

Balancing the Shift Between Hospital-Based and Freestanding Outpatient Sites

When developing an ambulatory care strategy, one key consideration for health systems is how to balance reimbursement concerns with strategic and operational priorities. The most important reimbursement factor for ambulatory care strategy is typically how to distribute services between hospital outpatient department (HOPD) sites and freestanding sites—and when to shift those distributions.

Current payment models incentivize health systems to retain services under the HOPD payment umbrella by reimbursing at significantly higher levels. For example, CMS Ambulatory Surgical Center (ASC) reimbursement averages approximately 60% of HOPD levels. As shown in Figure 1, rate variances differ significantly between procedures.

FIGURE 1: Medicare 2022 National Average Facility Fee Payment Rates¹

| CPT CODE | PROCEDURE SUMMARY DESCRIPTION | ASC | HOPD | ASC % OF HOPD |
|----------|-------------------------------|----------|-----------|---------------|
| 93451 | Right heart catheterization | \$ 1,254 | \$ 2,201 | 57% |
| 33208 | Pacemaker insertion | \$ 8,063 | \$ 10,619 | 76% |
| 27447 | Total knee arthroplasty | \$ 8,964 | \$ 12,593 | 71% |
| 47562 | Laparoscopic cholecystectomy | \$ 2,361 | \$ 5,167 | 46% |
| 55700 | Prostate biopsy | \$ 816 | \$ 1,828 | 45% |
| 72142 | MRI, cervical, with contrast | \$ 190 | \$ 376 | 51% |

So, why would a health system move services to sites of care with lower reimbursement levels? As shown in Figure 2, there are numerous forces driving this transition.

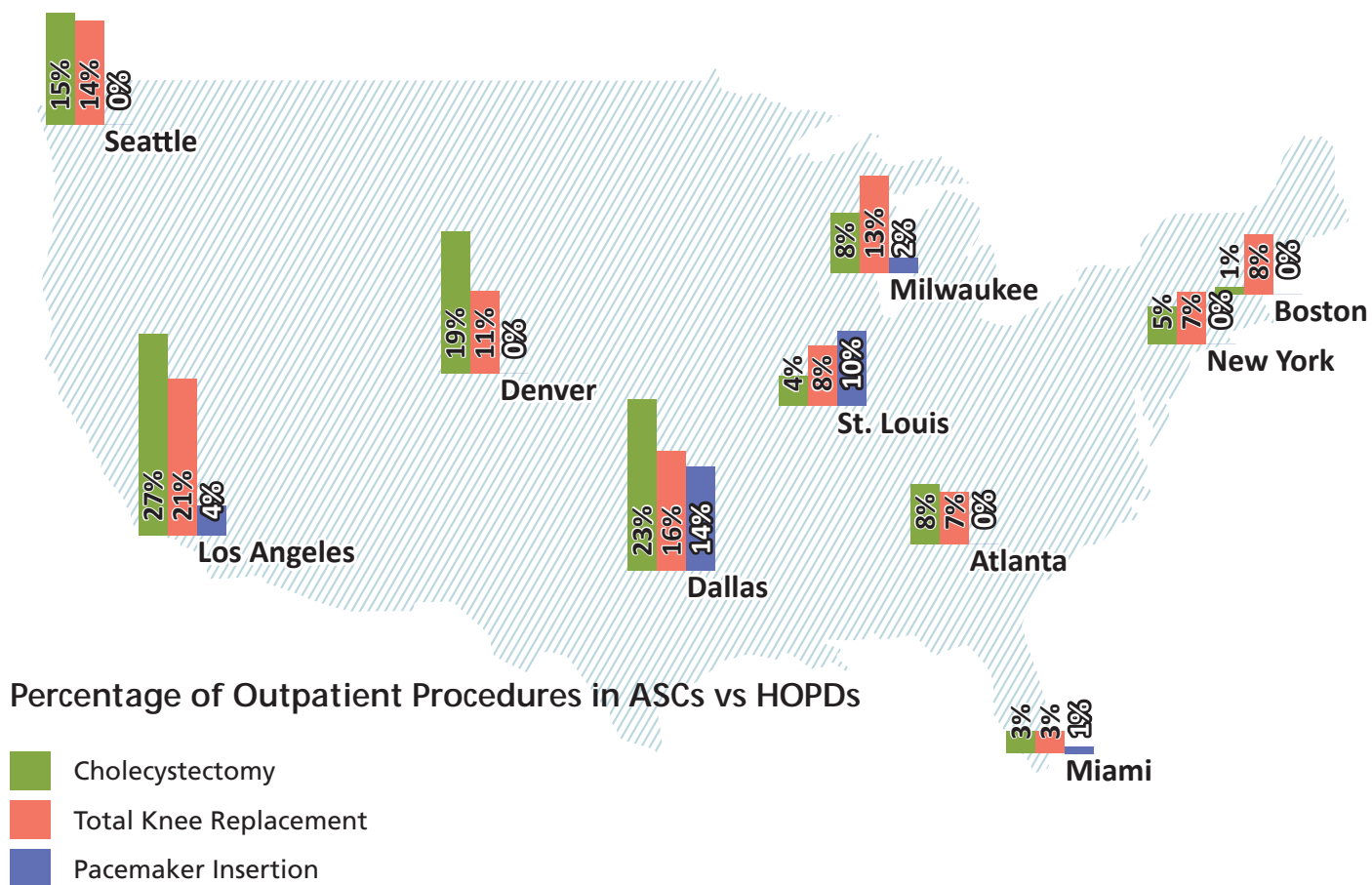
FIGURE 2: Strategic Imperatives to Drive Ambulatory Care to Lower Cost Sites of Care

| DRIVER | DESCRIPTION |
|--------------------|---|
| Growth | Reach new expanding markets outside of the HOPD constraints |
| Physician Partners | Retain or attract physicians who seek ownership of the technical fee revenue stream |
| Competition | Preempt or respond to competitors who offer lower cost models in the market |
| Payors/Employers | Address payor/employer redirection of enrollees to lower cost locations |
| Consumer Demand | Respond to rising patient demand for more convenient, lower-cost services |
| Value-based Care | Support a value-based reimbursement earnings structure by seeking high-quality/low-cost operating models |
| Facility Needs | Relocate low-acuity services from high-cost hospital campuses to create backfill capacity for higher-acuity services (e.g., “decant”) |

¹ Source: www.medicare.gov/procedure-price-lookup

Each institution faces a unique mix of these drivers and must balance its distribution accordingly. One size does not fit all. One of Innova’s clients in a south-Atlantic market has limited incentive to move away from its lucrative HOPD payments. Another in the mid-Atlantic has aggressive private equity funded outpatient centers luring its medical staff and patients away. Still another on the west coast must quickly move its business to freestanding rates or lose a significant portion of commercial revenues due to payor/ employer directives. Figure 3 illustrates differences between selected markets.

FIGURE 3: Percentage of Outpatient Procedures in Freestanding (non-HOPD) Centers: 2019²



While each market is different, national drivers will affect the entire industry. The most notable is CMS’s steady push towards site-neutral payments which seeks to “level the playing field” between hospitals and freestanding providers by providing similar Medicare reimbursement regardless of site-of-care. Despite ongoing legal and political challenges from hospital groups, CMS continues to expand the breadth of its site-neutral policies. As the Medicare payment gap between sites of care diminishes, commercial payors follow suit. The Blue Cross Blue Shield Association recently commissioned a study which concluded that broader site neutral payment policies could save \$471B over ten years.³

² Source: The Advisory Board. Using data from the National site-of-care shift maps which include commercial and Medicare Advantage claims.

³ “BCBSA: Broader site-neutral payment policies would save \$471B over 10 years” March 1, 2023, Fierce Healthcare.com

Services

Just as each market is unique, so is each service—which has its own distinct physician and competitive dynamics in the local market. Each is also subject to service-specific industry trends such as the following:



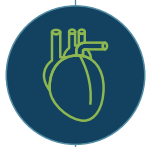
AMBULATORY SURGERY

There is a resurgence in interest for ambulatory surgery as more complex services are being removed from CMS’s inpatient only list and others are added to the ASC-approved list of procedures (e.g., total knee and hip replacements). However, it may take time for some of these more complex procedures to migrate from the relative safety of HOPD environments out to freestanding ASCs.



DIAGNOSTIC IMAGING

Diagnostic imaging is viewed by payors as more of a commodity service which is easier to redirect than most procedure-based services. For this reason, payors (and cost-conscious consumers) are choosing lower cost Independent Diagnostic Testing Facilities (IDTFs) over hospital-based services which are paid roughly twice the rate for the facility fee.



CARDIOVASCULAR

The office-based lab (OBL) model has created new opportunities for transitioning cardiac and vascular cath to freestanding centers. Cardiovascular focused ASCs are growing too with 31 new CV-focused ASCs opening in 2021.⁴ Interventional cardiologists and vascular surgeons are growing increasingly comfortable with performing these procedures away from hospital campuses.



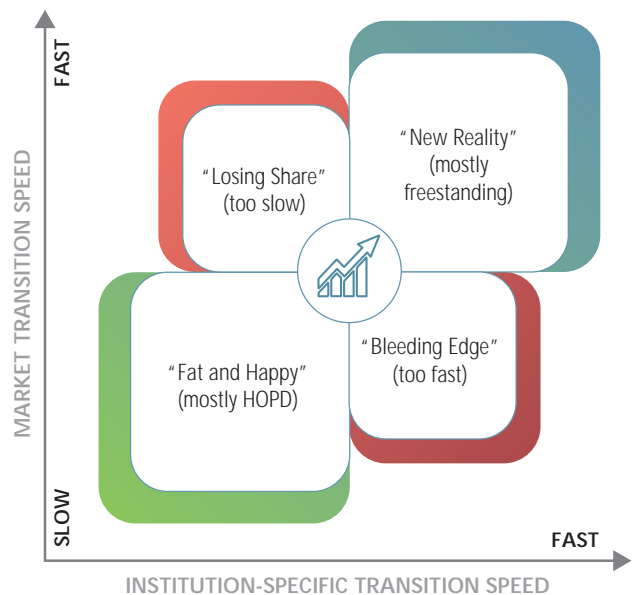
CANCER SERVICES

CMS has proposed (but delayed) a site neutral radiation oncology bundled payment program, signaling its direction for that service. Infusion therapy for hospital-based clinics and cancer centers with 340B drug pricing would face significant profitability reductions under freestanding status.

Timing: Speed of Transition

The common challenge for all institutions is how quickly to respond to these drivers. Move too fast and you are on the “bleeding edge” with too many lower-reimbursed services. Move too slow and you lose valuable market share. The leadership team must weigh these factors, often on a service-by-service basis, to anticipate the right pace for shifting the mix of services—and must do so looking through a 5–10-year lens. Figure 4 illustrates this relationship between market drivers and system positioning.

FIGURE 4: Ambulatory Payment Model Transition Speed vs Market



⁴ “Specialty breakdown of all 258 ASCs opened in 2021.” December 22, 2021, *Becker’s ASC Review*.

Developing a Plan to Transition Between Payment Models

Rather than react to market conditions annually as they occur, a plan to anticipate the transition between ambulatory payment models can provide a smoother glide path. Steps in such a plan would include the following:

1 ASSESS MARKET CONDITIONS: While most organizations have a clear understanding of local market conditions, it is helpful to filter a market assessment through the lens of ambulatory services by level of payment. Who are the low-cost providers in the market? Can claims data give us a clear view of market share and referral trends? Are regional competitors encroaching by developing ambulatory care centers? Are new competitors (e.g., national niche consolidators) approaching physicians about JVs? Are payors and employers directing patients to lower cost centers?

2 IDENTIFY HIGH-COST SERVICES MOST AT RISK: Not all services will be impacted equally. Some are at more risk than others. Local indicators include physician groups pushing to develop joint ventures or a slow deterioration of volumes from key groups; large specialty group mergers; low acuity services still on campus such as endoscopy. National payment trends from CMS will indicate the speed at which it will implement its site neutral agenda on a service-by-service and site type basis.

3 DEVELOP PRELIMINARY GROWTH/TRANSITION PLAN: Based on the organization's broader strategic plan and findings from the market and service assessment, the next step is to refine goals for ambulatory care development including service area expansion targets, service line growth, physician partnerships, value-based care network development, etc. Imbedded in the ambulatory growth plan would be initial timelines to relocate/transition specific services to freestanding payment models. The plan should also include key market indicators for annual review which would trigger acceleration or stall the timing. Finally, the plan should address the need to develop lower cost operating structures required for freestanding operations.

4 ESTIMATE NET STRATEGIC AND FINANCIAL IMPACT OF THE PLAN: This would incorporate the growth of new services, the revenue impact of transition for existing services, the capital investment requirements for growth, and an estimate of downstream margins. The impact of transitioning payment models (including relocating) services is the most sensitive and deserves annual and service line detail.

5 REFINE AND DEVELOP CONSENSUS FOR IMPLEMENTATION: Once the plan has been drafted and quantified, it's time to "pressure test it" by socializing within the organization. This helps to educate and inform key stakeholders, reveal potential obstacles or opportunities, identify critical details for implementation, and develop consensus for moving forward.

Continued movement towards lower-cost sites of care is certain. A plan to anticipate these changes and manage the transition will improve operational performance and increase the effectiveness of capital deployment.

About The Innova Group

The Innova Group is a national healthcare consultancy that specializes in strategic, operational, financial, and facility planning. Since 1995, health systems and medical groups have sought our advice on their most difficult strategic and facility planning challenges. More information about our team of professionals and consulting services can be found at www.theinnovagroup.com.

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