Ambulatory Surgery Centers

Your Guide to Success *in Outpatient Orthopedics*

Jack M. Bert, MD, FAAOS

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Jack M. Bert, MD, FAAOS is a board certified orthopedic surgeon with over 44 years of clinical experience. He served as the chairman of the AAOS annual meeting practice management committee for 4 years and is past president of the Arthroscopy Association of North America. He is an Emeritus Adjunct Clinical Professor at the University of Minnesota School of Medicine and has published over 100 articles and book chapters in peer-reviewed journals, many of which are specific to practice management issues and implementing ancillary services and ambulatory surgery centers successfully. He has given over 150 lectures on practice management subjects in the past 35 years and has been instrumental in helping large and small groups develop ancillary services for their practices.

This book explores how to successfully develop an ambulatory surgery center and pitfalls to avoid using nationally recognized experts with significant experience in each of the listed topics.

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Introduction

The purpose of this book is to explore subjects relevant to those surgeons interested in building or joining an ambulatory surgery center (ASC) and to those groups that are considering options to improve their ASC revenue or are considering private equity relationships or ASC partnerships with large health care entities.

It is not uncommon for an orthopedic group to receive 50% of their income from their ASC revenue stream. Furthermore, the existing climate with the challenge of large health care systems controlling the market share in an area may influence the group's decision as to whether they should partner with a local health care system, consider a joint venture with another group, or consider a buyout by a private equity firm.

For those surgeons building an ASC, the pros and cons of partnering with a large health care system will be analyzed and structuring a hospital-owned outpatient department to achieve success when performing outpatient total joint replacements will be reviewed. Setting up your center to do outpatient total joints will thoroughly be discussed by surgeons who have had significant experience in private and employed practice settings performing outpatient total joint replacements and why it is critical to organize and prepare the center appropriately for these cases.

One surgeon shares his experience of choosing the wrong ASC subspecialty partners, as well as hospital partner issues with "lessons learned" and how to potentially overcome them. The pros and cons of a using an ASC management company will be explored by an ASC management company executive. Direct contracting with employers will be discussed, using bundled payments to accomplish significant cost savings. A nationally recognized health care attorney summarizes the legal challenges associated with ASCs with explanations of federal laws, safe harbor statutes, and profit allocation that must be adhered to; and the advantages of using telemedicine for ASC patients for patient evaluation will be summarized.

It is my hope that the content of this book will assist you in determining whether to build an ASC in your community with or without partners, as well as methods for existing ASC owners to increase their revenue stream and improve their market share in the future.

Jack M. Bert, MD, FAAOS

Chapter 1

The Case for Outpatient Ambulatory Surgery Centers

Jack M. Bert, MD, FAAOS

In 1991, my 4 orthopedic partners and I opened a single room ambulatory surgery center (ASC) adjacent to our clinic space in downtown St. Paul, Minnesota. We hired an operating room (OR) manager from our hospital to obtain credentialing and contracts with the payors. This was an educational process for all of us since we were the first ASC to open in Minnesota. One of my partners was a generalist, 2 were hand surgeons, and 1 was a spine surgeon. At that time, ASCs were considered "nondesignated health care services," so the Stark Laws did not apply with respect to profit allocation base upon productivity. We all shared 50% of the net revenue for the ASC equally, and the remaining 50% was divided based upon case net revenue per individual surgeon. As a result, every surgeon was incentivized to do every single one of their outpatient cases in the ASC. Since the preoperative area only had 3 beds in it, it also served as the postoperative recovery area. Each patient was separated by a curtain. The ASC had a separate entrance and patient waiting room. Because the ASC had a private entrance at the end of the hall clinic area, a typical day for me was to begin a case at 7:30 AM (usually finishing by 8:15 AM) and then simply walk down the hall and begin seeing patients

while my PA closed the skin, placed the appropriate dressings, and assisted in turnover for the second case. I usually began the second case by 9 AM, finishing by 9:45 AM, then would see another 5 patients or so and begin the third case at 10:30. Then I would return to clinic and see another group of patients thus totaling about 20 patients for the morning finishing the fourth outpatient case by 12:30. We scheduled our last case at 3 PM, and our hand surgeons had no problem doing 3 to 4 cases in 2 to 3 hours.

We had originally asked the hospital if they wanted to become partners with us prior to building out the ASC, but their attorneys told hospital administration it would be a "conflict of interest" to do so. After we were up and running and the hospital (which was connected to our building by a skyway) realized that they were losing virtually all of their arthroscopic procedures and other outpatient cases, their attorneys recontacted us and told us they were "mistaken" and would like to resume talks regarding a financial relationship. Needless to say, we respectfully declined. We had become financially successful and our operating efficiencies, with the ASC being adjacent to the clinic, dramatically improved. I would often do 4 knee arthroscopies in a morning, see 20 to 25 patients, then do 2 total joint replacements in the afternoon at the hospital and be home easily by 4 PM.

I performed an outpatient unicompartmental arthroplasty (UKA) on a 60 year old, healthy, asthenic female in 1993. I coded it as a total joint replacement and received a facility fee reimbursement of $1200. When I appealed it, Blue Cross said there was not a facility fee reimbursement or code for doing a total joint arthroplasty at an ASC. The reimbursement fee that I received did not even cover the cost of the implant and they denied my appeal, despite a lengthy discussion with the claims department and peer reviewer regarding the savings that would occur if I began doing my UKAs in this fashion.

As our group grew larger, we continued to expand and built a larger, 2-room ASC one floor below our clinic, and also partnered with a large health care system to build a second ASC in a suburb of St. Paul—with the understanding that we would own 50% of the ASC and receive an 8% management fee. Our board of directors in this project consisted of 2 administrators from the hospital system and 2 surgeons from our group, and any decision required a majority vote to approve any changes to the

operation of the center. The only advantage of this partnership at that time was that the health care system employed over 150 family practitioners who were part owners of the ASC. and the family physicians were employed by the health care system. Thus, they were incentivized by the health care system to send all of their orthopedic referrals to our group.

There are currently over 11,000 ASCs in the United States and over 150 ASC corporations. Less than 1% of these have failed. Some of the most common ASC issues that need to be addressed are as follows:Overbuilding and overstaffing. A market and payor analysis is critical to avoid having this issue. Understanding the environment that you practice in will assist in determining the size of the ASC. Groups often just open a 2-room center with the ability to expand their footprint in the building as necessary.

Building an ASC in a highly competitive market. Large health care systems are able to drive patients to their employed orthopedic surgeons. If your group has a mature practice, collect your Explanation of Benefits (EOBs) requested from your patients and see what the reimbursement for cases to the hospital is—understanding that the reimbursement to the ASC in most cases will be at least 40% less. Discuss with your major payors what your plans are and make certain that they will reimburse surgeries performed at the ASC. Payors are usually receptive to this type of discussion, because for them it's all about money saved with appropriate care that yields satisfactory outcomes. Hospital systems may exert pressure on the payors, but remember during initial payor meetings that payors define quality as outcomes/cost. If your outcomes remain the same as hospital outcomes at a lower cost, then your quality of care actually improves in the payor's mind.

Choosing partners who are inefficient is a significant problem. For example, the surgeon that does 2-hour routine meniscectomies and/or 4-hour total knee replacements. These surgeons will always be a problem and this needs to be recognized prior to allowing the surgeon to be part owner or a become a staff surgeon of the ASC. This type of surgeon may actually result in reducing ASC revenue when performing a case due to the length of surgical time, staffing expense, and equipment necessary to complete the surgery. The best way to determine which surgeons fit in this category is to have a private discussion with the OR manager at the hospital (or the scrub and circulating nurses at the hospital) regarding a

surgeon's efficiency. Obviously, this has to be done in a nonthreatening manner and should be done discretely with nurses whom you have a good relationship.

Choosing partners who have low volume practices is also an issue. These physicians typically bring relatively few cases to the ASC because they see fewer patients. Thus, a common complaint from the other high-volume partners is that these physicians are receiving a similar financial distribution with limited involvement in the ASC.

Choosing the wrong subspecialty partners with low case reimbursement. The classic example of this is obstetrics and gynecology where, thru no fault of their own, they are unable to determine case costs or the length of time that a case will take prior to the procedure. This type of subspecialty can completely disrupt the schedule, especially if they are the first case of the day. Furthermore, before offering partnership to any subspecialty you are unfamiliar with, find out what their reimbursement per case is and what their payor mix is. This analysis should be done with **all** prospective partners.

Partners who are habitually late or are difficult for the staff to work with. It is critical to have the ability in the partnership documents to address this issue. For example, if the physician is late for a case, he receives a warning. If the physician is late twice in a quarter, he can be placed on probation. If he continues this behavior, he can lose his ownership interest in the ASC. Dealing with disruptive and disrespectful physicians must be dealt with in the initial partnership agreements as well. This must be documented in the partnership documents when opening the ASC to avoid expensive and prolonged litigation when the partner objects to the repurchasing of his ASC shares at market value of his ASC shares if he is terminated from the partnership agreement.

The best partners are predominantly orthopedics-related and pain control physicians. This would include hand surgeons (plastic or orthopedic), podiatrists, and spine surgeons (orthopedic or neurosurgeons). Ophthalmology and plastic surgery can be cost effective, however the Medicare reimbursement for ophthalmology is often extremely low unless they utilize an additional "cash based" aspect of their practice when performing cataract surgery for specific implants, part of which can be allocated to the ASC partnership. Despite an efficient surgeon desiring to join the center, as noted previously, his payor mix and reimbursement

should be reviewed. It is important when looking outside your group to know if these surgeons are efficient, which is the key to success in an ASC. Furthermore, as the group decides to perform outpatient total joints (TJAs), these patients absolutely need to be optimized prior to making the decision to perform the case in the ASC even if there are overnight rooms built into the ASC. Aggressive surgeons performing TJAs on obese, diabetic, and/or patients with other co-morbidities must be carefully monitored by the ASC's medical director to avoid a repetitive pattern of postoperative complications and admission to the hospital as a result of poor patient selection and lack of preoperative optimization. Pain control, usually by an anesthesiologist trained in epidurals and facet joint injections, can be a significant source of ancillary revenue for the ASC.

Consider joining forces with other groups in your area. If you are part of a smaller group (5 or less) consider creating a joint venture for the ASC. This involves a significant amount of due diligence (for the reasons discussed previously) to make certain that the other groups' surgeons meet the same case volume and efficiency requirements that you have determined for your own group. If the groups enjoy working with one another in the ASC, they can form a "divisional merger" that only requires a common provider number and common pension plan. These are inexpensive to establish and, if the arrangement does not work, can be quickly dissolved. Regardless of whether a more formal relationship exists between the practices, ie, a divisional merger or full asset merger, the joint venture can still exist. Remember that once fixed overhead for the center is achieved, variable overhead is significantly reduced and profit margins increase dramatically based upon case volume. Thus, the greater number of surgical cases (when efficiently performed with reasonably good profit margins) result in a greater revenue stream and profitability.

It is critical to have an attorney that specifically deals with contracting and health care law. The contracting attorney should be aware of the various health care laws that apply to ASCs, as well as the partnership and operating agreements and bylaw requirements of the ASC.

ASC corporations (management companies) that partner with ASCs have literally made billions of dollars managing ASCs. Their "pitch" to the surgeons is that they have better access to payor contracts and can

assist in finding a manager for the center. In return, the ownership percentage of the ASC management company varies between zero and 51%. Once the ASC is up and running, the passive income that these management companies receive is significant and is solely a result of the work product of the surgeons. There are some ASC companies that simply "manage" the ASC and receive a monthly management fee. They work on an hourly basis to do the initial contracting and credentialing and do not own any part of the center. We did not use a management company and hired an OR manager who we tasked with the job of credentialing the center and contracting with payors when we built our original centers and expanded them. This originally took the management team between 3 and 6 months for each center, and as our group grew, we simply added more inhouse employees to service the center's needs, including compliance, billing, and collections, and did not utilize the services of a management company. The groups that have done this receive 100% of the ASC revenue. If you decide to partner with an ASC company, be prepared to negotiate the amount of ownership and/or management expense before finalizing any agreement. Some ASC companies may be willing to assist in building the center, obtaining payor contracts, and providing management services in an "a la carte" fashion. Seriously consider this type of company to avoid regretting a relationship with an ASC company that has a more significant, permanent ownership position that you may regret in the future .

Chapter 2

Principles of Surgery Center Partnerships:

One Surgeon's Experience

Jason Lucas, DO, FAAOS

ASC surgical care is increasing exponentially with lower costs, higher productivity, and excellent outcomes, and has recently influenced the medical field markedly. The development of ASCs is also rising—with the opportunity for surgeons to provide outstanding surgical care while being financially invested. Surgeons who invest in an ASC have the potential for greater quality of care since they own the business and are responsible for outcomes of care. A critical step in creating a successful ASC is finding the right clinical partnerships that are developed for the center.

Many ASCs have a variety of partnerships allowing surgeon participation with these investors. Hospitals or medical and business companies commonly jointly venture with surgeons and provide capital, while periodically overseeing the business model of the ASC. These joint ventures are beneficial to the partnership, both in patient care and financial productivity, because all parties are invested in the outcomes. Together they work to achieve best patient outcomes, cost containment, staffing models, and quality.

One aspect of successful partnerships in ASCs is having a majority owned, surgeon-led center. This type of ASC involves having surgeons from a variety of surgical fields join the partnership. The ASC considers the surgical subspecialities appropriate for outpatient surgical procedures in their community and recruits them to join the partnership to provide outpatient high quality care. As part of the recruitment process, each surgeon should consider the best partnerships and practices, since not all surgical subspecialty fields are appropriate for efficient outpatient surgical procedures. Some surgical partners are more invested in the ASC and will thrive in the outpatient surgical setting. However, this is not true for all surgical subspecialties. It is critical when establishing an ASC partnership that one considers and realizes how critical selecting the best partners is for the success of the ASC.

My experience with our ASC has been educational. Our current ASC was created 24 years ago to solve the issues of delays and slow turnarounds at our local hospital. All efforts had been utilized for positive changes at the hospital, but it was to no avail. The hospital could not provide enough rooms, equipment, and/or staffing for the surgeons. The surgeons wanted to control the overall business model of an ASC and created a 60% investment for themselves and 40% ownership for the hospital. The primary surgeon owners were altruistic and felt this was best for the community to have combined ownership with the hospital. The partnership agreement allowed the hospital to share information, equipment, and staff with the ASC—while also allowing employed surgeons to work at the ASC. This model worked for a decade with a benevolent hospital CEO who appreciated this "united" medical community. Both the private and employed surgeons benefited from an efficient ASC.

Over time, with the transition of CEOs, dramatic changes occurred with the hospital/surgeon partnership. Hospital CEOs focused solely on the needs of the hospital and eliminated a shared vision for the medical community. Currently, the hospital does not provide any services, staffing, or employed surgeons for the ASC. They are an investor who reaps financial benefits of the ASC, while stating that they do not compete with the surgeons who practice at the facility. The current partnership of surgeons at our surgery center strongly agrees that reducing the hospital percentage of ownership is appropriate and also feels strongly that the competition is healthy with the hospital. This partnership is

strained at best and could have been avoided with more foresight in evaluating the future of the ASC and the medical community.

When surgeons in our community were asked to join the ASC originally, a united community plan was felt to be opportune. Each surgical practice was invited to participate, including orthopedics, podiatry, ophthalmology, ENT, plastics (hand), Ob/Gyn, urology, and pain management. This community of surgeons were asked to perform the majority of their outpatient surgical cases at the ASC, with inpatient and some outpatient surgical care at the hospital. The focus of the ASC over the past 2 decades has been to provide high quality care in an efficient environment. Cost containment and overseeing the business model and financial outcomes has been reviewed by the surgeon partners, monthly by the board, and semi-annually by all the surgeon partners. The surgeons' original desire was that the ASC would succeed with respect to high quality, efficient patient care as well as financially.

Each surgeon originally invested by purchasing a set priced share and then would receive a semiannual distribution based upon the shares that they owned. All of the community surgical groups were invited to join and invest. Because of the cost to build the center and the need for more investors, anesthesiologists were invited to invest and have been partners for the past 24 years. After the primary purchase of shares was completed, ASC center shares could be purchased from a resigning or retiring surgeon. This avoided dilution of share values.

Another option used was the dilution of shares or creating more shares to add to the overall investment. When new surgeons entered the community, shares would be made available to them, which added their services and overall financial profits from their surgical procedures. This worked very well when a surgeon would arrive participate and bring surgical cases to the ASC. However, there was also the risk that a new surgeon would not be as invested in the ASC and share distribution was diluted rather than increased due to lack of bringing cases to the ASC. Evaluating a potential partner's competence and willingness to bring cases to the center, as well as work efficiently, became critical factors in the surgeon recruitment process.

Dilution of shares has challenged the busy, efficient, invested surgeons compared to those who did just enough work to avoid violating the "1/3 rule" and yet still receive a significant financial distribution.

One surgeon thought that if all partners invested and purchased 6 shares each, then that would provide an incentive for higher work production. This assumes that the surgeons would be invested and create the best possible clinical and financial outcomes for the ASC owners. In this current, real example, compare a urologist who provides limited volume of cases (and even worse financial reimbursement) obtains 6 shares. In this example a urologist has a 3% total case volume and 2% total reimbursement to the center. An orthopedic surgeon provides 9% total case volume and a 22% total reimbursement to the center. Both have 6 shares and receive equal financial distributions semiannually. The partnership is strained by unequal distributions that were developed in the original bylaws. Unfortunately, this concept has failed miserably, with several partners who received the largest number of shares providing the least amount of work effort.

In this partnership model of surgical subspecialities, it became apparent shortly after the opening of the ASC that certain specialties did not perform as well both in terms of case efficiency and profitability as others. Thus, the selection of surgical partners is critical to the success of an ASC, especially in a community where surgical cases can be performed at either a hospital, hospital outpatient department, or ASC. Certain surgical specialties behave and perform extremely well, especially in terms of their return on investment. In a comparative review of financial outcomes at our surgical center, "orthopedic surgeon A "performed 14% of the financial revenue, "orthopedic surgeon B" performed 12%, and "orthopedic surgeon C" performed 11% for a total 37% of the total financial revenue—while each invested and received 6% of the semiannual distribution. In comparison Ob/Gyn A and B each contributed 1% of the financial revenue, while Ob/Gyn C contributed 0.79% of the total revenue. The Ob/Gyn "A and B physicians" each owned 3 shares and "Ob/Gyn C" owned 2 shares and thus each received 2.5% to 3% each of the semiannual distribution for a total of 8% of the total annual distribution while providing only 2.79% of the financial revenue. The Ob/Gyn group received 8% of the distribution, but only provided less than 3% of the total financial revenue; while the orthopedic surgeons provided 37% of the total revenue but received only 18% of the profit distribution. The orthopedic surgeons thus were doing the majority of the cases, but did not receive an equivalent financial reimbursement.

The Ob/Gyn surgeons stated they would consider doing more cases at the surgery center if they were able to purchase more shares. They wanted the same number of shares as the orthopedic surgeons, despite doing fewer cases. Other reasons besides financial concerns for avoiding partnership with Ob/Gyn surgeons is their desire for more expensive equipment. They also wanted newer, more costly equipment and they have an inability to determine their case times which greatly affects the efficiency of the center.

The Ob/Gyn reimbursement is also lower than orthopedic surgery and other surgical subspecialities. Their outcomes and quality were satisfactory, but they did not exhibit the same motivation for case efficiency—as well as a commitment to bring all their cases to the ASC. The staff appreciated the variety of cases from the Ob/Gyn surgeons, but the complexity of their cases resulted in longer case turnover and staff understanding of more complex equipment. In this example, Ob/Gyn was our most challenging partner, however, this conclusion was also true of other surgeons and surgical groups who were without the commitment and vision of those leading the surgery center.

In the operating agreement of the ASC (as determined and voted on by the membership) there is a bylaw to remove any surgeon with or without cause from the center as an owner with repurchase of their shares. This bylaw is used for multiple reasons, including poor behavior, lack of commitment to the surgical center, financial expense or "burdens." This bylaw would require a 67% vote of the members and does not need "cause" to be implemented. The bylaw was enacted and removal of the Ob/Gyn group was completed. This created some animosity in the community between ASC surgeons and the Ob/Gyn group. However, the united front of community surgeons had already evolved due to lack of ASC support by the Ob/Gyn group. In retrospect, it would have been better to partner originally with surgeons who had similar goals and work efficiencies.

There is a difference in outpatient case load, surgical time, and reimbursement between orthopedic surgeons and other surgical subspecialities, especially with Ob/Gyn and urology. Orthopedic surgeons including hand surgeons, podiatrists, and ophthalmologists seem to have similar goals which is to provide high quality surgical care in an efficient manner. The critical step in the partnership is deciding who will participate and provide excellent outcomes at the center.

Currently, our ASC consists of orthopedic surgeons, podiatrists, plastic (hand surgeons), ophthalmology, ENT, and urology. The four orthopedic surgeons currently provide 53% of the total revenue to the facility and, with recent changes in share purchases, there is improvement in share ownership and they now collectively receive 43% of the total profit.

The current mission of the ASC is to provide the highest standard of quality surgical care, while respecting and understanding patient needs. The ASC mission initially needs to focus on knowing which surgical partners should participate in ownership of the center. These guiding principles include quality of patient care and surgical outcomes, respect toward the patients and staff, cost containment for the patient and surgery center, financial reimbursement, appropriate block utilization and future investment with recruitment, leadership, and committee, as well as meeting attendance. When selecting a partner, a surgery center should focus on these principles, while evaluating the overall cost and financial reimbursement involved in the partnership. Not all partnerships are created equal, but it is critical to choose partners that have similar principles for success for the ASC.

Chapter 3

The Pros and Cons of Using a National Ambulatory Surgery Center Management Company

Traci Albers, BS, MBA

Managing an ASC requires a depth and breadth of knowledge that can be difficult to find and sustain. Many ASCs are managed by a working administrator. This person is required to have the requisite knowledge to manage all aspects of the ASC, yet at the same time be intimately involved in the daily operations of the ASC. This can be difficult to do, and many times this structure does not allow enough time for this person to accomplish everything required to optimize patient care, drive value, and deliver the financial results expected of the shareholders.

Partnering with a reputable, experienced national management company allows the local leadership to support day-to-day operations while at the same time having a partner with the depth and breadth of experience to optimize ASC success. Management companies can not only develop new *de novo* projects, but also are adept at managing and financially rescuing failing ASCs and enhancing surgery centers that are already in operation.

Case Volume Growth and Physician Syndication

ASCs are successful for several reasons, but the primary driver of ASC success is case volume. An advantage in partnering with a management company is their experience in the recruitment of new physicians, especially in a de novo project. Prior to onsite leadership being hired, a company can help recruit new physicians both to work at the ASC and also to invest in it. The management company will have experience in developing feasibility studies that are needed for assessing the financial viability of the ASC and, if that proves to be positive, they are needed to syndicate the center. In addition to the feasibility study, an operating agreement, private placement memorandum (in some cases), and subscription documents are also required. The management company will have experience with this process and can prepare necessary documents that will be needed for syndication and recruitment. Even after opening the ASC, a third-party company can help recruit new doctors and, if they have other ASCs in their marketplace, they will also have a good understanding of local market dynamics that may be helpful for the success of the center.

Payor Contracting

One of the most significant benefits of partnering with a national management company is access to their payor contracting staff, who have experience negotiating rates at a national level and havendemonstrated success through those contracts. What separates the local ASC leadership and the management company payor contracting staff is that the ASC management company staff will have multiple connections across the country with the different payors (e.g., UHC, Anthem) and will have access to payor rates across many different markets. This knowledge allows the management company to negotiate the best rates for the ASC and understand how that compares across other markets and ASCs. The payors also recognize that they are negotiating with someone who has experience and access to other state and local rates. They are less apt to propose lower than market contracts. In addition, many ASCs, due to their size and structure, may not have the team in place to run payor

analytics to understand the impact of the payor proposals. Just as volumes drive the success of an ASC, negotiating the best payor contracts to optimize ASC revenue is critical. It is exceedingly difficult to increase payor rates if you have accepted poor contract reimbursements from the beginning.

Revenue Cycle

Once the management company has successfully negotiated strong payor contracts, ASCs need a team of experts to ensure they are collecting the contracted rates in a timely manner. ASC coding and billing is different than the physician practice and hospital billing. The management company will have experienced ASC coders, billers, payment posters, and other billing staff with their sole focus on the ASC. They will understand the processes necessary to ensure prompt payment, validate payments to actual contract rates, and provide the necessary follow up. A key benefit if you are partnering with the right company is that all of their coders are certified for the ASC. In addition, management companies will be able to provide analytical reporting on revenue cycle metrics that not only provide facility-specific data but also benchmark results against other managed ASCs. A competent qualified management company will provide the benchmarks for days in accounts receivable (A/R), A/R over 90 days, time from case performed to claim submitted, time from claim submitted to payment, "clean" claim rates, and other key metrics to validate their performance.

Expense Management

Strong case volumes, excellent payor rates, and quick collection of cash on accounts positions the ASC for success. An ASC will also benefit from a management company to manage expenses. The two biggest expenses in an ASC are staffing and supplies. While a management company cannot affect the local compensation market, the company can provide best practices to staff your ASC most efficiently. The best management companies will also monitor and audit your staffing patterns to ensure that you are operating your ASC optimally. Metrics like staff hours per case and full-time equivalents (FTEs) will continuously

be monitored and provided. In addition to staffing efficiencies, you will also see the benefits with supply savings. Most management companies will participate in a larger group purchasing organization (GPO) and potentially even a larger collaborative to achieve the lowest pricing. ASCs that are part of these companies can participate in these programs, and many times benefit from additional aggregation of supply spending across all of the managed ASCs. Another significant advantage is having your management company negotiate on your behalf for the greatest savings. Because of their knowledge and awareness of other contracts across other ASCs, they will have access to benchmark data to help the owners negotiate what they know to be reasonable supply costs with the vendors.

Service contracts are another area where management companies can help an ASC. Many times, they negotiate service contract rates that their partner ASCs can access. Several examples where ASCs may achieve better pricing through aggregated spending might be with practice management and electronic health record (EHR) systems, employee education platforms, linen vendors, collection agencies, biomedical agreements, and other service agreements that are needed. Not only is access to best pricing critical, but the management company may have legal counsel to help review contract language and/or a team of experts to help review contracts for optimal language and key points that will be important to include or exclude.

Best Practices and Templates

For many ASC administrators, time management can be challenging with the competing priorities when operating an ASC. The management company can alleviate some of those issues by also providing policies and procedures, forms, templates, and best practice documents so that the ASC administrator and team do not have to create their own. This information can be purchased from numerous services as well, but this is typically an added benefit provided by the management company. In addition, the company will keep ASCs apprised of changes in regulations, accreditation standards, and/or other changes pertinent to the ASC. It is like having your very own ready-reference available to you

with not only the updated changes, but the policies and templates required for implementation.

In addition to the policies, documents, and other templates provided by the management company, the management company will also provide best practices for the ASC to implement. Rather than the ASC having to navigate through multiple process changes that may not work, management companies can share best practices they see at the multiple ASCs that they operate; whether it's best practices for front-end collections, employee onboarding, or any number of other aspects of the ASC. These best practices come from other partner ASCs, which is another network of resources and support that some independent ASCs do not have. Being part of a management company gives you access to other peers to network with and develop a relationship.

Leadership Succession Planning and Transitions

A significant benefit often overlooked when engaging a management company is their help with leadership succession planning. If an administrator leaves, the management company can step in to help mitigate any gaps in leadership. They will ensure processes remain and staff members have a resource during that time period. This can impact not only the staff but also the physicians and require the physician owners to assume a more active role in management during that time. It can also be easier to recruit administrators for the ASC because the prospective candidate likes having resources and support from the management team. If someone is inexperienced, management companies typically have thorough onboarding and mentoring available to guide this person. ASCs without management company support must seek out their own resources and network. With the changing workforce and individuals not staying as long at one job, it is critical to have a deeper bench available to the ASC through the management company. Lastly and more importantly, strong, competent leadership at the site-level is imperative to the success of the ASC.

Other Expertise and Resources

With the prevalence and importance of technology in the ASC, national management companies have experience with various software platforms that not only can be offered to partner ASCs at discounted rates but are also already vetted for the ASC. Examples of software platforms include a practice management system, an EHR, credentialing software, payroll software, and other technology that is needed or may enhance the efficiency of the ASC. In addition to the negotiated rates they can offer, they will also be able to support your implementation with best practices and additional resources. Because of the multiple systems they have implemented they can guide you on what to do, as well as the importance of the decisions, and how best to optimize your software. If a center has never had this experience, it will be critical for the successful implementation.

Other areas where an outside management company will offer support includes clinical operations' expertise, human resources and compensation support, regulatory guidance and compliance, information technology support, financial reporting, accounting functions, operational oversight and accountability, and leadership mentoring and guidance. These are invaluable benefits that are offered to stand-alone ASCs with limited resources and experience. As part of many ASC management company platforms they also offer benchmarking and reporting capabilities. Many companies will offer financial and clinical benchmarking for measuring ASC performance, in addition to required reporting ranging from monthly financial reports to quarterly net revenue and case costing reports to state reporting requirements and other reports to guide operations and the financial success of the ASC. Much of what is offered is then shared through annual education events hosted by the management company. Education and learning are a key service offered through national management companies that allow for networking and ongoing education.

Joint Venture Third-Party Intermediary

For those ASCs who are part of a joint venture between a hospital and a physician group or an ASC with many independent physician

partners, the management company can serve as the third-party intermediary to help manage the partnership relationships. There can be challenges in aligning goals with all partners and the management company can play a critical role in helping manage those relationships, provide unbiased third-party feedback in the best interest of the ASC, and ensure that the partners remain committed to the ASC. Managing an ASC not only involves technical expertise, but also experience in managing those relationships, engendering support from all partners and creating a value-added experience for all partners involved in the ASC.

Common Concerns

When ASCs are evaluating a partnership with a management company, common expressed concerns include the fees paid to a third party company, request for ownership in the ASC, mandated practices and standardization to management company principles, and loss of control from the local physicians and partners. These are legitimate concerns that should be addressed by any management company being considered.

As it relates to the fees paid to a management company, there are industry benchmarks for typical fees for both full management and revenue cycle services. According to the 2022 VMG Health's Multi-Specialty ASC Benchmarking Study, the average management fees paid are 4.8% of net revenue. In addition, you can expect to pay an average of 2.4% of net revenue for billing services from the management company.[1] There is a range in fees for both management and revenue cycle ranging between 3% up to 6% of net revenue. Another reference to help you assess management fee structures is the HealthCare Appraisers ASC Valuation 2018 Survey. They look at various management fee structures and options ranging from minimum management fees, sliding scale management fees at risk fees, and factors influencing the magnitude of the management fee (e.g., revenue, profitability).[2] Many ASCs believe they can provide all of the services and expertise inhouse that a management company can provide. Take the time to analyze what the staff and resources will cost to bring inhouse and then fairly evaluate if your ASC has the depth and breadth of knowledge and experience that a management company can provide. In most cases, and if evaluated fairly, it will be difficult to justify bringing all services inhouse and obtain the same level of experience, knowledge, and necessary redundancies.

Many management companies will request ownership in the ASC and in some cases will require majority ownership. The concept of all parties having an ownership in the ASC does align goals and incentives; but one could argue that your ASC management company, if they have any ownership, should only have a small ownership interest. The ASC management company should not have a majority interest in your ASC for the following reasons: they are not the ones bringing cases to the ASC; long-term physician partners become resentful of the management company taking distributions from the ASC in addition to management fees; if the management company is not the right fit for your ASC, it is more difficult to break ties with them if they have significant ownership; and if your ASC is a successful ASC and/or has potential for improvement, a management company will benefit through their contract fees and not require significant or any ownership whatsoever. The goal should be for the physician owners to maintain majority control of the ASC where applicable and not the management company.

Another common argument for not using management companies is the loss of control at the ASC level. This is where due diligence is exceptionally important in selection of a management company. Reference checks become imperative, because not all management companies require standardization and they are flexible in working with an ASC. The ideal management company should partner with you to provide best practices and sound advice, but it is the ASC board and leadership's discretion if they choose to implement those recommended strategies. In many cases, ASCs will adhere to the advice of the management company, but there may be times when it might not make sense due to unique reasons for that particular ASC, and those wishes should be upheld.

The most common frustrations from ASC's when they want to sever their management company relationship are: the management company is not delivering on the promises or value they sold and the amount of their investment surpasses the value they are provided to the ASC. Both of these are legitimate concerns and can be mitigated if you go through a thoughtful process when selecting a management company, in addition to defining terms in the agreement that address key deliverables.

Considerations When Choosing a Management Company

When you have seen one surgery center, you have seen one surgery center. Surgery centers have similar specialties, similar processes, and many other traits that are similar; however, no center is exactly alike and each one must be treated as such. The same is true for ASC management companies. Not all are created equal. It is imperative to select the management company that meets your ASC's needs and, more importantly, it is important to make sure the management company fits your ASC's culture, vision, and values.

Before selecting a management company, it is important to outline your ASC's needs and have a clear understanding of the roles you expect your management company partner to play. As an example, if you primarily need help with revenue cycle operations but your clinical and day-to-day operations are running well, you need to look for a company willing and able to provide revenue cycle. Possibly you are uncertain where you need help, you need to seek an experienced company who can assess your operations and then provide a roadmap for actions to take to improve your ASC. In other cases, you may not have a surgery center but need a trusted partner to help you develop your new ASC and, prior to that, you need a partner to validate the financial viability of an ASC. Many management companies will tell you they can provide all of these things, but it is imperative to do your homework to ensure you end up with the right partner who has extensive experience.

Assuming your surgery center does not require outside equity investment from a third party (i.e., you have enough cash raised through physician equity and financing), that is the first qualifier when searching for companies. As stated previously, the majority owner of the surgery center should be physicians. If a management company requires majority interest, this can automatically screen out several of the companies. There might be particularly good reasons you need that equity investment, but you should think beyond start up and the impact of that decision in the long term with future physician investors. Beyond this initial qualifier, you should look for a partner based on these characteristics:

- **Value alignment.** It is imperative to understand the management company's mission, vision, and values. Make sure this aligns with

your mission, vision, and values. For example, physician leadership may be critical to your ASC's values. If this is important, understand the management company's position on this, as well as who makes up their governing board and leadership team. If they do not have any physician leadership on their team, this is a sign that your values might not align on this one point and/or it should cause you to ask more questions to better understand how they live out that value. Take time when going through this exercise. If your values do not align, this will pose problems down the road.

- **Transparency.** Transparency is imperative on both sides. You must be straight forward in your needs and expectations, just as the management company must be transparent on what they can deliver and their expectations from you as a client. It is not atypical for the management company to "sell" you their services in the beginning, but as you progress through the process with them, you need to be able to see if their "pitch"matches their actions and portfolio of services and clients.
  - Assuming you have identified a reputable management company, you should expect honesty and candid feedback when they disagree with your strategies or decisions. Their job is to advise and counsel based on their vast amount of experience in the ASC industry. They should provide the tough feedback to your team on what it takes to make the ASC successful, even though you may not always like to hear what they say. Early on in the relationship, it is normal to have doubt or feel the need to validate the advice you are receiving. Make sure you have a trusted resource or reference you can contact to validate some of the advice and guidance you have received. This is very important. For example, call a colleague at another surgery center and run it by them. It will either engender additional confidence in your company or it will tell you to continue monitoring things until you are comfortable. Through all of this, be very transparent in your doubts and concerns, should you have any.
- **Trust.** A partnership will not work short or long term if there is not trust between the partners. Trust is built over time and is initially difficult to assess, which is why it is imperative to speak with references. You should ask for at least 3 to 5 references whom you can call.

In addition to the references provided by the management company, you should seek out your own resources and contacts to learn more about this company. A management company will typically provide their best references, but you need to seek out other contacts or resources to truly vet what they are telling you. Many of the best relationships have been forged through a referral or a common individual or company that brought you together. This is valuable because both your ASC leadership and management company know and trust the individual bringing you together, and it helps to build trust more quickly. After the initial vetting of the company, trust is built over time and through integrity. Actions speak louder than words in any relationship, especially with your management company.

> "Transcendent values like trust and integrity literally translate into revenue, profits, and prosperity."
>
> -Patricia Aburdene, author of *Conscious Money*

- **Mutual benefit.** The ASC and management company must both find value and benefit from this relationship. It is not a win-lose proposition; it must be a win-win proposition. The ASC must work with a partner who adds values and complements their skill set and experience. The management company must also find a partner ASC that is willing to heed their advice and counsel to make their company successful. In addition, the value provided by the management company must exceed the expense your ASC is paying. Now with that said, the management company must be fairly compensated for their time, effort, and expertise. A reputable management company will price their services based on market data. Should a company offer you lower than market rates for their services, be sure to clearly understand what they are offering.
  - The cost benefit proposition can be difficult to assess, because if a management company is doing their job well, it can work seamlessly, and your ASC leadership may not realize all the work being done behind the scenes. That is what you want,—a management company that gets the job done without a lot of fanfare. However, they must keep you informed of what they are doing

and the impact to your organization to ensure you understand the ongoing value proposition.

- **Experience and references.** We have discussed the value of experience and the criticality of references in the previous sections, but it deserves its own section. There are many players in the ASC management company market. There are niche companies that only focus on certain areas. There are others that are exceptionally large and can cover all your needs. There are others that are startups and have not been in business very long. You will also see everything in between. Make sure you look at legitimate experience and understand the tenure of leadership within the organization, as well as their prior histories. You want to work with a company whose leaders have worked in an ASC and have first-hand experience. After you have validated their experience in the marketplace, then you need to check both the references they provide you but also your own informal phone calls and outreach on your own. You will learn more from your own research and conversations then from the selected references provided to you by the management company.

Good management companies recognize that this is a partnership and they want to support your success. It is a relationship built on trust, integrity, and honesty. The question is not whether you should engage a management company to run your ASC, the question is which management company is best suited to meet your unique needs. Take your time, complete your due diligence, and speak to others who have partnered with a management company. Successful management company selection will lead to a long-term partnership supporting the success of your ASC and your physician partners.

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Chapter 4

Direct Contracting to Employers

Sam Moen, BA and Jack M. Bert, MD, FAAOS

Should I market directly to employers for general health and workers compensation procedures? How do I establish these relationships?

The advantage of direct relationships with employers is that you can manage their musculoskeletal (MSK) care and often establish compensation methods that avoid insurance reimbursements.

How do you differentiate yourself as an orthopedic group that will provide high quality care at a reasonable cost? This is the question many businesses are asking themselves right now. You need to differentiate yourself to gain market share as provider competition increases. The question is not should I market to employers, but how do I market and establish these relationships. Marketing to employers can be difficult because it requires offering a different care model that they may not understand. The advantages of doing this is that the group will receive more patient volume. This chapter will attempt to explain how to approach and market to employers.

What Employers Want: Quality is Critical

Let's start with what employers want. They want high quality care. Quality is defined as "outcomes over cost." Employers want the best outcomes for their employees at a reasonable cost. This concept is very important because quality of care is critical for employers, payors, and patients. This is how you can differentiate yourself. If you can demonstrate to an employer that you have equivalent or superior quality compared to your competitors at a lower price point, this objective information is the most rapid method to gain trust in your employer relationships.

However, you do need objective data to confirm the group's quality of care. There are specific metrics that will exhibit group quality compared to competitors, which will be discussed in the latter portion of this chapter. It's also important to understand the key players in an employer/physician group relationship.

Understanding Employer's Concerns: How Should You Approach an Employer?

Employers are difficult to approach. Their administrative teams have multiple different responsibilities. You need to understand who are the key stakeholders in these relationships.

Employers

Employers come in all "shapes and sizes." To contract with employers requires determining who to contact first in the organization—which can be very difficult to ascertain. The best place to begin is in the "benefits department." They are a part of human resources and, in large organizations, there may be one person responsible only for benefits and finance that may review the program costs. In smaller organizations, it could be the owner or president making these decisions, and in a mid-size company it is usually a mix of human resources and leadership, including the chief financial officer (CFO), chief executive officer (CEO), and/or the chief operating office (COO). This group is called the "C-suite." An integral part of an employer relationship is their health care program. Initial questions to ask are if they are "self-funded" or "fully funded"? I

will discuss the differences between these types of health care programs in the next section.

Insurance Brokers

Insurance brokers help employers buy and manage health insurance programs. Brokers obtain information from insurance companies, third-party administrators (TPAs), and cost containment solutions. They make recommendations on the best programs for the employer. Brokers are a trusted resource and are important to employers when determining their health programs.

Third-Party Administrators

Third-Party Administrators (TPAs) help employers by managing employees' health premiums and paying claims. They offer a variety of services such as health care networks and other provider partnerships. It is important to know if they are a self-insured provider. The BUCA (Blue Cross, United Health Care, Cigna, and Aetna) payors all provide both self-insurance and fully insured programs. They are considered by definitions to be a TPA.

Cost Containment Solutions

There are many different names for this group and this category is variable and complex. Employers are increasing the use of cost containment and/or management solutions. Examples range from specialty drug programs to onsite employer-owned clinics. Their goal is to help employers manage and control their health care expenses. For employers, this is where innovation and the benefits of self-insurance require cost savings solutions. The employer can choose their health care partners. Cost containment solutions are not specific to self-insured companies. Fully insured companies may choose these benefit programs, but do not determine which programs are part of their benefit package. In a self-insured model, the employer decides their own programs for their employees. Direct contracting with providers thus becomes part of this solution.

Self-Insured Versus Fully Insured

Employers fund and pay for their employee's health care in a variety of methods. The market is changing as it evolves and self-insurance is becoming more popular. A study by Deloitte found that 47% of companies and 80% of all plan participants or employees were covered by self-insurance (or partial self-insurance).[1]

Self-insured is a term describing how employers finance their employee's health care expenses. Self-insured organizations retain the risk of paying medical claims and operating the health plan. They use vendors such as TPAs and "stop-loss" coverage to assist in risk reduction. Stop loss coverage is an insurance premium added to avoid additional costs beyond a specific limit of loss occurring from a large insurance expense incurred as a result of a large medical claim.

Monthly premiums are placed into a company bank account. Self-insured employers then use a TPA to manage their claims, but the employer manages the risk. If employers are able to manage their health claim expense by having employees spend less per claim, then the employers save money. If they spend more and are unable to manage claim expenses, the employer must pay the additional cost. Examples of programs that assist employers and reduce their claim liability are stop-loss insurance coverage policies that insure for excessive claim expenses, benefit design programs, employee incentives (such as deductible reductions) to see physicians that are considered high quality at a reasonable cost, and other usage of cost management companies that work to route patients to cost savings physician groups and ancillary facilities.

Fully insured programs have been the traditional method of providing employee health insurance. Employers and employees pay monthly premiums, and the insurance companies pay the claims. They essentially manage the risk, design the plan, maintain a significant profit margin, and then pay the claims. Insurance companies are profit centers, so if there are high claims with exorbitant case costs, the insurer simply increases the premiums to the employer. The reason a company becomes fully insured is that they don't have to manage risk and premiums at the beginning of the 12-month period are fixed until the next billing cycle, when the insurer will usually increase premiums based upon claim expense.

Employers become self-funded because they realize that there is less expense *if* they can manage risk. Typically, companies save 7% with a self-funded program as compared to a fully-funded program. Fully insured organizations typically experience annual premium increases of 17% to 25%, and in larger organizations there is a greater incidence of self-insured programs and thus a trend of more companies moving to self-insurance.[1,2]

Approaching Self-Funded Employers

Option 1: Target Local Employers

- Pros: This does not require a partnership with other stakeholders. You can obtain a direct relationship with the employer.
- Cons: You need to manage customer services. This means having someone from human resources managing positive and negative employee feedback, as well as managing the contract process.
- When this could be a good idea: If you have only a few employers in your area and you have a good relationship with these employers already. A direct relationship can be a great source of new patient referrals.

Option 2: Use of a Third-Party Administrators

Partnering with a TPA is similar to what you do today with health insurers. You sign a contract for services and they add you to their customer network.

- Pros: It is a better way to scale your business and your relationship is directly with the TPA. It is a similar relationship as you experience today with insurance companies.
- Cons: There will be more competition with other providers, and it makes it difficult to differentiate yourself. Your relationship with the employer is indirect and it may result in the same amount of marketing as you need for fully funded groups.
- When this could be a good idea: The critical part is finding the right TPAs. The culture and mission will hopefully result in a successful

partnership. The most successful partnerships provide the highest quality of care to their employers.

Option 3: Using a Partner/Cost Management Company

These partners have contracts with employers. They need high-quality, local providers at a reasonable cost.

- Pros: It is easier to market your services within their programs if you can prove that you are a high quality, good outcome group at a reasonable cost. You will receive more patient volume if they market your services. If they can offer incentives for employees to utilize your services, this technique will result in a successful partnership.
- Cons: It is hard to find the right partners, some only have a few of the target customers that you are looking for. The partners will challenge you on your quality metrics and most will want annual metrics on their patients to determine if you are truly a high quality, good outcome, lost cost alternative.
- When this could be a good idea: Mission and culture fit is critical. If you find the right partner, a dramatic increase in patient volume may occur over time. Sharing data is critical to build trust.

Consider these 5 steps to begin marketing to a self funded employer:

- Step 1: Build and evaluate your internal data. Get buy-in from your group or hospital if you are helath care system employed and set a goal for the number of procedures to be performed within the next year.
- Step 2: Come up with a marketing 1-page handout. Build the message around your hospital/group/facility and the key differentiated aspects from other groups in your area.
- Step 3: Target, interview, and form partnerships with the partners previously discussed .
- Step 4: Sales and marketing!
- Step 5: Measure performance and track new cases from these partnerships.

Good marketing can affect customers to “think again” and hopefully change minds. To change minds there are 2 approaches that work. Based

on the book *Thinking Fast and Slow*,[3] there is "system I and system II thinking". System I is emotional and rapid. We make most of our decisions this way! System II is a logical approach. To do effective marketing, the best approach is to appeal to both systems I and II. Here are two ways to market to system I and system II.

- System I: Marketing with stories
- System II: Supporting the stories with data and evidence

Marketing in health care can be very meaningful by describing stories of treating patients that have benefited from your care.

The final step is understanding the types of patients you will be receiving from employers. There are 2 different categories: general health and workers' compensation. In each of these categories, employers will be looking for something different.

General Health

General health, from an employer standpoint, is their commercial business. They are looking for cost savings from certain procedures. The most popular direct contracts we have seen are for total knees, total hips, and spine procedures. Walmart/Lowes and other large employers use the center of excellence model.[4] The expensive procedures are a great place to start and "bundled procedures" are very effective because it shifts the cost of care back to the physician group.[5] We advocate including more routine procedures. High volume services such as arthroscopies are great services to add to the mix. It not only will differentiate you, but these procedures are easily bundled with minimal risk. Bundling payments and sharing risk is the best way to contract directly. Try to compare your case costs to your competitors. Remember the definition of quality, which is "outcomes/cost."

Workers Compensation

Each state has different requirements for workers' compensation patients. Some states allow you to set your prices, and some have a fee schedule or fixed amount that the state has established per case. Make certain you understandf which state the case is assigned to before engaging these patients.

Workers' compensation also has its own insurance providers. There are differences compared to general health insurers, and there are a wide variety of workers' compensation insurance companies. They range from huge worldwide providers to "monoline" workers' compensation carriers, which means the insurer only offers worker's compensation insurance. Each employer may have a different insurer, which can complicate the relationship.

Market Pressures

Denials and prior authorizations are increasing from insurance companies, which results in slower revenue cycle production and increases the time prior to payment. To reduce the risk of revenue loss and delay, direct contracts are a better option to control the prior authorization process—which should result in more prompt payment for services rendered.

Conclusion

It is an exciting time for developing relationships with employers since their premium increases are dramatically increasing annually and MSK costs are a significant expense in both general health and worker's compensation. The groups that are able to develop employer relationships and objectively manage their care costs will differentiate themselves as being high-quality, desirable MSK provider entities. Those that are unable to understand the current health care climate and are unwilling to change risk losing market share. Commercial insurance and Medicare reimbursement continues to decrease, and by appealing directly to employers a new sustainable revenue source for the group can be achieved by following the principles outlined in this chapter.

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Chapter 5

The Pros and Cons of Partnering With a Large Health Care System

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Introduction

The shift of TJA from the inpatient to the outpatient setting has led to significant changes for patients, providers, and health systems. Joint replacement in the ambulatory setting is expected to become one of the fastest growing segments of the orthopedic market over the next 10 years.[1,2] Since the removal of total knee arthroplasty (TKA) and total hip arthroplasty (THA) from the inpatient-only list by the Centers for Medicaid Services (CMS), there has been a significant increase in outpatient surgery. According to the National Ambulatory Surgery Sample, outpatient TKAs rose from 44,230 in 2016 to 301,910 in 2019, while outpatient THA increased from 26,406 to 49,826.[3] These trends are expected to grow even further in the coming years, especially with increased pressure to reduce inpatient hospitalization demand that began due to the Coronavirus Disease 2019 (COVID-19) pandemic.[4] Hospital systems are working to adapt to these changing trends in health care delivery, transitioning to a more enhanced perioperative patient experience and greater attention to optimized, patient-centric recovery

initiatives that are driving the outpatient paradigm shifts into this new setting. In some cases, this shift may occur into a Hospital Outpatient Department (HOPD), and in other situations it may occur into a free-standing ASC. While this chapter will focus on the ASC, the lessons learned translate to the HOPD. Tremendous benefits can be realized by an ASC partnering with hospital systems who already have established robust and structured arthroplasty programs. The opportunity to provide outpatient TJA(total joint arthroplasty) for patients provides similar advantages for ASC–surgeon partners, including cost control, patient satisfaction, surgeon efficiency, and creating a controlled environment for arthroplasty. In order to appropriately and effectively implement these initiatives, health care systems and surgeons must address both the potential challenges and opportunities to ensure success of the new programs.

Outpatient TJA provides several advantages for the partnering health system. This includes realization of improved profit margins for cases performed at the lower-cost outpatient center, increased number of cases given the expanded availability of operating rooms to perform arthroplasty surgery, and mitigation of loss of case volume as cases move from the hospital setting to independent ASC facilities. Traditional hospitals are high-cost centers as they have increased expenses for running the entire hospital including the emergency rooms, intensive care units, operating rooms, inpatient beds, staffing, and maintenance costs. In comparison, outpatient surgeries have been shown to have significantly reduced costs.[5-7] Aynardi et al. performed a case-control study of 119 outpatient THAs and found an average cost of $31,327 for inpatient THAs compared to $24,529 for outpatient THAs.[8] While insurers may reimburse at a lower rate for the HOPD or ASC, large affiliated hospital systems can often negotiate better reimbursement and payor rate pricing given their bargaining power and the necessity of having a 24-hour emergency room in the community, as well as intensive care units that often lose money due to their dramatically increased costs. Due to a dramatic increase in profit margin when surgery is performed outside the hospital, hospitals often desire development of an ASC that results in an advantageous financial outcome for all partners. Furthermore, as primary joint replacement cases move away from the traditional hospital setting, this can create operating room availability for more complex cases that can be backfilled and thus the overall net case volume is increased

for the hospital system. This again yields positive financial outcomes, while freeing the resources needed for the health system to care for other patients in need of surgery. Reallocating beds and nursing care may have additional downstream throughput, from improving nursing workloads to reducing emergency department (ED) wait times and decreasing the need for facility transfers due to bed capacity. Particularly during the COVID-19 pandemic, hospital bed and staffing utilization has become a major factor and operational focus in health care delivery. In addition, any adjustments or re-allocation of resources, such as the migration of (TJA) patients into the outpatient setting, could result in significant enhancement in overall patient care.

In addition to health care utilization and costs, outpatient total joint surgeries can provide excellent patient satisfaction.[9] Patients and their family members have reported positive perioperative experience from ASC joint replacement, as this allows for safe recovery from surgery followed by being discharged to their home. While many patients can be discharged home within several hours of their joint replacement (outpatient surgery), others may require a limited stay overnight (23-hour stay surgery). Moving patients out of a busy, inpatient setting and into the calmer, patient-focused, concierge model, patient-centered ambulatory center can significantly improve the patient experience. In a review of 1,230 outpatient arthroplasty patients, Berend et. al found that 98% to 100% of patients reported a good to great satisfaction score utilizing a program emphasizing patient engagement, education, and standardized protocols.[10] Nurse-to-patient ratios are improved, ASC facilities tend to be updated, and there is less fear of disease transmission as patients with infections and other communicable diseases are disallowed from being cared for at an ASC.

The ASC management team and surgeon-partners additionally realize enhanced benefits when partnering with a major health system. Policy adjustments and decisions in patient care tend to be protected from the hospital bureaucracy and multiple committees that may slow progress at major health systems. The ASC can take advantage of the significant infrastructure and economies of scale that allow for the integration of proven hospital-based processes to facilitate safe and efficacious joint replacement, rather than reinvent the wheel. This includes presurgical testing, medical clearance systems, surgical staffing and human

resources, insulation from supply chain delays, as well as legal and administrative relationships. A significant enhancement of the partnership is the negotiating power for implant costs and utilization, as well as the infrastructure for storage of both surgical trays and implants, including sterile processing of instrumentation. Utilization of the mid-level providers, nursing staff, and therapists available within a large health system can provide streamlined and cost-effective transitions of care, whereas physician-owned ASCs may not have the resources or staff available. Furthermore, the partnership with a large health care system gives the surgeon and their patients an additional layer of safety by facilitating an expeditious transfer system in the event of any possible perioperative complications that could occur at the ASC. While outpatient TJAs have been proven to be safe, the rare postoperative complication requiring inpatient admission and relocation can occur and partnership with health systems can provide both the resources and transfer agreements required to facilitate enhanced and more complex postoperative care.

While ASC partnerships with a large health care system provide many advantages, there are some potential drawbacks. Depending on the level of administrative involvement in the ASC, large health care systems can have many inherent administrative hierarchies that can impede major care decisions. While these larger health care systems have significant financial resources, these costs are carefully distributed throughout the health care network and require administrative approval for any new ventures. One of the greatest obstacles in partnering with a large health care system is the change in culture necessary to establish outpatient total joint procedures. The hospital based TJA culture is not necessarily established for rapid recovery protocols in all centers as large health systems commonly have traditional, less efficient, more expensive inpatient care models. The transition to a more highly efficient, outpatient, ambulatory care setting requires significant culture changes at many levels including office staff, operating room teams, nursing staff, administrative managers, and the surgeons themselves.

Utilization of Existing Infrastructure

Traditional medical centers commonly have robust infrastructure in place to facilitate TJA, which can benefit a partnering ASC facility.

These resources and infrastructure include referral patient feeder systems, medical professionals (including anesthesia and internal medicine or specialty physicians), as well as preoperative classes and presurgical testing centers. Utilizing a centralized presurgical testing system with proven, defined protocols can facilitate medical optimization and improve care coordination, while enhancing communication, because the process can be streamlined within the hospital's existing infrastructure. Additionally, involvement of hospital-affiliated or employed anesthesia staff within the preoperative work up provides an opportunity to ensure patients qualify for outpatient arthroplasty and have a standardized risk assessment plan with the same medical professionals who will be involved with the surgery.[11] Furthermore, many hospitals require patients undergoing arthroplasty to attend a preoperative "total joint class" to improve patient counseling and education to discuss preoperative, day of surgery, and postoperative expectations and treatment course. The ASC can leverage these existing classes and providers, with minor program adjustments tailored to the outpatient experience.

Equipment management and sterilization is another area where large health system partners can benefit smaller ASCs. Health systems have robust mechanisms for surgical instrument, implant storage, and sterilization. There is a major distinction between the ability of a traditional ASC to process a few equipment trays for foot and ankle, hand, or even sports medicine cases versus the multiple large equipment trays required to perform a hip or knee replacement. The significant increase in tray turnover required to support an ASC-based arthroplasty practice can quickly overwhelm an ASCs sterile processing department (SPD). These hospital-based mechanisms provide a major resource advantage to the ASCs. Physician-owned ASCs need to either expand their SPD facilities or reduce their surgical trays and implant manufacturers, which can be costly and require physical space that may not be easily available or accessible. While some element of streamlining surgical instrumentation for outpatient arthroplasty is beneficial, hospital-affiliated ASCs can leverage the existing sterile processing and storage infrastructure to allow surgeons to continue to use the same implants that are used in the inpatient operating rooms. Additionally, the resources of large health care systems can aide in maintaining sufficient trays and auxiliary backup instrumentation and better support as volume increases.

While surgical procedure workflows remain the same intraoperatively, hospital systems can provide certain human resources and staffing advantages that facilitate the outpatient operation. Large health care systems are accustomed to performing high-volume TJAs and have competent staff with significant orthopedic joint replacement experience including circulating nurses, surgical technicians, and nurse-first assistants that are well-trained to assist with the surgery. These nurses and technicians can be utilized in the ASC either when performing the procedure or by training the ASC staff, especially if the surgeon has previously worked with the hospital team. This familiarity can facilitate a smoother transition to outpatient arthroplasty, rather than working with an untrained support team unfamiliar with a specific surgeon's preferences or to arthroplasty surgical techniques and instrumentation.l Postoperatively, the post-anesthesia care unit (PACU) has further requirements for both staffing and room availability. Outpatient total joint programs need facilities to allow patients to recover for several hours, and potentially up to a 23-hour stay. This places demands on the nursing staff and room availability. If 23-hour stays are needed, there must be coordination of on-call or mid-level providers for overnight management. PACU nurses must be experienced in the management of short stay TJA patients and physical therapy providers may be needed to facilitate safe discharge to home. Hiring these personnel full time is expensive and many trained individuals are already contracted for employment. These existing hospital resources, when partnering with a large health care system, may also be leveraged as these perioperative personnel can be hired on a per diem basis from existing departments to minimize overhead costs.

Finally, partnership with a large health care system provides an advantage in crisis management. As mentioned earlier, should transfer be necessary to a medical center for an extended stay, or for a patient requiring a higher level of acute care, or in the unfortunate event of an emergency, seamless transfer of the patient to a tertiary care center can be facilitated if there is a partnering health care system. Often these large health care systems also have ambulances affiliated with them that can decrease the costs of transfer and reduce the time to transfer. Additionally, coordination of care between medical providers can occur more easily, especially if the health care system uses the same electronic medical records (EHR) system. These factors provide an additional layer

of safety when caring for patients in the event of an intraoperative or postoperative complication.

Changing the Culture

One of the biggest challenges in partnering with a large health care system to successfully execute an ambulatory surgery model is one of the inherent qualities that makes these systems successful, reliable, and reproducible. Culture is often based on past, shared experiences of successful, proven models of health care that can take a patient through an episode of care in a safe manner. The traditional culture associated with large medical centers is not typically designed to be cost-effective or efficient, and surgeons and staff may be resistant to change. Execution of an innovative ASC model demands a major adjustment from the traditional method in which health care is executed. These changes in culture need to be addressed at every level of patient care. Often in large health care systems, patient care is fragmented and delegated to various departments, which can be slow and often deferred to the next day. Physical therapy teams may not be motivated to see an additional patient and may defer to the following day, or there may be systems in place that predetermine when a patient is seen after surgery. Nurses may be accustomed to the traditional and historical model of joint replacement when patients stayed in the hospital for 2 to 3 days after surgery and the majority were discharged to subacute rehabilitation facilities. Floor nurses may have limited experience caring for joint replacement patients walking on the same day of surgery. Surgeons may not be facile with consolidation of surgical instrumentation, minimizing costs, and taking the additional time necessary to properly select and educate their patients.

The traditional cultures and methods must be effectively reversed, with a complete buy-in of all staff and related personnel, to allow an ASC to be successful. Culture is best changed when care models are proven through example. Surgeon-partners in the ASC need to become surgeon-champions in their partner hospital and retrain staff from every level of support managing a TJA program. One of the biggest advances in joint replacement surgery over the past 5 years is the optimization of patient care pathways. Demonstrating success in accelerated recovery protocols is important by leveraging those care pathways through perioperative

optimization, patient selection tools, and protocol standardization. These initiatives are mandatory to prove to the entire care team a history of success in executing a rapid stay model in a hospital setting before bringing those protocols to the ambulatory surgery center. Convincing another care provider that short stay models are not only successful but also safe can only be done when team members can demonstrate this in real time. Staff should additionally be retrained in their communication with patients, to maintain a positive attitude and avoid negative aspersions that can introduce doubt in the patient's mind that they should stay in the hospital or that TJA at the ASC is "unsafe." Mentioning that the patient or their family member should consider staying overnight or that going home is unsafe, even by just one team member, can introduce doubt for the success of discharge and result in the failure of a same-day discharge program.

The surgeon can be equally responsible for being limited by the hospital-based culture as well. Surgeons are often given leverage to organize and order individual trays and may use many different implant systems. Surgeon trays and implant manufacturers should be pared down to avoid overwhelming the SPD. Surgeons can also have varied perioperative protocols requiring different medications. Bringing multiple TJA surgeons to the same ASC can easily overwhelm resources and make it difficult to train staff. This can also limit the ASC ability to manage expenses as certain medications can be more costly and affect profit margins. Surgeons must therefore either work together to provide a streamlined, largely unified protocol, or individual surgeons must effectively communicate any protocol variations. Standardizing perioperative care protocols can be very effective and can be transitioned to the ASC after being proven at the large health system.[12] However, this does require communication and collaboration among the surgeons involved. Once these changes are made, the implementation of standardized processes can turn a potential weakness (many moving parts, entrenched processes) into a strength (large protocol-based systems with optimal resources). Surgeons can utilize resources to practice simulations and create backup plans with available trays, staff, and transfer protocol. This can create a more efficient and effective system that best utilizes the resources at hand.

Measuring Outcomes

As clinical arthroplasty cases are shifted into the outpatient setting, outcomes must be carefully monitored and assessed. Variables to be analyzed include morbidity, mortality, hospital transfers, as well as administrative processes and workflows. Hospital system partners often have performance improvement committees in place for reviewing and reporting morbidity and mortality, readmissions, ED visits, and other complications, as well as hospital transfers. Patient-reported outcomes can also be monitored through a variety of mechanisms, including patient surveys, digital remote monitoring applications, and other platforms. These outcomes can help drive research, patient engagement, and quality improvement. Monthly or quarterly reviews of data can help improve ASC performance metrics and patient safety.

Controlling cost is another potential area where partnership with a hospital system can help an ASC. Hospital systems in general are well-versed with analyzing and controlling expenses, including procurement and cost-savings work groups. Some systems provide surgeons with report cards indicating high-priced items used during a particular case or give feedback as to how expensive items can be substituted with similar, lower cost items. Minimizing variation in equipment and eliminating unused equipment and drapes can further reduce costs and results in saving ultimately positively affecting case margins. Consolidating equipment further saves on SPD costs, which are often charged by the tray weight or number of instruments in the tray. Studying these outcomes can enhance patient experiences, improve safety, and reduce expenses—making the ASC model more successful when partnering with a hospital system.

Summary

As joint replacement transitions from the hospital to the ASC setting, systems must be put in place to maximize success, maintain, and improve patient safety, and enhance care. With appropriate patient selection, outpatient surgery has been found to have similar complication and readmission rates compared to inpatient surgery.[13-15] Using the National Surgical Quality Improvement Program (NSQIP) database, Lan et al.

compared 21,506 outpatient arthroplasties with a propensity matched inpatient sample. Across TKA, THA, and unicompartmental knee arthroplasty (UKA), there was a decreased rate of adverse events in outpatient procedures compared to inpatient (3.18% vs. 7.45%).[16] Therefore, outpatient TJA is associated with a decreased cost for the health system as readmissions are further avoided.[5-7] However, the initiating programmatic and startup costs can be daunting, and creation of these systems can be facilitated by partnering with hospital systems to leverage the TJA programs and infrastructure already successfully implemented in those facilities. In some cases, traditional hospital culture must be addressed to mitigate potential negative consequences of "old-school" techniques and expectations from interfering with a successful ASC TJA program. However, there are certainly significant advantages in partnering with a large health care system that can positively benefit these processes, despite the challenges that exist when working with any large administrative system. As the paradigm continues to shift, this emerging segment of the TJA market will continue to expand and grow. It is critical during this process of change to maximize efforts in communication with administrators, nurses, and surgeons. Appropriate staff and patient education, process standardization, and patient follow up are important to the success of the center.

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Chapter 6

Structuring a Hospital-Owned Outpatient Department to Perform Outpatient Total Joint Arthroplasty Successfully

John R. Steele, MD and Michael P. Ast, MD

Introduction

Outpatient arthroplasty has been shown to be safe, cost-effective, and to result in equivalent or improved patient satisfaction and outcomes compared to inpatient arthroplasty.[1-4] As a result, the number of outpatient hip and knee arthroplasties continues to grow in the United States.[5,6] Despite this increase in outpatient TJA, there are important challenges that must be understood in order to safely perform them. These challenges include differences in infrastructure and resources between an ASC and a hospital, as well as clinical challenges associated with same-day discharge (SDD). It is paramount to understand these challenges in order to establish a multidisciplinary team and to structure an ASC or hospital outpatient department to successfully perform outpatient TJAs.

Infrastructure

There are major differences in infrastructure between ASCs and hospitals that must be understood in order to successfully perform outpatient TJA. These differences in infrastructure include overall space limitation, decreased sterile processing capabilities, decreased disposition and treatment capabilities, and decreased emergency capabilities at ASCs.[7] ASCs in general have smaller square footage for the continuum of care that encompasses SDD TJA, including operating rooms, waiting areas, recovery rooms, storage space, and sterile processing departments.[7] The typical ASC is often not prepared for TJAs, which are more resource-intensive than surgeries historically performed at ASCs. Unlike more traditional outpatient cases, TJA requires multiple trays and instruments and substantial equipment. Therefore, surgeons must ensure that the ASC has the appropriate equipment to successfully perform TJA. This equipment can include, but is not limited to, sterilizers, power tools, beds for longer recovery if necessary, helmets, and heavier mallets and other basic tools needed for arthroplasty. Sterilization is generally the earliest limiting factor, as ASCs typically only have 1 or 2 sterilizers on site. Thus, it is critical for surgeons to plan ahead to ensure the proper number of trays are available and to limit trays and turnover as much as possible. Similarly, surgeons must be cognizant of what equipment and implants are available at the surgery center and plan appropriately for any cases that require additional resources.

It is also critical to plan for complications and to avoid complications that cannot be dealt with appropriately based on the available equipment and resources. Complications to consider include femur fractures during THA, ligament injuries during TKA, dropped implants or instruments, and vascular injury during THA or TKA. Surgeons should be prepared for femur fractures in THA by having cables and cemented stems available, for ligament injuries in TKA by having suture anchors and constrained inserts available, and for dropped instruments or implants by having extras available. Vascular injuries are one of the most devastating complications during TJA, and this is accentuated at ASCs because vascular surgeons are generally not readily available. Surgeons should be prepared with silk ties, vascular clips, local hemostastic agents, and tourniquets available at the ASC.[8] The ASC should have hospital transfer policies in place and the team should have knowledge of the available

emergency medical services in the area to activate such as ambulance phone numbers.[7] When a vascular injury is encountered, identification of the bleeding source and communication with anesthesia are critical. In the setting of THA, surgeons can attempt to gain proximal control of the vascular injury if they are comfortable, and then pack the wound and then transfer the patient to a tertiary hospital center for vascular surgery consultation and treatment if necessary. In the setting of popliteal artery injury during TKA, a tourniquet should be placed or re-inflated and the patient transferred to a hospital setting immediately for vascular surgery consultation and treatment.[8]

Clinical Challenges

There are also many clinical challenges associated with outpatient TJA. The most common clinical reasons for inability to discharge home the same day after TJA include postoperative nausea/vomiting, somnolence, postoperative hypotension, postoperative urinary retention, pain, and social support issues.[7] Many of these issues can be mitigated with appropriate surgical and anesthetic techniques and perioperative protocols minimizing narcotics and maintaining euvolemia in order to maximize patients' functional status. Multimodal analgesia and effective blood and fluid management are critical in order to combat these clinical challenges. Although there are many different multimodal analgesic pathways, most center around pre-emptive analgesia with several different classes of medications: spinal anesthesia combined with regional nerve blocks, intraoperative peri-articular injections, perioperative steroids, and postoperative scheduled analgesics that limit the use of narcotics.[9] Blood management is critical in order to both avoid the need for transfusion that would require a hospital stay and also to improve the patients' physiologic response to physical therapy and allow for SDD.[10] Effective blood management centers around recognizing preoperative anemia that may be a contraindication to outpatient surgery, judicious use of tranexamic acid (TXA), and surgical techniques that are efficient and limit blood loss.[11] Lastly, fluid management is important in order to avoid nausea/vomiting and lightheadedness and allow for early active mobilization. Although patients in the hospital are often made NPO starting at midnight before their procedure, outpatient arthroplasty

patients undergoing spinal anesthesia are often encourage to drink clear liquids up to 2 hours preoperatively to maintain euvolemia and prevent postoperative hypotension.[12,13] Aggressive postoperative hydration is initiated after the patient has voided postoperatively.

Building the Perfect Team

The success of outpatient TJA requires multidisciplinary collaboration and a team approach that is different from a typical hospital setting.[10] The development of consistent protocols and teams dedicated to the mission is critical to success. The team consists of medical, anesthesia, and surgical personnel involved in the patient's care from preoperative visits to discharge the day of surgery to postoperative follow up. The perfect team consists of a surgeon champion, an anesthesiologist, physical therapist, nurse manager/coordinator, ASC administrator, and surgical team members. Each member of the team has a critical role and they should all convey the same message to alleviate patient concerns regarding SDD.[12] The role of each team member can be broken down through the phases of SDD—preoperative patient visit, perioperative anesthesia and pain management, surgery, and recovery—and illustrate the processes that need to be in place to successfully perform outpatient TJA. Understanding and thinking about these phases can aid in planning the layout for an ASC, where space is more limited and thus must be used efficiently.

Surgeons and their staff are responsible for indicating appropriate patients for SDD discharge as well as educating the patient about their surgery, recovery, and the SDD discharge plan. Surgeons must use their judgement and adhere to strict protocols, as patient selection is critical to avoiding complications and achieving success. Medical clearance should be obtained for each patient undergoing surgery. The care team should set clear expectations about the surgery, pain, physical therapy process, and postdischarge communication plan. Patients must designate someone who can assist them with activities following surgery and this person should be present during the preoperative educational process.[10,12]

On the day of surgery, SDD is again reinforced with the patient by all team members in order to maintain the preoperative expectations. As discussed previously, anesthesia centers around spinal anesthesia,

regional nerve blocks, and narcotic limitation in order to reduce the side effects of narcotics that are a major deterrent to SDD. Surgery itself should proceed efficiently with a surgical team made up of a surgeon who is consistent as well as surgical assistants and technologists who know and understand the steps in order to complete the cases efficiently. A standardized protocol should be in place for fluid and blood management, as well as medications that the patient receives perioperatively and upon discharge. Physical therapy should commence as soon as the patient has full neurologic recovery of their lower extremities.

The work does not stop when the patient is discharged after surgery. A team member should call the patient the night of surgery and/or on postoperative day one in order to assess the patient's pain and alleviate any concerns they have. Physical therapy continues, generally at the home for a few visits and then transitioning to outpatient physical therapy. In order to avoid complications and unnecessary ED visits, there should be a point of contact for patients if they have questions or concerns. It may also be prudent to maintain open office slots for urgent visits.

When establishing a SDD program at an outpatient hospital department, all of these principles apply. Surgeon champions must establish a team that is dedicated to the success of outpatient arthroplasty. This requires careful consideration, as the culture of team members in a SDD program can differ significantly from the culture of inpatient hospital staff, and it is critical that everyone on the team is consistent in their messaging towards patients regarding SDD. It is often difficult to work with the same staff in a hospital setting to establish a SDD program and therefore you must change the culture of those desirous of working on the SDD team. This requires aligning incentives for team members, and may require new job positions.

Conclusion

Outpatient arthroplasty is rapidly growing and has been shown to be safe and cost-effective, while maintaining excellent outcomes. However, it presents an entirely different set of infrastructure and clinical challenges compared to TJA performed in the hospital setting. Surgeons must adhere to strict protocols and have a multidisciplinary team in

place in order to meet these challenges and successfully establish an outpatient TJA program.

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Chapter 7

Establishing a Successful Private Practice Ambulatory Surgery Center Outpatient Total Joint Program

Justina Lehman, BA and Sam Moen, BA

Physician practices, patients, payors, employers, and partnering health care systems have the ability to benefit on multiple levels from a successful outpatient TJA program. More and more surgeries are being transferred from the inpatient setting to outpatient ASCs. There are significant benefits to an outpatient TJA program, but it requires the right leadership with support from the physician stakeholders, appropriate operational supervision, ASC design, and execution of the preoperative, intraoperative, and postoperative patient management.

The foundation of a successful outpatient TJA program is physician and administrative leadership as well as operational supervision. In our group of over 100 orthopedic surgeons with 10 years of experience performing outpatient TJAs we have identified 3 levels of governance that must be addressed for an outpatient TJA program to be successful.

These 3 levels are: clinical applications, operational considerations, and financial scrutiny. Implementing these programs has resulted in developing a framework that has resulted in the successful growth of the outpatient TJA program and have become integral components of the group practice. The outpatient TJA leadership team consisted of a

steering committee which was instrumental in monitoring the clinical, operational, and financial aspects of the ASC's outpatient TJA project. The steering committee consisted of the key orthopedic surgeons involved in performing the majority of the outpatient TJAs, the administrative team, operating room managers, and patient case managers. They were responsible for ongoing management, assessment, and strategy of the program. The steering committee is critical in managing the following areas.

Market Analytics

To assess the pros and cons of the program, it was important to gather market analytics. We reviewed key data to make decisions regarding the program's successes and failures. We evaluated the entire population of patients trending to total joint replacement opportunities based upon patients seen in the various orthopedic clinics. We also reviewed our current "market capture rate" compared to our competitors. Once we had this information, we evaluated the current inpatient and outpatient TJA cases based upon payor mix, average professional fees reimbursed, and facility fee reimbursement and compared this to the total cost of care. Once we assessed this data, we were able to determine which patients were financial candidates for outpatient TJA. Finally, we analyzed existing fee-for-service contracts and options for bundled episodes of care. Our finance team was then able to understand the impact on current patient volume and potential new patient capture rates.

Designing the Program

We evaluated 3 critical areas of the program before implementation: the clinical components of the preoperative and postoperative protocols, the financial design with emphasis on staffing, and the operational processes to ensure success of the project. The steering committee reviewed each area, including how our relationship with a large health care system affected these areas. We identified the clinical expertise of our surgeons, anesthesia, nursing, case managers, and support staff. The protocols are an important element of an outpatient TJA and include the following:

- Patient criteria
- Surgeon operation protocols

- Anesthesia protocols
- Nursing protocols
- Transfer protocols with nearby hospitals for inpatient admission if necessary

For example, transfer protocols covered necessary reasons for postoperative admission, including unmanageable pain control, urinary retention, blood loss, and cardiac and pulmonary complications.

Financial

We looked at the opportunity for revenue for our orthopedic group and did a "case cost" analysis. There were potential payor and employer reimbursement as well as Medicare and Medicare Advantage opportunities. Using that information we assessed the case costs of the program. One of the key areas in outpatient TJA are orthopedic implants, since this is a high-cost area. Convincing surgeons to use the same implant can be extremely difficult. If this becomes an impossibility, a base rate for any TJA implant must be agreed upon and related to the implant representatives. Often, the representatives will try to convince the specific orthopedic surgeon that his company's implant should be utilized. It is critical for any surgeon participating in the program to agree to the base rate for the program, or they will not be allowed to be part of the program. Partner incentives can be built into the program so that the surgeons are desirous of becoming part of it. We relied on our steering committee to lead this discussion.

Operational

We reviewed our overnight bed capacity and identified where the outpatient TJA cases could fit into the schedule. We focused on operational efficiency and designed solutions such as outpatient TJA cases always being the first cases of the surgical schedule. We also reviewed expansion plans and how this would impact current case levels. Operative room staffing and case manager staffing is important. Staffing affects all the clinical, financial, and operational levels of the program. We needed to make sure we had in place the clinical team to deliver the best

patient outcomes and ensure the protocols were followed. We also reviewed the criteria for surgeons performing total joints in an outpatient setting. There are a variety of resources available, like the Accreditation Association for Ambulatory Health Care (AAAHC) orthopedic certification template. This template includes privileges and credentialing specific for TJA.

Clinical

There are mandatory clinical guidelines that must be utilized to avoid medical and financial complications when doing outpatient TJAs. In the graphic from Bert and Moen (Figure 7-1),[1] it is critical to avoid patients with significant medical comorbidities including diabetes, obesity, cardiac disease, pulmonary disease, and depression. By "optimizing" patients prior to consideration of outpatient TJA, the complication rates are dramatically reduced. When following the recommendations noted in Figure 7-1 prior to and subsequent to outpatient TJA, the success rates for a patient undergoing outpatient TJA are dramatically improved. The only way to ensure a consistent and manageable episode of care is to mandate that each patient have a detailed risk assessment prior to their surgical event. Risk assessments give the surgical team accurate, updated information on the patient's risks of perioperative complications. This information also helps the surgeon determine whether a patient can safely proceed with outpatient TJA, if they are better candidates for inpatient TJA, or if further medical evaluation and optimization are necessary prior to surgery. Once a care plan is established and surgery is completed, postoperative management must be performed. Case management is critical to a successful result. We have 10 years of experience in our large orthopedic group, performing over 10,000 outpatient TJAs per year with a 9.9% patient satisfaction rate, 0.05% revision rate, $24 million health plan savings, and a 0.24% 30-day readmission rate. Hours of patient education was estimated at 3,181. In this patient group, we had less than an overall 1% complication rate when optimizing patients preoperatively appropriately and managing patients postoperatively utilizing case managers.

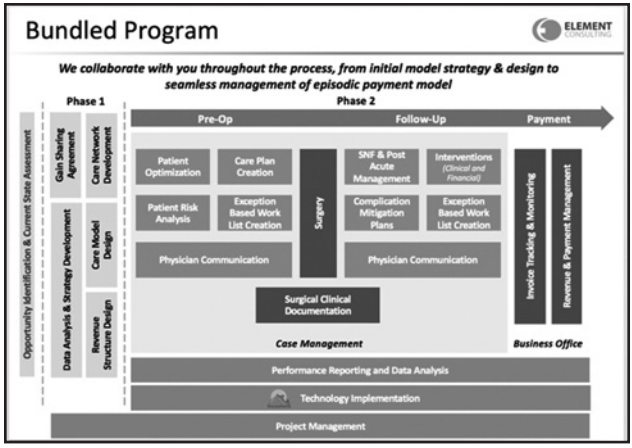


Figure 7-1. Bundled program for outpatient TJA. (Used with permission from Bert J, Hooper J, Moen S. Outpatient total joint arthroplasty. *Curr Rev Musculoskelet Med.* 2017;10:567-574.)

Health System Relationships

There are pros and cons when establishing relationships with health care systems. The benefits include access to capital, contracting advantages with payors, and negotiations with vendors. The areas we monitored were the "care culture" differences and decision-making criteria of the health care system that we already had a strong relationship with. Dealing with change is difficult for all organizations, and it is important to note there will be resistance to moving cases away from the hospital to an outpatient setting. This primarily is a financial concern to the health care system. We made sure to identify the benefits to both organizations, which are primarily improvements in the patient care experience and financial savings associated with removing the patient from an inpatient facility. These discussions can be difficult and challenging, but it is important to develop relationships with administrators to solve the issues associated with this transition.

Execution

Once the program was developed and put in place, we made sure to have a "trial run" with some mock cases. We tested our procedures and it helped us identify process flaws we were unaware of—which we became aware of when we went live with patients.

Monitoring and Steady State

Our team reviewed key metrics from the clinical, financial, and operational aspects of the program. This helped with accountability and program outcomes. Continual education has been key to keeping our teams focused on optimal outcomes. We use data and staff feedback to make sure there are no educational gaps in the process.

Conclusion

This program has become an important part of our local and regional strategy. We continually assess the benefits and risks of expanding the program to include more patients. There are significant opportunities for outpatient TJA, but the appropriate leadership team and physician and administration support is critical to success of the project.

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Chapter 8

Outpatient Total Joint Replacement

Maximizing Revenue, Patient, and Implant Selection Strategies

Trevor R. Pickering, MD, FAAOS, FAAHKS, FACS

Recent years have shown a steady increase in elective surgical cases in the United States transitioning from the hospital inpatient or hospital outpatient department setting to the ASC setting. Historically, orthopedic surgery has been no stranger to the ASC. However, the relatively recent launch of total joint replacement into the ASC arena has resulted in a very significant increase in the total number of orthopedic elective cases being performed outside of the hospital. Total joint replacement now represents the fastest growing orthopedic subspecialty in the ASC (Figure 8-1).

While greater efficiency and control are motivating factors for surgeons to move cases to the ASC, the push for total joints has been largely dictated by 2 factors: insurer demand and profit potential for the ASC and its surgeons. The improved efficiencies, reduced costs, and increased patient satisfaction at the ASC have resulted in a win–win-win scenario for payors, providers, and patients.

Commercial insurance was the first to recognize the significant cost savings that resulted from moving total joint cases from the hospital to the ASC. With an average savings of approximately 40% per joint

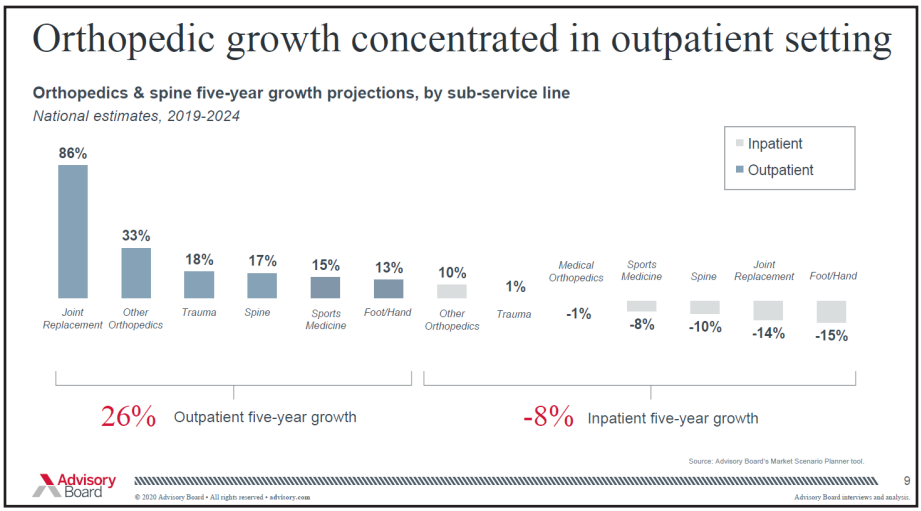


Figure 8-1. Orthopedic growth concentrated in the outpatient setting.

replacement case, commercial insurers are increasingly mandating that these cases be performed at an ASC and often require an approval if the surgeon wishes to take the case to the hospital. The savings for these insurance companies is even greater with a bundled payment arrangement. The Center for Medicare and Medicaid Cervices (CMS) projects a $73.4 billion savings over the 10-year period of 2019 to 2028 by moving elective surgical cases to the ASC. Orthopedic cases account for $6.6 billion of this savings. It comes as no surprise that CMS wants the same savings when it allows hip and knee replacement for Medicare patients to be done at the ASC and, in fact, CMS is seeing the same 40% savings per case by doing so. Total knee replacement alone accounts for $3 billion in savings. When looking ahead at the increased number of total knee replacements that will be performed in the coming decades, outpatient total joint replacement represents one of the most significant cost savings initiatives for CMS, leading many to speculate that CMS will in some manner mandate that total joints be performed at the ASC in the near future (Figure 8-2).

In addition to this exogenous push from the insurance companies, ASCs now recognize that a mature and organized outpatient total joint program drives significant revenue to the ASC. Total joints are now among the most profitable cases performed at the ASC, resulting in a

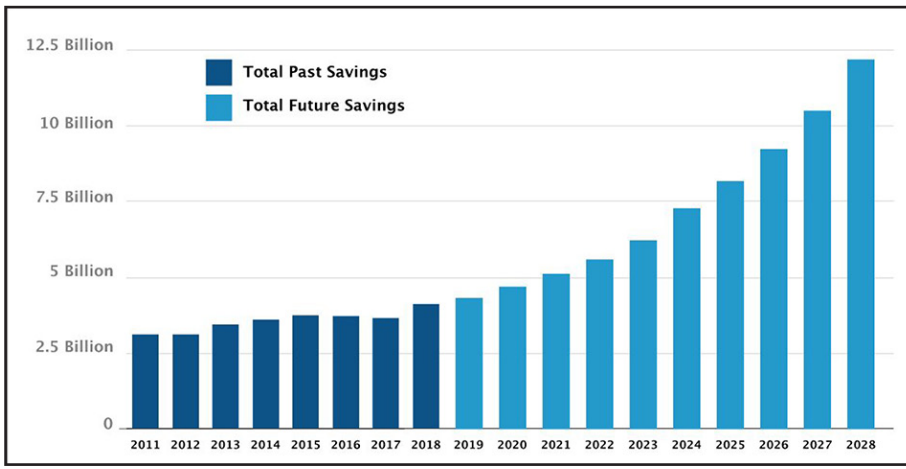


Figure 8-2. Total Medicare savings and projected savings (by year). (Reprinted from *Advancing Surgical Care*. Published October)

Table 8-1.

Average Revenue Per Case, Total Joint Versus Average Orthopedic Case[1,2]

CASE	REVENUE
Average Orthopedic Case	$3,791[1]
Medicare total knee	$8,610[2]
Medicare total hip	$8,924[2]
Commercial total knee	$18,234[3]
Commercial total hip	$18,575[3]

tremendous internal effort from surgeons and ASC administrators to move these cases from the hospital to the surgery center (Table 8-1).

Although profits per case vary significantly from region to region in the United States due to differences in employee costs, payor mix, insurance payment prices, volume, and so forth, total joint replacement dramatically reconfigures the bottom-line ASC profit contribution status of orthopedic subspecialties. At our facility, total joint cases are among the most profitable per case and are performed at a volume over 4 times

Table 8-2.

ASC Profits Tiers for Specific Orthopedic Cases

(per case, Tier 1 = most profitable).

TIER 1	TIER 2	TIER 3	OTHER
Commercial TKA/THA	Commercial UKA	Medicare TKA/ THA/UKA	ACL
ACDF		RTC	Foot/Ankle (average)
TLIF			Hand (aggregate)
TSA			

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higher than other Tier 1 cases, making them the highest profit-generating cases at the surgery center (Table 8-2).

To that end, the question of patient selection becomes important, as patient volume correlates with profit. With this in mind and when considering the previous data, the issue of patient selection at the ASC comes down to this: by default, every total joint replacement is done at the ASC. The question to ask is no longer "Am I able to take this patient to the ASC?" The question now is "Is there some reason that I must do this patient's surgery at the hospital?" This inversion occurs once the surgery center has established a sustainable and adaptable model for outpatient total joint replacement.

Strict exclusion criteria exist for patients undergoing joint replacement at the ASC (Table 8-3).

Today there is little difference between exclusion criteria from one group to another or one ASC facility to another. These criteria have evolved over the last 5 to 10 years, and result from evaluation of data and discussions with anesthesia and internal medicine consultants. At our facility, every patient is cleared for outpatient joint replacement by a primary care physician and the specialists (cardiology, pulmonary, etc.) the patient sees, if any. Each of these consulting physicians is aware of the exclusion criteria. In addition, anesthesia has the history and physical examination (H & P) and all clearance notes prior to the day of surgery so that they can alert the surgeon if they have concerns about sedating

Table 8-3.

Patient Selection Exclusion Criteria for Outpatient Total Joint

- Uncontrolled medical issues (CHF, COPD, ESRD, cirrhosis, uncontrolled HTN, poorly controlled DM/ A1C > 7.5, bleeding disorder)
- ASA > 3
- Untreated sleep apnea
- Recent MI (<6 mo), defibrillator
- Criteria result of physician agreement, evaluation of data, discussion with anesthesia

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any of the upcoming patients. Patients must have somebody at home with them for 48 hours following the surgery. It is important that joint replacement surgeons at any given ASC be in complete agreement regarding patient selection and exclusion criteria. Standardization is essential for ensuring both the safety of the patients and adequate volume to maintain sustainability of the ASC. It takes time for surgeons to trust that patients can safely be discharged home on the day of surgery and that they will do as well or better than patients who recover in the hospital. Ultimately, with these criteria in place approximately 90% of patients meet the criteria for ASC joint replacement.

Another factor to consider early in the process of moving total joints to the ASC involves implant selection. Implant price is often and correctly identified as the most significant cost issue when performing joint replacement in the outpatient setting. In this context, identifying a preferred vendor is not nearly as important as committing to selecting a single vendor for the ASC. Significant implant cost savings will not be achieved unless a practice leverages patient volume to that end. All surgeons must be in agreement and on the same page in order to overcome the personal relationships that vendors establish to maintain status quo pricing. Vendors must bid on implant prices in a competitive manner. Surgeons must work together to come to an agreement on selecting a single vendor.

There are many benefits to having a single vendor in addition to the cost savings. The reduction of storage space that comes with a single vendor cannot be underestimated in its importance. This is particularly true at ASCs that are smaller and attempting to integrate total joints into an existing facility with limited storage space. The tighter the storage space, the more difficult it is to drive high-volume. The use of a single implant also improves efficiency in the operating room. A tech that needs to know only one knee or one hip system will be far more efficient and far happier than a tech that needs to know multiple systems. In addition, vendors are more likely to provide additional products, services, and technologies when they have been chosen as a single vendor and want to sustain that status over a long period of time.

At our facility, the move to a single vendor resulted in a near 50% reduction in implant cost. In addition, we found that the vendor also provided other products needed such as bone cement and mixer, tourniquet, lavage, etc. By bundling these products, we were able to achieve an additional 20% in savings per case and now have a single bill for a knee replacement or a hip replacement rather than a dozen individual bills for each product. This means less time spent on invoices by our billing department, as well as additional cost savings. These tremendous cost savings translate to direct profit that is shared by all the partners. The professional surgeon fee for a hip or knee replacement does not change when moving cases to the ASC. But, in the ASC setting surgeons have an opportunity to take on new responsibilities and largely control profitability for all the partners in a way that is never possible when total joints are done at the hospital.

The issues of patient selection and implant selection are certainly important. But they are clearly small parts of a much larger conceptual model that is needed to establish a successful and profitable outpatient total joint program. The fact is, anyone can do a knee replacement at the ASC. But the goal is to do ALL hip and knee replacements at the ASC. This requires a sustainable and adaptable model to ensure adequate patient volume, patient safety, and ASC profitability.

The pathway to profitability begins with identifying and embracing all the new responsibilities that come with migrating total joints from the hospital to the ASC. The ASC now must take on all the duties previously performed by the hospital and rarely recognized by the surgeons.

Table 8-4.

Joint Replacement at the ASC: New Responsibilities

- Patient selection
- Patient preparation/education protocols
- Patient safety protocols
- Patient equipment/DME
- Preoperative/postoperative medications
- Physical therapy
- Home health
- Patient communication POD 0 and POD 1
- Operating room utilization
- Workflow efficiencies
- Preoperative/PACU standardization
- Anesthesia standardization
- Implant cost
- Suture/dressing cost
- Equipment/instrument cost
- SPD cost
- Insurer negotiations
- Complication management/risk penalty mitigation with insurers
- Data collection for insurers

Rather than avoiding such new responsibilities, surgeons need to know that each one is an opportunity not only to improve profit but also to improve the patient experience and patient outcomes (Table 8-4).

In this context, patient and implant selection are recognized as pieces of a sustainable model for total joint replacement at the ASC (Table 8-5).

One example of standardization are the protocols followed by the ASC staff when the patient arrives for a hip or knee replacement. When the patient presents to the ASC for knee replacement, the preoperative and postoperative nurses do not need to find "Dr. Smith's" preoperative medication list or "Dr. Jones's" postoperative instruction list. Rather, there is a single knee replacement protocol for all preoperative, intraoperative, and postoperative measures. All surgeons are on the same page and the same protocols are executed for each patient. This results in numerous downstream benefits. The operating room staff can function far more efficiently by not having to look up each surgeon's individual preferences. This makes their job easier and contributes to staff commitment and a high-volume ASC. The same can be said for anesthesia who can prepare more easily and execute blocks more efficiently. Clearly patient safety benefits from having a single protocol as less variability results

Table 8-5.

Organizing a Sustainable Model for Joint Replacement at the ASC

STANDARDIZATION	COST CONTROL	TECHNOLOGY
Patient selection	Implant cost	Patient education/ management
Patient preparation/ education protocols	Suture/dressing cost	Workflow efficiencies
Patient safety protocols	Equipment/ instrument cost	Operating room utilization/ scheduling
Preoperative/ postoperative medications	SPD cost	Billing and collections
Physical therapy	Insurer negotiations	Data collection
Home health	Complication management/risk penalty mitigation with insurers	
Patient communication POD 0 and POD 1		
Anesthesia standardization		
Preoperative/PACU standardization		

in fewer mistakes. Patients are happy because they are all receiving the same messaging and instructions; thereby greatly reducing confusion, anxiety, and phone calls upon discharge. Altogether, the result is a super-efficient system that can then accommodate additional operative cases and lead to significantly greater profitability.

Beyond the single vendor model, cost reduction is found in virtually every detail of a total joint replacement at the ASC. For example, few surgeons who are in the hospital setting can tell you how many trays are on the back table of one of their cases and how many instruments are in each tray. They do not need to know because they are not responsible for

the cost of processing and assembling and storing each of these trays. The fact is that each instrument tray in any surgical case is associated with a fixed cost. There is a cost associated with sterile processing itself; a cost attributed to employee time required to take apart, clean, and assemble trays and then wrap them; a cost of operating room time required to set up and take down additional trays, which runs between $25 and $65 per minute. Reducing the number of trays in a case from 5 to 3, for example, can result in a cost reduction of between $500 and $800 for each case. By simply taking the time to examine instruments they need to use, and by removing extraneous instruments and standardizing all the trays, surgeons can turn a seemingly trivial part of a surgical case into a significant $500 to $800 increase in profit.

Technology occupies a far more privileged role in a lean and efficient ASC than it does in an inpatient hospital setting. This is most pronounced when it comes to patient education and workflow issues. Gone are the days of the hospital's total joint "boot camp" in which patients sat for hours to receive preoperative and postoperative instructions along with a large booklet that was rarely read by patients. In the ASC setting, the number of full-time employees needed to organize and run such programs, the amount of patient materials that must be assembled and maintained, and the practicality and cost associated with finding space for such classes render them financially impossible. Instead, an app for a smart phone, tablet, or computer can provide more digestible, consistent, and reliable preoperative and postoperative education to patients at a fraction of the cost and in a far more convenient manner. Such apps have resulted in higher patient satisfaction scores, improved compliance with medications and exercises, and fewer phone calls to office staffs postoperatively. Other software is available to assist with numerous operational issues including inventory management, scheduling and operating room block time maximization, billing and collections, data collection, and so forth. Ultimately, the judicious implementation of technology in the ASC setting is vital for managing high patient volume, assuring patient safety, and improving profitability.

These examples illustrate some of the new responsibilities and opportunities for surgeons and administrators alike when total joints enter the ASC arena. The model for managing these responsibilities will differ from facility to facility depending on such factors as patient volume,

number of surgeons, payor mix, ownership model of the ASC, etc. Regardless of what the final model looks like, its foundation begins with a simple question: Is the ASC a business or a convenience? A sustainable and profitable outpatient total joint model must overcome personal preferences and pre-existing business relationships if the greatest potential for patient care and profit is to be realized. Other necessary steps outlined previously can be summarized here:

- Surgeons must commit to bringing ALL total joint cases that meet the agreed upon criteria to the ASC.
  - Efficiency, cost reduction, and profit are maximized when volume is maximized.
- Complete standardization of protocols and adoption of a single implant vendor are important.
  - Sustainability requires that each surgeon commits to good *business* decisions.
- Surgeons and administrators need to prioritize operating room time for total joint cases.
  - Maximizing the volume of high-profit cases adds to the bottom line for all ownership parties.
- A complete sustainable model is mandatory to achieve maximum volume, safety, satisfaction, and profit.

The work involved is by no means onerous. Today, resources are available from numerous entities as diverse as implant companies, insurance companies, independent consultants, and for-profit and non-profit ASC organizations. It has never been easier to transition total joint cases to the ASC without having to reinvent the wheel. The time to aggressively pursue this transition is now, as more and more insurers require that these cases be done at an ASC. Furthermore, the work required yields not only profit, but also an improved quality of life for the surgeon and a significantly enhanced experience for patients undergoing joint replacement.

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Chapter 9

Partnering With a Private Equity Firm in an Ambulatory Surgery Center Transaction

Louis McIntyre, MD

Introduction

Health care in the United States is a $2 trillion-dollar industry sector that commands almost 20% of the gross domestic product (GDP). The market for health care services has traditionally been a local one governed by community demand, culture, and state law. The increasing percentage of services paid for by the federal government and the consolidation of third-party insurance payors has created a trend away from local concerns toward regional and national considerations and has led to considerable consolidation over the last 30 years. This consolidation was intentionally accelerated by the Affordable Care Act in 2010, which established regulatory mechanisms for consolidated structures designed to coordinate care that would be subject to the economic risk of providing health care services. The trend of consolidation is not uniform around the country or across providers, with many regions and sites of service remaining fragmented in both ownership and delivery of care.

Current trends of utilization of health care services demonstrate considerable increases, mostly derived from demographics, as high as 400% over the next 15 years as the baby boom generation ages. This demand places significant pressure on tax rates and insurance premium prices in a system that already cannot accommodate the cost of current levels of spending. The need for cost containment is driving care into lower cost site of service settings away from hospital-based provision and toward outpatient ambulatory care. The emergence of value-based care (VBC) with coordinated episodic programs delivered at a set price is becoming a reality to offset increased health care spending. VBC care systems requires scale and infrastructure that a fragmented market cannot deliver. The trends are clear; increased demand for services, with increasing consolidation and market disruption, to accommodate these changes.

These trends present economic and operational opportunity to capture the value in a huge, growing, and volatile market. That opportunity is a challenge for businesses involved in delivering health care, because they have traditionally been locally oriented, undercapitalized, and do not have the skill sets required to implement change on a regional and national level. Private equity (PE) has recognized the value potential in health care for many years, and PE involvement in the sector has been accelerating for the last 10 years with purchases of private practices, device companies, health information technology, and ASCs. PE brings capital, business acumen, and operational capabilities that can facilitate consolidation and establish companies capable of providing value in a changing market.

PE entities are investment firms that utilize private and institutional funds to acquire and grow existing businesses. PE targets companies with growth potential with the goal of realizing that growth and capturing the value in future sale. PE usually acquires platform organizations with immediate size and scale, and then add on to that platform with additional businesses to increase profitability and market share. PE strategies include growing same store volumes and profitability, as well as adding new service lines to improve visibility and attraction to consumers. The new companies established in this fashion are then packaged for sale to other PE firms or investors. The time horizon for acquisition, growth

and sale varies between 5 to 10 years as the PE firm has dedicated funds that are accountable to its investors based on those specific timeframes.

Private Equity and Ambulatory Surgery Centers

ASCs are recognized for providing safe, high-quality care at a reduced cost as compared with hospital-based care delivery. The migration of orthopedic, cardiology, and cancer services from the hospital to the ASC in recent years, as well as the removal of surgical cases such as total knee and hip arthroplasty from the Medicare Inpatient Only list, has improved the volumes and profitability of ASCs. PE has been involved in ASCs for many years with interest in capturing value in a growing, fragmented market. Physicians and surgeons are interested in working in the efficient settings with low administrative and operational burdens that ASCs provide. In addition, the potential revenue stream afforded to doctors with an investment in an ASC has become essential to their economic sustainability, as procedural reimbursements have declined for the last 30 years. Many orthopedic surgeons now derive between 40% to 60% of their overall income from ancillary services, with the largest potential income being from ASCs. The challenge of operating independent ASCs regarding relations with payors and reimbursement, plus the need to grow and scale to provide more complex and integrated procedural services and VBC, has driven surgeon owners of ASCs to seek financial partners. The desire of many surgeons to realize the value they have developed in their ASCs is also increasing their interest in exploring PE as a financial and business partner. The alignment of both the seller and potential buyer and PE involvement in ASCs will increase in the next decade.

Physician ownership in ASCs is varied from the wholly owned practice ASC to partial ownership by share, and can include other partners such as joint ventures with hospitals, ASC management companies, or both. A PE firm may be interested in only free-standing ASCs or ASCs as a strategy that includes the practices affiliated with them. These differences will have influence on the scope, governance, and organization of any transaction between PE and an ASC. In general, however, any transaction will have similar characteristics.

Structure and Legal Considerations

When PE firms purchase an ASC, they will most likely buy a percentage of the center and leave equity aside for the surgeon owners to align incentives and provide for future utilization. This is accomplished by purchasing only a portion of the ASC or stipulating that a portion of the sale price be "rolled over" as equity in the new business. This "roll over equity" has tax advantages as being tax-deferred for any future sale of the ASC. The PE firm may form a new company to purchase the assets of the ASC or purchase a percentage of the ASC. State licensing regulations may determine which method is best, based on the difficulty of acquiring a new license for a new ASC entity. In some states it is nearly impossible to get such new licenses because of certificate of need (CON) laws. Local corporate practice of medicine (CPOM) laws will also impact this decision, depending on whether they exist and whether they have specific exemptions for ASCs. If no exemption exists, the PE firm may set up a management service organization (MSO) to manage the center in exchange for a management fee. Surgeons may have ownership in the center or the MSO, and that ownership is regulated by both state and federal securities laws. State licensure and CON laws govern the ownership of ASCs, and compliance with these are essential to maintain "good standing" in the state. The rules regarding notice and approval processes must be appreciated and followed to maintain proper licensure in local health departments, state, and federal agencies.

The contractual structure of the transaction will require that the selling doctors agree to practice in the center for some period of time, usually 5 to 10 years with penalties for early withdrawal. Since the PE firm is really purchasing future cashflow, this ensures that the future earnings of the center are commensurate with earnings documented during the due diligence period prior to closing. Similarly, there will be noncompete clauses included in the purchase that preclude involvement in competing ASCs in the catchment area of the center.

The sale of the center needs to follow certain fundamental concepts. First, the price of the shares should be consistent with fair market value. The value of shares cannot be based on the value or volume of services that the surgeons provide to the center, but only to the extent of their investment. The operating federal statute applicable to ASCs is the Federal

Anti-Kickback Statute (AKB), 42 U.S.C. § 1320a-7b(b), which prohibits anyone from paying anything of value to another person in exchange for the referral of health care business to another person or entity. Violation of the AKB is part of the criminal code and violations are subject to penalties, including fines of up to $25,000 per violation, imprisonment for up to 5 years, or both. Violations can also result in prohibition from participation in the Medicare or Medicaid programs. There are ASC Ownership Safe Harbors as part of the AKB statute, and ASC companies need to ensure that ASC governance language is in accordance with the Safe Harbor Laws. To fall within the Safe Harbor, the value a surgeon obtains in any sale cannot be related to past or expected volume of referrals, cannot include a loan or loan guarantee from potential investors to purchase shares in the new company, and any payments must be proportional to the investment the surgeon has in the center.

Valuation

PE firms value the companies they buy with a calculation of the business earnings before interest, taxes, depreciation, and amortization (EBITDA). EBITDA is a measure of business profitability and is used to calculate the total enterprise value (TEV) or purchase price for the ASC. The PE firm will analyze the ASC business financials and use pro forma business plan models to arrive at the ASC's EBITDA. The EBITDA is then multiplied by a figure, the multiple, that reflects local fair market value—to arrive at the TEV. The TEV is then distributed to the owners based on percentage ownership in the ASC. The PE firm will usually purchase only a percentage of the ownership of the center.

Table 9-1 illustrates a potential PE acquisition of an ASC owned by 6 orthopedic surgeons, each with equal ownership. The calculated EBITDA of the center is $800,000 with a multiple of 5, for a TEV of $4,000,000. The PE firm plans on purchasing 70% of the center for an adjusted transaction value of $2,800,000. The 6 owners of the center would each receive $466,667 at the close of the transaction and retain a 30% stake in the ASC going forward. The $466,667 is taxed at a favorable capital gains rate.

Partnering with a PE firm when contemplating partnering in an ASC has several advantages. PE firms have more unregulated capital at

Table 9-1.

The Pros and Cons of Partnering with Private Equity in an Ambulatory Surgery Center Transaction

PE FIRM ACQUISITION	
EBITDA	$800,000
Multiplier	5X
TEV	$4,000,000
Percentage Ownership	70%
Adjusted TEV	$2,800,000
Shareholders	6
Proceeds per Shareholder	$466,667

their disposal and the valuations and sale prices that they are willing to pay are usually higher, especially when compared to hospital partners. PE firms have been paying multiples between 6 and 12 for ASCs. Depending on the experience of the PE firm, many of the operational and risk liabilities of the center can be assumed by the new company or MSO. There is the potential for maintaining clinical operational control of the ASC in negotiations, as PE will usually be partners on the business side only. For well-run, physician-controlled centers, this is a major benefit in maintaining quality and efficiency in the ASC. The PE firm may have pre-existing relationships with payors to facilitate optimum reimbursement rates and the ability to do value-based and other innovative contracting paradigms. With both PE and surgeon partners aligned through ownership, growth is possible with mitigation of the income reduction surgeons will experience after closing. Any equity shares surgeons have represent an investment commensurate with the PE partners regarding share class. Since the PE firm is usually committed to a sale based upon their fund maturation, the investment has considerable value for potential second sales and beyond. Surgeon ownership of an ASC has traditionally been redeemed at retirement with value based on share price at that time and is a one-time event. The possibility of several sale events, based upon a multiple of EBITDA and not just share price, has the potential to provide much more value for the initial investment.

The disadvantages of partnering with PE include bringing on a new, usually majority partner with all the uncertainty that that entails regarding governance and operational issues. Will the new partners be focused on the top line growth they profess to want, or will cost-cutting maneuvers be implemented with all the concerns of ASC quality and efficiency that those present? Concerns regarding loss of authority in operations and business decisions is real, especially for surgeons who have managed their centers successfully for years. All PE firms are not created equal and have different experience and skill sets when managing health care facilities. Will new ownership negatively impact the culture of the ASC, employee and patient satisfaction, or the ability to recruit new high-quality staff? The PE due diligence process can be long and expensive with significant legal and accounting costs leading to "deal fatigue" and uncertainty for staff and operating surgeons. The potential disruption that this poses can negatively impact the operations, quality, and profitability of the center. There will also be "post close" holdbacks on the TEV based on the fulfilment of seller contractual obligations and proof of quality of earnings. All these potential downsides illustrate the need for proper due diligence and complete understanding of a transaction with any new ASC partner, PE or not.

Conclusion

There are considerable challenges and opportunities for owners of ASCs. To take advantage of the opportunity and mitigate challenges, many ASC owners are seeking and choosing partners with access to capital and business acumen. Choosing the right partner is essential for success, and to ensure success owners must have a clear reason why they are seeking a partner and what their priorities are in any potential transaction. A PE partnership will not be realistic for many, smaller independent ASCs, but those associated with larger practices or in areas where the creation of scale through consolidation is possible PE will be an alternative to explore. For maximum upfront value in exchange for the loss of some amount of independence, PE may represent the best alternative.

Chapter 10

The Preoperative and Postoperative Advantages in the Usage of Telemedicine for Ambulatory Surgery Centers

David M. Heath, MD and Thomas M. DeBerardino, MD, COL, US Army (Ret.), FAAOS, FAOA

The purpose of this chapter is to explore the evolution of telemedicine use, its benefits and limitations, and the role it may play in the future for patients who undergo outpatient orthopedic surgery.

Introduction

Telemedicine, which is defined by the World Health Organization as "the delivery of health-care services, where distance is a critical factor, by all health-care professionals … with the aim of advancing the health of individuals and communities," has become increasingly popular with the advent of new technology and especially within the constraints of the COVID-19 pandemic.[1] It can refer to the use of video visits, telephone calls, or online messaging.

While COVID-19 has been a devastating pandemic, it has led to 2 major advances in health care. These are the development of mRNA vaccines and the rapid growth and implementation of telemedicine. Prior to the COVID-19 pandemic, telemedicine use was modestly increasing but saw barriers to implementation such as issues with integration

into clinic workflow, limited renumeration, and lack of technologic infrastructure.[2-5] The challenges set forth by the pandemic led to a sharp increase in telemedicine use.[6] After mass rollout of the vaccines and the end of lockdowns, telemedicine use has remained high and is anticipated to continue to be a large part of health care moving forward.[7] The ability to continue regular outpatient follow up without risking virus transmission, along with the rapid focus on technology and workflow integration, led to quick adoption of telemedicine by many providers.[6-9] Part of this integration process was the adoption of telemedicine use in the perioperative period by surgeons. Despite the absence of an in-person postoperative examination, telemedicine has been demonstrated to be a safe and effective means of providing perioperative care.[9-12]

Benefits

The use of telemedicine has been shown to result in reduced travel time for patients, reduced cost to patients, equivalent or increased patient satisfaction with care, and improved access to care, especially by those in rural settings.[13-15]

A narrative review of telemedicine use in surgical clinics by McMaster et al. in 2021 identified 11 studies that demonstrated significant cost savings for patients with the use of telemedicine.[13] These savings were related to lower travel costs,[16-21] diminished loss of income due to missed work,[19,22-24] and reduced time burden.[11,20,25] These savings are more significant for patients in rural communities.[13]

A 2021 survey by GoodRx of 1042 people in the United States revealed that 667 (64%) had used telemedicine, or telehealth as it was called in the survey.[14] Of those who had used telehealth, only 12% said they would not use telehealth in the future. A total of 63% plan on using telehealth alongside in-person visits, and 25% plan on using telehealth exclusively. Most patients saw no difference between in-person and virtual visits regarding overall quality of care, comfort level with provider, privacy concerns, out-of-pocket cost, time spent with provider, appointment convenience, or scheduling convenience. More than one-third of patients rated telehealth as better or much better in each of those categories.[14]

Patient satisfaction with telemedicine is generally presented as favorable in the literature, with many studies across different specialties reporting high levels of patient satisfaction or at least equivalent satisfaction to in-person visits.[4,9-11,16,18,19,25] A randomized controlled trial by Cremades et al. in 2020 compared conventional office visits vs. telemedicine follow up in 200 general surgery patients.[26] There was no significant difference in patient satisfaction or clinical outcomes between the two groups.

Chaudhry et al. published a meta-analysis of patient and surgeon satisfaction with telemedicine in orthopedics during the COVID-19 era in 2021.[27] There were 12 articles and 1008 total patients included in this review. The authors found no difference in satisfaction between patients receiving telemedicine care vs. in-person care. There was no difference in patient-reported outcome measures evaluating pain and function. There was also no difference in surgeon satisfaction. Additionally, patients reported an average time savings of 17 minutes when travel time was excluded and 180 minutes when travel time was included.

Another benefit is that telemedicine use in the postoperative period for low risk, low acuity outpatient surgery has been shown to be just as safe as traditional in-person follow up. The previously mentioned narrative review by McMaster et al. in 2021 found 6 comparative studies showing no difference in safety between telemedicine and in-person follow-up,[11,17,26,29-31] 2 of which are randomized controlled trials.[17,26] The authors also found 7 studies that used telemedicine in lieu of traditional follow up and found no difference in complication rates when compared to in-person follow up.[11,16,26,28,31-33]

Limitations

The limitations of telemedicine continue to change with advancements in technology and should be taken into consideration when determining if telemedicine is right for a provider or their patient. These limitations are the absence of in-person physical examination, absence of same day in-office imaging, limited access for populations without access to technology, cost of implementation, possible decreased compliance with follow up, and concern over cybersecurity or patient health information security.[4,10,14,35-37]

The lack of an in-person physical examination is one of the most glaring differences between telemedicine and traditional in-person follow-up visits. While there is no replacement for a traditional exam performed with physical contact between the provider and the patient, many components of the exam can be performed remotely and some aspects can be changed to substitute traditional tests. This has led to the publication of new methods for remote examination, such as Tanaka et al.'s 2020 update on the remote orthopedic physical examination.[34] Validation of newer techniques is still needed in the literature. A randomized controlled trial by Buvik et al. in 2016 compared telemedicine to in-person orthopedic consultations and found no between-group differences in physician ability to examine patients or adverse events.[35]

Early concerns over lack of same-day patient imaging have been mitigated by technologic advancements. With the increased availability of electronic imaging viewers, patients are now able to have their imaging performed in the days leading up to their appointment and the physician can review the imaging online.[34] Some telemedicine applications even allow for screen sharing for physicians to review imaging with patients during their remote visit.[36]

While technologic advancements have improved access to health care for some, populations without access to technology or who are uncomfortable using it, such as the elderly, have not benefited from these advancements in the same way. Impoverished or remote populations without internet capability have yet to see the same benefits from telemedicine as the developed world.[37] This has the potential to improve with continued advancements in availability and affordability of technology and as the elderly population continues to become more familiar with technology.

A study by Luo et al. published in 2021 on telemedicine adoption in the Milwaukee, Wisconsin area during the COVID-19 pandemic found significant inequalities in those who were able to utilize telemedicine and those who were not.[38] A total of 104,139 patients used telemedicine during the study period. Patients who used video telemedicine were younger (median age 48 years), more likely to be Caucasian, and more likely to have private insurance. Patients who used telephone visits were older (median age 57 years), more likely to be African American, and more likely to have public insurance. Asian and Latino populations were

less likely to adopt telemedicine. College education had a strong correlation to video visit adoption rate.

Eberly et al. published patient characteristics associated with telemedicine access in the University of Pennsylvania system during the COVID-19 era.[39] Of the 148,402 patients scheduled for telemedicine visits in the study period, only 80,780 patients (54.4%) completed their visit. A total of 45.6% were conducted by video and 54.4% by telephone. Older age, Asian race, non-English preferred language, and Medicaid insurance were independently associated with fewer completed telemedicine visits. Older age, female sex, African American race, Latino ethnicity, and lower household income were associated with a lower usage of video for telemedicine visits.

Patients with lower household incomes are disproportionately affected by other barriers to telemedicine care, such as lack of broadband internet access, lack of technological devices needed for telemedicine, and technologic illiteracy.[40] The Federal Communications Commission estimated in 2019 that 19 million Americans did not have access to a fixed broadband service,[41] but recent scrutiny of this number and subsequent reinvestigation put the real number at nearly 42 million.[42] Additionally, those who do have access may not have a reliable connection or may have plans that limit their ability to participate in video visits. These differences in telemedicine adoption highlight the importance of social determinants of health and stress the importance of physician adaptability to their patients' preferences and circumstances.

Another barrier to telemedicine implementation is that while some EHRs now have fully integrated systems for telemedicine, others do not. In such a case, implementation of telemedicine requires investment into secure technologies with which to perform patient encounters. A 2015 study by Costa et al. showed at that time the cost of implementation of telemedicine videoconferencing ability averaged between $8,000 and $11,000.[43] This cost is highly variable and may be more affordable since rapid changes have occurred as a result of the pandemic, but the concept remains that the cost of implementation must be offset by the renumeration volume of telemedicine visits. A randomized controlled trial by Buvik et al. in 2019 in Norway showed telemedicine in remote communities to be cost effective if the volume is sufficient, specifically 151 consultations per year in that study.[19]

Another concern with telemedicine is possible decreased compliance with follow up. A total of 45% of 624 United States-based health care providers in a 2021 survey by GoodRx reported that no-show rates were "higher" or "much higher" in telemedicine visits when compared to in-person visits.[14] While this may hold true in further investigation across all specialties, it is disputed by Siow et al.'s findings in their orthopedic trauma clinic.[44] The authors found no difference in no-show rates in their clinic when comparing before the pandemic (100% in-person) to during the pandemic (50% in-person and 50% telemedicine).[44]

There are possible cybersecurity issues, with the potential for breaching guidelines for safe management of patient health information when utilizing online platforms. This is currently best addressed by investing in and using telemedicine applications that are secure and compliant with local laws and regulations.

A final limitation of telemedicine is that it is far from replacing inpatient care, which is still the gold standard for cases with high acuity or complexity. Telemedicine should be used to complement, but not replace, in-person medical care.

Telemedicine Use in Orthopedics

While there is no paucity of literature on telemedicine in general, there are few studies on the use of telemedicine in orthopedics. Some of the more notable studies are listed previously above, but some others are discussed here to further outline the utility of telemedicine to the orthopedic surgeon.

As previously mentioned, a randomized controlled trial by Buvik et al. in 2016 found no difference in physician ability to examine patients or adverse events when comparing telemedicine to in-person consultation.[33] Other studies on orthopedic consultations have confirmed similar results.[19,43-46]

A 2021 study by Zhang et al. on the efficacy of orthopedic telemedicine encounters during the COVID-19 pandemic included 298 patients treated by 41 providers.[47] There were 200 encounters performed with video, and 98 were performed with telephone. Three (1%) patients presented to the emergency department within 6 weeks of their new patient telemedicine encounter, and 8 (3%) patients presented for a planned

supplementary in-person encounter. The providers were able to effectively direct patients to a variety of treatments and dispositions with a low rate of unplanned presentation to the emergency department and a low need for supplementary in-person assessment.[47]

A systematic review of 13 articles and meta-analysis of 8 articles on telemedicine in orthopedics by Melian et al. in 2020 showed no significant difference in patient satisfaction, length of visit, or time spent with the physician between the telemedicine and in-office control group.[48] Additionally, patients in the telemedicine group showed a preference for telemedicine over in-office visits not seen in the in-office control group (odds ratio 1.44, 95% confidence interval 1.12 to 1.87, $p = 0.005$).[48]

As mentioned earlier in the chapter, Chaudhry et al.'s meta-analysis of patient and surgeon satisfaction with telemedicine in orthopedics during the COVID-19 era showed no difference in patient or surgeon satisfaction.[27] The authors also found no difference in patient-reported outcomes between the 2 groups. These findings are consistent with Melian et al.'s findings, except patient-reported outcomes were not examined in that study.[48] However, whereas Melian et al. found no difference in patient time spent between the in-person and telemedicine cohorts, Chaudhry et al. found significantly shorter times for patients in the telemedicine cohort. Specifically, patients in the Chaudhry study reported an average time savings of 17 minutes when travel time was excluded and 180 minutes when travel time was included.[27]

Grandizio et al.'s 2020 prospective study of telemedicine implementation after upper extremity surgery in 57 patients demonstrated decreased travel burden, decreased visit times without affecting patient satisfaction, and no change in surgeon ability to detect postoperative complications.[49] While this study is low power, it is consistent with larger studies in nonorthopedic outpatient surgery populations as outlined earlier in this chapter.

This evidence indicates orthopedic consultations and follow-up meetings using telemedicine are safe, cost effective, and preferred by patients who have used telemedicine for this purpose. Telemedicine may be used in the ambulatory orthopedic setting without sacrificing quality of care, patient-reported outcomes, and the ability to detect postoperative complications. Both patients and surgeons find telemedicine to be a

useful tool and report equal or higher satisfaction with telemedicine use when compared to traditional in-person visits.

Who May Benefit From Telemedicine Use?

The patient populations traditionally thought to benefit from telemedicine use are rural populations and those who have limited travel resources. The purpose of this chapter is to explore the utility of telemedicine use in the orthopedic outpatient surgical setting.

As demonstrated by the articles mentioned in the prior sections, orthopedic care in the perioperative setting for low risk, low acuity outpatient surgery is safe, effective, financially beneficial for patients, and leads to equivalent or higher levels of patient and provider satisfaction.

As the world continues to evolve in the post-COVID-19 era, the use of telemedicine perioperatively in outpatient orthopedic surgery should be further utilized and explored. This is especially true for patients with the financial means and internet connectivity to utilize telemedicine for follow up and should also include patients who live far from their surgeon.

This may also be of use in scenarios where interdisciplinary perioperative care is necessary. For instance, a cancer patient undergoing tumor removal could meet with their surgeon, medical oncologist, radiation oncologist, radiologist, and primary care physician remotely in a streamlined, patient-centric care model. This may even be part of a remote tumor board discussion session, which could allow for high-quality, interdisciplinary care at the convenience of the patient and providers.

Many academic centers have transitioned to a telemedicine model for tumor board in the COVID-19 era. The University of Pittsburgh Otolaryngology-Head and Neck Surgery Department published their experience with this transition and found overall positive results regarding provider perception of the changes.[50] The meetings involved physicians from otolaryngology, medical oncology, radiation oncology, neuroradiology, and pathology. There were 19 participants, who had all attended at least one telemedicine tumor board session, that responded to their survey. A total of 78.9% of respondents said they would prefer to continue the virtual format over the in-person format for future meetings. The authors noted the virtual format allowed for the inclusion of

satellite campus physicians who practice over 200 miles away from the main medical center. They also noted the virtual format allowed providers to attend the meeting from their workstations, which facilitated access of patient records for discussion.

A pilot study utilizing telemedicine for multidisciplinary tumor board at the Michael E. DeBakey Veterans Affairs Hospital in Houston, Texas for 16 patients with hepatocellular carcinoma was also recently published.[51] In this study, 94% of patients said they would recommend telemedicine to other patients with hepatocellular carcinoma. Furthermore, 50% said they preferred telemedicine over in-person visits. Advantages noted by patients in the study included feeling more involved in the decision-making process and easier inclusion of family members who live in different cities in the visit. This study found that 81% of patients thought telemedicine was an acceptable method to deliver difficult information about cancer. The flipside of these numbers is important to note. A total of 50% of patients did not prefer telemedicine to in-person visits, and 19% did not find telemedicine to be an acceptable method of delivery of difficult information about cancer. These are significant numbers, but it is important to note that the total number of patients in this study is low and the public opinion about virtual visits is likely to change over time as the younger patient population has already been exposed to virtual visits for school, work, and health care. Physicians must consider their own patient population and tailor their care appropriately.

The Future of Telemedicine

As technology continues to evolve, so will the role that telemedicine plays in patient care. Patient follow up may soon be as simple as getting lab work and imaging done ahead of time for a physician to access online and then signing in on your smartphone to talk to your physician. Your smartphone may link to your smartwatch or other mobile health device to give real-time vitals. Patient weight, blood pressure, blood sugar, and other patient health statistics may be tracked automatically using smart devices that are linked to the patient's mobile device. All of these work to give the physician a better sense of patient health and are simpler for the patient than a standard in-person visit.

This type of monitoring could be expanded to include 24/7 remote monitoring with an on-demand rapid response teams available to deliver care and supplies to patients as needed.[52] This could eventually reduce the need for extended hospital or long-term care facility stays for stable patients with chronic illnesses. As artificial intelligence continues to develop, these remote diagnostic tools may be used to identify health problems, such as heart failure, before symptoms begin.[53]

The use of a mobile app to monitor postoperative patients following ambulatory lumbar discectomy was published by Debono et al. in 2016.[54] The authors monitored 60 consecutive patients for 15 days postoperatively with alarms based on symptom severity of pain, temperature, deficit, and bleeding. No action was required in the follow up of 41 patients. There were 36 patients (60.0%) who completed the initial checklist within 48 hours, with no triggered severity and 5 patients (8.3%) triggered a non-response alarm. There were 19 patients (31.7%) that triggered a cumulative total of 29 alarms, resulting in a neurosurgeon being contacted automatically. These alarms were for postoperative pain management in 21 cases (72.4%), low-grade fever <38.5°C in 4 cases (13.8%), urinary retention in 2 cases (6.9%), and a problem related to the surgical dressing in 2 cases (6.9%). On a scale from 1 (poor) to 4 (excellent), the overall satisfaction mean score for the mobile handheld device was 3.5/4. A total of 91.6 % of patients said they would agree to repeat the postoperative experience.[54]

Similarly, wound checks during postoperative visits may be as simple as a patient taking a picture with their smartphone to upload securely into their chart. This eliminates the need for patient travel into clinic and taking time off from work. As complex coding continues to evolve, machine learning will allow for predictive and perhaps even diagnostic feedback in real-time to the patient and provider using the app. This has been trialed by Jiang et al. in 2019.[55] The authors describe the utility of a patient-taken image software on their mobile device that integrates machine learning to predict surgical site infection and transmits the image and data directly to the physician. Other applications involve patient preoperative checklists and questionnaires, alerts for upcoming events and appointments, postoperative surveillance applications, and other user-entered information that is directly transmitted to the surgeon.[56-59]

Such applications could be a standard aspect of postoperative follow-up care in the future.

Another rising area of technology in health care is the automation of documentation through ambient listening. One such application is Nuance's Dragon Ambient eXperience (DAX), which listens to a clinic visit between a health care provider and the patient and automatically generates a note based on the conversation.[60] This may allow for increased time spent with the patient, less time documenting, and enhanced patient satisfaction. Such technology could also be integrated into virtual care visits.

Conclusion

The use of telemedicine in outpatient orthopedic surgery for low acuity, low complexity patients is safe, cost effective, and leads to equivalent or improved patient and provider satisfaction. Its use should be considered by providers and patients moving forward in the post-COVID-19 era. As technology continues to evolve, so will this rapidly changing field of medicine.

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Chapter 11

The Legal Requirements of Ambulatory Surgery Centers

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ASCs provide an opportunity for orthopedic surgeons to earn ancillary income while also reducing health care costs. Because the cost of a surgery performed in an ASC is typically far lower than the cost performed in the outpatient hospital setting, the Medicare program has been very tolerant (even encouraging) of physician ownership of ASCs. The government has created 4 safe harbors under the Anti-Kickback Statute to protect various ASC structures. There is widespread misunderstanding about how these safe harbors operate, with many people mistakenly believing that failure to fit within a safe harbor suggests that a particular structure is improper. In fact, there is no requirement that an arrangement fit within a safe harbor, and the overwhelming majority of ASCs do not. This chapter will explore many of the legal issues surrounding ASCs, with a focus on the Medicare Anti-Kickback Statute.

Medicare Enrollment/Licensure

Before exploring the regulatory restrictions on financial relationships, it's worth spending a few minutes discussing the legal framework

surrounding ASCs. A variety of state and federal regulations govern their operation.

Medicare reimbursement for ASCs is authorized in the Social Security Act. (See § 1832(a)(2)(F) and § 1833(i).) Medicare has created a specific list of procedures for which it will provide reimbursement in an ASC. Note that this list does not prohibit the ASC from performing any procedure; it merely limits the range of procedures eligible for Medicare reimbursement. When a procedure is not eligible for Medicare reimbursement, it can still be performed for patients with private insurance or who lack insurance coverage. Medicare imposes a number of Conditions of Participation that an ASC must meet to be eligible for enrollment. Those conditions are laid out in federal regulations. (See 42 Code of Federal Regulations Part 416.) Perhaps the most practical tool for understanding how Medicare evaluates ASCs during enrollment surveys is Appendix L of the State Operations Manual. The government uses the State Operations Manual to provide instructions to the governmental surveyors for use when they review an ASC. Those instructions include limits on the ability of an ASC to share space, which will be discussed more in the following sections.

Even if you chose not to participate in the Medicare program, most states will require the ASC to be licensed. While licensure surveys are often conducted by the same agencies that perform Medicare enrollment surveys, they are technically a different process. Each state has its own licensure requirements, which are typically described in state statutes or in regulations issued by the Department of Health.

Private Insurance Reimbursement

Private insurance companies are free to impose their own limits on ASCs. It is common for insurance companies to require some type of approval process in addition to licensure before they will cover services at a surgery center. Before starting a new ASC, it is important to be sure you understand the expectations of key payors. Some physicians have opened ASCs, only to discover that the largest payors in the area will not cover any services performed there. That is a very expensive mistake.

Note that private payors may impose requirements that are inconsistent with Medicare requirements. If you choose to enter a contract with a third-party payor, it may impose any condition that is permitted by

state law. Those conditions can include the ability to withdraw the contract with little or no warning. It is important to carefully review your contract and any incorporated policy manuals.

When an ASC provides services to a patient insured by a plan with which it does not contract, the plan has much less ability to impose terms upon the ASC. Generally, in the absence of a contract, courts act as if there is an "implied contract" between the parties. That means that the ASC must charge a reasonable rate for its services and the insurer must pay all reasonable charges. An insurer does not have the right to impose its own fee schedule upon an ASC.

Federal Limits on Financial Relationships

Note that ASCs are not considered a designated health service under the Stark law. That means that, for the most part, Stark is inapplicable to ASCs. Under Stark, when a physician creates a plan of care that involves something defined as a "designated health service" under the law, the entity providing the designated health service may not bill for the service unless the financial relationship between the physician and the entity meets one of the exceptions to Stark.

Since ASCs are not a designated health service, Stark will generally not be relevant, except to the extent that the physician's participation in the ASC creates a financial relationship with a hospital or other entity that provides designated health services ordered by the physician. If physicians enter into a financial relationship with a hospital as part of the development of an ASC, it is important to verify that the financial relationship meets a Stark exception. That is generally not a problem, because Stark will not be triggered simply because both a physician and a hospital have an ownership interest in an ASC. To implicate Stark, money must flow from the hospital to the physicians, or vice versa. For example, if the hospital finances the ASC, that could implicate Stark. However, it would still be possible to structure the arraignment in a way that satisfies an exception to Stark. (Moreover, since the Anti-Kickback Statute and safe harbors do not permit such financing, hospital financing is relatively uncommon.) The bottom line is that Stark typically has very little impact on services performed in an ASCs.

By contrast, the Medicare Anti-Kickback Statute does apply to ASCs. As mentioned previously, federal regulations create an array of safe

harbors protecting certain ASC structures. However, it is very important to understand how the Medicare Anti-Kickback Statute works. While the safe harbors provide absolute protection to any venture that meets all of their conditions, you are never required to meet a safe harbor. The benefit of meeting a safe harbor is that arrangements within a safe harbor cannot be prosecuted by the government. However, because of this the safe harbors are designed to be incredibly narrow. In fact, some of the ASC safe harbors are functionally impossible to meet.

When an arrangement does not qualify for a safe harbor, it's legality is determined solely by the participant's intent. The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving any remuneration (that is, any sort of financial compensation) if one reason for the payment is to influence referrals under a federal health care program. To analyze compliance with the Anti-Kickback Statute, one asks a very basic question: Is anyone paying, or seeking payment, for referrals? This analysis is very important because the Anti-Kickback Statute is a criminal statute and violations are a felony. In addition, while there is no private right of action that allows a person to bring their own lawsuit based on violations of the Anti-Kickback Statute, a whistleblower can bring a False Claims Act case by alleging that the claims that are submitted after a kickback are improper. The bottom line is that violations of the Anti-Kickback Statute can give rise to significant penalties.

Courts have generally applied a "one purpose" test when considering the legality of an arrangement. If there are many motivations for a financial relationship, but *one* of the motivations is to pay for referrals, that is sufficient to convict the participant of a felony. In the context of an ASC, there are some arrangements that would be quite suspect. For example, if a single-specialty orthopedic group was forming an ASC and offered investment to a group of internal medicine physicians who referred patients to the surgeons, that would pose a significant risk under the statute. The internal medicine physicians aren't in a position to operate at the center. It would seem quite likely that at least one of the reasons the internists were offered ownership was to encourage them to refer patients to the surgeons and the ASC.

By contrast, there is no material risk under the Anti-Kickback Statute if the investors are not in a position to refer. If a physician group in Nevada sought investors from Florida, there is no need to worry about

the Anti-Kickback Statute unless there was a plan to have patients from Florida flying to Nevada for surgery. Similarly, investment by people outside of the health care industry poses no real risk except when the person has the ability to influence referrals though an unusual relationship with potential patients. For example, a worker's compensation attorney may be in a position to influence referrals, while a lawyer specializing in first amendment law likely would not.

To offer some protection for arrangements, the Office of Inspector General (OIG) of the Department of Health and Human services has issued a variety of safe harbor regulations. When an arrangement meets all of the terms of a safe harbor, the government is not allowed to prosecute the arrangement. The safe harbors for ASCs are found at 42 C.F.R. § 1001.952(r). The safe harbors address 4 different basic ASC structures. The first protects surgeon-owned ASCs, the second single specialty ASCs, the third multi-specialty ASCs, with the fourth and final safe harbor protecting hospital–physician joint ventures. Before reviewing the broad criteria in the ASCs, it's important to reemphasize that it is **not** necessary to satisfy the terms of a safe harbor. We know this for a number of reasons. First, the Medicare Anti-Kickback Statute was passed in 1972. Safe harbors were not issued until 1991. If it were required for an arrangement to satisfy a safe harbor, every health care arrangement entered into during those 20 years would have constituted a felony. Obviously, that is not the case. (The safe harbor protections for ASCs were not issued for another 8 years, in 1999!) While that fact should, by itself, end any doubt on the issue, the OIG has been very direct in confirming it. For example, in December of 2020, the Office of Inspector General issued some new safe harbors. While explaining them, the Office of Inspector General explained:

> Arrangements are not necessarily unlawful because they do not fit in a safe harbor. Arrangements that do not fit in a safe harbor are analyzed for compliance with federal Anti-Kickback Statute based on the totality of their facts and circumstances, including the intent of the parties (§ 85 F.R. 77684, 77685).

Despite this, it is relatively common for conservative lawyers to insist that a relationship fit within a safe harbor. Sometimes the lawyers will mistakenly claim that it is requirement, but more commonly the lawyers will acknowledge it is not *required* to fit within a safe harbor, but insist

that it is foolhardy to choose any structure that does not fit all safe harbor elements. The lawyers will often act as if anyone willing to enter a relationship outside of the safe harbor is reckless.

But even a cursory review of the safe harbor protecting ASCs that are a joint venture between a physician and hospital demonstrates the fallacy of that position. Statute 42 C.F.R. § 1001.952(r)(4)(viii) provides that to fit within the safe harbor, "the hospital may not be in a position to make or influence referrals directly or indirectly to any investor or the entity." When that safe harbor was issued, CMS explained that if the ASC is located within the hospital's service area, the ASC will not meet this element of the safe harbor because the hospital will be in a position to refer patients to the ASC. Obviously, it would be foolish for a hospital to participate in a joint venture for an ASC located *outside* of the hospital's service area. In fact, there is probably not a single physician–hospital ASC joint venture that is outside of the hospital's service area. That would mean that there is not a single physician–hospital ASC joint venture that fits within the safe harbor. If you encounter a hospital insisting that your proposal is unacceptable simply because it doesn't meet a safe harbor, ask them to explain how they believe any arrangement is satisfying element (viii) in the safe harbor.

A helpful analogy for framing anti-kickback risk is a rheostat. Various actions and structures can increase or decrease the risk that an ASC will be challenged. The content of the safe harbors offers a sense of the factors that dial risk up or down.

When the safe harbors were issued in 1999, the OIG provided insight into its rationale. First, they noted that safe harbor protection for ASCs derives in large measure from this longstanding policy encouraging freestanding ASCs as a less costly alternative to hospitals for appropriate surgeries. The OIG explained that "many hospitals were reluctant to open or invest in ASCs that competed with their own outpatient and inpatient surgery departments. Accordingly, many of the early ASCs were financed and owned by surgeons and other physicians who worked in them" (64 F.R. § 63518, 63537). The preamble makes it clear that the government is most comfortable when the surgeon is closely connected to the ASC and is basically treating it as a part of their medical practice.

> We believe these standards ensure that a physician investment in an ASC will truly represent an extension of their office. Where physicians own an ASC in which they will personally

> perform a significant number of procedures, obvious and legitimate business reasons exist for the ownership, including convenience, professional autonomy, accountability, and quality control. Moreover, any risk of utilization for unnecessary surgery is already present by reason of the opportunity for a surgeon to generate his professional fee; the additional financial return from the ASC is not likely to increase the risk of over utilization of procedures significantly." 64 F.R. § 63537.

The government realizes that when a surgeon is actively involved in a surgery center, the various professional and risk management considerations greatly reduce the risk that the surgeon will allow their judgment to be swayed by the economics of the facility fee. The preamble makes it clear that the government isn't very concerned about the surgeon investors. If there are anti-kickback issues present in an ASC, they almost certainly arise from non-surgeons who are permitted to invest in the center with the hope that they will send patients. When investment is limited to surgeons who are active at a center, the risk the government will view the arrangement as a kickback risk is very small.

In multi-specialty clinics, there is often a question of whether the clinic can own the center, or whether ownership must be limited to the surgeons. While having non-surgeon physicians who can refer patients generally would be considered a very high risk, we believe that the multi-specialty clinic is an exception to that principle. It is true that there is not explicit safe harbor protection for such an arrangement, but the government has also indicated that the Anti-Kickback Statute does not apply to payment within a corporation.* As long as the ASC is a legitimate

* 56 F.R. 35952 (July 29, 1991) states that: "Comment: Many commenters requested the OIG to clarify that payments between corporations which have common ownership are not subject to the statute. Commenters cited as examples intracorporate discounts and payments between two wholly owned subsidiaries. Some commenters argued that referral arrangements between two related corporations do not constitute 'referrals' within the meaning of the statute, and suggested that the OIG define the word 'referral' to exclude such activity.

Response: We agree that much of the activity described in these comments is either not covered by the statute or deserves safe harbor protection. We believe that the statute is not implicated when payments are transferred within a single entity; for example, from one division to another. Thus, no explicit safe harbor protection is needed for such payments."

investment by the clinic, the risk under the Anti-Kickback Statute appears to be very low.

While there is no requirement to fit within the safe harbor, and the risk associated with most ASCs is quite low, it is still worth understanding the terms of the safe harbors because they do offer insight into factors that raise the regulatory risk. Describing each element of all 4 safe harbors in detail would be too lengthy for this chapter, but it is possible to point out the broad themes that run through the safe harbors, and draw some broad inferences about factors that are likely to increase the risk of government scrutiny.

To fit within a safe harbor, the ASC should not lend money to investors nor should it guarantee the physicians' loans. The safe harbor expects that payout will be proportional to an investment. The safe harbors generally indicate that the investment terms should not relate to referrals, and they prevent discrimination against federal beneficiaries. One of the elements present in most of the exceptions is the so-called "1/3 test." This test is really 2 different tests, both involve a fraction of 1/3. First, to meet the safe harbor, 1/3 of each physician investor's medical practice income must come from the physician's performance of surgical procedures that appear on Medicare's ASC outpatient list. Second, 1/3 of the types of surgeries that are on that outpatient surgery list must be performed at the investment entity. (It is easy to misunderstand this element of the safe harbor because it simply refers to "procedures." But the safe harbor has defined the term "procedure" in a restricted fashion, using it only for a procedure that appears on Medicare's ASC outpatient procedure list. Whenever the word "procedure" appears in the safe harbor you should read it as "procedure on the ASC outpatient procedure list.")

The 1/3 tests have interesting ramifications. The tests often form the basis of a facility refusing to allow investment by a surgeon who doesn't meet both prongs of the test. For example, a hospital may point to the test to justify refusal to permit a multi-specialty group from owning the ASC as part of the group because some of the group's physicians will not meet the 1/3 test. Sometimes the ASC will use the test as a tool to force physicians who are not bringing a large share of their cases to the ASC to divest their ownership. While it can be a smart business practice to limit

investment to surgeons who meet the 1/3 tests, as discussed previously, there is absolutely no requirement that an ASC meet these 1/3 tests.

An excess focus on the 1/3 test can cause people to lose track of the big picture. For example, imagine an orthopedic group with offices scattered throughout the state. The group proposes to establish a joint venture with the hospital operating in the northern part of the state. The group wants to have all of its physicians share in the investment because the group believes sharing strengthens the group. The hospital insists that physicians from the southern part of the state should not be allowed to participate in the venture because they will not meet the 1/3 test because they won't be bringing patients to the facility. The hospital's concern is inappropriate since the Anti-Kickback Statute only applies when there's a payment for referrals, thus there is no problem with payments to physicians in the southern part of the state who are unlikely to be sending a material number of referrals to the center. Anti-kickback issues require a payment for referrals. If either the payment or referrals are lacking, there's really no concern under the law. If including physicians from the southern part of the state has any impact on the anti-kickback analysis, it is to *lower* the risk, not raise it.

While it is unnecessary to apply the 1/3 test, there can be benefits to using the 1/3 test as a means of ensuring all investors in the ASC remain active. Returning to the policy discussed previously, CMS is most comfortable with physician investors when they are active participants in the center. Passive investors create 2 types of risk for the facility. First, the passive investor represents some regulatory risk. But they also present an economic risk. When individuals are taking money out of the center without actively aiding its economic performance, the ASC quickly can become unstable. The professionals who are bringing cases to the center may choose to leave if they feel passive owners are profiting from the active investors' work. Therefore, while the 1/3 tests may not be a regulatory necessity, they can be an important tool for ensuring the viability of a center.

Allocating Profits From an Ambulatory Surgery Center

By far, the safest strategy for allocating ASC income is based on ownership. The safe harbors envision such an ownership-based distribution methodology. For freestanding ASCs, distributions based on ownership are almost certainly the best strategy. However, when a physician group chooses to invest in an ASC, the group may wish to distribute the ancillary income through the group's compensation formula. There are compelling reasons to believe this is permissible. As discussed previously, when ASC safe harbors were first issued back in 1991, the OIG explained that the Anti-Kickback Statute doesn't generally apply to payments within a corporation. That language strongly suggests including ASC revenue in the compensation formula is permitted under the Anti-Kickback Statute.

Perhaps the largest potential issue with allocating ASC income through the compensation formula is that the IRS will attempt to argue that the money is a distribution, rather than income. Over the years, there have been a few isolated instances where the IRS has taken this position. For example, in a case involving a Texas pediatric surgeon, the government argued that to the extent an associate physician generated more revenue than was paid to the physician, allocating that excess revenue to a shareholder physician constituted a dividend rather than income. These cases appear quite isolated, and are inconsistent with the general practice of professional corporations including law firms, accounting firms, as well as medical practices.

State Laws Governing Financial Relationships

Many states will have laws that regulate a physician's ownership of an ASC. It is common for states to require physicians to disclose their financial interest to patients when the physician brings the patient to an entity for services in which the physician has a financial interest. The state law may require a handout, a sign, or other written notice. Even

when state law does not explicitly include such a requirement, it is prudent to inform patients.

In addition, many states have laws that are similar to the Federal Stark and Anti-Kickback Statutes. While it is rare to find a state law that is more restrictive than the federal law, it is important to be certain that you confirm state law does not impose any additional restrictions.

Special Considerations for Ventures With Tax-Exempt Hospitals

Many ASCs are structured as a joint venture between physicians and a tax-exempt hospital. Such joint ventures typically involve an analysis of the following issues:

1. Will the hospital's participation further the tax-exempt hospital's charitable purpose?
2. Is the joint venture structured to ensure the tax-exempt entity has sufficient control to ensure the furtherance of such purposes?
3. Are all financial transactions involving individuals and for-profit partners consistent with fair market value?

If the joint venture is not structured correctly, the hospital could lose its tax-exempt status and the government could impose sanctions on certain individuals involved in the transaction. Because of these risks, many hospitals request (sometimes demand) at least 51% ownership or control of the joint venture's board of directors, even though the law does not require tax-exempt organizations to have such ownership or control to protect its tax-exempt status. Rather, the IRS simply requires that the tax-exempt hospital has adequate control to ensure the joint venture will be operated in a manner consistent with the hospital's tax-exempt status. This control can be provided through contractual "reserve powers" (often included in the ASC operating agreement), including the power to initiate (not simply veto) certain actions and also through provisions requiring the joint venture to comply with the hospital's charity care policy.

It is important for all financial transactions involving the tax-exempt hospital and for-profit ASC and individuals be consistent with fair

market value (preferably as determined by a third-party appraisal whenever possible) to avoid any "private inurement" or "improper benefit" issues with the IRS (e.g., possible sanctions and loss of tax-exempt status). It is also important to structure the joint venture to comply with any tax-exempt bond requirements.

No Surprises Act

ASCs are considered "facilities" under the No Surprises Act. That means that if the ASC is participating in a health insurance program, but physicians who are providing services to patients are out of network, there are a variety of restrictions for the out of network physician's ability to balance patient's bills. In addition, the ASC must provide a notice to patients about rights under the No Surprises Act.

In addition, when a patient will not be using insurance to pay for a procedure, either because they lack insurance or they are choosing not to use it, the patient must receive a Good Faith Estimate of the fee they will be charged, assuming the procedure is scheduled at least 3 business days in advance. (Note that at the time of publication there is no Good Faith Estimate requirement for patients with insurance, but it is anticipated that one will be issued effective in 2023.) For more information about the No Surprises Act you may watch free webinars at our firm's website; search for "No Surprises Act" at https://www.fredlaw.com/health_law_webinars/.

Frequently Asked Questions

We will close the chapter by addressing 3 questions we are often asked about ASCs.

Can We Treat Out of Network Patients as if They Are in Network?

One of the most common questions asked by ASCs is whether they can adjust their fees to a patient who is out of network so that the patient doesn't face a significant financial disincentive to using the ASC. For example, if a plan requires the patient to pay 30% of the bill when the

patient goes out-of-network, but only 20% when the patient visits an in-network facility, can the ASC choose to write-off 1/3 of the copayment so the patient only pays the 20% they would pay in-network?

The answer to this question is not clear. Insurers routinely argue that if you waive any portion of the patient's copayment, that should lower the amount that the insurer must pay in a way that preserves the patient's percentage of liability. For example, for a $1,000 bill, if the patient is responsible for 30% ($300 from the patient and $700 from the insurer), but you choose to lower the patient's liability to $200, that effectively lowers the total bill to $666, because $200 is 30% of $666. That would mean that the plan would only be required to pay $466. In that case, the $100 discount to the patient winds up costing $334 in total reimbursement. In essence, the plans will argue that their liability is calculated based on the patient's liability.

Courts that have been asked to analyze this issue have reached different conclusions. For example, in New Jersey a court ruled against Health Net when it attempted to make this argument in a dispute where ASC waived co-insurance. This case was Garcia v. Health Net of New Jersey, Inc., No. A-2430-07T3, 2009 BL 295398, 2009 WL 3849685 (N.J. Super. Ct. App. Div. Nov. 17, 2009). But a court in Texas reached exactly the opposite conclusion, holding that limiting the patient's liability limited the plan's liability in the same fashion. This case was North Cypress Medical Center Operating Co., Ltd. v. Cigna Healthcare, 781 F.3d 182 (2015)781 F.3d 182, 197, (5th. Cir. 2015). The bottom line is that there is a very real risk that lowering the patient's responsibility can drastically reduce the ASCs reimbursement.

Can a Hospital Penalize Us if We Open an Ambulatory Surgery Center?

Perhaps. Some hospitals have provisions in their bylaws that prevent members of the medical staff from competing with the hospital. This is often called "economic credentialing." While some states have laws that prohibit these provisions, many states permit them. While antitrust laws will, in some instances, permit a physician to challenge a hospital that attempts to prevent the physician from opening a competing ancillary such as an ASC, you should review your hospital bylaws so you can better anticipate any challenge. Note that even if the bylaws do not currently

contain anything that would allow the hospital to base a medical staff action on economic competition, if the hospital is able to persuade its staff to change the bylaws such a provision may be added at any time.

Can the Ambulatory Surgery Center Share Space With a Clinic or Another Ambulatory Surgery Center?

Generally not during the hours the ASC operates if the ASC is enrolled in Medicare. Note that the *Medicare Interpretative Guidelines* mentioned previously contain strict limits on the ability of an ASC to share space with a physician office or other entity. Those instructions tell state surveyors to be certain that none of the ASC's space is used by any other entity during the time that the ASC is in operation. Here is the excerpt from the *Guidelines:*

> Adjacent physician office: Some ASCs may be adjacent to the office(s) of the physicians who practice in the ASC. Where permitted under State law, CMS permits certain common, non-clinical spaces, such as a reception area, waiting room, or restrooms to be shared between an ASC and another entity, as long as they are never used by more than one of the entities at any given time, and as long as this practice does not conflict with State licensure or other State law requirements. In other words, if a physician owns an ASC that is located adjacent to the physician's office, the physician's office may, for example, use the same waiting area, as long as the physician's office is closed while the ASC is open and vice-versa. The common space may not be used during concurrent or overlapping hours of operation of the ASC and the physician office.
>
> Furthermore, care must be taken when such an arrangement is in use to ensure that the ASC's medical and administrative records are physically separate. During the hours that the ASC is closed, its records must be secure and not accessible by non-ASC personnel. It is not permissible for an ASC during its hours of operation to "rent out" or otherwise make available an operating room or procedure room, or other clinical space, to another provider or supplier, including a physician with an adjacent office.

Note that the government takes the position that even nonclinical space like a waiting room may not be shared during the hours that the ASC is in operation. That guidance would permit an ASC to lease its space to another entity during the times that the ASC is closed; but when the ASC is operating, Medicare takes the position it may not share any of its space with another entity, even an entity related to the ASC's owners.