elective Hip Replacement % Outpatient Commercial Claims, 2018

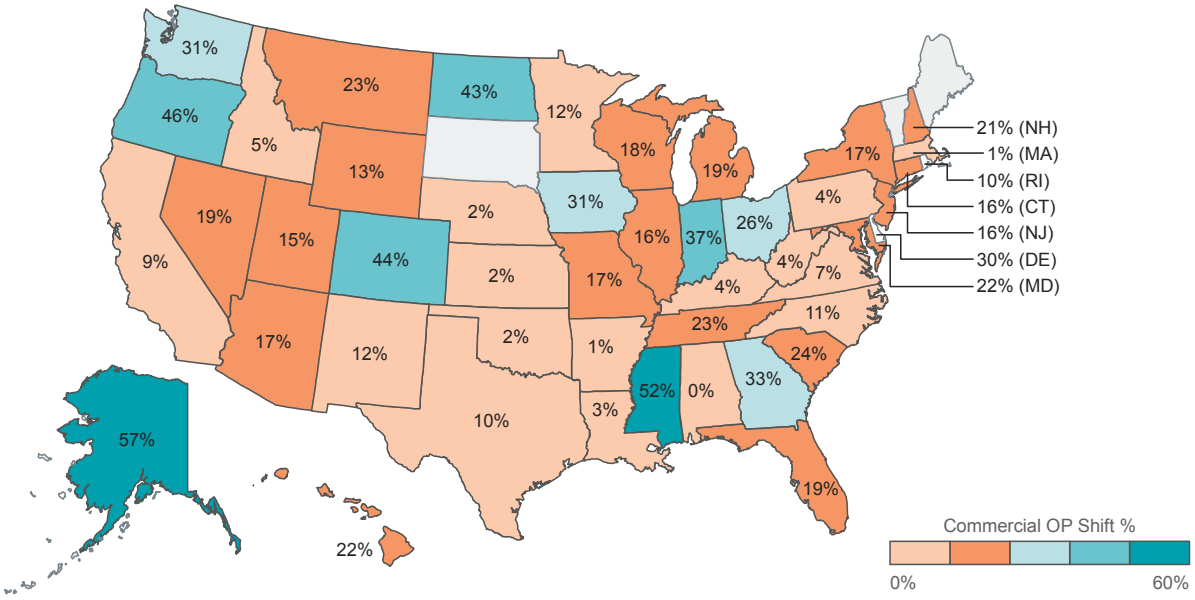
Elective Hip Replacement % Outpatient Commercial Claims, 2021 Q1-Q3



Note: Analysis excludes 0–17 age group and includes commercial claims only. Elective hip replacement includes primary hip replacement and Osteoarthritis CARE Family only. 2021 data includes Q1–Q3 data only. ASC = ambulatory surgery center; IPO = Inpatient Only. Sources: Proprietary Sg2 All Payer Claims Data Set, 2021; Sg2 Analysis, 2022.

Figure 5. Ambulatory shift opportunities require awareness of market dynamics and patient demographics

Elective Hip Replacement % ASC Commercial Claims, 2021



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Variation by service line

In addition to considerations around procedure shifts and changes from regulators and payors that drive these shifts, LSI suppliers should also consider changes to approach based on service line. As shown in Figure 6 below, ASCs serving different service lines have different needs structurally from their suppliers, depending on how mature they are in their markets, the regulatory hurdles they face and the clinical, strategic and financial pain points each ASC encounters.

Figure 6. Considerations vary by service line

Provider Pain Points	Cardiovascular	Neurosciences/Spine	Orthopedics	Optho/GI
REGULATORY—CON, credentialing and certifications	• Emerging market • State regulatory hurdles can include volume impact for cath lab and IC procedures • OBL is often included in ambulatory strategy and is state regulated	• Emerging market • Procedure-specific regulatory hurdles are minimal	• Developing market • Regulatory hurdles are minimal • SoC restrictions by payors limit what procedures can shift	• Developing market • Regulatory hurdles are minimal • SoC restrictions by payors limit what procedures can shift
CLINICAL—Physician comfort, patient selection, workforce, clinical innovation and technology	• Patient risk assessment drives site of care decisions • Staffing can impact physician comfort • Dedicated clinical staff can be hard to duplicate across sites	• Patient risk assessment and procedure complexity drives site of care decisions • Pain control and minimal sedation • Equipment in the room, implant/device costs • Post-procedure recovery time	• Availability of equipment, OR tables, robots, implants • Supply storage and costs • Size and number of rooms • Post-procedure recovery time and personnel	• Physician equipment preferences matter • Some GI patients with significant comorbidities may still belong in hospital OP setting
STRATEGIC—Physician alignment, hospital lab capacity/efficiency, consumerism	• Mostly employed physicians that work in both hospital and non-hospital settings • Largely hospital-based procedure volumes today • Hospital capacity constraints may be driver for shift to ambulatory sites	• Independent groups drive growth in ASC market	• Independent ortho groups invested • PE backing standalone ASCs • Hospital capacity and payors are driving shifts to ASCs	• PE activity is prominent • Health systems mostly working with independent physician groups
FINANCIAL—Volume, reimbursement, construction and plant considerations, supply chain	• Revenue shift out of the hospital will slow shift for some organizations • Tighter margins due to lower reimbursement and similar supply costs • Payor mix varies greatly by procedure • Supply costs and management can be challenging	• Revenue shift out of the hospital • Tighter margins due to lower reimbursement and similar supply costs • Novel reimbursement models are at play • Payor mix varies greatly by procedure • Limited set of neurosurgical procedures reimbursed in ASC	• Lower reimbursement; shifting $ out of hospital settings • Margin is often significantly impacted by implant costs • Largely commercial population	• Low margin, but high volume • Relatively low-cost plant considerations

*National perspective, local considerations will impact market-level shift potential. CON = Certificate of Need; NCDR = National Cardiovascular Data Registry. Source: Sg2 Analysis, 2021.

Tailor messaging and strategy by ASC ownership type

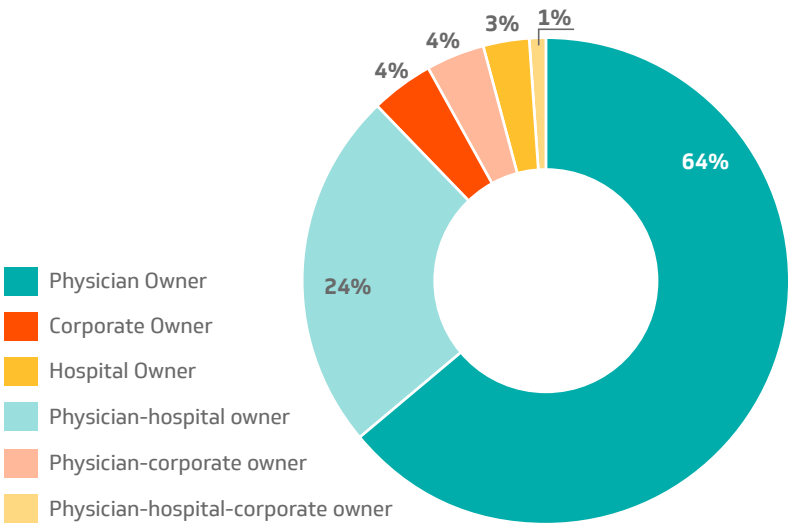
The dominating ASC ownership type also varies by market. ASCs that years ago were primarily physician-owned have evolved to ownership by both hospital and corporation-owned facilities, as well as joint ventures (Figure 7).

As such, LSI supplier strategies around partnering for success will differ, depending on ASC ownership. See the below suggested approaches for each ASC ownership type:

- Hospital owned: Determine how to plug into the value analysis process. Develop relationships with system medical staff leadership and consider an at-risk arrangement. Identify influencers versus decision-makers and determine if diversity-related strategies exist. Be transparent on supply availability. Leverage metrics on return to work, connectivity to rehabilitation and patient education.
- Physician owned: Stress value, ease of use and provider education support. Develop a strong value proposition tailored to both physicians and the operations manager. Determine how much control individual consumers have over where they go for procedures.
- Corporate owned: Focus on efficiency, throughput and national contracting benefits. For private equity-owned, anticipate who the next buyer will be and begin to build the value proposition.
- Health system and physician owned: Identify key decision-makers and align the value proposition accordingly as this may vary depending on who has budget decision-making authority.

Figure 7. ASC ownership type distributions

Percent Distribution of ASC Ownership Type



Source: A. Stewart, 64% of ASCs are physician-owned, Becker's ASC Review, September 8, 2020. L. Drydea, The number of ASCs in the US: A state-by-state breakdown, Becker's ASC Review, June 19, 2021.

How providers and suppliers form ASC strategy

Providers and LSI firms must consider both growth and market assessments when forming ASC strategies. A one-size-fits-all strategy for suppliers engaged in the ASC marketplace will not be sufficient. The migration and growth of procedures in the ASC is a local phenomenon requiring manufacturers to have a full understanding of the unique distinctions required by these settings and the physician-entrepreneurs running them. See Figure 8.

It is crucial for suppliers to think out of the box when it comes to marketing their products to ASC sites, especially when it comes to educational initiatives. For example, one major supplier of implant devices runs an ASC preceptorship program that familiarizes physicians and clinical staff with their products to ensure procedure efficiencies, the best patient outcomes and the highest profitability. Proactive suppliers will focus on customized solutions that mesh with the needs of surgeons and other ASC staff.

Suppliers that have traditionally catered to inpatient sites of care must quickly pivot and determine what the shift to ASC sites means when it comes to product design, product features, sales strategies and margins.

Figure 8. Forming an ASC strategy

For providers	For suppliers
Evaluate current case mix of procedures in IP and HOPD settings to identify opportunities and points of vulnerability	Understand the ASC ownership type and how it influences timing of ASC development
Assess the financial impact of a shift to the ASC setting	Identify market leaders and fragmentation both qualitatively and quantitatively
Measure the competitive landscape to determine the mix of current players – independent and health system	Quantify market capacity for future procedural growth, staying attuned to demand forecasts across service lines and procedures
Quantify internal capabilities supportive of ASC market entry	Gauge consumer and employer interest in lower-cost options for procedures

Abbreviations: IP = inpatient; HOPD = hospital outpatient department; ASC = ambulatory surgery center

Building a sample service line scenario: cardiovascular

When creating a layered approach to outpatient strategy, LSI suppliers must consider trends within service lines, as well as local market dynamics that could accelerate or impede the outpatient shift. An excellent example of local dynamics playing into the pace of shift is the cardiovascular (CV) service line. Following is a stepwise process to develop an outpatient CV strategy that can serve as a guide to LSI suppliers developing their own unique approach.

STEP 1: Understand national trends

Hospital capacity constraints may force more aggressive inpatient to outpatient movement in the future. While the Sg2 2022 Impact of Change® forecast shows a demand increase in both inpatient and outpatient care over the next 10 years, outpatient care growth (18%) is expected to outpace inpatient growth. The hospital forecast shows how capacity will become challenged and further push cardiovascular procedures to the HOPD and ultimately the ASC, though this will vary significantly by market.

Hospital forecast highlights

HOPD ↑ 11%

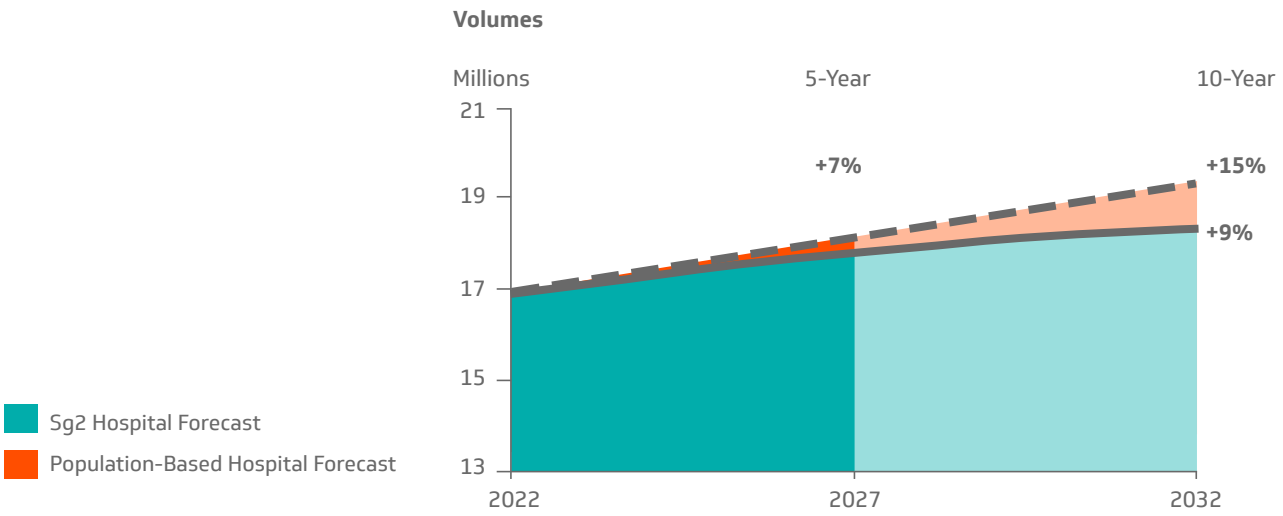
As this site remains important for key CV procedures (e.g., electrophysiology, interventional cardiology) in the short term, it will become a future source of significant outpatient volume.

IP Discharges ↑ 6%

IP discharges are set to grow due to rising complexity among chronic disease patients, primarily those with congestive heart failure (Figure 9).

Figure 9. Hospital forecast, cardiovascular service line U.S. market, 2022-2032

Inpatient Cardiovascular Forecast US Market, 2022-2032



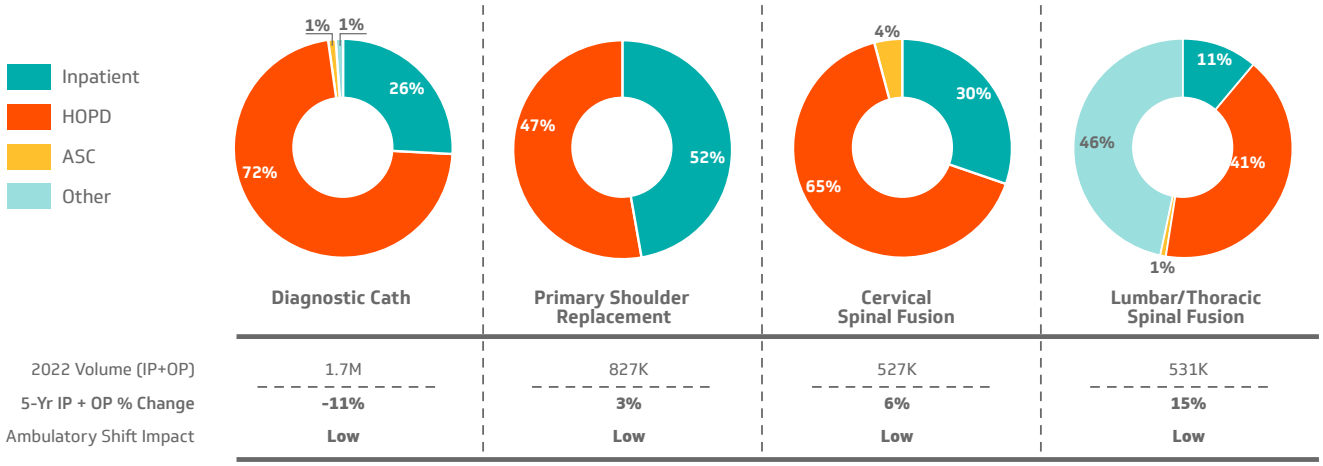
Note: Analysis excludes 0–17 age group. Sources: Impact of Change®, 2022; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2019; The following 2019 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2022; Sg2 Analysis, 2022.

V: IP = inpatient; HOPD = hospital outpatient department; ASC = ambulatory surgery center

STEP 2: Drill down to procedure and site-specific details

Assess which procedures have already shifted and where, as well as the potential for further shifting (Figure 10).

Figure 10. Care shifts differ for CV procedures



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Abbreviations: PCI = percutaneous coronary intervention; ICD = implantable cardioverter defibrillator; IP = inpatient; OP = outpatient; CMS = Centers for Medicare & Medicaid Services

STEP 3: Consider and incorporate local market factors

Including local factors will result in a site-based forecast that looks very different than a national perspective. This also will help inform the approach LSI firms take by providing insight into area challenges, stakeholders and individual objectives (Figure 11).

Figure 11. Local market factors considered by health systems

REGULATORY Certificate of need (CON), credentialing and certifications	What are local regulations and state requirements? What is the level of payor support?
CLINICAL Physician comfort, workforce, clinical innovation and technology	How are patients selected for ASC procedures? Do you have the clinical staff to provide an additional site of care?
STRATEGIC Physician alignment, hospital lab capacity and efficiency, consumerism	How will physician dynamics be impacted – both those that will and will not operate in an ASC, as well as independent and employed physicians?
FINANCIAL Volume reimbursement, construction and plant considerations, supply chain	What is the impact of moving low-risk, low complication patients from the hospital to an ASC? What are the current volumes across IP/HOPD, ASC sites?

Sg2 insight:

Some states, such as Texas and Florida, have a history of building freestanding catheterization labs before Centers for Medicare & Medicaid Services approval, and other states like Pennsylvania recently changed their certificate-of-need laws to allow for CV procedures to be performed in ASCs. Other complicating challenges include restricted capital and workforce, which are unlikely to abate for at least the next 24 months. This environment opens the door for private equity to step in and take a piece of the hospital's procedural pie.

Next steps for LSIs

As the industry consolidates and continues shuffling cases to the most appropriate sites of care, stakeholder impact across the healthcare ecosystem should not be underestimated — particularly for LSI firms providing products and services to both the acute and ambulatory marketplace.

Successful LSI suppliers must:

- Understand national trends affecting relevant procedures.
- Identify the players within a market and tailor their value proposition, building a specialized go-to-market plan.
- Stress to business development teams the importance of breaking away from a one-size-fits-all approach. ASC ownership types matter and the value proposition must support each stakeholder's goals and priorities.
- Recognize that each ASC type comes with its own politics and influencers. Identify the real decision-makers, or in the case of private equity-owned ASCs, the "next/future" influencer.

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