



Private Payer Coverage of Ambulatory Surgery Centers – Final JCR Report

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2024 Joint Chairmen's Report Requirements

- ▶ Requires MHCC to examine three broad areas:
 1. Private health plan coverage of ambulatory surgery centers (ASCs) including policies and procedures
 2. Cost differential between ASCs and hospital outpatient departments
 3. The impact of integrating ASCs with the TCOC Model or AHEAD Model



Methodology

- ▶ MIA Network Adequacy Requirements
 - ▶ Review of existing COMAR policies
- ▶ ASC/HOPD Cost Differential Analysis
 - ▶ Comparison of average costs between ASC and HOPDs
 - ▶ Decomposition of cost differences
 - ▶ Identification of high-impact procedures
- ▶ Stakeholder feedback
 - ▶ MHCC Survey administered to all ASCs in Maryland
- ▶ Data Sources
 - ▶ ASC data: Maryland Medical Care Database (APCD/MCDB)
 - ▶ HOPD data: Maryland HSCRC Case Mix dataset
 - ▶ MHCC Survey of ASCs & Private Payer coverage
- ▶ Time Period – CY2023
- ▶ Study Limitations
 - ▶ Incomplete APCD
 - ▶ Variations across payer contracts
 - ▶ One year of data; does not account for pandemic-related shifts



Findings

- ▶ Current ASC Landscape in Maryland
 - ▶ 344 ASCs in Maryland – among the top 5 states nationally
 - ▶ Majority have two or fewer operating rooms due to Maryland’s CON policy
 - ▶ Distribution of facilities is largely concentrated in urban regions
 - ▶ Procedure volumes are highest in specialties including gastroenterology, ophthalmology, and with CPT codes related to colonoscopies, upper endoscopies, and cataract surgery
- ▶ Commercial Insurance Network Participation
 - ▶ Insurers are not mandated to contract with ASCs
 - ▶ MIA network adequacy requirements based on travel distance for services
 - ▶ Payer network adequacy policies and procedures considered proprietary and confidential
 - ▶ Can result in limited patient options and reduced access to care
 - ▶ 38% of ASC survey respondents reported the process to join commercial networks as difficult



Findings (continued)

- ▶ ASC/HOPD Cost Differential Analysis
 - ▶ Comparison of average costs between ASC and HOPDs
 - ▶ Cost per service is substantially lower in ASCs compared to HOPDs
 - ▶ Decomposition of cost differences
 - ▶ ~\$9.27 million in cost differential is attributable to differences in unit reimbursement amounts—reflecting that HOPDs, on average, charge more per service than ASCs for the same CPT codes
 - ▶ ~\$101.4 million in differential is attributable to case mix, suggesting that HOPDs are performing a greater volume of higher-cost procedures
 - ▶ Identification of high-impact procedures
 - ▶ A small number of procedures account for a large share of ASC volume and associated savings potential.
 - ▶ Example: Five endoscopic and five ophthalmologic codes account for over 25% of total ASC procedures and demonstrate cost differentials between \$1,700 and \$4,700 per case



Findings (continued)

- ▶ Quality and Transparency
 - ▶ ASCs in Maryland are not currently subject to HSCRC's Quality Based Reimbursement (QBR) or other all-payer performance initiatives
 - ▶ Many federally based ASC reporting requirements focus on rare events or process compliance
 - ▶ Limited insight into patient outcomes, functional status, or disparities in care
 - ▶ Lack of standardized reporting limits the ability to compare ASC to HOPD performance



Recommendations

- ▶ Recommendation #1. Enhance MIA oversight and review of plan network adequacy requirements
 - ▶ Policy development may promote broader access to cost-effective outpatient surgical services
- ▶ Recommendation #2. Collaborate with MDH, HSCRC in aligning ASCs and AHEAD model
 - ▶ Advance statewide goals of cost containment, equitable access, and care delivery transformation
- ▶ Recommendation #3. Establish a joint ASC/HOPD Quality Monitoring Program
 - ▶ Would provide the necessary infrastructure to ensure standardized, transparent, and equitable performance metrics.
- ▶ Recommendation #4. Sustain analytic work and ongoing data evaluation
 - ▶ Would ensure that Maryland's health system transformation efforts are responsive, evidence-based, and continuously improving



Implementation Considerations

- ▶ Centralized but multi-agency collaboration required
 - ▶ Workgroups could provide oversight, coordination and policy alignment
 - ▶ Ensure consistent standards, leverage statutory authority and technical expertise
- ▶ Establish a core set of metrics to track progress on integrating ASCs into regulated models to included:
 - ▶ Quantitative indicators – e.g., changes in procedures costs by site of service, and rate of payer network participation
 - ▶ Quality metrics – e.g., postoperative complication rates, unplanned hospital admissions, or emergency department visits within 7 days
 - ▶ Equity metrics – e.g., average travel distance to in-network ASCs, utilization rates stratified by race/ethnicity, Medicaid status, rurality



Questions?