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BECKER'S
ASC REVIEW

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Optum vs. Tenet: How ASC strategies are shifting

Tenet Healthcare, parent company of United Surgical Partners International, and Optum, parent company of SCA Health, are looking at different ASC growth strategies.

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ASC leaders' top priorities

From evaluating market growth opportunities to strengthening social media presences and focusing on staff recruitment and retention, 10 ASC leaders share their biggest priorities for 2023.

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Why cardiology is ASCs' next big thing

ASCs have seen a massive opportunity for growth in cardiology in recent years, as CMS and commercial payers see financial gain in performing these procedures in the ASC setting.

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†Results from a retrospective chart review (N=323) of 129 patients treated with standard recovery protocol and 194 patients treated with a rapid recovery protocol that included cryoneurolysis.[2]

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KOOS=Knee Injury and Osteoarthritis Outcomes Score; LOS=length of stay; ROM=range of motion; TKA=total knee arthroplasty.

References: 1. Dasa V, Lensing G, Parsons M, Harris J, Volaufova J, Bliss R. Percutaneous freezing of sensory nerves prior to total knee arthroplasty. *Knee*. 2016;23(3):523-528. **2.** Plessl D, Salomon B, Haydel A, Leonardi C, Bronstone A, Dasa V. Rapid versus standard recovery protocol is associated with improved recovery of range of motion 12 weeks after total knee arthroplasty. *J Am Acad Orthop Surg*. 2020;28(21):e962-e968.

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BECKER'S HEALTHCARE

PUBLISHER'S LETTER

This issue of *Becker's ASC Review* covers the biggest ASC and ASC management company news. We also highlight the key challenges, opportunities and advice from well-known industry leaders from across the U.S.

Mark your calendars for our conference, the 20th Annual Spine & Orthopedic + Pain Management-Driven ASC Conference, June 15-17, 2023, at the Swissotel in Chicago. Hear from experts around the industry about the trends shaping the future of healthcare.

Should you have any questions or comments, please contact me at sbecker@beckershealthcare.com or Editor-in-chief Laura Dyrda at ldyrda@beckershealthcare.com or President and CEO Jessica Cole at jcole@beckershealthcare.com

Very truly yours,

Scott Becker

510 of America's 'Best' ASCs in 2023: Newsweek

By Alan Condon

Newsweek partnered with global research firm Statista for the 2023 edition of its "America's Best Ambulatory Surgery Centers," which ranks 510 of the more than 5,000 Medicare-certified ASCs in the country.

The ranking includes ASCs in the 25 states with the most facilities, according to CMS data, by individual state and groups facilities in the remaining states into four regions: Northeast, Midwest, West and South. The rankings are based on recommendations by medical professionals and an analysis of the ASCs' performance data.

Here are the 25 best ASCs in the country, according to the *Newsweek* ranking:

1. Cedars Sinai-90210 Surgery Medical Center (Beverly Hills, Calif.)
2. Gramercy Surgery Center (New York City)
3. SCA Health-Surgical Center of South Jersey (Mount Laurel, N.J.)
4. Froedtert Surgery Center (Milwaukee)
5. The University of Kansas Health System-KU MedWest Ambulatory Surgery Center (Shawnee)
6. The University of Kansas Health System Indian Creek Ambulatory Surgery Center (Overland Park)
7. Coral Gables Surgery Center (Miami)
8. Capital City Surgery Center (Raleigh, N.C.)
9. University of Maryland Medical Center-Ambulatory Surgery Center (Columbia)
10. Allegheny Health Network-Monroeville (Pa.) Surgery Center
11. UCLA Health-Ambulatory Surgery Center Westwood (Los Angeles)
12. Center for Ambulatory and Minimally Invasive Surgery (Eatontown, N.J.)
13. Southwest Medical Surgery Center at W. Charleston (Las Vegas)
14. Wills Eye Surgical Network-Surgery Center in Northeast Philadelphia
15. Saint Peter's Healthcare System-Cares Surgicenter (New Brunswick, N.J.)
16. Emory Healthcare-Emory Ambulatory Surgery Center (Atlanta)
17. SCA Health-Texas Health Surgery Center Rockwall (Rockwall)
18. SCA Health-UCSD Center for Surgery of Encinitas (Calif.)
19. Duke Health-Davis Ambulatory Surgical Center (Durham, N.C.)
20. Mayo Clinic-Building Scottsdale (Ariz.)
21. Johns Hopkins Endoscopy & Surgery Center - Columbia (Md.)
22. Virtua Health-Summit Surgical Center (Voorhees, N.J.)
23. SCA Health-Bloomfield (Conn.) Ambulatory Surgery Center
24. SCA Health-St. Cloud (Minn.) Surgical Center
25. Virtua Health-Jersey Shore Ambulatory Surgical Center (Somers Point, N.J.) ■

ASC that closed due to 'adverse business conditions' struggling to collect payments

By Alan Condon

The Surgery Center of Fort Collins (Colo.) is working on collecting past due bills more than two months after it announced it was closing for good, *BizWest* reported Oct. 26.

The ASC decided to close on Aug. 12 because of "adverse business conditions," according to its website.

The surgery center has appealed to former patients to follow through with payments as many "outstanding bills are due," according to the report.

Medical records held by the surgery center are available through Cariend, a medical records company. "Requestors should be prepared to complete the records release authorization form and provide a copy of their government-issued photo ID, as required by the HIPAA laws," the surgery center said on its website.

The ASC did not respond to *Becker's* request for comment. ■

Kaiser Permanente may convert San Jose hospital into ASC

By Marcus Robertson

Oakland, Calif.-based Kaiser Permanente is considering converting a San Jose hospital into an ASC, *SiliconValley.com* reported Oct. 21.

The health system is considering multiple options, the report said. Among them are demolishing the 242,900-square-foot hospital and adding surface parking; decommissioning and vacating it; and repurposing 149,000 square feet for outpatient surgery, with the remainder left vacant. ■

The state of the ASC industry: 3 earnings call notes from HCA, USPI & SCA Health

By Patsy Newitt

United Surgical Partners International, SCA Health and HCA Healthcare are all indicating different growth strategies in the company's third quarter earnings calls.

Here are three major earnings call notes to know that point to the state of the ASC industry:

USPI:
United Surgical Partners International executives revealed the company is behind on its year-long growth plan in an Oct. 21 third quarter earnings call from Tenet Healthcare, USPI's parent company.

Despite this, the company is still optimistic about the revenue-generating power of USPI.

"It's a great business, great margins, great cash flow generation. And we believe we have competitive advantages when we engage in [mergers & acquisitions] when there's a competitive process based on the value that we can bring to the table," Tenet's executive vice president and CFO Dan Cancelmi said in the call. "So, we do believe that the pipeline is robust, and so it gives us a lot of optimism as we think about 2023 and beyond."

HCA Healthcare:
Nashville, Tenn.-based HCA Healthcare's outpatient revenue jumped 36.6 percent in the third quarter, according to financial results released Oct. 21.

In the last two years, the company has seen substantial migration of total joint procedures to the outpatient setting, according to an earnings call transcribed by *The Motley Fool*.

"Anecdotally, we've heard from some of our physicians that their clinic practices are starting to recover [from COVID-19] in ways that maybe earlier in the year, they didn't recover. So that's encouraging to us at some level," CEO Samuel Hazen said. "Obviously, during the comparison of 2019 to today, our total joint business migrated fairly significantly to outpatient activity."

SCA Health:
Optum, parent company of ASC chain SCA Health, is doubling down on value-based care and higher-acuity surgical procedures.

Optum's third-quarter revenue is up 17 percent from the same quarter last year, reaching $46.6 billion, according to financial results released Oct. 14 by parent company UnitedHealth Group.

OptumHealth's 31 percent revenue-per-customer growth is attributed to the increasing number of patients served under value-based care, according to an Oct. 14 call with investors transcribed by *The Motley Fool*. OptumHealth is Optum's care delivery platform.

"Growth continues to be led by the increasing number of patients served under value-based care relationships and the expanding types of care settings offered by Optum, from meeting behavioral needs to comprehensively serving people in their homes to higher acuity ambulatory surgery," CFO John Rex said in the call. ■

'All of society has suffered financially': How ASCs are navigating physician pay changes

By Riz Hatton

As inflation and the cost of running a practice rises, CMS's Medicare physician fee schedule proposed rule for 2023 suggests further cuts to physician pay.

An orthopedic surgeon and a cardiovascular ASC director connected with *Becker's* to answer: "How is declining physician pay affecting the ASC industry?"

Editor's note: Response has been lightly edited for length and clarity.

Henry Goitz, MD. DMC Orthopedics and Sports Medicine (Warren, Mich.): While all aspects of reimbursements have been affected, and while COVID-19 income losses are real, it is my hope that physicians remain ethical in their care and management of our patients and realize that all of society has suffered financially. Needless to say, however, we must effectively negotiate with insurers to obtain a fair price commensurate with the service we, as surgeons, provide.

Luis Paz. Director Business Development and Marketing at Cardiovascular Surgical Suites (Coral Springs, Fla.): The feedback from many physicians I run across varies. Some of the comments are:

1. If I had known I would be dealing with so many regulations and constraints that would not allow me to be a doctor, I would have chosen a different career.

2. I don't know how much longer I can continue to be a doctor. It gets more difficult every year.

3. While reimbursements are getting smaller, the cost of running a practice keeps increasing. It's unsustainable.

Many of them are feeling anxiety or depression and are considering early retirement. Others are consolidating or selling their practices. The younger ones are more open to changes as they are not sure what to expect but want to feel they made the right decision by going into the medical field. ■

How physician pay cuts could affect ASCs

By Riz Hatton

With CMS' potential 4.42 percent physician fee cut looming, that decision likely will have implications in the ASC industry.

Five ASC and healthcare leaders connected with *Becker's* to answer: "How is declining physician pay affecting the ASC industry?"

Editor's note: Response has been lightly edited for length and clarity.

Sandy Berreth, RN. Medicare Surveyor at the Accreditation Association for Ambulatory Health Care: I'm not sure it is. Declining physicians' pay may lead to more physician/hospital employment. However, the key for our industry to succeed is the ASC industry itself. Payers are starting to realize and promote ASC services. Therefore, healthcare organizations big and small are going to need to develop relationships or partnerships with existing ASCs or build their own.

The ASC industry shouldn't suffer. Will private ownership of ASCs by physicians decline? That's a possibility, but ASCs have the key for the future of surgical service healthcare. ASCs deliver the highest quality of care, close to zero percent infection rates, friendly services and reduced cost of care. The cost to the patient is reduced, which is most important in a recession.

The answer is there is only one way the ASC industry is heading and that's forward; it has very little to do with the physicians and everything to do with the payers. The payers are the drivers.

Jodi Brooks, MSN, RN. Regional Director for FlexEd: From my conversations with physicians, the impact will be felt in the years to come. Physicians discourage interested students from joining the profession and especially from practicing in states like California with high tax rates. Many would-be doctors are choosing to go into different professions where they don't have to dedicate as many years or financial resources to complete their education. This will create a larger shortage of primary care physicians and any other specialty that doesn't pay as well.

Nicholas Morse. Chief Marketing Officer at Nadora Healthcare (Johnstown, Colo): It can make it difficult to recruit surgeons if you're not in a large group or if you're in a market that is dominated by health systems. Fortunately for us, we've become a destination center for medical tourism and we've been able to supplement surgeon pay through additional cases that come to us outside of insurance and Medicare and Medicaid. Being able to think differently and creatively to recruit surgeons is key. Otherwise it's going to be very difficult for ASCs without a large equity partner to continue to exist.

Maxim Sheinman. Director of Business Development Hospital Corp. of America: I believe these are the factors that will affect the ASC industry with declining reimbursements:

Declining reimbursement will lead to additional physician employment by larger health systems. Will also cause declining quality and availability of physician services. More physicians will become employed and will perform less cases in an ASC setting. We will continue to see the consolidation and corporatization of medical practices. More physicians will seek employment in private equity-backed corporations for stable income. Finally, the standard of medicine in this country will continue to decline.

Rob Taylor, RN. Clinical Director and Total Joint Coordinator at Constitution Surgical Center East (Waterford, Conn.): Declining physician pay is forcing providers to seek out additional means of income. This is helping to create growth potential for ASCs. For providers, performing surgery in an ASC generates an income stream separate from one's practice or hospital obligations. For an ASC, more providers equal more scheduled cases. More scheduled cases equal more revenue. Providers with the opportunity to invest in the ASC's ownership structure further strengthens their return on investment and the overall financial stability of the ASC.

ASCs present a viable option for providers to invest in their future. Hospitals have recognized this too, as seen in their continued efforts to participate in ASCs, often through joint ventures. Healthcare is ever changing and through continued efficiency and productivity, ASCs have truly earned their place at the table. ■

SCA Health, USPI antitrust suit moving forward, judge rules

By Patsy Newitt

A federal judge ruled an antitrust suit, filed by former employees of Deerfield, Ill.-based SCA Health, can move forward against Dallas-based Tenet Healthcare, DaVita and UnitedHealth Group affiliates, *Bloomberg Law* reported Sept. 27.

The ruling denied the defendants' motion to dismiss claims that between 2010 and 2019, the defendants engaged in an antitrust conspiracy where employee compensation was reduced by agreeing not to solicit or hire each others' senior employees. The allegations involve SCA Health and United Surgical Partners International, which is now fully owned by Tenet.

Denver-based DaVita and its former CEO was also indicted on three counts in connection with the collusion allegations in July 2021 and SCA Health was indicted in January 2021.

SCA Health, formerly Surgical Care Affiliates, was acquired by Optum, a UnitedHealth subsidiary, in 2017. SCA allegedly had agreements with an unnamed company in Texas from May 2010 to October 2017 and one in Colorado from February 2012 to July 2017.

The judge dismissed allegations against UnitedHealth Group, but gave the plaintiffs a chance to refile an amended complaint that states a viable claim against the company. The defendants have denied claims of a conspiracy. ■

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The rise of orthopedics in ASCs

By Riz Hatton

Orthopedics is the most common specialty for ASCs in 2022, according to March data from the ASC Association.

Here are insights from two CEOs and an orthopedic surgeon on what orthopedics has to offer ASCs and why the specialty has been so successful in the surgery center industry.

Editor's note: Responses were edited lightly for clarity and brevity.

Michael Boblitz. CEO of Tallahassee (Fla.) Orthopedic Clinic: Spine and joint replacement services have historically been performed predominantly in the hospital setting mingled with the wide range of surgical specialties that span well beyond orthopedics. At Tallahassee Orthopedic Clinic, these services now reflect 75 percent [of cases] plus outpatient case mix.

John Ryan. CEO of OrthoIndy (Indianapolis): Among several challenges for ASCs, I think the three most significant are procedure volume, payer contracting and case mix. Any one of these three challenges can mean the difference between an ASC that is successful and one that fails. I am no doubt biased, but orthopedics is a single solution to address all three of these challenges. Regarding procedure volume, predictive modeling in demographics points to a population boom of those seeking orthopedic care, so we know that orthopedic procedures will be a meaningful source of ASC case volume growth in the future. We also know that more and more orthopedic procedures are migrating into the outpatient setting from the inpatient setting, providing yet another source of growth in ASC procedure volume opportunity. Regarding payer contracting and case mix, a few thoughts come to mind.

First, reimbursement for orthopedic cases could always be better, but as reimbursement goes, it is better than several other specialties, making it an attractive specialty to offer at an ASC. Related, I am likely stating the obvious when I say that ASCs with meaningful orthopedic volume stand a much better chance of financial viability and sustainability than those [without]. While it is absolutely possible for an ASC to be financially successful without orthopedics, those ASCs with orthopedic procedure volume at or above 25 percent have a far clearer path to navigate the other economic pressures on an ASC's financial health.

Alexander Sah, MD. Orthopedic surgeon in Fremont, Calif.: So the nice thing about when orthopedic surgeons work closely with ASCs to provide this specialty care is that you can provide much better and efficient orthopedic care, because you're not distracted by the other challenges of the main hospital. So in the main hospital, you're going to have other surgeries, you're going to have emergencies, you're going to have shortages of staff, people are going to get pulled in different directions.

But the movement of orthopedics to ASCs is almost creating a specialty-like hospital so that you could really fine-tune the care to that specific procedure so that you can do more cases more efficiently, more safely for the patients and have better overall outcomes. So that's where that partnership between surgeons and ASCs have an opportunity to continue to grow. ■

Why cardiology is ASCs' next big thing

By Patsy Newitt

ASCs have seen a massive opportunity for growth in cardiology in the last few years, as payers and CMS see financial gain in performing these procedures in the ASC setting.

Cardiology procedures received the highest estimated Medicare payment increases in 2021, making it the fastest growing ASC specialty, according to Avanza's "2022 Key ASC Benchmarks and Industry Figures" report. Additionally, a 2020 Bain & Co. report projected that by the mid-2020s, 33 percent of cardiology procedures will be performed in ASCs, a 23 percent increase from 2018.

ASC leaders are seeing this play out on the policy side, with CMS adding cardiac procedures to the ASC-covered list.

"In the near future we will see more orthopedic, spine and cardiac procedures in the ASC setting," Cherise Brown, administrator of Andover (Kan.) Surgery Center, told *Becker's*. "CMS recently added several cardiac procedures to the ASC covered procedure list, including diagnostic and interventional coronary procedures, peripheral vascular interventions, and placement of pacemakers and defibrillators."

ASC chains are also seeing this opportunity. This year, Brentwood, Tenn.-based Surgery Partners inked a deal with ValueHealth to expand access to high-value surgical care. Alongside a value-based focus, the partnership will also try to capitalize on cardiology's migration to the outpatient setting.

In June, Atlas Healthcare Partners, a company that manages and develops ASCs, partnered with MedAxiom to create a joint venture specializing in improving cardiovascular care in surgery centers. The company will collaborate with health systems and physicians to improve patient outcomes, patient experience and access to cardiovascular care.

Single-specialty cardiology ASCs, like the new Cardiovascular Experts of Central Pennsylvania ASC in Camp Hill and the Pacific Cardiovascular Surgical Center in Salem, Ore., are increasing in popularity. Existing ASCs are adding stationary catheterization labs to their centers or higher-acuity procedures such as cardiac rhythm management to their portfolios.

Payers are also taking note. In July, Aetna dropped its policy to not cover cardiac PET/CT scans following a joint letter from the American Society of Nuclear Cardiology and the Society of Nuclear Medicine and Molecular Imaging.

"I do see cardiology as a trend there as well," Randy Reynolds, senior vice president of field operations for HealthCrest Surgical Partners in Edmond, Okla., told *Becker's* last year. "Cardiology is probably the biggest thing coming forth, especially with all the codes that CMS has added to the list." ■

Image Credit: Adobe Stock

Culture is king: How ASCs are winning in the staffing crisis

By Patsy Newitt

While ASCs in many markets can't compete with hospital salaries, many are coming out on top with creative recruiting strategies and a positive work environment.

"We are engaging our teams in meaningful ways to promote a positive culture. We are putting our talented team members first. We are creating staffing models that will allow for greater job satisfaction and work life balance," Amanda Sosnosky, administrator of Orthopedic Surgery Center of Green Bay (Wis.) and Orthopedic Surgery Center of the Fox Valley in Elgin, Ill., told *Becker's* Oct. 12.

Ms. Sosnosky's team is creating a better culture for employees by allowing for flexible shift options. While this is an added cost, she hopes it will foster a positive workplace culture.

Staffing costs are soaring for ASCs amid a tightening job market, with many employers setting aside an average of 3.9 percent of payroll this year for wage increases, according to *The Wall Street Journal*. Surgery centers spend on average $2.2 million on employee salary and wages, about 21.3 percent of net revenue, according to the VMG Health's "Multi-Specialty ASC Benchmarking Study." Pay for ASC administrators is also rising, hitting $100,000 to $119,000 on average, according to *OR Manager*.

ASCs reimbursements are historically lower than hospital outpatient departments for the same procedures, meaning low staffing costs are critical to meet margins, but many ASCs are opting for long-term retention strategies over salary boosts.

"The ability to hire good people and keep them has changed immensely over the last two years," Jeremy Statton, MD, orthopedic surgeon at Arthritis & Total Joint Specialist in Atlanta told *Becker's*. "We used to take outstanding staff for granted, and now that has changed. We are working on finding new ways to show our staff how much we appreciate them. "

Some physicians are also looking to ASCs over hospital settings for the workplace culture they can provide. ASCs can not only give financial opportunities for physicians in the form of equity or ownership, but they also can offer a more flexible work experience and an opportunity for autonomy.

"We believe our best medicine is practiced when physicians work collaboratively in an environment where mutual respect is paramount and trusting collegiality is the norm," Ronjon Paul, MD, spine surgeon and chair of the spine surgery department at Naperville, Ill.-based Duly Health and Care, told *Becker's*. "Staying open, honest and authentic sounds simple, but it must be deliberate and organic. Creating this environment is a priority because it's where I enjoy spending my time."

Many physicians are also seeking a work-life balance that ASCs can offer. With set schedules and a smaller team, most ASCs can ensure physicians a structure that many employed models cannot.

It's not just smaller ASCs focusing on culture. SCA Health CEO Caitlin Zulla told *Becker's* her team is also prioritizing culture.

"We are passionate about creating a culture where every teammate can bring their full, authentic self to work and one where inclusion, integrity, trust, and transparency are at our core," she said. ■

5 USPI execs to know

By Patsy Newitt

Dallas-based United Surgical Partners International is the largest ASC chain in the country with 410 ASCs and 24 surgical hospitals.

Here are five of USPI's major leaders, pulled from the company's website.

Brett Brodnax. President and CEO. Mr. Brodnax joined USPI in 1999 and has previously served as the senior vice president, executive vice president and chief development officer. Before joining USPI, Mr. Brodnax was an assistant vice president at Dallas-based Baylor Healthcare System, now known as Baylor Scott & White Health. He has served on several company boards including Ameripath, K2M and Emerus.

Owen Morris. CFO. Mr. Morris joined USPI in 2019 and also serves as treasurer of Tenet Healthcare, parent company of USPI. During his tenure at USPI, Mr. Morris has overseen some of the company's major acquisitions, including the acquisition of 45 ASCs from SurgCenter Development in 2020. Prior to joining USPI, he served as managing director of Goldman, Sachs & Co.

Peter Blach. COO. Prior to becoming COO of USPI, Mr. Blach served as a market president for USPI, where he was responsible for operations in North Texas and Houston. Before joining USPI in 2007, he was the vice president of operations for Innova Healthcare. Mr. Blach is one of the 10 company leaders on Tenet Healthcare's Diversity Council.

Margie Arion. Senior Vice President and Chief Human Resources Officer. Ms. Arion serves as the senior vice president for Tenet Healthcare's talent management program and chief human resources officer of USPI, Tenet's Hospital Operations and Tenet Physician Resources. She has more than 30 years of human resource experience. Before joining Tenet in 2018, she served as chief human resources offices at Acosta and worked for 15 years at PepsiCo.

Collee Everett. Vice President and Chief Compliance Officer. Ms Everett has 20 years of healthcare experience, previously serving as a regional compliance officer for more than 20 Tenet hospitals in California and Arizona between 2019 and 2021. Before joining Tenet, she served in compliance roles for Logan Health Montana in Kalispell, Sheridan (Wyo.) Memorial Hospital and Kaiser Permanente. ■

What happens when the COVID-19 PHE ends: 6 things ASC leaders should know

By Claire Wallace

On Oct. 13, the Biden administration extended the U.S.' COVID-19 public health emergency for another 90 days; it has been in effect since January 2020, according to *ABC News*.

The emergency declaration changed many elements of the healthcare industry, including regulations around telehealth and the price of vaccines.

The declaration has been extended through January 2023, but when it ends, it will likely change the healthcare landscape leaders have come to know over the past two years.

Six things ASC leaders should know about the end of the PHE:

1. The declaration allowed the FDA to fast-track COVID-19 vaccines, including the new bivalent booster. Ending the declaration could change the speed at which future vaccines are developed.
2. Under the PHE, COVID-19 vaccines and tests are free for consumers. Once the PHE ends, they will enter the open market, meaning they could cost patients and providers.
3. The emergency extends Medicare coverage, with millions at risk of losing their insurance when the declaration ends.
4. The declaration opened up telehealth to Medicare patients; they may lose insurance coverage for telehealth.
5. Medicare reimbursement for mental health telehealth will end when the declaration expires.
6. Practitioners are able to prescribe controlled substances via telehealth under the declaration; that will be rolled back when it ends. ■

Ohio surgery center marks 15 years

By Paige Haeffele

USPI affiliate Mayfield Spine Surgery Center recently celebrated its 15th year serving patients in the Cincinnati area.

The physician-owned center's surgeons have completed more than 86,000 outpatient procedures since its inception in 2007, according to a Sept. 27 news release from the center.

"We are proud to commemorate [our staff's] dedication to serving Cincinnati and we look forward to making a continued impact over the next 15 years and beyond," Brad Skidmore, MD, chairman of the center, said in the release. ■

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Where ASC consolidation is headed

By Riz Hatton

Prashanth Bala, vice president of ASC operations at Shields Health in Quincy, Mass., spoke with *Becker's* to discuss the trajectory of ASC consolidation.

Editor's note: This piece was edited lightly for brevity and clarity.

Question: How do you see consolidation evolving?

Prashanth Bala: Consolidation is an interesting question. Here in Massachusetts, we have seen private equity start to move into the orthopedic space. We've also seen it move into the vascular space. With it being such a small state, that has resounding impacts. So we're seeing how that's playing out now. I think only time will tell how much of a true impact private equity will have on care delivery or the access to care that such funds are able to help bring to the community. We're really optimistic that, even despite that, our partnerships are strong. That's our opportunity to continue to work with our partners to maximize our ability to transform healthcare and also provide that care for our communities. We're really excited about where we are and what we're doing in that space.

Q: Can you talk more about the shift of orthopedics and cardiovascular into ASCs?

PB: Office-based labs are starting to grow in Massachusetts and that's prevalent around the country. We're also looking at the office-based lab ASC hybrid space in Massachusetts and New England in general.

That's probably the next foray that most organizations are going to have to start to look at if they aren't already. What's after your bread and butter? Orthopedics is our bread and butter. We have other specialties within our mix as well within our multispecialty surgery centers. But I think the future really has those higher acuity cases that have predominantly been hospital procedures now coming to the outpatient setting, vascular surgeons and some cardiologists are just perfect for. So creating those opportunities — especially if their employment is such that they can take those cases to where they can, such as an ASC — does great things for the community, great things for the patients, and ultimately, for healthcare in general. ■

3 HCA Healthcare leaders to know

By Patsy Newitt

Here are three major leaders to know from Nashville, Tenn.-based HCA Healthcare, pulled from the company's website:

Sam Hazen. CEO of HCA Healthcare. Mr. Hazen was named CEO of HCA Healthcare in 2019 after working for the company for 39 years. From 2016 to 2019, he served as president and COO, and from 2011 to 2015, he served in various senior positions, including president of operations. He currently serves on the board of directors for the Federation of American Hospitals and the HCA Healthcare Foundation.

William Rutherford. Executive Vice President and CFO. Mr. Rutherford is responsible for the company's treasury department, office of the controller, information technology, government programs, development, investor relations, Parallon and HealthTrust Purchasing Group. He has served at HCA Healthcare for 33 years, formerly as director of operations support, CFO of the outpatient services group and CFO for the Georgia division, among other positions.

Jennifer Berres. Senior Vice President and Chief Human Resources Officer. Ms. Berres leads a team of more than 1,600 HR professionals and is in charge of talent acquisition, leadership development, compensation benefits, labor and employee relations, and more. She joined HCA in 1993, and has served as the vice president of HR business partners and the vice president of talent management, among other roles. ■

3 pieces of legislation ASC leaders should know

By Claire Wallace

The American Medical Association is involved in lobbying and advocacy efforts for legislation involving Medicare, physician's practices and more, according to an Oct. 4 report from the organization.

Three pieces of legislation ASC leaders should know:

1. **House bill 8800:** This bill, sponsored by Reps. Ami Bera, MD, and Larry Bucshon, MD, aims to stop the scheduled 4.42 percent cut to the Medicare physician pay rate.
2. **House bill 3173:** This bill, which would reform prior authorization for Medicare Advantage plans, passed in the House. A companion bill now has 43 co-sponsors.
3. **The Advancing Telehealth Beyond COVID-19 Act:** This bill aims to extend telehealth flexibilities currently made possible under the COVID-19 public health emergency. It would extend flexibility in telehealth rules through Dec. 31, 2024. ■

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Indication

EXPAREL® is indicated for single-dose infiltration in patients aged 6 years and older to produce postsurgical local analgesia and in adults as an interscalene brachial plexus nerve block to produce postsurgical regional analgesia. Safety and efficacy have not been established in other nerve blocks.

Important Safety Information

EXPAREL is contraindicated in obstetrical paracervical block anesthesia.

Adverse reactions reported in adults with an incidence greater than or equal to 10% following EXPAREL administration via infiltration were nausea, constipation, and vomiting; adverse reactions reported in adults with an incidence greater than or equal to 10% following EXPAREL administration via interscalene brachial plexus nerve block were nausea, pyrexia, and constipation.

Adverse reactions with an incidence greater than or equal to 10% following EXPAREL administration via infiltration in pediatric patients six to less than 17 years of age were nausea, vomiting, constipation, hypotension, anemia, muscle twitching, vision blurred, pruritus, and tachycardia. If EXPAREL and other non-bupivacaine local anesthetics, including lidocaine, are administered at the same site, there may be an immediate release of bupivacaine from EXPAREL. Therefore, EXPAREL may be administered to the same site 20 minutes after injecting lidocaine.

EXPAREL is not recommended to be used in the following patient populations: patients <6 years old for infiltration, patients younger than 18 years old for interscalene brachial plexus nerve block, and/or pregnant patients.

Because amide-type local anesthetics, such as bupivacaine, are metabolized by the liver, EXPAREL should be used cautiously in patients with hepatic disease.

Warnings and Precautions Specific to EXPAREL

Avoid additional use of local anesthetics within 96 hours following administration of EXPAREL.

EXPAREL is not recommended for the following types or routes of administration: epidural, intrathecal, regional nerve blocks **other than interscalene brachial plexus nerve block**, or intravascular or intra-articular use.

The potential sensory and/or motor loss with EXPAREL is temporary and varies in degree and duration depending on the site of injection and dosage administered and may last for up to 5 days, as seen in clinical trials.

Warnings and Precautions for Bupivacaine-Containing Products

Central Nervous System (CNS) Reactions: There have been reports of adverse neurologic reactions with the use of local anesthetics. These include persistent anesthesia and paresthesia. CNS reactions are characterized by excitation and/or depression.

Cardiovascular System Reactions: Toxic blood concentrations depress cardiac conductivity and excitability, which may lead to dysrhythmias, sometimes leading to death.

Allergic Reactions: Allergic-type reactions (eg, anaphylaxis and angioedema) are rare and may occur as a result of hypersensitivity to the local anesthetic or to other formulation ingredients.

Chondrolysis: There have been reports of chondrolysis (mostly in the shoulder joint) following intra-articular infusion of local anesthetics, which is an unapproved use.

Methemoglobinemia: Cases of methemoglobinemia have been reported with local anesthetic use.

Please refer to brief summary of Prescribing Information on adjacent page.

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Brief Summary
(For full prescribing information refer to package insert)

INDICATIONS AND USAGE

EXPAREL is indicated for single-dose infiltration in patients aged 6 years and older to produce postsurgical local analgesia and in adults as an interscalene brachial plexus nerve block to produce postsurgical regional analgesia.

Limitation of Use: Safety and efficacy has not been established in other nerve blocks.

CONTRAINDICATIONS

EXPAREL is contraindicated in obstetrical paracervical block anesthesia. While EXPAREL has not been tested with this technique, the use of bupivacaine HCl with this technique has resulted in fetal bradycardia and death.

WARNINGS AND PRECAUTIONS

Warnings and Precautions Specific for EXPAREL

As there is a potential risk of severe life-threatening adverse effects associated with the administration of bupivacaine, EXPAREL should be administered in a setting where trained personnel and equipment are available to promptly treat patients who show evidence of neurological or cardiac toxicity.

Caution should be taken to avoid accidental intravascular injection of EXPAREL. Convulsions and cardiac arrest have occurred following accidental intravascular injection of bupivacaine and other amide-containing products.

Avoid additional use of local anesthetics within 96 hours following administration of EXPAREL.

EXPAREL has not been evaluated for the following uses and, therefore, is not recommended for these types of analgesia or routes of administration.

- epidural
- intrathecal
- regional nerve blocks other than interscalene brachial plexus nerve block
- intravascular or intra-articular use

EXPAREL has not been evaluated for use in the following patient population and, therefore, it is not recommended for administration to these groups.

- patients younger than 6 years old for infiltration
- patients younger than 18 years old for interscalene brachial plexus nerve block
- pregnant patients

The potential sensory and/or motor loss with EXPAREL is temporary and varies in degree and duration depending on the site of injection and dosage administered and may last for up to 5 days as seen in clinical trials.

ADVERSE REACTIONS

Clinical Trial Experience

Adverse Reactions Reported in Local Infiltration Clinical Studies

The safety of EXPAREL was evaluated in 10 randomized, double-blind, local administration into the surgical site clinical studies involving 823 patients undergoing various surgical procedures. Patients were administered a dose ranging from 66 to 532 mg of EXPAREL. In these studies, the most common adverse reactions (incidence greater than or equal to 10%) following EXPAREL administration were nausea, constipation, and vomiting. The common adverse reactions (incidence greater than or equal to 2% to less than 10%) following EXPAREL administration were pyrexia, dizziness, edema peripheral, anemia, hypotension, pruritus, tachycardia, headache, insomnia, anemia postoperative, muscle spasms, hemorrhagic anemia, back pain, somnolence, and procedural pain.

Adverse Reactions Reported in All Local Infiltration Clinical Studies in Pediatric Patients Aged 6 to Less Than 17 Years

The safety of EXPAREL in 110 pediatric patients between the age of 6 and 17 years old undergoing various surgical procedures was evaluated in one randomized, open-label, clinical study in which EXPAREL was administered by infiltration into the surgical site and one single-arm, open-label study in which EXPAREL was administered by infiltration into the surgical site. Patients were administered a weight-based dose of EXPAREL at 4 mg/kg (maximum dose of 266 mg) or bupivacaine HCl 2 mg/kg (maximum dose of 175 mg). In these studies, the most common adverse reactions (incidence greater than or equal to 10%) following EXPAREL administration were nausea, vomiting, constipation, hypotension, anemia, muscle twitching, vision blurred, pruritus, and tachycardia.

The common adverse reactions (incidence greater than or equal to 2% to less than 10%) following EXPAREL administration were bradycardia, muscle spasms, tachypnea, hypoesthesia oral, anemia postoperative, dizziness, pyrexia, diarrhea, hypoacusis, hypoesthesia, back pain, hematuria, incontinence, muscular weakness, and visual impairment.

Adverse Reactions Reported in Nerve Block Clinical Studies

The safety of EXPAREL was evaluated in four randomized, double-blind, placebo-controlled nerve block clinical studies involving 469 patients undergoing various surgical procedures. Patients were administered a dose of either 133 or 266 mg of EXPAREL. In these studies, the most common adverse reactions (incidence greater than or equal to 10%) following EXPAREL administration were nausea, pyrexia, and constipation.

The common adverse reactions (incidence greater than or equal to 2% to less than 10%) following EXPAREL administration as a nerve block were muscle twitching, dysgeusia, urinary retention, fatigue, headache, confusional state, hypotension, hypertension, hypoesthesia oral, pruritus generalized, hyperhidrosis, tachycardia, sinus tachycardia, anxiety, fall, body temperature increased, edema peripheral, sensory loss, hepatic enzyme increased, hiccups, hypoxia, post-procedural hematoma.

Postmarketing Experience

These adverse reactions are consistent with those observed in clinical studies and most commonly involve the following system organ classes (SOCs): Injury, Poisoning, and Procedural Complications (e.g., drug-drug interaction, procedural pain), Nervous System Disorders (e.g., palsy, seizure), General Disorders And Administration Site Conditions (e.g., lack of efficacy, pain), Skin and Subcutaneous Tissue Disorders (e.g., erythema, rash), and Cardiac Disorders (e.g., bradycardia, cardiac arrest).

DRUG INTERACTIONS

The toxic effects of local anesthetics are additive and their co-administration should be used with caution including monitoring for neurologic and cardiovascular effects related to local anesthetic systemic toxicity. Avoid additional use of local anesthetics within 96 hours following administration of EXPAREL.

Patients who are administered local anesthetics may be at increased risk of developing methemoglobinemia when concurrently exposed to the following drugs, which could include other local anesthetics:

Examples of Drugs Associated with Methemoglobinemia:

Class	Examples
Nitrates/Nitrites	nitric oxide, nitroglycerin, nitroprusside, nitrous oxide
Local anesthetics	articaine, benzocaine, bupivacaine, lidocaine, mepivacaine, prilocaine, procaine, ropivacaine, tetracaine
Antineoplastic agents	cyclophosphamide, flutamide, hydroxyurea, ifosfamide, rasburicase
Antibiotics	dapsone, nitrofurantoin, para-aminosalicylic acid, sulfonamides
Antimalarials	chloroquine, primaquine
Anticonvulsants	Phenobarbital, phenytoin, sodium valproate
Other drugs	acetaminophen, metoclopramide, quinine, sulfasalazine

Bupivacaine

Bupivacaine HCl administered together with EXPAREL may impact the pharmacokinetic and/or physicochemical properties of EXPAREL, and this effect is concentration dependent. Therefore, bupivacaine HCl and EXPAREL may be administered simultaneously in the same syringe, and bupivacaine HCl may be injected immediately before EXPAREL as long as the ratio of the milligram dose of bupivacaine HCl solution to EXPAREL does not exceed 1:2.

Non-bupivacaine Local Anesthetics

EXPAREL should not be admixed with local anesthetics other than bupivacaine. Nonbupivacaine based local anesthetics, including lidocaine, may cause an immediate release of bupivacaine from EXPAREL if administered together locally. The administration of EXPAREL may follow the administration of lidocaine after a delay of 20 minutes or more. There are no data to support administration of other local anesthetics prior to administration of EXPAREL.

Other than bupivacaine as noted above, EXPAREL should not be admixed with other drugs prior to administration.

Water and Hypotonic Agents

Do not dilute EXPAREL with water or other hypotonic agents, as it will result in disruption of the liposomal particles

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no studies conducted with EXPAREL in pregnant women. In animal reproduction studies, embryo-fetal deaths were observed with subcutaneous administration of bupivacaine to rabbits during organogenesis at a dose equivalent to 1.6 times the maximum recommended human dose (MRHD) of 266 mg. Subcutaneous administration of bupivacaine to rats from implantation through weaning produced decreased pup survival at a dose equivalent to 1.5 times the MRHD [see Data]. Based on animal data, advise pregnant women of the potential risks to a fetus.

The background risk of major birth defects and miscarriage for the indicated population is unknown. However, the background risk in the U.S. general population of major birth defects is 2-4% and of miscarriage is 15-20% of clinically recognized pregnancies.

Clinical Considerations

Labor or Delivery

Bupivacaine is contraindicated for obstetrical paracervical block anesthesia. While EXPAREL has not been studied with this technique, the use of bupivacaine for obstetrical paracervical block anesthesia has resulted in fetal bradycardia and death.

Bupivacaine can rapidly cross the placenta, and when used for epidural, caudal, or pudendal block anesthesia, can cause varying degrees of maternal, fetal, and neonatal toxicity. The incidence and degree of toxicity depend upon the procedure performed, the type, and amount of drug used, and the technique of drug administration. Adverse reactions in the parturient, fetus, and neonate involve alterations of the central nervous system, peripheral vascular tone, and cardiac function.

Data

Animal Data

Bupivacaine hydrochloride was administered subcutaneously to rats and rabbits during the period of organogenesis (implantation to closure of the hard plate). Rat doses were 4.4, 13.3, and 40 mg/kg/day (equivalent to 0.2, 0.5 and 1.5 times the MRHD, respectively, based on the BSA comparisons and a 60 kg human weight) and rabbit doses were 1.3, 5.8, and 22.2 mg/kg/day (equivalent to 0.1, 0.4 and 1.6 times the MRHD, respectively, based on the BSA comparisons and a 60 kg human weight). No embryo-fetal effects were observed in rats at the doses tested with the high dose causing increased maternal lethality. An increase in embryo-fetal deaths was observed in rabbits at the high dose in the absence of maternal toxicity.

Decreased pup survival was noted at 1.5 times the MRHD in a rat pre- and post-natal development study when pregnant animals were administered subcutaneous doses of 4.4, 13.3, and 40 mg/kg/day buprenorphine hydrochloride (equivalent to 0.2, 0.5 and 1.5 times the MRHD, respectively, based on the BSA comparisons and a 60 kg human weight) from implantation through weaning (during pregnancy and lactation).

Lactation

Risk Summary

Limited published literature reports that bupivacaine and its metabolite, pipecoloxylidide, are present in human milk at low levels. There is no available information on effects of the drug in the breastfed infant or effects of the drug on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for EXPAREL and any potential adverse effects on the breastfed infant from EXPAREL or from the underlying maternal condition.

Pediatric Use

The safety and effectiveness of EXPAREL for single-dose infiltration to produce postsurgical local anesthesia have been established in pediatric patients aged 6 years and older. Use of EXPAREL for this indication is supported by evidence from adequate and well-controlled studies in adults with additional pharmacokinetic and safety data in pediatric patients aged 6 years and older.

Safety and effectiveness have not been established in pediatric patients aged less than 6 years old for local infiltration or less than 18 years old for interscalene brachial plexus nerve block.

Geriatric Use

Of the total number of patients in the EXPAREL local infiltration clinical studies (N=823), 171 patients were greater than or equal to 65 years of age and 47 patients were greater than or equal to 75 years of age. Of the total number of patients in the EXPAREL nerve block clinical studies (N=531), 241 patients were greater than or equal to 65 years of age and 60 patients were greater than or equal to 75 years of age. No overall differences in safety or effectiveness were observed between these patients and younger patients. Clinical experience with EXPAREL has not identified differences in efficacy or safety between elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Hepatic Impairment

Amide-type local anesthetics, such as bupivacaine, are metabolized by the liver. Patients with severe hepatic disease, because of their inability to metabolize local anesthetics normally, are at a greater risk of developing toxic plasma concentrations, and potentially local anesthetic systemic toxicity. Therefore, consider increased monitoring for local anesthetic systemic toxicity in subjects with moderate to severe hepatic disease.

Renal Impairment

Bupivacaine is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. This should be considered when performing dose selection of EXPAREL.

OVERDOSAGE

Clinical Presentation

Acute emergencies from local anesthetics are generally related to high plasma concentrations encountered during therapeutic use of local anesthetics or to unintended intravascular injection of local anesthetic solution.

Signs and symptoms of overdose include CNS symptoms (perioral paresthesia, dizziness, dysarthria, confusion, mental obtundation, sensory and visual disturbances and eventually convulsions) and cardiovascular effects (that range from hypertension and tachycardia to myocardial depression, hypotension, bradycardia and asystole).

Plasma levels of bupivacaine associated with toxicity can vary. Although concentrations of 2,500 to 4,000 ng/mL have been reported to elicit early subjective CNS symptoms of bupivacaine toxicity, symptoms of toxicity have been reported at levels as low as 800 ng/mL.

Management of Local Anesthetic Overdose

At the first sign of change, oxygen should be administered.

The first step in the management of convulsions, as well as underventilation or apnea, consists of immediate attention to the maintenance of a patent airway and assisted or controlled ventilation with oxygen and a delivery system capable of permitting immediate positive airway pressure by mask. Immediately after the institution of these ventilatory measures, the adequacy of the circulation should be evaluated, keeping in mind that drugs used to treat convulsions sometimes depress the circulation when administered intravenously. Should convulsions persist despite adequate respiratory support, and if the status of the circulation permits, small increments of an ultra-short acting barbiturate (such as thiopental or thiamylal) or a benzodiazepine (such as diazepam) may be administered intravenously. The clinician should be familiar, prior to the use of anesthetics, with these anticonvulsant drugs. Supportive treatment of circulatory depression may require administration of intravenous fluids and, when appropriate, a vasopressor dictated by the clinical situation (such as ephedrine to enhance myocardial contractile force).

If not treated immediately, both convulsions and cardiovascular depression can result in hypoxia, acidosis, bradycardia, arrhythmias and cardiac arrest. If cardiac arrest should occur, standard cardiopulmonary resuscitative measures should be instituted.

Endotracheal intubation, employing drugs and techniques familiar to the clinician, maybe indicated, after initial administration of oxygen by mask, if difficulty is encountered in the maintenance of a patent airway or if prolonged ventilatory support (assisted or controlled) is indicated.

DOSAGE AND ADMINISTRATION

Important Dosage and Administration Information

- EXPAREL is intended for single-dose administration only.
- Different formulations of bupivacaine are not bioequivalent even if the milligram strength is the same. Therefore, it is not possible to convert dosing from any other formulations of bupivacaine to EXPAREL.
- DO NOT dilute EXPAREL with water or other hypotonic agents, as it will result in disruption of the liposomal particles.
- Use suspensions of EXPAREL diluted with preservative-free normal (0.9%) saline for injection or lactated Ringer's solution within 4 hours of preparation in a syringe.
- Do not administer EXPAREL if it is suspected that the vial has been frozen or exposed to high temperature (greater than 40°C or 104°F) for an extended period.
- Inspect EXPAREL visually for particulate matter and discoloration prior to administration, whenever solution and container permit. Do not administer EXPAREL if the product is discolored.

Recommended Dosing

Local Analgesia via Infiltration Dosing in Adults

The recommended dose of EXPAREL for local infiltration in adults is up to a maximum dose of 266mg (20 mL), and is based on the following factors:

- Size of the surgical site
- Volume required to cover the area
- Individual patient factors that may impact the safety of an amide local anesthetic

As general guidance in selecting the proper dosing, two examples of infiltration dosing are provided:

- In patients undergoing bunionectomy, a total of 106 mg (8 mL) of EXPAREL was administered with 7 mL infiltrated into the tissues surrounding the osteotomy, and 1 mL infiltrated into the subcutaneous tissue.

ASC leaders' secrets to success

By Patsy Newitt

Ten ASC leaders joined *Becker's* to discuss their secrets to success.

Editor's note: These responses were edited lightly for brevity and clarity.

John Martin, MD. Gastroenterologist at Mayo Clinic (Rochester, Minn.):

1. Second-to-none workplace culture
2. Helping all staff feel valued, respected and appreciated — as individuals, and as a team
3. Everything for the patient, all for the team is our culture: "The needs of the patient come first"
4. Fair compensation for all physicians and staff and a meaningful benefits package for all
5. Emphasis on high-quality care from all angles, not just measured by technical success; best-in-class tech and highly qualified caregivers, but also patient-centered care that considers patient convenience, comfort, respect, dignity, efficiency and transparency

Pankaj Vashi, MD. Chief of Gastroenterology/Nutrition Department and Vice Chief of Staff at Cancer Treatment Centers of America Chicago: I have been a gastroenterologist for over three decades. There is really no secret for my success. I have done what every physician should do — that is to spend time listening to your patients; be thorough, honest, compassionate; and provide the best care in a timely manner to all your patients. The healthcare system today incentivizes the physician only on volume and relative value units. I personally feel the incentives should also include quality, safety and patient satisfaction. Value-based care is also important to cut down the cost of healthcare in our country.

Julie Billingsley. Director of Patient Care Services for Orthopedics & Neurosciences at Sentara Northern Virginia Medical Center and Lake Ridge Ambulatory Surgery Center (Woodbridge, Va.): One word: flexibility. If we've learned nothing else in the last few years, it's that change will remain a constant in our field. It's our job to make sure we continue to quickly adjust to whatever new challenge of the day/week/month we face. Our team has been exceptional at adjusting their sails with the shifting waves in healthcare.

Amber Mitchell, MD. Neurologist at Nuvance Health (Kingston, N.Y.): If you pick a field that interests you and you love, then you will be successful, and then it won't feel like it is a job. You can see yourself there in the future and that motivates you to persevere. If you pick a field for other reasons like money, then you might be disappointed, because you can never have enough money!

Christy Bray Ricks. Vice President of Provider Talent at Ardent Health (Nashville, Tenn.): Listening — seek first to understand the issue or concern, then collaborate with our stakeholders in order to best facilitate our desired outcome. Transparent and honest conversations about the difficulties facing not only our organization, but the country, as it relates to healthcare staffing shortages. Being an advocate for my team, our candidates and the communities we serve in order to save lives.

Alopi Patel, MD. Assistant Professor of the Department of Anesthesiology at Icahn School of Medicine at Mount Sinai (New York City): My secret to success is to stay persistent. If something is worth working hard for and building, then keep on going. There will be obstacles and it may take a long time, but persistence pays off.

John Woodward Jr., MD, Orthopedic Surgeon at Orthopaedic Physicians of Colorado (Englewood): Always plan. Be prepared. Work hard. Work smart. Be kind. Thank the people that help you to be successful.

Mark Mattar, MD. Director of MedStar Georgetown University Hospital's IBD Center (Washington, D.C.): My secret to success stems from the framework of transformational servant leadership. Leading in a successful GI practice in a health system as we come out of a pandemic brings its own special challenges. At the end of the day, we focus on the people. We prioritize patient care without compromising associate wellness. We work as a team to evaluate each of the provider's needs and how we can help them work toward our common mission. This isn't easy, but when you pay attention to the needs of the team and act on them, we all succeed.

Chris Blackburn, BSN. Administrator of South Kansas City SurgiCenter (Overland Park): I am an open book ... no secrets, but I hope my positive energy does help.

Mark Mineo. Director of the Millard Fillmore Surgery Center (Williamsville, N.Y.): Nothing replaces teamwork and hard work. ■

ASC leaders' top priorities

By Patsy Newitt

Ten ASC leaders joined *Becker's* to discuss their top priorities through the end of the year.

Editor's note: These responses were edited lightly for brevity and clarity.

John Martin, MD. Gastroenterologist at Mayo Clinic (Rochester, Minn.):

1. Access, access, access! Demand is high for elective, semi-urgent and urgent cases, while staffing remains a challenge
2. Maintaining patient satisfaction and quality of care in spite of high volume, high demand, access bottlenecks and staffing challenges
3. Keeping staff and physician morale high through this period of record demand, pressures on access, lingering COVID absences and uncertainties, and staffing challenges
4. Staff recruitment
5. Staff retention

Pankaj Vashi, MD. Chief of Gastroenterology/Nutrition Department and Vice Chief of Staff at Cancer Treatment Centers of America Chicago: My priority for the rest of this year is to continue to make people aware of the importance of screening for colon cancer. Due to the pandemic, there has been a significant drop in the number of people getting screening colonoscopies done. The impact of this could be an increase in colon cancer's incidence over the next decade. The earlier age (45) for screening has also increased the need for more providers. Noninvasive screening tests like Cologuard and FIT tests should be considered in average risk patients.

Julie Billingsley. Director of Patient Care Services for Orthopedics & Neurosciences at Sentara Northern Virginia Medical Center and Lake Ridge Ambulatory Surgery Center (Woodbridge, Va.): We will continue to evaluate vendor options for medications, materials and services in order to mitigate cost increases. Our team has done a remarkable job with staffing challenges, and we intend to adopt this new staffing matrix, reflecting the positive changes in culture and hiring practices. Keeping an eye on market growth opportunities for 2023, and planning for such, will also be a priority through the rest of this year.

Amber Mitchell, MD. Neurologist at Nuvance Health (Kingston, N.Y.): Be efficient with tasks and avoid procrastination. Time is the most precious commodity.

Christy Bray Ricks. Vice President of Provider Talent at Ardent Health (Nashville, Tenn.): To continue building and centralizing our provider talent team in order to best position us for future success. As a multi-state healthcare organization, my team is distributed across the country so I rely on structured and intentional touchpoints in order to address my team's needs as well as those of the communities we serve.

Clarence Foster, MD. Physician Advisor at St. Rose Dominican San Martin Hospital (Las Vegas): Right now we are battling three things: low hospital census, high seven-day readmission rates and finding ways to lower the cost of hospital care.

Alopi Patel, MD. Assistant Professor of the Department of Anesthesiology at Icahn School of Medicine at Mount Sinai (New York City): My top priority through the end of the year is to grow my social media presence and brand called The Female Pain Docs. It is a platform I am passionate about as we focus on women's health based topics via social media and podcasting

3 ASC leaders on the best decisions they made this year

By Claire Wallace

Moving into the direct pay market and increasing wages are among some of the best decisions ASC leaders report having made this year.

Question: What was the best decision you made for your organization this year?

Michael Powers. Administrator, Children's West Surgery Center (Knoxville, Tenn.): We are planning to implement a new information system capable of supporting numerous services, including scheduling, billing, operating room management, medical records and e-prescribing. I expect other ASCs to implement similar systems in the coming years. Like us, some centers are using older software provided by multiple vendors. This makes workflow disjointed and inefficient. Over the last few years, a few companies have produced single systems that include everything under one umbrella. This allows for greater interoperability and avoids siloed applications.

Tina Krause. Administrator, NW Surgery (Houston, Texas): The best decision we have made for our organization this year is to move into the direct pay market. We attended the Free Market Medical Association conference earlier this year and it was a game changer.

Jennifer Book. Nurse Administrator, Monocacy Surgery Center (Frederick, Md.): The best professional decision for our facility was a recent market wage increase that I requested for the clinical staff, specifically nursing. The industry has changed and it is very difficult to retain staff when competing with inflated agency and acute care wages, temporary or not. We are very fortunate to have a full team of dedicated staff that has endured these last two years. Without staff. we cannot perform procedures, so the feeling is that we needed to invest in our staff in order to retain them and maintain business operations. ■

John Woodward Jr., MD, Orthopedic Surgeon at Orthopaedic Physicians of Colorado (Englewood): Keep the volume up as the flu season is on the way. Keep the staff working a full schedule. Work a little harder to make up for lost productivity over the last year. Improve the supply chain issues that have continued to plague health care.

Mark Mattar, MD. Director of MedStar Georgetown University Hospital's IBD Center (Washington, D.C.): My secret to success stems from the framework of transformational servant leadership. Leading in a successful GI practice in a health system as we come out of a pandemic brings its own special challenges. At the end of the day, we focus on the people. We prioritize patient care without compromising associate wellness. We work as a team to evaluate each of the provider's needs and how we can help them work toward our common mission. This isn't easy, but when you pay attention to the needs of the team and act on them, we all succeed.

Chris Blackburn, BSN. Administrator of South Kansas City SurgiCenter (Overland Park): Increase volume by retaining staff and recruiting surgeons

Mark Mineo. Director of the Millard Fillmore Surgery Center (Williamsville, N.Y.): My top priority is to get fully staffed throughout the ASC so we can start the new year with volume growth and continue to recruit new surgeons.

Omar Khokhar, MD. Gastroenterologist in Bloomington, Ill.: Facilitating access to colonoscopy screening remains a priority. Colorectal cancer screening rates nationwide are still short of our goal of 80 percent. Getting to that number requires a team effort: patient education and awareness, prompt primary care physician referrals, seamless scheduling and a great patient experience throughout the process. Medicine is undergoing a "Starbucks" moment — we need to improve our experience. ■

'Historically' slow payers hindering ASC procedure migration, admin says

By Patsy Newitt

While many procedures are migrating to the ASC setting, "historically" slow payer policy changes could create delays, according to administrator Brenda Carter.

Ms. Carter, administrator of Wilmington (N.C.) Surgcare, joined *Becker's* to discuss what procedures she sees moving to the ASC setting, along with potential barriers.

Editor's note: This response was edited lightly for brevity and clarity.

Question: What procedures are moving to the ASC setting?

Brenda Carter: The future looks bright for more total joint cases in the ASC, along with spine and cardiology. The push to the ASC creates a better patient experience, reduces costs and can ease the burden on overwhelmed, understaffed hospital facilities.

However, insurance carriers will need to revisit the procedures previously only allowed in the hospital setting to create an easy transition to ASCs. As the carriers have historically been slow to respond to changing trends, this may initially present some challenges. ■

Prior authorization: 3 leaders' thoughts

By Patsy Newitt

Seventy-nine percent of medical groups said that payer prior authorization requirements increased in the last year, according to a March poll conducted by the Medical Group Management Association.

Here are three leaders' thoughts on prior authorization:

Vladimir Sinkov, MD. Sinkov Spine Center (Las Vegas): The biggest issue with Medicare is the ever-increasing regulatory and documentation burden. It is getting more difficult and requires more practice resources to stay compliant with all of their regulations, most of which do not actually benefit patient care. For example, the recent development of requiring prior authorization for cervical fusion surgery made it much more difficult to get those operations done in a timely manner.

Kenneth Nwosu, MD. Spine surgeon at NeoSpine (Burien and Puyallup, Wash.): My biggest industry concern is the ever increasing barriers by payers to provide high value care to our most vulnerable patients in a timely fashion. Over time, it appears that the default decision for procedures needing prior authorization is a denial, as indicated by a rising number of peer-to-peer reviews where the reviewing physician openly states that the ordered surgery should not have been denied. Alternatively, I am seeing more denials where a peer-to-peer review time is dictated by the payer, which is often in conflict with the treating physician's availability. In some instances, there is not an option to partake in a peer-to-peer review following a denial.

Nick Jain, MD. DISC Sports & Spine Center (Newport Beach, Calif.): While prior authorization for [anterior cervical discectomy and fusion] is an obvious target due to the increased authorization process burden and delay in care, I think the decreasing CMS fee will prove to be the most detrimental recent change to patient care. As reimbursement costs decrease while staffing costs and inflation soar to all-time highs, physicians will be forced to spend less time with patients to make ends meet, resulting in shorter face-to-face visits with an increasingly sicker and older patient population who require our full attention and dedication. This will only lead to the further degradation of the physician-patient relationship and, for that reason, I would eliminate the recent cuts to the CMS fee schedule. ■

High patient deductibles are disrupting the ASC industry, physician says

By Patsy Newitt

High patient deductibles are shifting the way physicians deliver care, according to Eric Anderson, MD, a pain management physician in Lewisville, Texas.

Dr. Anderson joined *Becker's* to discuss the biggest disrupters of the ASC industry and what procedures he sees migrating to the ASC setting.

Editor's note: This interview was edited lightly for clarity and brevity.

Question: What's the biggest disrupter of the ASC industry?

Dr. Eric Anderson: I think the biggest disrupter is going to be the ever-increasing high patient deductibles. This squeezes the pain management space in the ASC setting for procedures that could be done in an office setting. Patients simply have difficulty affording these large out-of-pocket costs for pain conditions that require more than one procedure, such as medial branch blocks.

Q: What procedures are migrating to the ASC setting?

EA: I think there will be an increase in the size and scope of ASC development, utilization and type of cases expanding in the pain management space — for certain cases. I think pain management implants, devices and minimally invasive treatments will continue to see preference in the ASC setting as CMS has already started preferring this route for spinal cord stimulator systems, for example. ■

Good wages the key to success, 1 ASC CEO says

By Claire Wallace

In a competitive job market, good wages and a positive work environment are the key to making sure that your organization retains top talent, according to one ASC CEO.

Question: What was the best thing that you did for your organization this year?

Julie Greene. CEO of Muskegon Surgery Center and Orthopaedic Associates of Muskegon (Mich.): Keeping many staff engaged and satisfied with good wages and bonuses and a positive environment was key to our success in 2022. We hold our staff in high regard. We have an outstanding team of individuals who have multiple options to work wherever they want because of their knowledge, skills and attitude. They get offered significant "deals" from other organizations, and our staff is the reason for great physician and patient satisfaction. We appreciate their loyalty.

The best decision of 2021 was to refinance the entire building at an extraordinarily low interest rate on a 10-year loan, which is allowing us to add on rooms in 2022 with a large addition. It was great timing. Our team also added additional equipment for increased efficiency with robotics and navigation for knees and hips, which allows for maximum efficiency with multiple physicians doing total joints at once. ■

Supply chain, staffing becoming 'challenging beyond words,' administrator says

By Patsy Newitt

For many ASCs, including Wilmington (N.C.) Surgcare, staffing and supply chain issues have plagued operations since the beginning of the COVID-19 pandemic.

Administrator Brenda Carter joined *Becker's* to discuss the biggest disruptors in the ASC industry.

Editor's note: This response was edited lightly for clarity and brevity.

Question: What are the biggest disruptors of the ASC industry?

Brenda Carter: As we continue to hear about staffing and supply chain, these two aspects of healthcare operations can really be a challenge. There is no way to "cut corners" on qualified staff when candidates are limited, so ASCs must find a way to improve retention and recruitment. Qualified teams are essential for patient safety and efficient care. The cost of staff turnover is incredible.

As for the supply chain, where to start? The lists of backordered or unavailable items continue to grow every day. Everything from medications to tubing is more difficult to get, and a new mindset and process is required to have what you need without causing materials staff to lose their minds. It is challenging beyond words, so everyone must adopt the thought of substitution should a preferred item be unavailable – this is easier said than done for complex surgical cases. This task has become more time-consuming and less efficient than ever before. ■

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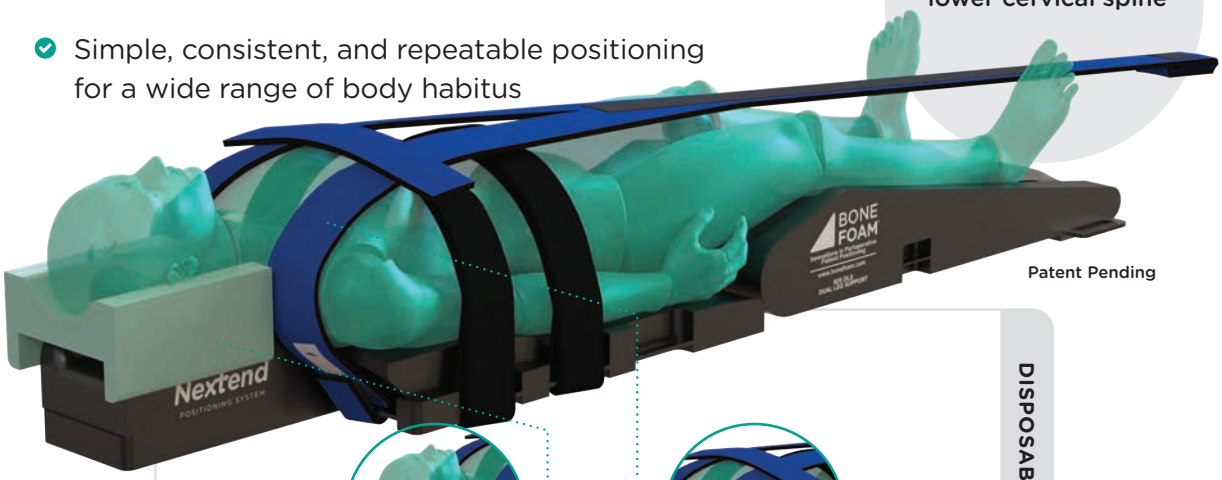

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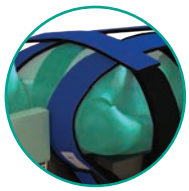

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‘Every day there is a new player in the ASC space’: 5 leaders weigh in on private equity

By Patsy Newitt

Five leaders joined *Becker’s* to discuss private equity’s influence in the ASC industry:

Michael McClain. Executive Director of Ambulatory Surgery at Providence (Renton, Wash.): It seems like every day, there is a new player in the ASC space, be it private equity, large medical groups, insurance carriers, or even tech and sales giants entering the fray. While those parties bring big purse strings and expertise, many of these organizations lack the deep relationships and multilevel community connections that local health systems and medical groups have. In my mind, the MOST important aspect of maintaining and growing our businesses and margins is maintaining and improving our relationships with our physicians and community leaders. Those relationships help organizations weather the storms of pandemics, capital challenges, regulatory changes and growth.

Prashanth Bala. Vice President of ASC Operations at Shields Health (Quincy, Mass.): Consolidation is an interesting question. Here in Massachusetts, we have seen private equity start to move into the orthopedic space. We’ve also seen it move into the vascular space. With it being such a small state, that has resounding impacts. So we’re seeing how that’s playing out now. I think only time will tell how much of a true impact private equity will have on care delivery or the access to care that such funds are able to help bring to the community. We’re really optimistic that, even despite that, our partnerships are strong. That’s our opportunity to continue to work with our partners to maximize our ability to transform healthcare and also provide that care for our communities. We’re really excited about where we are and what we’re doing in that space.

Catherine Retzbach, BSN, RN. Director of ASC Operations at Virtua Health (Marlton, N.J): Leaders and executives will need to be flexible and focused regarding how they want their centers to succeed. Change is always difficult, so it takes dedication and focus to achieve change. Adding service lines takes research and commitment. Also, sometimes difficult decisions need to be made, such as decreasing days of service if volume does not warrant being open every day. If you want to add a new service line, will you have enough procedures performed to cover the costs? The next five years will bring more private equity involvement along with consolidation, so leaders will need to stay on top of business trends and regulatory updates.

Maxim Sheinman. Director of Business Development at HCA Healthcare (Nashville, Tenn.): I believe these are the factors that will affect the ASC industry with declining reimbursements:

Declining reimbursement will lead to additional physician employment by larger health systems. Will also cause declining quality and availability of physician services. More physicians will become employed and will perform less cases in an ASC setting. We will continue to see the consolidation and corporatization of medical practices. More physicians will seek employment in private equity-backed corporations for stable income. Finally, the standard of medicine in this country will continue to decline.

Neal Kaushal, MD. Chief of Gastroenterology and Chair of the Department of Medicine at Adventist Health (Sonora, Calif.): I’m most nervous about the consolidation of larger health systems making care delivery less nimble and flexible. Healthcare delivery has to evolve continuously along with the needs and wants of the consumers — i.e., the patients. With smaller entities being acquired by larger ones, whether that be health systems, private equity firms or university-based medical centers, increased standardization can also spell a decreased ability to adapt quickly to changes in the healthcare landscape. It will be more important than ever to keep this in mind going forward as mergers and acquisitions continue to take place. ■

‘Change will remain a constant in our field’: How an ASC leader remains flexible

By Patsy Newitt

For ASC leader Julie Billingsley, the key to success is flexibility.

Ms. Billingsley, director of patient care services for orthopedics and neurosciences at Sentara Northern Virginia Medical Center and Lake Ridge Ambulatory Surgery Center in Woodbridge, Va., joined *Becker’s* to discuss her secrets to success and her top priorities through the end of the year.

Editor’s note: These responses were edited lightly for brevity and clarity.

Question: What’s your secret to success?

Julie Billingsley: One word: flexibility. If we’ve learned nothing else in the last few years, it’s that change will remain a constant in our field. It’s our job to make sure we continue to quickly adjust to whatever new challenge of the day/week/month we face. Our team has been exceptional at adjusting their sails with the shifting waves in healthcare.

Q: What are your top priorities through the end of the year?

JB: We will continue to evaluate vendor options for medications, materials and services in order to mitigate cost increases. Our team has done a remarkable job with staffing challenges, and we intend to adopt this new staffing matrix, reflecting the positive changes in culture and hiring practices. Keeping an eye on market growth opportunities for 2023, and planning for such, will also be a priority through the rest of this year. ■

Banner Health, Atlas Healthcare Partners acquire 2 Arizona ASCs

By Claire Wallace

Atlas Healthcare Partners and Banner Health have partnered in the acquisition of two Arizona ASCs in Scottsdale and Tucson.

This brings Atlas Healthcare Partners to 27 ASCs, defending its title as the fastest-growing company in the ASC industry.

Scottsdale-based acquisition Banner Surgery Center features two operating rooms and provides pain management and spine services with two physician investors.

Tucson-based acquisition Banner Cardiovascular Center was converted from a laboratory to an ASC that focuses on vascular and endovascular surgery.

"Over the last nearly four years we have created an integrated partnership with Banner focused on creating a great experience for physicians and patients," Aric Burke, CEO of Atlas, said in an Oct. 12 press release. "These additional ASCs to the network are a critical part of the Banner/Atlas growth strategy. By continuing to expand service lines such as pain and spine, and cardiovascular we are providing outstanding customer service to physicians in a place where they can better care for patients." ■

2 Michigan hospitals form joint venture, build pediatric ASC

By Riz Hatton

Livonia-based Trinity Health Michigan and U-M Health in Ann Arbor, Mich., are forming a joint venture to bring pediatric care to Trinity Health Oakland hospital in Pontiac, *Michigan Medicine Headlines* reported Oct. 21.

The joint venture allows the hospitals to expand access to pediatric care from Ann Arbor-based C.S. Mott Children's Hospital to patients in the Metro Detroit area, according to the report.

As a result of the partnership, Mott pediatric urology and orthopedic clinics will open in November, and a pediatric ASC will open in January 2023.

The joint venture is expected to be formalized in November. ■

Atlas Healthcare Partners joins with MedAxiom for cardiovascular-focused ASCs

By Claire Wallace

Atlas Healthcare Partners has joined with cardiovascular organizational improvement company MedAxiom to form a joint venture, MedAtlas.

MedAtlas is a cardiovascular-focused ASC company that will expand patient-centered heart care in ASCs.

"MedAtlas will provide a better experience for physicians and patients through strategic alignments, including bridging the gap between health systems and physicians," Jerry Blackwell, MD, MedAxiom's president and CEO, said in an Oct. 18 press release. "The combination of Atlas' expertise in ASC development and management, and MedAxiom's deep insights into cardiovascular care delivery, ensures high-quality clinical and patient outcomes." ■

Ascension Seton breaks ground on joint venture ASC

By Claire Wallace

Ascension Seton Health Center Georgetown (Texas) has broken ground on a 60,000-square-foot building that will house a 19,664-square-foot surgery center, according to an Oct. 17 report from *Hello Georgetown*.

The outpatient surgery center will be associated with Ascension Texas.

"We are proud to expand multidisciplinary expertise in this growing community at Ascension Seton Health Center Georgetown," Andy Davis, president and CEO of Ascension Texas, told Hello Georgetown. "As we celebrate 120 years of service, Ascension Seton will continue to focus on ways to meet the healthcare needs of Central Texans and be a destination for high quality care provided by experienced specialists." ■

Firm aims to disrupt ASC superpowers with new management model

By Marcus Robertson

In the shadow of growing giants like Dallas-based USPI, Brentwood, Tenn.-based Surgery Partners and Deerfield, Ill.-based SCA Health, a new ASC management model is emerging.

The big chains offer owners freedom from many of the responsibilities and headaches that come with running a business, but that often comes at the cost of ownership and control. For several years, the choice appeared to be binary for many owners and physician partners: You can relinquish control to get expert help running the business, or you can retain control and shoulder the burden yourself.

The space between those two choices is starting to fill in, however. Companies like Capital Surgical Solutions are positioning themselves as a much-needed "in-between" option.

CSS offers ASCs management expertise without handing down mandates. The company looks for ASCs with surgeons who want to be involved in operational decision making. When they find a willing partner who is a good fit, they acquire a minority position and then get out of the way.

"We have to be very selective about the physicians we pick, because we're giving them all the control," CSS Vice Chair Basheer Alismail told *Becker's*.

The approach may have a positive impact on patient care, according to CSS Chair Benjamin Stein, MD. Partner ASC Capital Orthopaedic Surgery Center in Germantown, Md., performed more than 2,750 orthopedic surgeries — including more than 1,000 total joints — in its first 18 months, while garnering 118 unanimous five-star Google reviews.

"There's nobody more vocal in improving the patient experience than the surgeons," Dr. Stein said. "When the surgeons have the ability to dial the knobs and invest in what they think is going to help patients, it translates. The [Capital Orthopaedic Surgery Center] shows it over and over again."

CSS is not the only firm that offers ASCs minority investment, but often even those partnerships are structured in a way that takes power away from the surgeons.

> **Physicians and payers alike are getting smarter about the ambulatory setting. The second wave of spine, total joints and cardiovascular into the outpatient setting is really the catalyst to why you're seeing physicians raise their hand and say, 'Wait a minute, we know our worth, and we know it's more than what these big firms are willing to give us.'**
>
> – Basheer Alismail, Vice Chair of Capital Surgical Solutions

"Physicians and payers alike are getting smarter about the ambulatory setting," Mr. Alismail said. "The second wave of spine, total joints and cardiovascular into the outpatient setting is really the catalyst to why you're seeing physicians raise their hand and say, 'Wait a minute, we know our worth, and we know it's more than what these big firms are willing to give us.'"

While the big firms continue to grow, CSS has placed a hard cap on its own growth in the interest of maintaining its personal touch. But if its boutique management model catches on, ASCs and surgeons could find themselves with a true spectrum of partnership options. ■

CoFi and Alphaeon partner for ophthalmology financing

By Claire Wallace

Payment platform CoFi partnered with financing company Alphaeon to launch a financing solution for ophthalmology practices.

With the financing solution, practices can finance all fees associated with procedures including LASIK and cataract surgeries.

Any physicians currently using CoFi's payment platform are eligible to participate in the financing partnership, including ASCs.

"Our practice has been using the CoFi-Alphaeon solution for several months now," Gregory Parkhurst, MD, founder and physician CEO at Parkhurst NuVision in San Antonio, Texas, said in a Sept. 27 press release. "This product addresses the last mile of compliance and convenience related to how payments are handled. We no longer have to inconvenience our patients by requiring them to come up with funds or a separate loan to pay the co-managing optometrist or other third party like the surgery center." ■

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Earvin ""Magic"" Johnson

Role Model, Sport Legend and Successful Entrepreneur

Michael A. Slubowski

FACHE, FACMPE, President and Chief Executive Officer, Trinity Health

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Ketul Patel

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John Couris

President and Chief Executive Officer, Tampa General Hospital

Amy Perry

President and Chief Operating Officer, Banner Health

'The proof is in the results': 1 physician's perspective on MSO partnerships

By Carly Behm

Showing the value proposition of deals and having physician leadership from the top down can help management service organizations draw interest from independent practices, according to Emil Engels, MD, CEO of Aligned Orthopedic Partners.

Dr. Engels spoke with *Becker's* about his goals for Aligned Orthopedic Partners and his advice for physicians looking into management service organization partnerships.

Note: This conversation was edited for clarity and length.

Question: What are your goals for Aligned Orthopedic Partners in the next five years?

Dr. Emil Engels: Our goal for the next five years is to continue to bring together the best and brightest in the orthopedic surgery and spine world. This growth will be achieved through acquisitions, as well as attracting fellows from top programs and other high performing physicians in the community. We also anticipate double digit organic growth by opening new offices and forming innovative partnerships to drive referrals. It's really exciting to be part of a platform like this. We are looking to build a best-in-class musculoskeletal platform that includes orthopedic surgeons, neurosurgeons, physiatrists and pain physicians. As far as goals, we want to continue to grow, and bring value to our patients, facilities, and physician partners. We are focused on achieving density in the mid-Atlantic market and building out ancillary services like physical therapy. Our growth trajectory is remarkable, having quadrupled in size in two years.

It's worth noting that we are physician led and majority physician owned. Our physicians have created work groups in all the orthopedic specialties to standardize care to best-in-class evidence-based protocols. We're also realizing synergies and taking advantage of economies of scale by getting bigger. In doing all of this, we believe we will bring value to healthcare. We will achieve better outcomes by bringing together high-quality physicians and coordinating the care we're providing. We are collecting data with PatientIQ and will be able to demonstrate superior outcomes. It will be at a lower cost because we are reducing complications and shifting care from inpatient hospital settings to outpatient surgery centers.

Q: How do you approach conversations with potential partners?

EE: It's really about demonstrating the value proposition. I have a unique perspective in that I am a physician by training who previously sold my practice. I understand how the physician views this. Most of the practices we're looking to partner with are very high-functioning practices. They don't need to do anything. Their practices are thriving. They're doing well financially. We need to answer the age-old question: "What's in it for me?" It's about being able to partner with some of the most skilled surgeons in the country to deliver better clinical outcomes. As a result of getting bigger, practices will realize synergies on the business side. These could be things like better managed care contracting, malpractice rates or purchasing agreements. Larger entities have the ability to self-insure when it comes to health insurance. There's also the ability to do things that you couldn't do as a smaller group, like having an organized research foundation, planning conferences, and hosting residency or fellowship programs. Joining a larger platform gives you access to capital. With capital, you can broaden your business and get involved in a lot of interesting activities. At Aligned Ortho, we're getting into the urgent care space and investing in surgery centers. Our surgery centers are jointly owned by our surgeons and the platform.

One aspect that surgeons focus on is the ability to monetize their practice. Physicians invest a lot of time and energy in building a practice. Partnering with us and selling is a way to capitalize on that in a tax-efficient way. The proceeds from selling a practice are usually taxed at long-term capital gains rates. There is also the ability over time to repair income through growth, efficiencies on the business side, and better managed care contracts. And then there's the ability to benefit from a second bite of the apple. All of our doctors are owners and investors in the platform. Eventually, we will sell this business to someone else. This will be another opportunity for the physicians to benefit financially.

Q: Some surgeons have expressed skepticism about private equity investment. What would you say to physicians and practice owners who are skeptical about private equity investment? What advice would you give to investment firms to help them build trust with potential partners?

EE: I understand the sentiment from the physicians. I've been on the other side of this. There will always be a healthy amount of skepticism when looking at some of these deals. The proof is in the results. I tell physicians evaluating this that it's critically important to partner with a platform that is physician led and owned. When I say physician led, it's not just at the top. We have a physician CEO, but our practices are governed by orthopedic surgeons in clinical governance committees. In addition, our private equity partner has a physician on their advisory team.

I tell physicians who are considering this to talk to your peers. Ask them if they're happy and how much autonomy they have. Has their practice changed after they joined the platform, and did it change for the better or for the worse? At the end of the day, physicians trust other physicians. As a leader of a platform like this, I need to make sure that we're delivering on what we promised to our physicians and that they're happy professionally and satisfied with the way their practices are running. Quality of care will always be our top priority. As a testament to our approach, we consistently attract surgeons from top residency and fellowship programs and have zero attrition.

Q: How do you expect the rising number of overall outside investors to affect the orthopedic landscape in the U.S.? Do you think we'll see more MSOs popping up?

EE: I absolutely believe we will see more MSOs in the future. I follow the PPM market closely, and I have spent time as a business professional in two different specialties. I attend meetings with other physicians, and I can say without hesitation that orthopedics and spine is the most exciting and interesting specialty to be a part of right now. I think there will be tremendous activity with more private equity backed platforms entering the market. In fact, we see a new platform popping up every few months. It's becoming a very competitive landscape, and that's good for physician practices. It's causing disruption. There are going to be companies that succeed and companies that don't. As a result, it's driving innovation and forcing platforms to differentiate themselves from others. ■

Medtronic to spin off 2 businesses

By Alan Condon

Medtronic plans to separate its combined patient monitoring and respiratory interventions businesses, which are part of the company's medical surgical portfolio.

The planned spinoff, NewCo, will allow for greater investment focus in the areas of "highest strategic priority" and help execute Medtronic's leadership strategy in attractive medtech markets, the company said in an Oct. 24 news release.

"Independently, NewCo will be a leading connected care company with a compelling leadership position, attractive margins, and potential for growth acceleration with increased investment and dedicated capital allocation," said Geoff Martha, chair and CEO of Medtronic. "Looking ahead, we remain focused on active portfolio management with an ongoing process of evaluating potential additions and subtractions to further accelerate Medtronic's growth over the long-term."

Following the separation of NewCo, Medtronic said it will have:

- A more streamlined portfolio with increased focus on investing capital into opportunities that align with its long-term growth strategies.
- Modestly faster organic revenue growth and an increased weighted average market growth rate.
- A strong balance sheet and continued commitment to its strategy of driving durable growth.

The patient monitoring technology portfolio includes Nellcor pulse oximetry, Microstream capnography, BIS brain monitoring, Invos perfusion monitoring, and HealthCast connected care platforms. The respiratory interventions technology portfolio includes Puritan Bennett ventilators, Shiley airway portfolio, McGrath Mac video laryngoscopy, DAR breathing systems, as well as ventilation software systems designed to improve workflow and care delivery.

The patient monitoring and respiratory interventions, part of the respiratory, gastrointestinal and renal division, generated global revenue of about $2.2 billion in fiscal year 2022. The business comprises more than 8,000 employees worldwide.

Medtronic expects the separation to be completed in the next 12 to 18 months subject to certain closing conditions. The company plans to redeploy net proceeds consistent with its stated capital allocation priorities and does not expect the spinoff to affect its dividend policy.

Medtronic said it will provide more details on the transaction at a later date. ■

3 new orthopedic ASCs

By Patsy Newitt

Here are three new orthopedic ASCs opened or announced since Aug. 31:

1. Medical City Orthopedic and Spine Surgery Center Dallas opened on the Dallas-based Medical City Spine Hospital Campus. The ASC will be operated by 15 orthopedic and spine surgeons and will feature 25,000 square feet of space, four operating rooms, two procedure rooms, three overnight observation rooms and modern surgical technology.
2. Mercy Hospital will begin construction on a 13,500-square-foot ASC in Durango, Colo., later in 2022 focused on orthopedics and gastroenterology. Three Springs Surgery Center will include three operating rooms and two procedure rooms and will have 23-hour overnight stay capabilities.
3. Gainesville, Fla.-based UF Health East is renovating a facility in collaboration with Jacksonville-based Jax Spine & Pain Centers, which will include a new ASC. The three-story, 52,146-square-foot Jacksonville facility will house the ASC on its first floor. Other new renovations include an MRI unit and other upgrades totaling about $1.4 million. ■

2 Florida orthopedic providers merge to form 17-physician practice

By Carly Behm

Fort Walton Beach, Fla.-based Orthopaedic Associates and Panama City, Fla.-based Southern Orthopedic Specialists will merge in November.

The merged practice will have five locations, according to a news release shared Oct. 21 with *Becker's*. Orthopaedic Associates has 12 physicians, and Southern Orthopedic Specialists has five physicians.

The merged practice will operate under Orthopaedic Associates' name. Orthopaedic Associates was founded in 1988. ■

2 surgeons under 40 on private equity, the future of orthopedics

By Claire Wallace

Two surgeons under the age of 40 discuss where they see the future of orthopedics heading, and the role of private equity in practices moving forward.

Question: What are the biggest challenges facing orthopedic surgeons moving forward?

Phillip Louie, MD. Virginia Mason Medical Center (Seattle, Wash.): Some of our biggest challenges include upcoming production and volume goals amidst enormous financial losses throughout healthcare, short staffing, burnout and hospital capacity amidst an ongoing pandemic and financial losses that may be generational.

With mounting pressures to produce financial and volume targets with limited resources (and temporary resources at many locations), there will be an enormous focus on producing quantity of work. I worry that all the work that we have accomplished in building value-based care pathways, developing quality-based programs and academic pursuits to innovate, will take a back seat to providing the greatest volume of care to "catch up."

We are all facing the same pressures, so we must all continue to find opportunities to innovate, invest and collaborate in areas that support quality of care — knowing that best care will also be the one that is in the best interest of all stakeholders: the patients, the providers, the administrators/executives and healthcare as a whole.

Jeffrey Mullin, MD. University at Buffalo Neurosurgery (N.Y.): I think barriers preventing surgeons from providing the best care to our patients will continue to be our biggest challenges. This includes insurance denial processes and hospital staffing issues.

Q: What are your thoughts on the role of private equity in orthopedics?

PL: I see both sides of this issue. The private equity collaboration is likely here to stay, and is part of our new environment. The forces of an ongoing pandemic, hospital/medical center financial crises, insurance companies and the government have significantly altered the healthcare environment in which we work today. In the setting of smaller private practices, private equity ultimately provides an exit strategy for those who have devoted years to building the practice, while also obtaining potential access to the best technology, education and resources to care for patients. In groups with a spectrum of seniority, private equity may present opportunities to reduce the "buy in" for your partners.

But I feel like there is a fundamental lack of mission-agreement between the business models of private equity and healthcare practices. In medical practices, the physician-owners are responsible for the success of the practice, often by placing the primary focus on patient care, and allowing revenue and profits to follow. Once private equity becomes involved, there becomes a much greater focus on maximizing those revenues/profits. Of primary importance, now becomes the ability to grow the practice's value and EBITDA in the

This is why orthopedic groups are dropping out of bundled payments, 1 surgeon says

By Carly Behm

Bundled payments, which were once adopted at many orthopedic groups, wasn't a trend that held long-term. Groups, including Philadelphia-based Rothman Orthopaedics, took them on but eventually dropped them as a payment model.

One California surgeon told *Becker's* why he believes bundled payments don't work for everyone.

Editor's note: This response was lightly edited for clarity and length.

Question: Why are so many orthopedic groups dropping out of bundles?

Hooman Melamed, MD. The Spine Pro (Marina Del Rey, Calif.): To me this is very straightforward. Unfortunately many of these bundle programs were putting profits before patient care. It was about, "How can we save the most amount of money?" which unfortunately ended up resulting in patient care getting compromised.

At the end of the day, we as surgeons will be liable for anything happening to our patients. Every patient expects their surgeon to provide the best care at the highest level. And yes this might be a little bit expensive at times, but it delivers high superior care when the right intentions and the right ethics have been utilized.

What is also sad is that these bundling programs would punish any surgeon's reimbursements if the care delivered to the patient ended up costing more than anticipated only because the patient required the best care and instead the surgeons' pocketbooks were pinched more. ■

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event of a future liquidation event, in which all the major stakeholders would benefit. That practice must find the right private equity partner and hope that this new governing body will be a good steward of patient care and practice culture.

JM: I have made my practice decisions to maximize my autonomy. I have concerns about the benefits of partnering with private equity (often to offset frustrations with question 1) being nothing more than a Faustian bargain.

Q: What new medical advancements are you keeping an eye on right now?

PL: Machine learning and artificial intelligence. This hot topic will play a large role in providing greater safety and value to our patients, through the growth of enabling technologies and reducing the cost of surgery (and spine care as a whole). The expansive data we are currently collecting through diverse avenues will allow multidisciplinary teams to assess how we can perform surgery through the use of more integrated real-time systems that will reduce the number of trays necessary, improve surgical accuracy, reduce operative times and radiation exposure, as well as decreasing the risk of iatrogenic complications during surgery.

Augmented reality has been a game-changer in how we prepare and perform spine surgery. However, much like the current widely-adapted robotic technology, the initial focus has been on osseous anatomy. The ability to evaluate neurologic, vascular, muscular, and other anatomic variables will be critical in the advancement of this technology. Specifically in spine surgery; portions of surgery including exposure, removal of soft-tissue masses, decompression and osteotomies will greatly benefit from these advancements.

We will see the collaboration of multiple industries and research minds that will drive these changes in an evidence-based manner that can keep up with the demands for higher quality care in a cost-constrained landscape.

JM: The advancements I am most focused on are at opposite ends of the spectrum. I believe there is some potential in patient specific implants/planning that could be rewarding in the future.

On the other end, I believe we will learn a lot in the coming years using big data. This can allow AI and predictive modeling to hopefully result in better outcomes for our patients. ■

New Mexico ASC adds 2 knee replacement robots as industry competition heats up

By Alan Condon

New Mexico Surgery Center Orthopaedics, a 27-physician ASC in Albuquerque, installed the first two Rosa Knee robots in the state, the *Santa Fe New Mexican* reported Oct. 17

Designed by Zimmer Biomet, the Rosa Knee robot for joint replacement costs about $700,000.

The technology features 3D preoperative planning tools and intraoperative data on soft tissue and bone anatomy to improve bone cut accuracy and range of motion gap analysis.

Rosa Knee also collects data to help surgeons make more informed decisions on patient care.

Many surgeons are wondering if joint replacement robots, which are still in their infancy, will become the standard of care in the future. The next generation of orthopedic surgeons will likely be more adept at adapting to robots, but the jury is still out on long-term outcomes for robotically-assisted joint replacements.

"The future, in part, depends on if it will be reimbursable by insurance," Bill Ritchie, MD, an orthopedic surgeon at New Mexico Surgery Center Orthopedics, told the Santa Fe New Mexican. "Long-term results we don't know yet."

Competition among device companies is expected to intensify in the orthopedic industry, where Stryker is leading the pack, according to market research and consulting firm ReAnIn. More than 1,000 of Stryker's Mako systems for total knee replacements have been installed worldwide. Zimmer Biomet's Rosa robot is gaining traction, and Johnson & Johnson's Velys launched in 2021. ■

Hospital for Special Surgery launches independent orthopedic company

By Carly Behm

New York City-based Hospital for Special Surgery received a $21 million series A funding round to launch RightMove, a company focused on virtual physical therapy.

Amy Fahrenkopf, MD, senior vice president at HSS and president of HSS Health, will be interim CEO of the company, according to an Oct. 25 news release. An executive search is underway.

"We believe RightMove can address an unmet need in the market by being a true value-based partner to health plans and employers through our proven care model, use of specialty trained physical therapists and unparalleled experience providing telerehabilitation," she said in the release.

The funding will build out RightMove's technology platform and create a network of physical therapists. RightMove plans to go live and treat patients in 2023. Flare Capital led the funding round. ■

A new $1B spine company: Inside the Orthofix, SeaSpine merger

By Carly Behm

SeaSpine and Orthofix entered an agreement to merge, with the deal expected to close in early 2023. Both companies boast emerging technologies in spine and orthopedics, and together they plan to rake in $1 billion in their early years.

Six details to know:

1. Orthofix CEO Jon Serbousek said on an Oct. 11 investor call that the merger could put them in "amongst the top tier" of spine and orthopedic devicemakers. In its first three years, the merged entity expects to hit $1 billion in revenue, he said. By 2025, he said he expects gross margins to exceed 70 percent and adjusted EBITDA margins to be in the midteens.

2. Both companies boast strong product portfolios. SeaSpine has the radiation-free Flash imaging system from its $110 million acquisition of 7D Surgical. Orthofix's M6-C artificial cervical disc replacement device will add to SeaSpine's NorthStar posterior cervical fixation system, SeaSpine CEO Keith Valentine said on the investor call.

3. The merged company has ambitions to form one of the industry's broadest biologics portfolio, Orthofix said in an Oct. 11 news release. The combined technologies include CervicalStim bone graft therapy device, the Virtuos Lyograft and the OsteoStrand Plus and OsteoSurge demineralized bone matrix products.

4. A key asset Orthofix brings to the table is its international infrastructure, Mr. Valentine said. Although SeaSpine conducts business primarily in the U.S., Orthofix sees 20 percent of its revenue from international channels.

5. Long before the merger was announced, SeaSpine had grown its foothold in the market, making it well positioned to support Orthofix's portfolio. SeaSpine rebounded from COVID-19 and saw continued year-over-year quarterly growth. In 2020, full-year revenue was $154.3 million, a 3 percent dip. The company recovered from that mild decline quickly in 2021 as it continually beat its year-over-year quarterly revenues. In the first half of 2022, SeaSpine has already surpassed its revenues compared to the same period in 2021.

6. The company will be based in Lewisville, Texas, with additional offices in Carlsbad, Calif., and Verona, Italy, Mr. Serbousek said. ■

ASC leaders ask CMS to pay separately for different levels of spine procedures

By Patsy Newitt

On Sept. 13, the Ambulatory Surgery Center Association submitted comments to CMS on the Medicare 2023 proposed payment rule, including asking that CMS pay separately for different levels of spine procedures.

The packaging of different levels for spine codes, the letter reads, impedes Medicare beneficiaries' access to ASCs for procedures with significant device costs.

Anterior cervical discectomy and fusion and lumbar spine fusion procedures, for example, involve multiple levels. However, add-on CPT codes – such as implants, hardware and grafts – for these procedures are packaged with no additional payment.

Here are the impacted codes:

- Allograft CPT codes: 20390, 20931
- Autograft CPT codes: 20936-20938
- Each additional interspace (cervical fusion): 22552, 22585
- Each additional vertebral space (lumbar fusion): 22614
- Instrumentation: 22840, 22842, 22845
- Application of cage: 22853, 22845, 22859 ■

Orthopedic surgeons at SSM Health resign, plan to start independent group

By Carly Behm

Several orthopedic surgeons at SSM Health Dean Medical Group in Madison, Wis. are resigning, saying they want to start an independent practice, the *Wisconsin State Journal* reported Oct. 25.

Most of the resigning surgeons turned in 90-day notices in September, the report said. *The Journal* didn't specify how many surgeons planned to resign. SSM Health spokesperson Kim Sveum told the publication the resignations were "a fluid situation" and that the health system has the coverage needed for patient care. SSM Health is also recruiting more orthopedic surgeons.

Still, some surgeons are remaining with SSM Health. The Journal was unable to reach SSM's orthopedic chair and other orthopedic surgeons.

SSM Health acquired Dean Clinic in 2013, the report said. It has locations in Fort Atkinson, Stoughton, Sun Prairie and Waunakee, Wis. ■

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Why it's time to move provider credentialing into the 21st century: Insights from Modio Health CEO Dr. Kirk Heath

Physician shortages are a major concern for healthcare organizations. Yet, it can take as long as four months for a physician to get privileges at a hospital due to manual, outmoded credentialing processes.

Becker's Hospital Review recently spoke with Kirk Heath, MD, CEO and founder of Modio Health, A CHG Company, about the need for more streamlined healthcare employment processes and how technology can help.

Question: It's no secret healthcare is experiencing a workforce crisis that is likely to persist for years. How are healthcare organizations managing this crisis in the near term? What about planning for long-term solutions?

Kirk Heath: The shortage of providers has been worsening for a number of years and was present even when I finished residency. The crisis is real and COVID only made it worse. According to the Association of American Medical Colleges, the U.S. could see a shortage of as many as 139,000 physicians by 2033.

In the near-term, healthcare organizations have increased their usage of locum providers to provide the necessary care. It is estimated that 88% of healthcare organizations who provide medical services utilize temporary, or locum, providers. It was common for the usage of locum providers to carry a negative perception, which I feel was mostly because it was contrary to the traditional medical group. Healthcare services have changed over time, with groups no longer being independent, so staffing solutions need to continue to change. Flex pools are utilized in other areas of medical care, so utilizing locums and flex pools are becoming more common. It will require an investment of time and creativity with creating and sustaining these models that include temporary providers, but the result is a 'covered' patient population. Locum providers can relieve much of the causes of burnout, listed as a top reason why providers are leaving medicine.

In the long term, healthcare organizations need to make themselves attractive places to work. Everyone wants to feel valued and part of a team, no matter what job they have. Some hospitals and systems perform that better than others, but there is a large gap among the entire population of organizations. When a group is short-staffed, providers will cover the gap, taking more call and covering patients in the office, but this leads to burnout. It is all too often that a group is left short-handed, relying on the remaining providers for coverage, because it is difficult to find a replacement. This is where locums and temporary staffing come in. When good organizations have a staffing shortage, they pull in locum tenens physicians, temporary staffing or flex pool employees. That makes life more manageable. Benefits, a positive workplace environment, and that sense of value plays an extremely important role in creating long term relationships with the workforce and low attrition.

Q: Can you talk more about why it's so important to streamline the clinician credentialing process in the current healthcare environment?

KH: Credentialing is highly inefficient and hasn't changed for decades. There are many reasons for this, ranging from fear of litigation to the way healthcare organizations are set up. When I practiced as a surgeon, I was credentialed at three hospitals, with three separate medical staffs and three separate credentialing committees. I had state licenses and was credentialed with around 20 payers. They all used the same data for credentialing, but their processes were all slightly different. A lot of redundant work goes on. In addition to the repetitive nature of credentialing, it's also done manually. Since it takes 90 to 120 days on average to complete the credentialing process, physicians can't work in a hospital for three or four months.

If it's painful for physicians to become credentialed, the likelihood they will get an extra license or take a locum tenens assignment in a new hospital is pretty small. The extra income simply may not be worth the hassle. In rural areas, this issue is particularly acute. There may not be, for example, a general surgeon or an endoscopist in the community. If it takes 120 days for physicians to get credentialed, the patients who need care have to wait too. It's imperative we credential quickly to improve patient outcomes and the quality of life for providers.

Q: Physicians with multi-state credentials used to be somewhat rare. Is this changing? Is there an easier way to standardize credentialing across states and hospitals?

KH: Licensure across state lines is extremely important and telemedicine has definitely shined a light on this. The amount of time required to get a license varies dramatically by state. It could be six months in one place and two months in another. The Interstate Medical Licensure Compact model works well. Unfortunately, the Drug Enforcement Administration doesn't have an interstate compact, so physicians still need a DEA license in every state where they practice. I think we're moving toward a central physician licensing organization, but it's an uphill battle. When we look for solutions, everyone needs to keep an open mind and focus on the greater good.

Q: What role does technology play in the credentialing process? How might technology be used to support more streamlined credentialing in the future?

KH: I left my practice to start Modio Health because I saw a need in this area. In most places, credentialing is still manual, whether that's at critical access hospitals, ASCs, provider groups, multispecialty groups or health systems. We timed it and it takes an hour and a half to manually complete a typical state credentialing application with common provider data.

What if all my data was in a central place, I could push a button and the information was sent to the form? That would reduce the process from an hour and half to five minutes. The amount of time, the hassle factor and the labor costs would all be dramatically reduced. It's imperative we use technology across all the components of the credentialing process. That's why we started Modio Health.■

Where GI execs are seeing the greatest opportunity

By Riz Hatton

Here are three key areas within gastroenterology where leaders such as U.S. Digestive Health CEO Jerry Tillinger believe opportunity is ripe:

Artificial intelligence: The use of artificial intelligence for polyp detection has become a key component of innovation within gastroenterology. According to a study in the journal *Gastroenterology*, using artificial intelligence during colonoscopies may help decrease adenoma miss rates.

Medtronic's AI-assisted polyp detection device GI Genius has been at the forefront of the industry's interest in AI. In February, Medtronic formed a partnership with Amazon Web Services to create a health equity assistance program to donate GI Genius endoscopy modules to facilities in low-income and underserved communities to increase access to AI-assisted colorectal cancer screenings. Organizations implementing GI Genius include Salt Lake City-based Intermountain Healthcare, Hackensack (N.J.) University Medical Center and Exton, Pa.-based US Digestive Health. Iterative Scopes also has its own AI-assisted polyp detection device, Skout, which recently received FDA 510(k) clearance.

Consolidation: According to a report from Avalere, 108,700 formerly independent physicians are now employed by hospitals, private equity firms, insurers or other corporate entities. Gastroenterology is one of the many healthcare sectors experiencing high rates of consolidation. Four percent of surveyed gastroenterologists intend to join management organizations in 2022, according to a report jointly published by consulting firm Fraser Healthcare and pharma research firm Spherix Global Insights. Some gastroenterology executives view consolidation within the industry as a necessity due to rapid consolidation in other areas of healthcare.

Private equity: The amount of private equity gastrointestinal groups grew to 68 percent last year and is projected to expand throughout 2022, according to the Fraser Healthcare report. With recent private equity megadeals such as GI Alliance's $785 million physician-led buyout, it has become clear that private equity is taking root in gastroenterology. Several private-equity backed MSOs have seen success acquiring practices and growing their networks in 2022 alone, and these trends are expected to continue. ■

5 numbers GI leaders should watch

By Riz Hatton

From a projected gastroenterologist shortage to a salary reduction, here are five numbers gastroenterology leaders should keep an eye on:

1. The average base salary for gastroenterologists decreased 1.2 percent since 2016, according to recruiting firm Merritt Hawkins' 2022 "Review of Physician and Advanced Practitioner Recruiting Incentives."
2. Gastroenterologist productivity dropped 16.2 percent from March 2020 to March 2022, according to Kaufman Hall's "Physician Flash Report."
3. Colorectal cancer, the third leading cause of cancer-related deaths in men and in women, is projected to cause 52,280 deaths this year, according to the American Cancer Society.
4. Gastroenterology is the most-represented specialty among ASCs, making up 32 percent of all cases, according to VMG Health's "Multi-Specialty ASC Benchmarking Study" for 2022.
5. Gastroenterology is expected to be down 1,630 physicians by 2025, according to Physicians Thrive's "2022 Physician Compensation Report." ■

4 numbers pointing to gastroenterology consolidation

By Patsy Newitt

Healthcare is increasingly consolidating, and gastroenterology is one of the many specialties with physicians migrating to employed models.

Here are four stats pointing to consolidation in gastroenterology:

28 percent. The growth percentage of private equity gastrointestinal groups in 2021, according to a report jointly published by consulting firm Fraser Healthcare and pharma research firm Spherix Global Insights.

4 percent. The percentage of surveyed gastroenterologists who intend to join management organizations in 2022, according to the same Fraser Healthcare report.

250. The number of gastroenterologists who converted to a management organization format in 2021, according to the Fraser report.

108,700: Number of formerly independent physicians who are now employed by hospitals, private equity firms, insurers or other corporate entities, according to a report from Avalere. ■

The future of gastroenterology: 5 leaders' insights

By Riz Hatton

From new technologies to physician autonomy, here are five leaders' perspectives on where the GI industry is headed.

Editor's note: Responses were edited lightly for clarity and brevity.

Latha Alaparthi, MD. President and Chair of the Board of Directors of the Digestive Health Physicians Association (Silver Spring, Md.): In GI, I'm really excited about newer medications, [such as] other modes of delivery where there's cognitive behavioral therapy or alternative therapies for some of these psychosomatic issues that we tackle on a day-to-day basis and all the [artificial intelligence] and database delivery changes that we may make. I don't know what the data actually will bring us in terms of interventions that we can change, but I think we are just at the beginning of collecting data since [electronic health records] have become so widely adapted now. It'll be interesting to see that information play out in the next few years as well.

Kevin Finnegan, MD. Gastroenterologist with One GI and Associated Endoscopy (Brentwood, Tenn.): Gastroenterology is becoming a lot more specialized, but certainly there's a lot more focus on specific disease processes. There's not just colon cancer screening — there's chronic liver disease and management of folks with chronic liver disease. Fatty liver disease is becoming an epidemic in our country, and we're seeing more individuals with chronic liver disease related to fatty liver. I think treatment and development of treatments for these conditions will continue to grow in gastroenterology.

Bill Snyder. CEO of Vivante Health: When I think about the future of GI tech, it's going to be hyperpersonalized. It goes back to the ability for us to collect data from all these different sources. Whether that's a platform like [Vivante Health's] or through a smartwatch or different wearables pulling in things like … notes from the care team [when] you go in and see your different providers or gastroenterologist or doctor. It's the aggregation of all that information to really know the patient. That's the gap that we need to continue to focus on as we really personalize the experience and know what people are going through. I think there's an opportunity to add all types of different information when you think about social determinants of health. There's individuals out there that might not have access to fresh food, for example. So how do we gain that information on a member and personalize it so their experience is meaningful? Just like everything else in our lives. When we try and watch something on Netflix, they know exactly what we like and are helping guide our choices. Anything we do today is all about personalization. I think that's a big opportunity that will get better and better over the next five to 10 years.

Jerry Tillinger. CEO of U.S. Digestive Health (Exton, Pa.): The evolution of GI practices is really in a full transition right now. For many, many decades there have generally been smaller local practices, and they've been able to succeed in that model very well. But as you've seen consolidation among health systems and among payers, those small practices have found themselves under-resourced to have a strong voice in the overall healthcare community. So they've been coming together in different ways. In some cases they've been able to form larger independent GI groups on their own and there are some really great examples of those out in the market. But for many other practices, they simply haven't been able to provide the capital and infrastructure to do that successfully.

Michael Wallace, MD. Chief of Gastroenterology and Hepatology at Mayo Clinic/Sheikh Shakhbout Medical City (Abu Dhabi): Everything we look at through an endoscope is now being applied through an [artificial intelligence] lens. The polyp detection is the most obvious application of that — it's the low-hanging fruit. What we're going to see quite rapidly now is AI applied to everything else that we look at. ■

Gastro Health, GI Alliance and more: 8 industry updates

By Riz Hatton

Here are eight updates on gastroenterology companies *Becker's* reported on during the third quarter of 2022:

Capital Digestive Care

- Silver Spring, Md.-based Capital Digestive Care added Gastroenterology, Ltd. of Virginia Beach (Va.) to its network.

Gastro Care Partners

- Gastro Care Partners, appointed Brooks Marshall as its senior vice president of business development.

Gastro Health

- Gastro Health finalized its acquisition of Charlottesville (Va.) Gastroenterology Associates.
- Gastro Health added gastroenterologist and internal medicine physician Keith Moore, MD, to its network.

GI Alliance

- Private equity firm Waud Capital Partners sold its controlling ownership stake in GI Alliance.
- GI Alliance finalized its physician-led buyout facilitated by a $785 million investment from private equity firm Apollo Hybrid Value.

US Digestive Health

- US Digestive Health added Southwestern Gastrointestinal Specialists to its network.
- US Digestive Health is offering patients artificial intelligence-assisted colonoscopy screenings using the largest installation of GI Genius intelligent endoscopy modules in the world. ■

Gastroenterology megadeals shaping the industry in 2022

By Riz Hatton

Four percent of surveyed gastroenterologists intend to join management organizations in 2022, according to a report jointly published by consulting firm Fraser Healthcare and pharma research firm Spherix Global Insights.

Here are four of the biggests deals from GI megagroups that have occurred in 2022:

Gastro Health

Gastro Health entered its seventh state after a three-practice acquisition in Massachusetts.

The acquired practices are Greater Boston Gastroenterology, Digestive Health Specialists and Middlesex Gastroenterology.

GI Alliance

GI Alliance finalized its physician-led buyout facilitated by a $785 million investment from private equity firm Apollo Hybrid Value.

The transaction resulted in Apollo serving as GI Alliance's long-term strategic partner and receiving two seats on the GI Alliance board.

Waud Capital Partners, the private equity firm under which GI Alliance was founded, sold its controlling ownership stake in the practice management company.

United Digestive

United Digestive added Daniel Mullady, MD, to its network.

Dr. Mullady merged his practice with United Digestive's Center for Digestive & Liver Health in Savannah, Ga.

US Digestive Health

US Digestive Health added Southwestern Gastrointestinal Specialists to its network.

Southwestern Gastrointestinal Specialists has locations in Uniontown and Connellsville, Pa. ■

AGA: Controversial colonoscopy study findings not necessarily applicable to U.S.

By Riz Hatton

The American Gastroenterological Association has released a statement regarding the controversial study in *The New England Journal of Medicine* saying its conclusions are not necessarily applicable to colorectal cancer screening in the U.S.

The study found the risk reduction for those who were invited to receive a colonoscopy screening compared those who did not to be just 18 percent – but those who actually underwent the procedure saw larger reductions. Read more about the study here.

Three key statements about the study from David Lieberman, MD, chair of the AGA's Colorectal Cancer Task Force:

Note: These statements come from an Oct. 11 email from the American Gastroenterological Association shared with Becker's.

1. The study shows that colonoscopy screening is effective when completed. Just 42 percent of patients randomized to colonoscopy completed the screening. Those who received the colonoscopy saw a 31 percent decrease in colorectal cancer prevention and a 50 percent decrease in mortality.

2. Quality matters. Several endoscopists had adverse drug reactions below the 25 percent benchmark, which are associated with a higher risk of colorectal cancer post-colonoscopy.

3. The benefits of colonoscopy take time. The detection and removal of polyps prevent future cancers. ■

US Digestive Health gains 35 providers through partnership

By Riz Hatton

Exton, Pa.-based US Digestive Health has partnered with Delaware Center for Digestive Care in Newark.

Delaware Center for Digestive Care brings three locations, two ASCs, more than 35 providers and more than 140 employees to the US Digestive Health Management network, according to an Oct. 4 news release.

US Digestive Health Management's network consists of more than 200 gastroenterology professionals and service providers, 29 locations, 17 ASCs and more than 950 employees. ■

10 statistics on gastroenterologists' wealth, debt

By Riz Hatton

Here are 10 statistics on gastroenterologist salary, wealth and debt:

1. The average base salary for gastroenterologists has decreased 1.2 percent since 2016, according to recruiting firm Merritt Hawkins' 2022 "Review of Physician and Advanced Practitioner Recruiting Incentives."
2. Twenty-two percent of gastroenterologists reported a net worth of more than $5 million, according to *Medscape's* "Physician Wealth & Debt Report 2022."
3. Median gastroenterologist revenue hit a two-year high March 1, according to consulting firm Kaufman Hall's "Physician Flash Report."
4. Gastroenterology is the sixth-wealthiest medical speciality, according to *Medscape's* "Physicians Compensation Reports."
5. The average incentive bonus for a gastroenterologist is $74,000, according to *Medscape's* "Physician Compensation Report 2022."
6. Dallas is the highest-paying U.S. city for midcareer (eight to 14 years) gastroenterologists, according to the *Medscape* Salary Explorer.
7. Atlanta is the highest-paying city for late-career (22 to 28 years) gastroenterologists, according to the *Medscape* Salary Explorer.
8. Seventeen percent of gastroenterologists reported a net worth of less than $500,000, according to *Medscape's* Physician Wealth & Debt Report 2022.
9. Seventeen percent of gastroenterologists said they are still paying off student loans, according to *Medscape's* Physician Wealth & Debt Report 2022.
10. More than half of gastroenterologists younger than 40 have student loan debt, according to *Medscape's* "Young Physician Compensation Report 2022." ■

GI OnDemand strikes 2nd partnership in 2 days

By Claire Wallace

GI OnDemand has partnered with Mindset Health, the developer of a hypnotherapy program mobile app, just a day after announcing its partnership with irritable bowel disease management solution Trellus Health.

GI OnDemand has partnered with Mindset Health to provide patients with a six-week, gut-focused hypnotherapy program that helps patients with irritable bowel syndrome manage their symptoms.

GI OnDemand is a joint venture between Bethesda, Md.-based American College of Gastroenterology and Gastro Girl.

Mindset's gut hypnosis program, Nerva, was developed by Simone Peters, MD, a GI researcher who discovered the benefits of gut-directed hypnotherapy in a study at Monash University in Melbourne, Australia.

"Given the multifactorial nature of IBS, a multidisciplinary approach that includes brain-gut behavioral therapies is critical for many patients," Megan Riehl, PsyD, director of behavioral health services for GI OnDemand, said in an Oct. 20 press release. "Direct access to a GI psychologist remains limited and has been a significant barrier to receiving this evidence-based care. Providers now have a trusted solution for access issues with an excellent product. Nerva is a self-directed digital therapeutic with proven benefits that patients will find easy to use and effective." ■

Maryland endoscopy provider opens 323,000-square-foot manufacturing plant in Mexico

By Claire Wallace

Columbia, Md.-based single-use endoscopy developer Ambu has opened a 323,000-square-foot manufacturing plant in Ciudad Juarez, Mexico, to ramp up supply production.

Ambu hopes that having more plants in North America will allow them to be closer to the U.S. sales market, according to an Oct. 13 press release.

The company anticipates the plant will create 2,000 to 3,000 jobs in the region.

"Demand for single-use endoscopes continues to grow in the U.S., and with the Mexico plant, we will be able to maintain a strengthened supply of medical devices, which will ultimately benefit our customers and their patients – for years to come," Ambu President Steven Block said in the release. ■

Optum vs. Tenet: How ASC strategies are shifting

By Patsy Newitt

Tenet Healthcare, parent company of ASC chain United Surgical Partners International, and Optum, parent company of ASC chain SCA Health, are looking at different ASC growth strategies as the year comes to a close.

Optum and SCA Health

Optum is doubling down on value-based care, and SCA Health is expanding its focus to the larger care continuum, rather than just ASCs.

OptumHealth's 31 percent revenue-per-customer growth is attributed to the increasing number of patients served under value-based care, according to an Oct. 14 call with investors transcribed by *The Motley Fool*. OptumHealth is Optum's care delivery platform. The growth is also linked to an increasing focus on higher acuity ambulatory procedures.

The company, previously known as Surgical Care Affiliates, also rebranded to SCA Health in May, with intentions to expand beyond ASC management.

SCA Health CEO Caitlin Zulla told *Becker's* this rebranding represents the company's transition to "support physician specialists more holistically across the specialty care continuum," rather than an ASC company "singularly focused on partnering with surgeons in their ASCs."

"In addition to our continued ASC leadership, we've grown our business to support specialty practices, patient navigation, value-based care, anesthesia, ancillary services and more," she said.

More than two-thirds of Optum's revenue is derived from value-based care contracts, and that number is expected to grow, OptumHealth CEO Wyatt Decker, MD, said in the earnings call. The company's third-quarter revenue is up 17 percent from the same quarter last year, reaching $46.6 billion.

In the third quarter, Optum also made two major acquisitions. The company acquired Houston-based multispecialty physician group Kelsey-Seybold Clinic for around $2 billion and Healthcare Associates of Texas, a Dallas-based physician practice management company, for $300 million.

Tenet and USPI

USPI is the largest ASC chain in the country, both by market share and number of ASCs. The company added 122 ASCs in the last year, ending the third quarter with 440 ASCs and 24 surgical hospitals across 35 states.

USPI executives revealed the company is behind on its year-long growth plan in an Oct. 20 third quarter earnings call from Tenet, but USPI's mergers and acquisitions pipeline remains strong. The company still expects to deploy $250 million in acquisitions this year.

Like SCA Health, higher-acuity procedures are a point of focus. By the end of the third quarter, orthopedic and spine procedures made up 20 percent of USPI's total volume.

Tenet has been bolstering its ASC business to drive revenue in the last few years. The company has spent more than $2.5 billion in capital investment to scale USPI since December 2020 and expects to see 12 percent growth after acquiring interest in about 160 ASCs in less than two years.

USPI also aims to have 575 to 600 ASCs by the end of 2025.

In the second quarter, Tenet paid $406 million to acquire Dallas-based Baylor Scott & White Health's 5 percent equity position in USPI. In June, USPI and United Urology Group signed an official agreement to form a joint venture partnership in 22 ASCs. ■

5 biggest ASC deals in Q3

By Patsy Newitt

Here are the biggest deals in the third quarter of 2022 that ASC leaders need to know:

1. CVS Health entered a deal to acquire home health company Signify Health for $8 billion, a move that marks the company's efforts to expand its value-based care offerings. Signify's value-based provider network includes 50 health plan clients and members and has focused on value-based care offerings since it acquired Caravan Health in March 2022.
2. Amazon said it would acquire virtual and in-person primary care company One Medical in a cash deal valued at $3.9 billion. The deal will combine One Medical's technology and team with Amazon to offer more convenient and affordable healthcare in-person and virtually.
3. UnitedHealth subsidiary Optum, which owns and operates ASC management company Surgical Care Affiliates, acquired Houston-based Kelsey-Seybold reportedly for around $2 billion. Optum has yet to confirm the terms of the deal.
4. Dallas-based Tenet Healthcare now owns 100 percent of United Surgical Partners International's voting shares. It acquired the ASC chain for $406 million.
5. HCA Healthcare has expanded its network of 153 ASCs by acquiring interest in Performance Health Surgery Center in Fort Myers (Fla.) along with five physician partners. Performance Health Surgery Center is 14,910 square feet, with four operating rooms and state-of-the-art equipment for minimally invasive outpatient procedures. ■

Private equity turns to ophthalmology with billion-dollar deals

By Patsy Newitt

Private equity firms are seeing increasing opportunity in ophthalmology firms, reflected in the increase in multimillion-dollar investments in the industry in recent years, *Kaiser Health News* reported Sept. 19.

Ophthalmology Consultants, for example, is a part of St. Louis-based EyeCare Partners, a private equity-backed eye group that boasts a portfolio of 300 ophthalmologists and 700 optometrists in 19 states.

The group was acquired by private equity firm Partners Group in 2019, one of the many PE firms looking to ophthalmology groups. Retina Consultants of America, another eye group, was formed in 2020 with a $350 million investment from Webster Equity Partners.

"Acquisitions have escalated so much that private equity firms now are routinely selling practices to one another," the report reads.

As the population ages, private equity groups are seeing opportunities in eye care. While private equity groups can provide investments for physicians to expand their practice and negotiate better drug and supply contracts, some studies suggest their focus on profitability could affect patient care.

A *Kaiser Health News* analysis of the top 30 prescribers of macular degeneration eye drugs Lucentis and Avastin found that PE companies invested in 23 percent of the top Avastin prescribers and 43 percent of the top Lucentis prescribers. This could mean PE firms are investing more in the offices of physicians who are seeing high volumes of patients and thus are more profitable, rather than selecting processes randomly.

Additionally, the analysis found PE-backed Retina Consultants of America invested in the practices of four of the top Avastin prescribers, and nine of the top Lucentis prescribers. Retina Consultants of America did not respond to Kaiser Health News' requests for comment.

This private equity interest is expected to continue, particularly as increasing margins make it more difficult for independent groups to break even. ■

3 universities opening ASCs

By Riz Hatton

Here are three universities that are opening ASCs that *Becker's* has reported on since Aug. 29:

1. Little Rock-based University of Arkansas for Medical Sciences is opening a urology ASC as part of its upcoming $20 million Health Specialty Center.
2. The University of Maryland Upper Chesapeake Health broke ground on a new ASC on its campus in Bel Air, Md.
3. Through a partnership between Tallahassee (Fla.) Memorial Healthcare, Tallahassee-based Florida State University and developer St. Joe Company, an 87-acre medical complex in Panama City Beach, Fla., with an ASC is being built. ■

Atlas Healthcare Partners dives deeper into ASCs with physicians, health systems

By Claire Wallace

From a joint orthopedic ASC venture to a Banner Health investment, here are five updates on Phoenix-based Atlas Healthcare Partners that *Becker's* has reported on this year:

1. BHSH Spectrum Health West Michigan broke ground on a $15.1 million orthopedic ASC in Grand Rapids in partnership with Atlas Healthcare Partners.
2. Phoenix-based Banner Health and Atlas Healthcare Partners jointly acquired two Arizona ASCs.
3. Atlas Healthcare Partners secured an investment from Southfield, Mich.-based BHSH System.
4. Banner Health invested in Atlas Healthcare to spur growth and reach 50 ASCs acquired by the end of 2025.
5. Atlas Health Partners began a cardiovascular ASC venture with MedAxiom. ■

National Medical Billing Services inks acquisition to expand ASC revenue offerings

By Patsy Newitt

National Medical Billing Services has acquired MedTek, an ASC revenue cycle management provider, the company said Oct. 25.

MedTek was founded in 2001 and offers medical transcription, coding, billing and other software products to ASCs in nearly 50 states. It employs more than 100 surgical coders through a management tool and interactive dashboard.

The acquisition will enhance RCM company National Medical Billing Services' offerngs for ASCs, surgical practices and anesthesia groups.

The deal marks National Medical Billing Services' fourth transaction since January 2021, including a partnership with private investment firm Aquiline Capital Partners.

"We are constantly evaluating strategies to add value for clients, and we are ecstatic to partner with the MedTek team to further expand our offering," Nader Samii, National Medical's CEO said in a news release shared with *Becker's*. "MedTek brings unmatched, ASC-specific medical transcription, surgical coding and related revenue cycle software and services, which are all extremely complementary to National Medical's existing portfolio." ■

EyeSouth Partners to be purchased by private equity firm

By Carly Behm

Private equity firm Olympus Partners inked an agreement to acquire ophthalmology management services organization EyeSouth Partners.

EyeSouth Partners' network spans 11 states and covers more than 155 locations. The more than 270 physicians with EyeSouth Partners will remain investors along with Olympus and management, the private equity firm said in a Sept. 30 news release.

Olympus Partners was founded in 1900 and manages in excess of $8.5 billion in industries from healthcare to manufacturing. ■

Kaiser Permanente expands ASC presence: 3 updates this year

By Claire Wallace

From a new Maryland ASC to a potential California addition, here are three ASC updates from Oakland, Calif.-based Kaiser Permanente that *Becker's* has reported on this year.

1. Kaiser Permanente opened a Lutherville-Timonium, Md., outpatient-focused medical center with a three-operating-room ASC.

2. Kaiser Permanente may convert a 242,900-square-foot San Jose, Calif., hospital into an ASC.

3. Kaiser Permanente submitted applications to build a second ASC in Folsom, Calif. ■

Surgeon sells Arkansas ASC building for $2.6M

By Marcus Robertson

John Kendrick, MD, sold the building housing the Springdale, Ark.-based Minimal Access Surgery Clinic for $2.6 million, *Arkansas Business* reported Sept. 26.

A real estate firm bought the 13,156-square-foot facility, the report said. Dr. Kendrick runs the practice, which offers services in general surgery, pediatrics, lab, ultrasound, endoscopy and biopsies. ■

Physician group acquires $44.5M California medical office building

By Patsy Newitt

A medical office building in San Francisco was sold for $44.5 million, *REBusiness* reported Sept. 23.

Pan-Med Enterprises, a group of physicians that operates practices at the property, acquired the five-story building. They were represented by CBRE Capital Markets.

The 97 percent-leased building features an outpatient radiology lab, testing lab, pharmacy and health resource center. ■

$50M outpatient facility breaks ground in South Carolina

By Alan Condon

Roper St. Francis Healthcare has broken ground on a 40,000-square-foot, two-story outpatient facility in Summerville, S.C.

The $50 million center, expected to open by 2025, will offer a variety of outpatient services, including orthopedics, cardiology, women's services and multidisciplinary specialists, according to *The Post and Courier.*

The outpatient facility is expected to complement the health system's nearby urgent care facility and its 50-bed Roper St. Francis Berkeley Hospital in Goose Creek, S.C.

"Roper St. Francis Healthcare is determined to provide residents in and around Summerville with a wide variety of services to keep them healthy and thriving while being convenient to their homes and workplaces," Dr. Jeffrey DiLisi, president and CEO of Roper St. Francis Healthcare, said in an Oct. 14 news release. "Three years ago, we opened a new hospital down the road and have steadily added healthcare services because the residents of Summerville want our high-quality, compassionate care that's easy to access." ■

$1.7B for the most expensive ASC projects in Q3

By Patsy Newitt

Here are the seven most expensive ASC projects in the third quarter of 2022, totaling $1.7 billion:

1. Mission Viejo, Calif.-based Providence Mission Hospital is building a multispecialty ASC as part of a $712 million expansion project.
2. The University of Illinois Chicago cut the ribbon on a $194 million project that features an ASC.
3. The Austin-based University of Texas System Board of Regents approved a $145.7 million cancer and surgery center at the University of Texas Rio Grande Valley's McAllen Academic Medical Campus.
4. University Medical Center of El Paso is proposing a $345.7 million expansion project that would create a new ASC and increase capacity at its medical center, children's hospital and cancer institute.
5. New York City-based Cohen Children's Medical Center opened its $110 million Pediatric Surgical Operating Complex.
6. A $100 million project in Lancaster, Pa., will include a three-story medical office building. Lancaster General Health, part of Philadelphia-based Penn Medicine, and developer Hankin Group will develop the medical office building through a partnership.
7. The University of Chicago Medicine is breaking ground on an $86 million Crown Point, Ind., project that will be the system's largest off-site facility. The 130,000-square-foot outpatient center and microhospital will include an ASC. It will offer services including an emergency department, cancer center, imaging center, lab services and medical offices. ■

Ophthalmology MSO partners with 5-physician ASC

By Claire Wallace

Unifeye Vision Partners added Fargo, N.D.-based Northern Plains Surgery Center to its network.

The addition marks the management service organization's fifth practice in the Upper Midwest and the 13th partnership, UVP said in an Oct. 4 news release. Northern Plains Surgery Center was founded by Steven Bagan, MD, and Lance Bergstrom, MD, in 1999. The duo and three more physicians will remain active partners in the ASC with UVP having majority ownership.

UVP is backed by private equity firm Waud Capital Partners. It has a network of 38 clinic locations and nine ASCs. ■

Highest-paying physician specialties in the US | 2022

By Patsy Newitt

Cardiology is the highest-paying U.S. physician specialty, according to a Aug. 8 report from *Forbes*.

Forbes analyzed 2022 data from the U.S. Bureau of Labor Statistics' Occupational Employment Statistics and isolated occupations that fall into the Healthcare Practitioners and Technical Occupations category to develop a list of the most lucrative medical jobs in the country.

Here are the physicians on the list, broken down into average hourly pay and average annual pay: ■

Occupation	Average Hourly Pay	Average Annual Pay
Cardiologist	$170.18	$353,970
Anesthesiologist	$159.22	$331,190
Oral and Maxillofacial Surgeon	$149.74	$311,460
Emergency Medicine Physician	$149.35	$310,640
Orthopedic Surgeon, Except Pediatric	$147.22	$306,220
Dermatologist	$145.55	$302,740
Radiologist	$145.06	$301,720
Surgeon, All Other	$143.17	$297,800
Obstetrician and Gynecologist	$142.41	$296,210
Pediatric Surgeon	$139.57	$290,310
Ophthalmologist, Except Pediatric	$129.85	$270,090
Neurologist	$128.68	$267,660
Physician, Pathologist	$128.45	$267,180
Psychiatrist	$120.08	$249,760
General Internal Medicine Physician	$116.44	$242,190
Family Medicine Physician	$113.43	$235,930
Physician, All Other	$111.30	$231,500
Pediatrician, General	$95.40	$198,420
Podiatrist	$76.15	$158,380
Optometrist	$60.31	$125,440

2023 CMS physician pay schedule could destabilize Medicare, AMA says

By Patsy Newitt

Physicians are expecting to see a 4.42 percent pay cut in January with the proposed 2023 Medicare physician payment schedule, and paired with rising operating costs and inflation, this could further destabilize Medicare, according to a Sept. 8 article from the American Medical Association.

"The payment system is on an unsustainable path that is jeopardizing patient access to physicians. The resulting discrepancy between what it costs to run a physician practice and actual payment, combined with the administrative and financial burden of participating in Medicare, is incentivizing market consolidation," AMA said in a Sept. 6 letter to CMS.

In the letter, AMA urges Congress to do the following:

1. Extend the 3 percent temporary increase in the Medicare fee schedule
2. Provide relief for an additional 1.5 percent budget cut planned for 2023
3. End the statutory annual freeze and provide an inflation-based update
4. Waive the 4 percent pay-as-you-go sequester
5. Extend the 5 percent incentive payment physicians can earn for participating in an advanced alternative payment model ■

A new name joins Forbes' growing list of healthcare billionaires

By Claire Wallace

The number of healthcare billionaires in the U.S. has grown from 29 to 30 as of Oct. 14, according to *Forbes*' real-time net worth tracker.

John Oyler, a biotech CEO, reached a $1 billion net worth, earning himself a spot on the list.

Mr. Oyler is the CEO and co-founder of BeiGene, which was founded in Beijing in 2010. He owns 6 percent of the company.

Mr. Oyler also started and sold two companies before BeiGene, including telecom research firm Telephia and drug outsourcing company BioDuro, which he sold for $77 million in 2010. ■

'I don't know how much longer I can continue to be a doctor': Physicians fight pay cuts as operating costs soar

By Patsy Newitt

Physician owners are struggling to meet margins as they face skyrocketing operating costs and consistent pay cuts.

The cost of running a medical practice increased 39 percent between 2001 and 2021, according to data from the American Medical Association, but physicians aren't seeing a correlating increase in pay from CMS and insurance companies.

Medicare's physician fee schedule proposed rule for 2023 would reduce the conversion factor by 4.42 percent to $33.08. CMS is also planning to remove the 4 percent statutory pay-as-you-go sequester, which was implemented to offset Congressional spending outside of healthcare.

"It is immediately apparent that the rule not only fails to account for inflation in practice costs and COVID-related challenges to practice sustainability, but also includes a significant and damaging across-the-board reduction in payment rates," Jack Resneck Jr., MD, president of the American Medical Association told *Becker's*. "Such a move would create long-term financial instability in the Medicare physician payment system and threaten patient access to Medicare-participating physicians."

While more than 120 state and national medical associations are asking Congress to reform Medicare's physician payment rates, many physicians need help in the short term. With inflation remaining higher than 8 percent in the last few months, and labor, materials, business expenses, health insurance, malpractice insurance and rent on the rise, physicians are wearing thin.

Luis Paz, director of business development and marketing at Cardiovascular Surgical Suites in Coral Springs, Fla., told *Becker's* he hears many physicians make comments such as, "I don't know how much longer I can continue to be a doctor. It gets more difficult every year," and "While reimbursements are getting smaller, the cost of running a practice keeps increasing. It's unsustainable."

Physician groups are increasingly consolidating as operating independently becomes more difficult — acquisitions jumped 145 percent from 2020 to 2021, according to a report from VMG Health.

Additionally, 36 percent of physicians have considered early retirement in the last year, according to "Back From Burnout: Confronting the Post-pandemic Physician Turnover Crisis," an October report from the Medical Group Management Association and Jackson Physician Search.

Many physicians are worried about how patient care will be affected by these losses.

"To be facing these rising costs (aka rising 'overhead'), and then to have the largest governmental payer suggest a reduction in reimbursement is seemingly tone deaf to the physician ecosystem and its current difficulties," Cory Calendine, MD, orthopedic surgeon at the Bone and Joint Institute of Tennessee in Franklin, told *Becker's*. "Without physicians, we will not have coordinated patient care. Patients will suffer." ■

Stark Law changes: Physician compensation arrangements to keep an eye on

By Patsy Newitt

Hospitals and health systems need to update their physician compensation plans after CMS' recent changes to the Stark Law, according to an article in *JDSupra* from the law firm Foley and Lardner.

These arrangements should be "carefully reviewed" if the hospital seeks to meet the Stark Law employment or indirect compensation arrangement exceptions, according to the Sept. 7 report.

Three things to note:

1. Physician compensation plans where productivity is above the 75th percentile could trigger review. These plans should ensure that compensation is consistent with the physician's personal productivity, instead of assuming anything below the 75th percentile will be fair market value.
2. Compensation should also be consistent with the services performed by the practitioner. If a physician is compensated based on their advanced practice providers' work relative value units, for example, hospitals should ensure that compensation is explicitly for the services performed by the physician, such as supervision.
3. Indirect compensation agreements should be reviewed, because certain compensation agreements that consider APP work relative value units as physician compensation might not meet commercial reasonableness and fair market value tests. ■

5 ways Medicare's proposed cuts will affect physicians in 2023

By Alan Condon

Physicians are bracing for an 8.42 percent drop in CMS payment rates in 2023 and many medical groups are considering limiting the number of new Medicare patients or reducing charity care as a result, according to the Medical Group Management Association.

The proposed cuts are projected to significantly disrupt access to care, practice operations and investment throughout the healthcare industry. If implemented, here are the top five practice trends that will occur, according to MGMA:

1. Reducing or eliminating the number of Medicare beneficiaries served.
2. Projected delays in scheduling care, resulting in up to six months' wait for visits.
3. Decreased ability to recruit staff at all levels, including physicians, clinical support staff and administrative staff, especially in rural areas.
4. Reduced participation in value-based contracts as limited resources and revenue divert away from nonessential practice activities.
5. Closing satellite offices or selling the practice due to insufficient revenue streams.

The projected Medicare cuts will also affect Medicaid and private payer rates, which are often contracted as a percent of Medicare rates, according to the MGMA. As Medicare reimbursement declines, practices will likely see a decrease in operating revenues, which will further reduce their ability to provide timely, high-quality care to patients. ■

Biogen pays $900M to settle physician kickback allegations

By Patsy Newitt

Pharmaceutical company Biogen has agreed to pay $900 million to resolve allegations it paid kickbacks to physicians to prescribe Biogen drugs, the U.S. Justice Department said Sept. 26.

The False Claims lawsuits alleged that Biogen submitted false claims to Medicare and Medicaid by paying kickbacks to its top physician prescribers to dissuade them from prescribing drugs from competitors.

The lawsuit was filed in Massachusetts in 2012 by whistleblower and former employee Michael Bawduniak. According to the complaint, from Jan. 1, 2009, to March 18, 2014, the company paid remuneration – including in the form of speaker honoraria, speaker training fees, consulting fees and meals – to physicians who attended their speaker programs or consultant programs to induce them to prescribe Avonex, Tysabri and Tecfidera.

Biogen will pay $843.8 million to the U.S. and $56.2 million to 15 states. Mr. Bawduniak will receive approximately 29.6 percent of the settlement's federal proceeds. ■

3 changes affecting physician group reimbursements

By Patsy Newitt

Since 2015 there have been three major changes to physician group reimbursements, according to VMG Health's "Annual Healthcare M&A Report 2022."

The organization laid out the three biggest changes:

1. The Senate passed the Medicare Access and CHIP Reauthorization Act in April 2015, which removed the sustainable growth rate formula from the Medicare physician fee schedule conversion factor. The formula was then replaced with a fixed .5 percent annual increase through 2019.

From 2019 to 2025, individual physicians can still achieve payment increases through participation in the merit-based incentive program.

2. The annual increase was then reduced to 0.25 percent by the Balanced Budget Act of 2019.

3. In November 2021, CMS released the Medicare physician fee schedule final rule payment for 2022 with a conversion factor of $33.59, a decrease of $1.30 from the 2021 conversion factor of $34.89. ■

Arizona health system files $10M breach of contract suit against physician group

By Patsy Newitt

Community Health has filed a suit to recover nearly $10 million from Fresno, Ariz.-based physician group Santé Health System, *The Sun* reported Oct. 5.

Community Health, which entered an agreement with Santé in October 2017 to provide millions in grant money, alleges an independent audit revealed the group did not distribute or account for various grants.

According to the report, Santé asked the health system in 2019 to increase the grant to cover management service fees. Community Health then solicited an independent audit for fiscal year 2020 and found the group allegedly misappropriated $9.89 million of grant funds.

The suit alleges the grant money was "distributed for unincurred expenses, disbursed in excess of permitted expenditures and dispersed or retained by Santé after the grant periods expired," the report said.

Santé has allegedly admitted it has possession of grant funds due but is refusing to return the funds, Community said in a statement, according to *The Sun*. The lawsuit also states that Santé is not operating medical clinics, enrolled in Medicare nor offering genuine financial assistance.

"In the last month of the grant period alone, Santé disbursed $6.8 million in grant funds to medical providers before expenses were incurred in order to avoid having to return those funds to Community when the grant period expired on Aug. 31, 2020," the statement reads, according to *The Sun*.

Santé, which has a portfolio of more than 1,500 providers who serve more than 120,000 people, has claimed in response that Community severed their agreement more than two years ago and "breached the exclusivity provision in the contract in a way that Community is obligated to pay $5 million in liquidated damages," the report said. ■

4 physician practice deals that are shaping industry

By Patsy Newitt

Physician groups are increasingly consolidating – acquisitions jumped 145 percent in 2021, according to a report from VMG Health.

Here are four big deals since the beginning of 2021 that point to a consolidating industry.

1. UnitedHealth Group subsidiary Optum, which owns and operates ASC management company Surgical Care Affiliates, acquired Houston-based Kelsey-Seybold for around $2 billion. Optum has yet to confirm the terms of the deal, which closed earlier this year.

Kelsey-Seybold is a multispecialty physician group with cancer and women's health centers, two ASCs and a sleep center. The group is building another ASC on a campus that will eventually have space for 82 providers.

2. Optum also agreed to acquire Atrius Health, which employs 645 physicians and primary care providers, for $236 million in March 2021. Although the acquisition came under scrutiny by the Massachusetts attorney general, the deal was confirmed in 2022. Atrius Health employs 645 physicians and primary care providers, along with 421 additional clinicians.

3. Mednax acquired nine physician practices for a total of $34.9 million in 2021, according to VMG – this included a pediatric orthopedic practice, a multilocation pediatric primary and urgent care practice, a pediatric cardiology practice, two pediatric neurology practices, one maternal medicine practice, an OB-GYN practice, a pediatric intensivist practice and a neonatology practice.

4. Babylon, a digital health company in London, acquired Novato, Calif.-based medical group Meritage Medical Network and its 700 physicians in 2021. ■

Market share of the 10 largest payers

By Patsy Newitt

UnitedHealth Group is the insurer with the largest market share, according to a September report from ValuePenguin.

Here is the market share of the 10 largest payers:

- UnitedHealth Group:12 percent
- Anthem: 11 percent
- Centene: 10 percent
- Humana: 7 percent
- HCSC: 6 percent
- CVS Health: 5 percent
- Molina Healthcare: 2 percent
- Cigna: 2 percent
- Kaiser Permanente: 2 percent
- Guidewell: 2 percent ■

Private equity acquisitions of physicians' practices associated with healthcare spending spikes

By Armani Washington

Private equity acquisitions of physician practices are associated with increased healthcare spending and utilization, according to research published in *JAMA Network* Sept. 2.

Researchers from Baltimore-based Johns Hopkins University and Portland-based Oregon Health and Science University analyzed claims data from 578 private-equity-acquired dermatology, gastroenterology and ophthalmology physician practices and 2,874 similar independent practices.

The researchers found the private-equity-backed physician practices had an average increase of $71 charged per claim and $23 in the allowed amount per claim.

Additionally, the volume of encounters increased by 16.3 percent, and the number of new patients increased by 37.9 percent. ■

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