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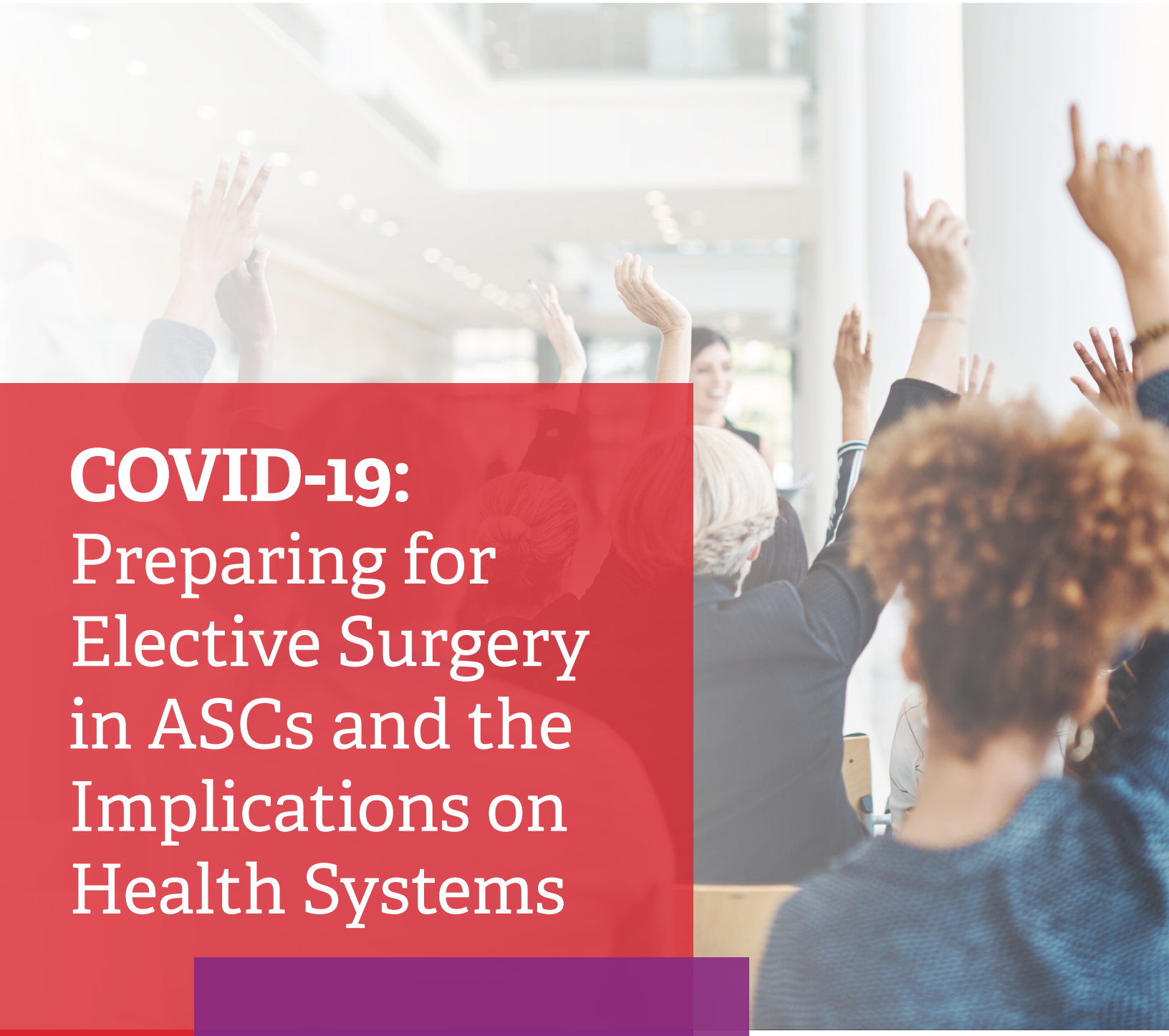

COVID-19: Preparing for Elective Surgery in ASCs and the Implications on Health Systems

WEBINAR QUESTIONS AND ANSWERS

OVERVIEW

On April 23, 2020, ECG conducted a webinar titled "COVID-19: Preparing for Elective Surgery in ASCs and the Implications on Health Systems." Morgan Leske, Senior Consultant at ECG, moderated a discussion between the following speakers:

- Naya Kehayes, Principal, ECG
- Sean Hartzell, Associate Principal, ECG
- Matt Kilton, Associate Principal, ECG
- Catherine Ruppe, RN, CASC, Associate Principal, ECG
- Greg DeConciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites

Topics in this discussion included:

- The potential impact of COVID-19 on surgery migration, expansion of services, payer contracting, and ASC operations.
- The implications on the demand for elective surgery when ASCs and health systems reopen their ORs.
- How surgical volume limitations and access may redefine business relationships and the alignment of ASCs with health systems.

Prior to and during the webinar, the more than 280 participants asked the panel many thoughtful questions. Numerous questions were addressed during the roundtable discussion, a recording of which can be found here. Below are the panel's answers to the questions that were not addressed during the session.

ABOUT ECG MANAGEMENT CONSULTANTS

With the knowledge and expertise built over the course of nearly 50 years, ECG is a national consulting firm that is leading healthcare forward. ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to providers, building multidisciplinary teams to meet each client's unique needs—from discrete operational issues to enterprise wide strategic and financial challenges. ECG is an industry leader, offering specialized expertise to hospitals, health systems, medical groups, academic medical centers, children's hospitals, ambulatory surgery centers, and healthcare payers.

DISCLAIMER

These answers are advisory and are based on ECG's understanding of the situation at the time of publication. These answers do not constitute legal or medical advice.

INDEX OF TOPICS AND QUESTIONS

1 | QUESTION:

Where can ASCs find specific guidelines to follow when reopening?

ANSWER:

Catherine: ASCA has posted a number of resources on its site, including links to the CMS and White House guidelines and a checklist for reopening:

- https://www.ascassociation.org/asca/resourcecenter/latestnewsresourcecenter/covid-19-cms-recommendations-for-reopening

Also refer to your specific state and local public health officials for guidance on reopening.

2 | QUESTION:

What are the preadmission testing requirements for COVID-19 in the ASC setting?

ANSWER:

Catherine: It is up to each ASC to follow the guidance of its state and local public health officials. General guidance is that if testing is not widely available, then the center will need to create policies and procedures for screening all patients prior to and on the day of surgery, as well as all staff and anyone who enters the facility.

3 | QUESTION:

When reopening, what is the impact on ancillary services (e.g., lab, imaging) that ASCs need to utilize?

ANSWER:

Catherine: The same screening process, as well as enhanced cleaning protocols, should be followed regardless of the site of service.

4 | QUESTION:

What will the role of COVID-19 pretesting be in the future?

ANSWER:

Catherine: Given the current situation—and with consideration of CDC, federal, and state guidelines to ensure patient, staff, and provider safety—it is expected that COVID-19 pretesting will take on a greater role. We believe day-of-surgery patient testing, as well as daily staff and provider testing, will become the norm as the industry looks to move forward with the highest-quality care.

5 | QUESTION:

Given the national shortage of PPE and the 30% false-negative rate of our best COVID-19 test, is there a minimum number of N95s we need to reopen?

ANSWER:

Catherine: The general guidance is that a facility should have enough PPE to protect patients and staff, not a specific number. The facility will need to continually reassess and manage all its supplies and resources. The FDA and CDC have published guidance on N95 mask use and reuse during the COVID-19 pandemic:

- https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

6 | QUESTION:

What factors should help determine when to start elective procedures and how to prioritize them?

ANSWER:

Catherine: CMS has published general recommendations and considerations that the facility should carefully consider as it prepares to restart elective procedures. Follow your state guidelines, and assess the presence of COVID-19 trends in your area. Create a process at your facility to review patient-selection criteria and case prioritization.

7 | QUESTION:

Is there a recommended ramp-up by percentage or by service line based on geographic location? Should ASCs look at hot spots versus non–hot spots of COVID-19 patient density?

ANSWER:

Sean: At this time, there is no formal guidance on what types of services should open. COVID-19 patient density and the trend in new cases over 14 days will be critical. Furthermore, ASC leaders will need to examine service lines and procedures for patients who are more susceptible to contracting or transmitting the virus (i.e., age and comorbidities).

8 | QUESTION:

Will insurance companies cover pre-op COVID-19 testing?

ANSWER:

Catherine: At this time, ASCs are not able to bill Medicare for lab tests under their CLIA waiver. As testing becomes more widely available from commercial labs, patients can be referred for pre-operative testing by their surgeon's office. However, there may be access to coverage with commercial payers.

Naya: With respect to commercial payers, they will likely follow the Medicare guidelines where laboratory services are not paid separately in an ASC with a CLIA waiver. However, the ASC should check with the commercial payers in the event they are willing to provide access to reimbursement; this would likely require an amendment to contractual provisions in an ASC with a CLIA waiver, that outlines the payment terms and rates for these services.

9 | QUESTION:

Should we have separate facilities for surgeries and care of COVID-19 cases? Or is separating the care enough?

ANSWER:

Catherine: The WHO recommendation does not include a requirement for separate facilities. It will be important to have strict screening protocols in the absence of the availability of testing. The facility needs to implement stringent infection-control protocols and monitor any movement between COVID-19 and non-COVID-19 zones.

10 | QUESTION:

How can facilities transition back from an HOPD to an ASC when the enrolled ASC has applied for temporary hospital privileges?

ANSWER:

Naya: CMS has provided definitive guidelines and protocols for transitioning back to an ASC. The following link provides the guidelines:

- https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

11 | QUESTION:

Is there a thought that large, system-owned ASCs will reopen at the same time as smaller, independent ASCs, or will there be staggered/different timing?

ANSWER:

Sean: Currently, no guidance has been announced on what type of facilities will open or when. It is anticipated that ASCs that have hospital partners will be able to open earlier, assuming they have introduced new COVID-19 guidelines, have PPE in place, and are working and communicating with patients and families to ensure a COVID-19-free environment.

12 | QUESTION:

Do you feel that physician majority-owned or totally owned entities will be more aggressively seeking hospital or IDN ownership or joint ventures as a way to protect themselves in the future from situations like this? Do you think this will be similar to physicians moving to more salary-driven positions versus self-employment?

ANSWER:

Sean: I do think there will be a cadre of physician-owned ASCs that will look for a capital partner, be it a hospital, health system, or venture capital or private equity firm, to help reduce potential exposure to this type of pandemic in the future.

13 | QUESTION:

What are the implications down the road for children's hospitals, given the decrease in elective procedures?

ANSWER:

Sean: As the decrease in elective procedures will continue to put pressure on children's hospitals, children's hospitals will need to understand how opening an outpatient department or pediatric-specialty ASC will help change the capital structure and provide a vehicle for procedures that are appropriate for the outpatient setting, thereby opening needed surgical capacity at the main hospital.

14 | QUESTION:

What is driving the thought that overall outpatient surgeries could decrease in the long term?

A. Is it mostly because of patient behavior?

B. Is it because patients are scared to have elective surgery?

C. Will payers actually make it harder to have those elective procedures going forward?

ANSWER:

Naya: Initially, we anticipate that ambulatory surgery will be scheduled over time; overall, we do not expect that elective surgery will decrease in the long term.

To the contrary, we think many of the fundamental reasons we identified during the discussion will remain in place and actually accelerate as patients look for alternative sites to the hospital. In addition, providers, patients, and payers—including CMS—will search for more optimal outlets from a cost perspective, etc.

In addition, there are no indications that payers will impact access to elective surgery as long as ASCs and hospitals providing outpatient surgery have the proper protocols, policies, and processes in place that are responsive and comply with CDC, federal, and state guidelines and/or regulatory requirements.

Matt: If there are decreases in outpatient surgery volumes, they are most likely to occur as a result of financial rather than clinical drivers. If economic variables result in increased unemployment, the number of insured lives may decrease, resulting in delays in treatment for elective surgery. The other financial influencer will be related to managed care contracts at the individual center level. ASCs will need to ensure they have contract rates in place to deliver a changing case mix, and if they do not, it will take some time to coordinate updated rates with payers.

15 | QUESTION:

Will shifting patients from commercial insurance coverage to Medicaid impact post-COVID-19 surgeries and the migration of cases from inpatient to ASCs?

ANSWER:

Naya: Naya: While we expect there will be a greater population of patients who may lose access to commercial insurance, it is unknown how much of the payer mix of the ASC-eligible population for surgery migration will shift to Medicaid. We anticipate there will be an impact on all payers relative to ASC-eligible cases that are eligible for surgery migration. Overall, this certainly can impact the number of surgeries that migrate from inpatient to ASCs.

Matt: If there is a surge in Medicaid covered lives, it may actually reduce the migration from inpatient to ASCs, since most Medicaid reimbursement methodologies do not include reimbursement for traditional inpatient surgical services in an ambulatory surgery setting. The lack of Medicaid payment will render ASCs unable to provide care for inpatient services, and migration won't occur.

Sean: While this is still an evolving situation and a potentially temporary influx of Medicaid patients, we may see a short-term blip in case migration. On the other hand, for those patients who are furloughed and still receiving full health benefits, we may see a boost in demand related to surgical care that has been put off due to lack of vacation time.

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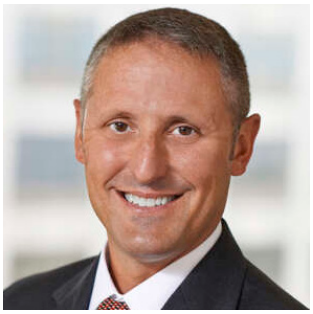

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