Private payer coverage of ambulatory surgery centers

2024 Joint Chairmen's report, p. 135

Maryland Health Care Commission

January 13, 2025

MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq., Chairman
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January 13, 2025

The Honorable Guy Guzzone, Chairman,
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, Maryland 21401-1991

The Honorable Ben Barnes, Chairman,
House Appropriations Committee
121 House Office Building
Annapolis, Maryland 21401-1991

Re: JCR Report – 2024 _ p135_MHCC – Private Payer Coverage of Ambulatory Surgical Facilities

Dear Chairman Guzzone and Chairman Barnes:

The Maryland Health Care Commission (MHCC) is submitting this letter as the interim report on private health insurance carriers and HMOs coverage of ambulatory surgical facilities as required by the 2024 Joint Chairmen's Report (JCR). Under the 2024 JCR the MHCC has to conduct a comprehensive study on the policies and procedures for including ambulatory surgical centers (ASC) in private health insurance carriers and HMOs plans.[1] Additionally, the report must include: a detailed analysis of the cost differential between procedures performed in hospitals [outpatient departments] and procedures performed in ASCs; and an assessment of the impact of integrating ambulatory surgical centers with the Total Cost of Care Model or its successor model under the States Advancing All-Payer Health Equity Approaches and Development model (also referred to as the AHEAD model) administered by the Centers for Medicare and Medicaid Services. MHCC must submit an interim report and a final report on Private Payer Coverage of Ambulatory Surgical Centers by June 1, 2025.

This interim report includes the workplan for completing the study. It also provides background information on the Maryland ASC industry, cost and utilization data for ASCs and hospital outpatient departments (HOPDs), and a discussion of private insurance payer requirements and regulations.

Background on Maryland ASCs: Establishment, Operations, and Ownership

[1] Under the MHCC's enabling statute and regulations, ASCs with two or fewer ORs are referred to as Ambulatory Surgery Centers (ASC). ASCs with more than two ORs are defined in MHCC regulations as an ambulatory surgical facility (ASF). The Office of Health Care Quality refers to all ASCs as freestanding ambulatory surgery centers (FASC). For purposes of this report all surgical facilities be referred to as ASCs.

According to the Ambulatory Surgery Center Association, a national industry association for ASCs, Maryland is ranked fifth in terms of states having the highest number of ASCs in the country. Although Maryland ranks high in the absolute number of ASCs, Maryland's ASCs tend to be small and most have two or fewer operating rooms (ORs).[2] This is due in part to Maryland's Certificate of Need (CON) policy that excludes the establishment of ASCs with two or fewer ORs from the full and comprehensive CON review process. Instead, a more limited review process for requests to establish small centers with procedure rooms only or up to two ORs is available in Maryland. This more streamlined process is called a Determination of Coverage review and is conducted by staff and monitored by the Commission. Smaller ASCs are also common in Maryland because most operators partner with small groups of surgeons that will also use the facility. There are about 344 licensed freestanding ambulatory surgery centers across the state, and only 18 have been subject to full CON review. There are 206 facilities that have OR capacity. Table 1 shows the number of ORs for large and small facilities.

Table 1: Number of ORs Based on ASC Size Designation

Smaller facilities: = or <2 ORs (n=326)		**Total Number of ORs**
Procedure room only (no ORs)	138	0
1 OR	137	137
2 ORs	51	102
Larger facilities: > 2 ORs (n=18)		
3 ORs	7	21
4 ORs	8	32
5 ORs	2	10
6 ORs	1	6
TOTAL	344	308

ASCs have been established in all Maryland jurisdictions except in Caroline, Garrett, Kent, and Somerset Counties. Table 2 shows the distribution of ASCs, ORs (HOPDs and ASCs), and procedure rooms by county. Capabilities vary significantly among ASCs; over 50 percent of ASCs in Calvert, Charles, Frederick, Harford, Howard, and Queen Anne's counties have no operating rooms. These centers, largely single specialty, are limited to performing simple minimally invasive surgeries, endoscopies, and certain other diagnostic procedures. These procedures do not require the use of general anesthesia [unless the patient has other associated comorbidities].

[2] COMAR 10.24.11 defines an OR as a sterile room in the surgical suite with appropriate equipment and restrictions that allow for an aseptic working environment. Open surgical procedures and certain closed surgical procedures are typically conducted in an OR where general anesthesia may be used as well as sedation therapy and local anesthetics. Procedure rooms (PR) are non-sterile rooms where minor surgical procedures can be performed using sedation therapy and local anesthetics.

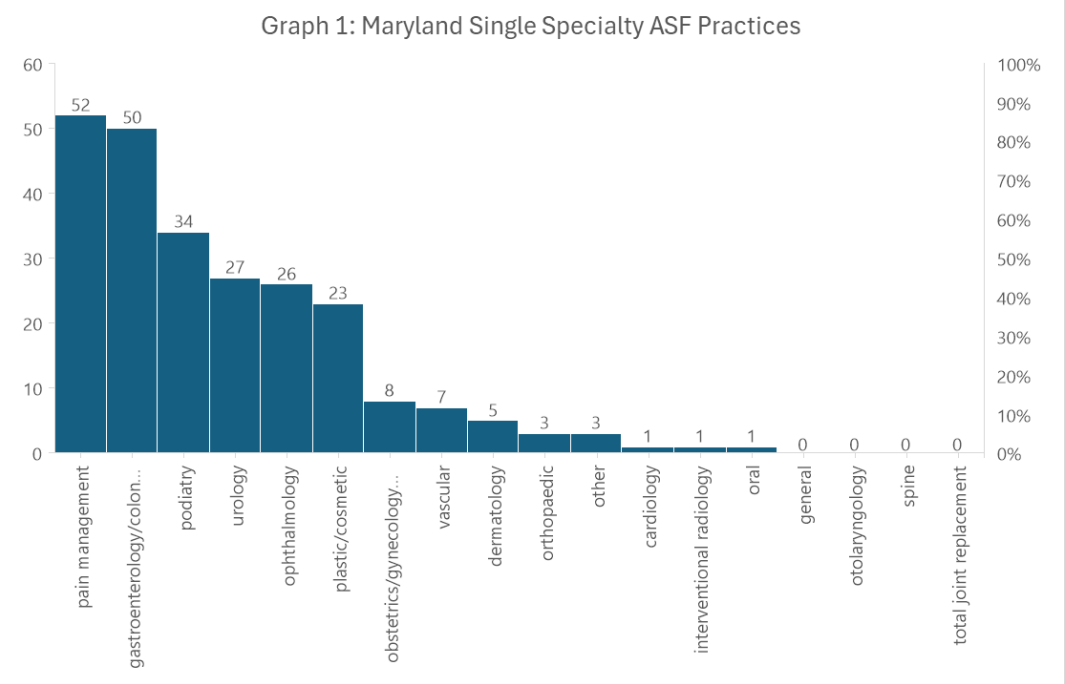
In Maryland, there are about 549 HOPD ORs and 308 ASC ORs. Some ORs combine traditional OR functions with advanced imaging technology to enable minimally invasive procedures to be performed when appropriate (i.e., mixed use or hybrid ORs). However, currently the Commission does not collect data to assess how many ORs in Maryland have this expanded capability.

Table 2: Distribution of ASCs and Operating and Procedure Rooms by County

County	# of ASCs	# of ASCs with no ORs	# of ASC ORs	# of Hospital ORs	# of ASC Procedure rooms	# of Hospital Procedure rooms
	ASCs		ORs		Procedure rooms	
Allegany	5	1	4	14	7	6
Anne Arundel	34	10	35	42	56	10
Baltimore City	7	3	4	212	11	96
Baltimore County	71	27	72	78	101	19
Calvert	7	4	3	6	7	4
Caroline	0	0	0	0	0	0
Carroll	9	4	5	10	13	3
Cecil	3	1	2	4	4	7
Charles	11	9	3	4	21	2
Dorchester	1	1	1	0	1	0
Frederick	22	14	14	11	37	3
Garrett	0	0	0	3	0	2
Harford	15	7	10	15	20	2
Howard	22	11	16	10	35	3
Kent	0	0	0	2	0	1
Montgomery	66	26	71	64	110	18
Prince George's	38	13	38	34	46	16
Queen Anne's	2	1	1	0	4	0
St. Mary's	4	1	3	6	5	2
Somerset	0	0	0	0	0	0
Talbot	6	2	4	6	11	1
Washington	10	1	11	11	11	3
Wicomico	9	1	11	13	16	4
Worcester	2	2	0	4	3	4
TOTAL	344	139	308	549	519	206

It is important to note that most of Maryland ASCs are single specialty facilities. In fact, 244 of the 344 ASCs in Maryland report that they are a single specialty facility. Graph 1 shows the distribution of single specialty ASCs by the specialty they support. Pain Management and gastroenterology account for the highest number of single specialty ASCs. In fact, 32% (n=109) of all ASCs support

pain management services. Many of the gastroenterology ASCs offer a limited range of procedures such as colonoscopies. The remaining 97 facilities are considered multiple specialty and support various surgical disciplines.



Ownership of ASCs

Most ASCs in Maryland are owned by the surgeons who provide the services (i.e., surgical procedures) at those facilities. Physician ownership and control have been key factors in the growth of the ASC sector. As value-based payment models have gained momentum, insurance carriers and HMOs have pursued more restrictive payment formulas, and staffing issues are proving ever more daunting, many ASCs have sought support from ASC management companies.

Large ASC management companies, like United Surgical Partners International (USPI), owned by Tenet Healthcare reports having agreements with 46 Maryland ASCs. SCA Health, owned by Optum, itself a subsidiary of United Health Group, is also active in Maryland with at least six affiliated Maryland ASCs including a University of Maryland ASC in Howard County and a Luminis ASC in Pasadena Maryland. Other large ASC management companies including HCA Surgical Ventures and Surgery Partners are possibly active in Maryland. Surgery Partners is reported in merger discussions with SCA Health. If the merger occurs, Optum's SCA Health would leapfrog over USPI to become the largest ASC management company with over 650 ASCs nationally under their management.

Private equity organizations have also shown increased interest in the last several years. Summit Ambulatory Surgery Centers, a subsidiary of Chesapeake Urology, now operates 18 ASCs in

Maryland. Chesapeake Urology's expansion has been fueled in part through private equity investments, but not ownership control. Chesapeake Urology operates in several other states as United Urology. Clearway Pain Solutions operates 20 ASCs in Maryland focusing on pain management. Clearway also operates in several other states. Like Chesapeake Urology, Clearway Pain Solutions has attracted private equity investment, but not control. All but one Clearway Pain Solutions ASCs in Maryland have procedure rooms, but no ORs as most pain management procedures do not entail the use of general anesthesia or involve open surgical procedures.

Maryland health systems have taken a more active interest in owning and operating ASCs as the incentives under the hospital payment system have changed. University of Maryland Medical Systems (UMMS), Luminis, and MedStar expanded their ASC capacity in 2024 by establishing new ASCs or partnering with physician practices.

Utilization of Outpatient Surgeries in Maryland

Over time, the MHCC and the Health Services Cost Review Commission (HSCRC) have utilized the All-Payer Claims Database (APCD), national commercial claims data, and the HOPD database to analyze and compare volume and cost trends in outpatient surgeries performed in the ASC and HOPD settings. Using 2022 data, the HSCRC found that Maryland performs a high volume of outpatient surgery as compared to other states, and a high percentage of those surgeries are performed in ASCs. HSCRC developed a benchmark for Maryland based on matching each Maryland geography to a set of similar national geographies to calculate various metrics. They also applied some risk adjustment to further improve the comparison. Overall, HSCRC found that "ASCs tend to perform more simple surgeries than HOPDs and that adding additional ASCs to a plan's network could lead to provider driven demand and dissipating volume to smaller facilities at a risk to quality."[3] Inappropriate use of surgical interventions can occur in any setting. In Maryland, the inappropriate use of angioplasty from 2008-2010 occurred at several large community hospitals. MHCC intends to further examine the HSCRC findings using more current hospital and ASC claim data.

MHCC conducted analyses using claims from the Maryland Medical Care Data Base and the HSCRC HOPD dataset to determine the cost differential between outpatient surgeries performed in the ASC as compared to HOPD. Specifically, comparing over 100 common procedures performed in an ASC with the same procedures performed in a HOPD (excluding Emergency Department data). Results show that the average cost per procedure is about 38% lower when performed in an ASC than in the HOPD.

Policymakers have questioned differences in payment levels at ASCs and HOPDs and argued for gradual elimination of site of service differentials. Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no

[3] Based on communications with HSCRC staff. It is important to note that ASCs are limited to performing procedures authorized by CMS for ACSs.

discernible effect on patient care, it may impact Medicare's and commercial carriers and HMOs' payment for such services and patient cost-sharing expenses. Medicare, Medicaid, and commercial health insurance carriers and HMOs' pay higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure. These discrepancies are somewhat magnified in Maryland because of our unique hospital payment system.[4]

The Medicare Payment Advisory Commission (MedPAC) has recommended in multiple MedPAC Reports to Congress that site of service differentials be gradually eliminated.[5] CMS has not acted on these recommendations in part because of staunch opposition from the hospital industry. Hospital representatives argue that the payment differences are warranted given higher operational costs and hospital obligations to provide care to all patients, including the uninsured.

In Maryland, the site of service differential is substantial because hospitals' bill HSCRC-approved hospital rates (applying to all payers) that tend to be somewhat higher than what Medicare pays for hospital outpatient surgeries using the outpatient prospective payment system. ASCs in Maryland are paid using a similar framework to what applies nationally --- Medicare pays according to the ASC payment system, Maryland Medicaid has its own payment system, and private payers set their payment levels for procedures delivered at ASCs. Medicaid and private payers often derive their ASC fee levels from the ASC payment framework established by Medicare. Medicaid Managed Care Organizations (MCOs) set their own fee for ASC services. ASCs generally argue that these fee levels, which are generally less than what is paid under the Medicare ASC payment system for the same surgery are not adequate. Generally, ASCs will contract with at least one MCO. Given eight MCOs operate in Maryland, many Medicaid beneficiaries maybe more likely to use HOPDs. Hospitals do not experience fee reductions for treating Medicaid beneficiaries because unlike ASCs, hospitals are paid the same HSCRC authorized rates for providing outpatient surgical services to Medicaid, Medicare beneficiaries, and the commercially insured. This issue can be further examined in the final report.

Recent research found similar results even after adjusting for patient characteristics. Total payment for an ambulatory service was, on average, 145% higher in a HOPD than the same service in a physician office. Out-of-pocket spending was 109% higher. Patients receiving services in outpatient departments had higher mean risk scores and received more services on the date of their visit (in

[4] The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program's and other payers use of separate payment systems for different sites of service such as an ASC versus a hospital outpatient department.

[5] See June 2023 MedPAC Annual Report to Congress. MedPAC recommended that the Centers for Medicare & Medicaid Services align payment rates across hospital outpatient departments (HOPDs), ambulatory surgical centers, and physician office settings for select services determined to be safe and appropriate to provide to Medicare beneficiaries in all settings. This recommendation was repeated in the 2024 June Report to Congress.

addition to the index CPT being studied) than patients receiving the same index CPT in a physician's office.[6]

MHCC has begun an examination of payment differences as part of this study. This work will be expanded in the final report. To date, MHCC staff have found that the ten procedures with the largest cost differences among the 101 procedure codes studied show that the average cost per procedure is substantially lower in an ASC than in a HOPD. Looking at the number of services per 10,000 patients per year, in general, more procedures are conducted in HOPDs than in ASCs. That is consistent with the much higher number of operating rooms in HOPDs compared to ASCs in Maryland.

Commercial Insurance Statutes and Regulations

		ASC Inst MCDB (In-Network)*		Hospital OutPatient Casemix		ASC vs. Hospital Outpatient	
Procedure Code	Description	Number of Services Per 10,000 Patients per Year	Cost Per Procedure	Number of Services Per 10,000 Patients per Year	Cost Per Procedure	Cost Differential	Cost Differential %
27784	Open treatment of proximal fibula or shaft fracture	12	$1,061	12	$19,926	-$18,865	-95%
19340	Immediate insertion of breast prosthesis	3	$2,512	79	$42,833	-$40,321	-94%
49321	Laparoscopy, surgical; with biopsy (single or multiple)	3	$751	438	$9,809	-$9,058	-92%
19303	Mastectomy, simple, complete	47	$2,144	1,526	$25,803	-$23,659	-92%
19370	Open periprosthetic capsulotomy, breast	15	$794	517	$9,298	-$8,504	-91%
19316	Mastopexy	30	$1,042	195	$11,101	-$10,059	-91%
28810	Amputation, metatarsal, with toe, single	6	$925	61	$9,723	-$8,798	-90%
19301	Mastectomy, partial	142	$1,016	26,500	$10,493	-$9,477	-90%
28124	Partial excision; phalanx of toe	130	$533	128	$5,179	-$4,646	-90%
19302	Mastectomy, partial ; with axillary lymphadenectomy	6	$1,722	97	$15,890	-$14,168	-89%
Total	101 procedure codes	8,493	$6,709	248,669	$10,853	-$4,144	-38%

*The MCDB excludes data for self-insured ERISA health plans and FEHB plans, which, due to federal decisions, account for about 44% of the privately insured population in the MCDB.

Over the years more and more surgeries are being performed in ASCs because of the lower cost to perform those services within an ASC as opposed to an inpatient hospital stay or HOPD. To maintain an equitable playing field among commercial insurance carriers and HMOs and to ensure subscribers have access to covered services, the Maryland Insurance Administration (MIA) sets standards for health insurance providers. Section §15-112 of the Insurance Article contains the standards for network sufficiency in commercial plans. This statute outlines the timeframes in which a commercial insurance provider must respond back to a requestor for inclusion in their network. The statue also identifies three main reasons why a commercial insurance provider could deny a requestor:

- A full network
- Any non-prohibited reason that is given within 90 days written notice, and
- Fraud, patient abuse, incompetence, or loss of licensure status without advance notice to the commercial insurance provider.

[6] Sen AP, Singh Y, Anderson GF. Site-based payment differentials for ambulatory services among individuals with commercial insurance. Health Serv Res. 2022 Oct;57(5):1165-1174. doi: 10.1111/1475-6773.13935. Epub 2022 Feb 15. PMID: 35041209; PMCID: PMC9441285.

Commercial Health Insurance Network Adequacy Requirements

The Maryland Insurance Administration (MIA) is responsible for ensuring each commercial health plan adequately meets the needs of Maryland residents. MIA's network adequacy regulations guide how commercial plans ensure access to covered healthcare services by qualified healthcare providers. Representatives of MIA noted that "there are no specific benefits mandates within Maryland laws or regulations requiring insurance carriers to cover treatment performed at an ASC." MIA's network adequacy rules located in COMAR 31.10.44.03 states, "a carrier shall develop and maintain a network of providers in sufficient numbers, geographic locations, and practicing specialties to ensure enrollees have access to participating providers for the full scope of benefits and services covered under the carrier's health benefit plan." The network adequacy standard includes in its sufficiency standard a travel distance mapping to ensure that a network carrier offers services within a maximum distance of travel for urban, suburban, and rural areas. Reports from MIA since 2018 indicate that carriers have complied with the travel distance standard. Most carriers maintain that much of the supporting documentation in the network access plan files are proprietary and confidential. Reviewing the state's statues and regulations on requirements for commercial insurance providers could lead to a recommendation calling for more detailed information on the plan's rationale for determining a "full network." Under current MIA regulations, the provider is not required to share this information publicly.

A workplan is attached that outlines the tasks required to complete the study and submit the final report by June 2025.

Sincerely,

Ben Steffen
Executive Director

cc:
The Honorable Bill Ferguson, President, Senate
The Honorable Adrienne A. Jones, Speaker, House of Delegates
The Honorable Laura Herrera Scott, Secretary, Maryland Department of Health
Senate Budget and Taxation Committee Members
House Appropriations Committee Members
Kimberly Landry, Committee Manager, Senate Budget and Taxation Committee
Carole Smith, Assistant to Chair, House Appropriations Committee
Jonny Dorsey, Deputy Chief of Staff, Governor's Office
June Chung, Deputy Legislative Office, Governor's Legislative Office
Jason Heo, Governor's Office
Sophie Bergmann, Governor's Office

Sarah Albert, Department of Legislative Services (5 copies)
Theressa Lee, Director, Center of Quality Measurements and Reporting, MHCC
Mariama Simmons, Chief, Outpatient Quality Reporting Initiatives, MHCC
Tracey DeShields, Director, Policy Development and External Affairs, MHCC

Workplan for the Study of Private Payer Coverage of Ambulatory Surgical Facilities

Task To Completed	**Status**
Introductory meeting with Health (HSCRC) to define project scope	Completed
Collaborate with Maryland Insurance Administration (MIA) to identify and understand network adequacy requirement for private insurance carriers	Completed
Generate 2023 (most current) ASC claims data extract from All Payer Claims Database (APCD)	In Progress
Generate 2023 (most current) hospital outpatient department (HOPD) data extract from HSCRC outpatient claims file	In Progress
Define CPT codes for the study	In Progress
Create ASC survey to gain understanding of provider perspective on network participation/challenges issues	Completed
Administered ASC survey	Completed
Draft preliminary interim letter of findings	In Progress
Outreach to health plans to inform understanding of their policies and procedures of network adequacy	In Progress
Compile and format ASC survey results	Due February 2025
Conduct surveys of the larger commercial insurers	Due January 2025
HOPD and ASC data analyses, and other data gathering activities (MHCC and HSCRC analyses)	Due March 2025
Draft final report with findings and recommendations	Due May 2025