“Trends in the Ambulatory Surgery Center Industry”

Mark Wainner VP, Financial Operations
AmSurg
Introduction

- AmSurg
- Overview of ASC Industry
- Change from in-patient to out-patient to ASC
- Growth drivers
- Most common specialties performed in the ASC
- Medicare reimbursement changes
- Commercial reimbursement
- ASC ownership
- Selling to ASCs
- Future of ASCs
AmSurg

- Founded 1992
- Partner with Physicians to operate freestanding outpatient surgery centers
- Managing and General Partners in 203 Surgery Centers in 33 States and DC
- Our portfolio of centers consists of 142 Endoscopy, 36 Eye, 8 Orthopedic, and 18 Multi-Specialty Centers.
- Our model is 51% AmSurg / 49% Physician
- 2010 – AmSurg centers will perform over 1.25 million outpatient surgical procedures.
- 2010 Medical Supply and Drug spend ~ $100 million
Overview: ASC Industry

- 1970 - First ASC opened in Phoenix, AZ
- 1982 - Medicare began reimbursing for outpatient surgical services
- Today, ASCs are an integral component of U.S. healthcare delivery system
- Today, 40% of outpatient surgeries performed in ASCs
- Today, patients access ASCs through over 5,200 facilities in nearly every state
- Each year, technology advancements allow more procedures to be safely performed in the outpatient setting.
ASCs by State - 2007

Source: ASC Association brochure
CON regulations by State - 2008

Source: VMG Health Intellimarker, 2008
OP Surgeries in ASC vs. HOPD

- Medicare approves ASCs in '82, several years after JAMA and commercial payers endorsed ASCs
- Limited to early adopters
- Increasing comfort level of physicians and anesthesiologists
- Influx of colonoscopies and cataract surgeries
- Increased use of physician offices due to payer pressures
- Trends slowing and will depend on pressure from payers to accelerate the shift from HOPD

Sources: AHA 2008 Trends Affecting Hospitals and Health Systems, Verispan Profiling Data, BRP Analysis.
Growth of outpatient surgery over time

The volume of outpatient surgery has grown at a predictable rate, consistent with technological advances and clinical guidelines.

Note: Average annual percent change in total surgery volume 1981-2006 was 3.8%
Growth Drivers

- Technology
- Cost Savings
- Acceptance as a viable alternative
- Cancer Awareness – Colon Cancer (i.e. Katie Couric Effect)
- Demographics – Baby Boomers
- Setting change from Inpatient/Hospital Outpatient (HOPD) to Outpatient ASC
Site of service for outpatient surgery has shifted from HOPD to ASC

Recent KNG Health study: 70% of growth in ASCs from 2000 to 2007 is the result of moving procedures from HOPDs into the less expensive ASC setting

Note: Pain Management services, a relatively new field, grew substantially in physician, HOPD, and ASC settings from 2000-2007. As a result, little migration is observed.
Growth rate in the number of ASCs is slowing

Figure 3. Annual Net Growth Rate in Medicare-Certified ASC Facilities

Source: CMS Provider of Service Files (various years) and MedPAC March Report 2003
Figure ES1. ASC Share of Medicare Allowed Charges by Service Category, 2007

Source: KNG Health analysis of PSPS files. Includes FFS Medicare claims only.

- Eye procedure - cataract removal/lens insertion, 40%
- Eye procedure - other, 6%
- Orthopedic, 7%
- Pain management, 10%
- Endoscopy - upper gastrointestinal, 8%
- Endoscopy - colonoscopy, 17%
- All other, 12%
Medicare - Changes in ASC payment

- Medicare froze ASC rates from 2003 to 2007
- Four year (2008 – 2012) transition to new payment methodology
- Medicare pays ASCs around 59% of the fee that the Hospitals gets for doing the same procedure

<table>
<thead>
<tr>
<th>Procedure</th>
<th>HOPD</th>
<th>ASC</th>
<th>$ Difference</th>
<th>ASC % of HOPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984 Cataract</td>
<td>$1604.94</td>
<td>$962.44</td>
<td>$642.50</td>
<td>60%</td>
</tr>
<tr>
<td>45378 Diagnostic Colonoscopy</td>
<td>$593.76</td>
<td>$380.23</td>
<td>$213.53</td>
<td>64%</td>
</tr>
<tr>
<td>29881 Knee Arthroscopy</td>
<td>$1943.12</td>
<td>$1049.62</td>
<td>$893.50</td>
<td>54%</td>
</tr>
</tbody>
</table>
### Medicare - Changes in ASC payment

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Medicare %</th>
<th>Commercial %</th>
<th>06 to 07</th>
<th>07 to 08</th>
<th>08 to 09</th>
<th>09 to 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye</td>
<td>71%</td>
<td>29%</td>
<td>-3%</td>
<td>-2%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>GI</td>
<td>31%</td>
<td>69%</td>
<td>0%</td>
<td>-5%</td>
<td>-6%</td>
<td>-5%</td>
</tr>
<tr>
<td>Ortho</td>
<td>10%</td>
<td>90%</td>
<td>0%</td>
<td>31%</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Pain</td>
<td>40%</td>
<td>60%</td>
<td>0%</td>
<td>-7%</td>
<td>-9%</td>
<td>-12%</td>
</tr>
</tbody>
</table>

*Note: Based on the weighted average reimbursement for the Top 5 CPT codes performed for each specialty*
ASC are still much cheaper for the patient

<table>
<thead>
<tr>
<th>Procedure</th>
<th>HOPD Co-Pay</th>
<th>ASC Co-Pay</th>
<th>% Savings at ASCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984 Cataract</td>
<td>$495.96</td>
<td>$192.24</td>
<td>61%</td>
</tr>
<tr>
<td>45239 Upper GI Endoscopy, Biopsy</td>
<td>$143.38</td>
<td>$78.41</td>
<td>45%</td>
</tr>
<tr>
<td>45378 Diagnostic Colonoscopy</td>
<td>$186.06</td>
<td>$79.77</td>
<td>57%</td>
</tr>
<tr>
<td>45380 Colonoscopy and Biopsy</td>
<td>$186.06</td>
<td>$79.77</td>
<td>57%</td>
</tr>
<tr>
<td>66821 After Cataract Laser Surgery</td>
<td>$104.31</td>
<td>$51.72</td>
<td>50%</td>
</tr>
</tbody>
</table>
How do commercial plans pay us?

- Old Medicare Methodology
- Current Medicare Methodology
- Hybrid of the old and the new methodology
- No correlation to Medicare
- Based on charges
## Medicare vs. Commercial Payment

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multiple procedures</strong></td>
<td>1&lt;sup&gt;st&lt;/sup&gt; – 100% 2&lt;sup&gt;nd&lt;/sup&gt; and Subsequent – 50%</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; – 100% 2&lt;sup&gt;nd&lt;/sup&gt; and Subsequent - Varies</td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td>Typically included</td>
<td>May be included Payable to 3&lt;sup&gt;rd&lt;/sup&gt; party May not reimburse at all Cost plus % of billed charges</td>
</tr>
<tr>
<td><strong>Tissue</strong></td>
<td>Typically paid at cost</td>
<td>May be included Payable to 3&lt;sup&gt;rd&lt;/sup&gt; party May not reimburse at all Cost plus % of billed charges</td>
</tr>
</tbody>
</table>
Why does it matter how ASCs are paid?

- Positive or negative changes in reimbursement will impact procedures performed
  - Payment may make certain procedures worthwhile
  - Payment may not be adequate to cover cost to perform certain procedures
  - Payment may not be adequate to cover cost of implants or tissue
- Negative changes will impact margins and influence purchasing behavior
- Significant variation from payer to payer and market to market
Who are the owners of the ASCs?

ASC OWNERSHIP STRUCTURE

- Physician Only: 61%
- Corporate-Physician: 11%
- Hospital-Physician: 16%
- Corporate-Hospital: 2%
- Hospital Only: 3%
- Corporate Only: 7%

ASC ownership

- 25% - 30% or 1,300 to 1,560 of ASCs have Hospital Ownership
- HCA ~ 95 ASCs
- Several companies specialize in Hospital/Physician/Corporate JVs
  - United Surgical Partners (USPI) in Dallas
  - Symbion in Nashville
- 10% - 15% are Physician/Corporate JVs
  - AmSurg (AMSG) in Nashville
  - Surgical Care Affiliates (formerly HealthSouth) in Birmingham
- The remainder (50% - 60%) are owned by physicians
- It is estimated that 20% – 30% of ASCs are not making money at any one time.
Why is it important to you who owns the ASC?

- Decision making – Centralized vs. Local
- Control – Corporate or Independent
- Hospital and Corporate partners typically work with GPOs and attempt to drive compliance to preferred vendors
- Independent representatives are often referred to Corporate to evaluate products as our Center Administrators are strongly encouraged to purchase through our preferred agreements.
Selling to our ASCs – Things to consider

- AmSurg’s GPO is HealthTrust Purchasing Group (HPG)
- We also have many direct purchasing agreements that are outside of our HPG agreement
- AmSurg steers our centers to our corporate agreements or preferred vendors – Others may do the same
- E-Procurement – AmSurg’s Supplier Network Automated Procurement (SNAP)
- AmSurg conducts periodic purchasing business reviews (PBRs) in an effort to reduce our spend for high volume items.
Selling to our ASCs – Things to consider

- Price – Very important but not always the deciding factor
- Value purchasing = best product at the best price
- The Big Picture – Pricing, administrative and staffing cost of using a product, and quality of care provided for our patients (i.e. lower risk of undesirable incidents and infections)
- Soft cost - savings or increases when changing products
Selling to our ASCs – Things to consider

- Pricing confidentiality
- Give us your best price without the knowledge of the competitor pricing
- Beware of “Loss Leaders”
- Understand that in aggregate that our pricing is very competitive
- Wary of pricing creep
- Adding a vendor may cost more than we save
What is the future of ASCs?

- Increasing regulatory pressure
- Increasing focus on infection control
- Little growth in new ASCs
- Positive Demographics continue
- Shortage of specialty physicians
- Continued downward reimbursement pressure
- Compelling pricing for payer, employers, and consumers
- Squeezing center profit margins
What is the future of ASCs?

- **Health Care Reform**
  - Influx of patients at lower reimbursement
  - Physician shortage worsens

- **Accountable Care Organizations (ACOs)**
  - ACOs will be controlled by hospital systems and possibly large physician groups
  - Global payments
  - Unsure of ASCs place with ACOs
  - Anticipate steerage of volume to hospital owned ASCs or continued downward pressure on ASC reimbursement
Questions?