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THE ASCA JOURNAL | JANUARY 2025 | *ascfocus.org*

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NEW YEAR, NEW TRENDS

Experts weigh in

ASCA
Ambulatory Surgery Center Association

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Last year, ASCs continued to grow despite physician burnouts, a nursing shortage, an anesthesiologist shortage and regulatory challenges. This year, surgery centers are expected to further expand their capabilities and range of procedures, experts opine.

Navigating the Headwinds and Tailwinds of ASC Strategy

The new year brings opportunities and challenges

BY DONNELLE JAGEMAN, TONY GUTH AND JOSH AAKER

KEY LEARNINGS

- Overall ASC procedure volume will rise, but growth will not be uniform
- Orthopedics and cardiovascular procedure volumes are expected to grow rapidly
- Surgical robots can influence ASC growth

ASCs continue to demonstrate their vital role in the health system's continuum of care. The future ambulatory surgery landscape presents opportunities and challenges as ownership structures, specialties and procedure volumes continue to evolve. Physician-owned ASCs remain the most common, but partnerships between hospitals, physicians, private equity firms and management companies bring diversity to the types of ASCs operating across the country.

The US has more than 6,350 ASCs with a growing number focused on complex procedures that were historically performed in hospital settings. While routine colonoscopies and cataracts still dominate the ASC case mix, novel techniques, physician preference and changing reimbursement policy are increasing the prevalence of specialties such as orthopedics and cardiovascular (CV). Orthopedics, in particular, is expected to grow rapidly as Sg2 projects increases in outpatient knee, hip and shoulder replacements.

While the overall volume of ASC procedures continues to rise, this growth is not uniform, and it is not guaranteed for every new ASC. Regional regulatory environments, physician alignment models, population growth and local competitive dynamics have caused market disparities in ASC penetration. Also, surgical robots can reshape the future of ASCs as they accommodate more sophisticated surgeries in smaller, more efficient spaces. As the shift from inpatient to outpatient care accelerates, understanding the forces shaping ASC development is critical for healthcare organizations aiming to stay competitive.

Let's explore how market and internal assessments can help healthcare executives navigate ASC strategy, using the orthopedic and cardiovascular service lines as examples. By examining strategic, financial, regulatory and clinical considerations, organizations can position themselves in the fast-evolving ASC landscape.

CONSIDERATIONS
REGULATORY—CON, credentialing and certifications, payment policies
CLINICAL—Physician preference, workforce, clinical innovation and technology
STRATEGIC—Physician alignment, hospital capacity and efficiency, consumerism
FINANCIAL—Volume, reimbursement, construction and plant considerations, supply chain

SOURCE: SG2

Assessing the ASC Landscape in Your Market

Because each service line faces its own unique challenges, it is important to understand your organization and your market given the wide range of considerations and dynamics that impact existing or emerging opportunities. Much of the data and information that will inform your organization and market assessments will be based on the particular site of care, but below are some general considerations to look out for.

Market Assessment

- General headwinds: labor and construction cost, legacy ASC capacity, traditional robotics, hospital-outpatient department rates
- Headwinds or tailwinds: physician alignment, Certificate of Need (CON) regulations, physician preferences, capital, consumer preference, commercial payer rates
- Tailwinds: private equity, site of care restrictions, expansion of patient eligibility, innovation

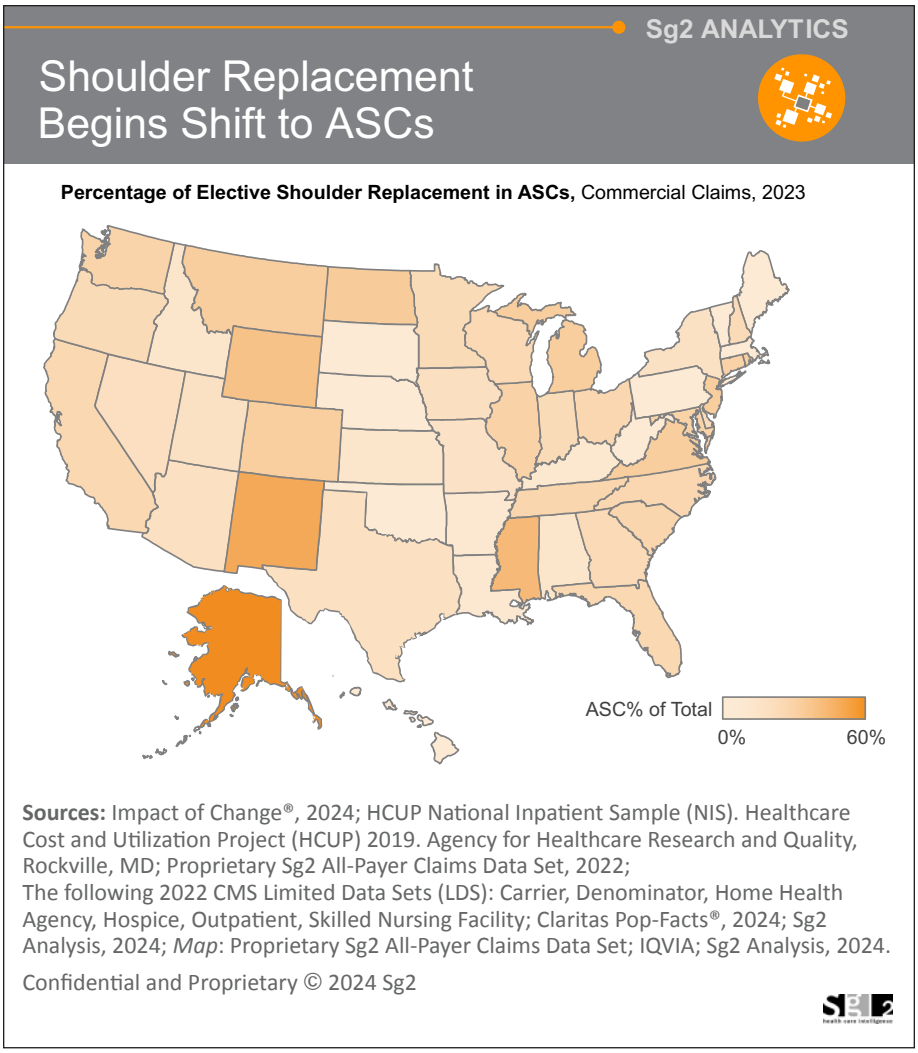
Internal Assessment

- Medical staff alignment
- Facilities
- Supply chain
- Finance and budget projections
- Reimbursement/payer contracting
- Data infrastructure
- Operations
- Clinical and administrative leadership

Your market and internal organizational assessments will guide your strategic position. There are four general positions when it comes to ASC strategy but as always, there may be caveats depending on your organization.

Strategic Positions

- Halt development: forgo initial or further investments in ASCs
- Pursue partnerships: explore physician groups, private equity, national companies
- Focus development: move forward with creating primary/initial ASC capacity or adding capacity through de novo development or partnerships
- Ongoing commitment: make intentional investments in becoming an ambulatory first organization



Orthopedics

Sg2 projects outpatient volumes for primary knee, hip and shoulder replacements will grow 69 percent in the next decade and that more than 90 percent of all primary joint replacements will occur in outpatient settings—either hospital outpatient departments (HOPD) or ASCs.

Sg2 analyzes historical commercial claims data on an annual basis; the most recent analysis, 2022–2023, showed a stalling of ASC volume growth across all three elective joint replacements: hip, knee and shoulder. Only 13 percent of commercial primary joint replacements were inpatient in 2023. The ceiling for the outpatient shift might be near; however, the ASC remains the next frontier for orthopedic and spine procedures despite potential barriers.

Two of the most influential considerations for orthopedics are the complement of existing ASCs and the national and regional regulatory environments.

In 2024, one of many barriers was eliminated when the Centers for Medicare & Medicaid Services (CMS) approved ASC coverage for total shoulder replacement. This increased coverage will encourage shift across both Medicare and commercial patient populations. The ASC penetration for total shoulder replacement varies largely on a state-by-state basis (see map above). Leading markets already perform 30–60 percent of commercial primary shoulder replacements in ASCs. Lagging markets perform none.

Spinal fusion procedural shift also stalled in 2023 with no increase in percentage of ASC volumes for commercial patients from 2021 to 2023. Cervical fusion volumes related to degenerative spine and disc injury experienced some backsliding with small decreases in hospital outpatient volumes that were reflected in increased inpatient volumes.

Several other drivers will influence how much or how little orthopedic and spine volumes will shift.

Financial: Existing ASCs

The capacity, layout and size of existing ASCs are notable barriers specific to the shift of orthopedic procedures. Originally, ASCs were not designed to accommodate complex procedures that involve large devices and the volume of trays that are required of joint replacements and spinal fusions, but new ASCs with a layout that is functional for orthopedics can be a significant capital investment. Additionally, most orthopedic robots are still located in hospital-based operating rooms, and the square footage required to house existing robotic platforms is not available in legacy ASCs. Plus, the additional costs associated with acquiring a robot and the robotic procedures will impact adoption and placement.

Robotic manufacturers are working to reduce the size and complexity of robotics to make them more compatible with smaller spaces. De novo ASCs will likely have the square footage to accommodate more equipment, staff and supplies.

With the limitations on ASC capacity, low-acuity procedures in specialties like gastroenterology, ophthalmology and general surgery that are still in the hospital are likely to transition to ASCs ahead of joint replacements and spinal fusions, given the favorable reimbursement in hospital-based settings for most procedures.

Regulatory: Certificate of Need and CMS

Even regulatory dynamics are market dependent. Certificate of Need (CON) and CMS bundled care programs

might or might not impact your market, now and in the future.

CON, although influential in some markets, is not the largest barrier to ASC shift as illustrated by the low ASC case distribution in several states without CON, including Pennsylvania, which had some of the lowest total joint and spinal fusion ASC claims in 2023. However, it is still a barrier. In states that recently relaxed CON ASC regulations, new ASCs will open in the next 18–24 months and volumes could start to shift immediately but not for orthopedics alone.

The new CMS TEAM (Transforming Episode Accountability Model) will likely encourage the shift of total joints to ASCs because the model applies to all Medicare Fee for Service beneficiaries for three different orthopedic-related procedure groups in all hospital-based sites of care, inpatient and outpatient. Sg2 projects 1.4 million lower extremity joint replacement Medicare volumes across inpatient and outpatient in 2026, 46 percent of those will be Medicare Fee for Service, and more than 80 percent are currently delivered in the hospital settings. Those volumes are projected to increase 17 percent by 2030. The burden of measuring and achieving reductions in spending and improvements in quality performance will encourage more physicians and health systems to provide this care in ASCs, instead of within the walls of hospitals. TEAM also impacts surgical hip femur fracture treatment and spinal fusions, the latter of which are also experiencing shifts to ASCs.

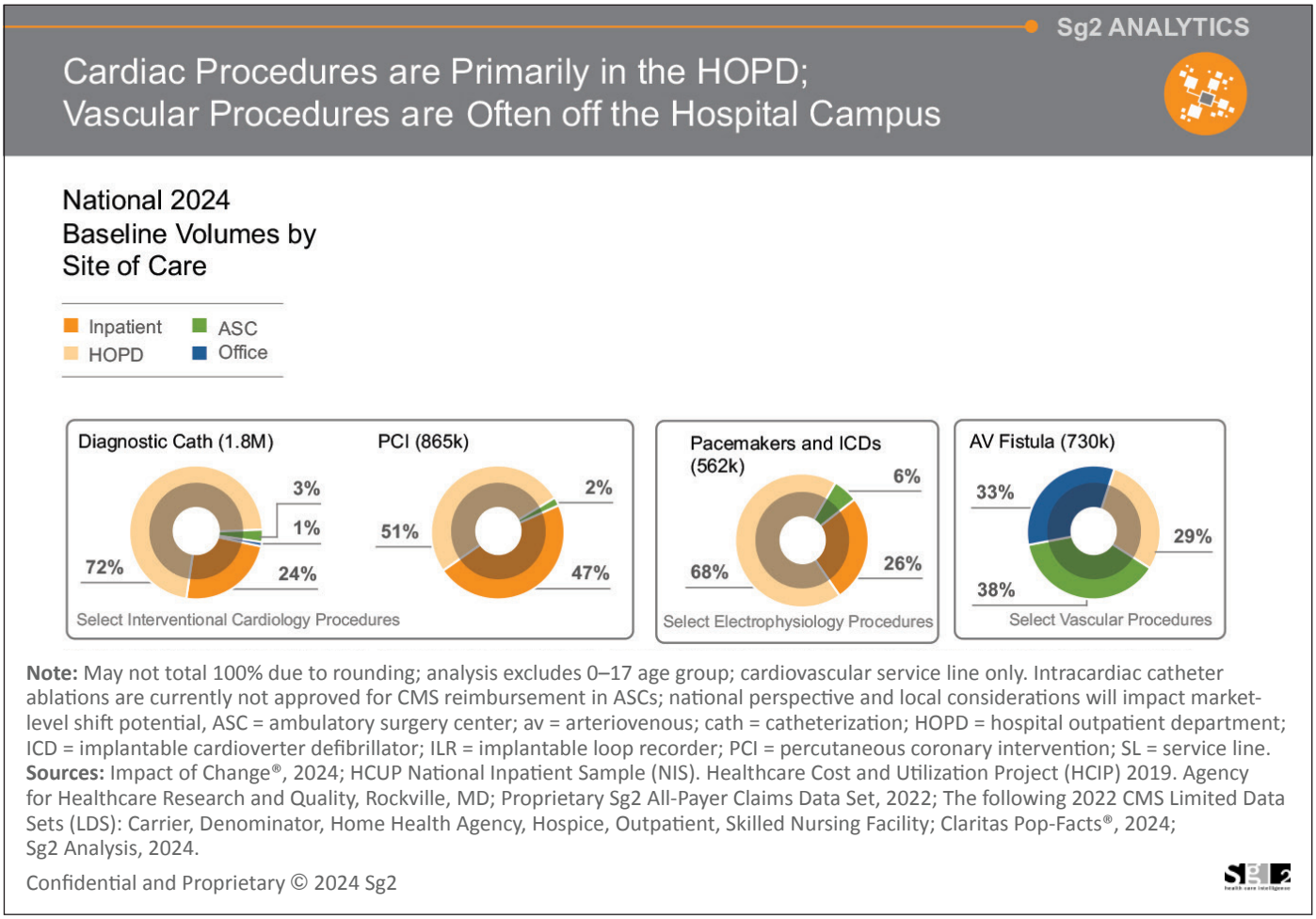
Medicare Fee for Service patient copays are capped for inpatient and hospital-based claims but not for ASCs. What does that mean for patients? For a total knee replacement, traditional Medicare patients will pay 15 percent more for an ASC procedure than a hospital-based procedure, even if it is inpatient.

Cardiovascular

Over the last decade, many cardiovascular procedures have shifted to outpatient. However, this shift has primarily been a change of status rather than a shift in the actual site of care, with the procedures and services remaining in the hospital setting. With the addition of cardiac diagnostics and interventions to the CMS ASC Covered Procedures List (ASC-CPL) in recent years, cardiovascular programs now have the opportunity to deliver procedures across multiple sites on the care continuum, such as an ASC or office-based lab. As payer support, technological advances and care redesign enable care to be delivered in lower-acuity and lower-cost settings, the opportunity to shift procedures to the ambulatory setting is top of mind. Procedures under consideration fall into multiple subservice lines, such as electrophysiology (EP), interventional cardiology and vascular services.

This shift, however, is highly market dependent. A complex combination of forces, including new clinical guidelines, physician alignment, federal and state regulations, new market entrants and financial considerations must be assessed to understand if this shift aligns with and supports the broader goals of an organization's cardiovascular program.

Health systems are looking at ambulatory sites of care to address the anticipated 8 percent increase in adult inpatient discharges and 25 percent increase in adult outpatient volumes by 2034 for the CV service line. These increases indicate a shift toward more noninvasive and fewer resource-intensive procedures that can be performed outside the traditional hospital setting. While

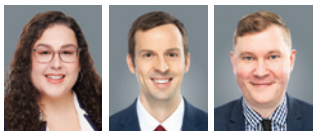


recent interest in the ambulatory shift in CV procedures has most often been about interventional cardiology procedures, a portfolio approach that also includes EP and vascular procedures involving multiple rooms can be leveraged as the case mix shifts due to local or national trends. The shift of CV services to ambulatory sites of care has already begun but is generally small in volumes nationally (see graph above). This is not isolated to ambulatory strategy—as procedures such as transcatheter aortic valve replacement move to catheter labs, exacerbating the "room crunch" and increasing the need for strategy discussions about long-term growth opportunities and challenges.

Ambulatory strategies will differ by service line, with orthopedics and CV being more like cousins rather than siblings. The high percentage of employed physicians, along with regulatory challenges, are strong headwinds for adopting CV ASCs and are different from orthopedics, ophthalmology, gynecology, etc.

Organizations with capacity challenges, however, might leverage CV ASCs as a way to channel low-acuity cases outside of high-cost/high-resource areas. The graph above demonstrates that many cardiac procedures still remain in the hospital outpatient department. While many headwinds, such as physician alignment, reimbursement, backfill strategy, regulatory constraints, etc., exist, local markets have unique opportunities to offer services. For example, in the graph above, atrioventricular (AV) fistulas, performed in the treatment of dialysis patients, are nationally evenly distributed amongst sites. Are there opportunities for your organization to drive this market? Is this an opportunity to build out a patient-centered access point for care? AV fistulas can be performed by a variety of clinical practitioners such as vascular surgeons, interventional cardiologists and interventional radiologists.

Forward thinking organizations will leverage ASCs as additional sites of care within their service line rather than a replacement. Their strategy will include seeking ways to colocate additional resources through the ASC to meet the needs of patients. Market level factors will likely be the important indicator of if/when a market would see ASC builds. «



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