Testimony

Senate Bill 2334

House Human Services Committee

Chairman, Representative Robin Weisz

Vice Chairman, Representative Karen Rohr

3/17/2021

Chairman Weisz, Madam Vice Chairman Rohr, and distinguished members of the House Human Services Committee, my name is Duncan Ackerman. I am native to North Dakota, born and raised in Minot, and I am an Orthopedic Surgeon who has practiced in North Dakota since completing my residency and fellowship training at The Mayo Clinic in 2009. My family proudly chose to return to our great state to practice medicine and have since been afforded the opportunity to improve the lives of many our friends and neighbors.

I am also an owner / partner in two small businesses. The first, The Bone & Joint Center, is an Orthopedic Surgery clinic that provides a broad scope of musculoskeletal care. There are nine partners in the practice with eight of the partners hailing from North Dakota. The places we grew up include Hillsboro, Bowman, Kenmare, Lansford, Minot, Turtle Lake, and Bismarck. The Bone & Joint Center was established in 1973 and continues to serve the residents of North Dakota. We have permanent offices in Bismarck, Dickinson, and Minot along with outreach locations in Garrison, Turtle Lake, Hazen, Beulah, Williston, Hettinger, Linton, and Wishek.

I am also an owner / partner of Bismarck Surgical Associates (BSA). BSA is an outpatient ambulatory surgery center (ASC). My partners are Orthopedic Surgeons, Anesthesiologists, and an Ophthalmologist. We perform a full array of outpatient procedures from cataract surgery to total joint replacement. ASCs, which were established in 1970, have proven to provide lower cost, high quality care.

Today I am here representing North Dakotans for Open Access Healthcare.

The public's demand of price transparency has resulted in a shift in health care delivery to lower cost alternatives. The Centers for Medicare and Medicaid Services (CMS) has developed an online tool (https://www.medicare.gov/procedure-price-lookup/cost) for patients to research the difference in cost when comparing surgery at an ASC versus a Hospital Outpatient Department (HOPD). Using national data, an ASC is paid about 56.39% of the HOPD rate for the exact same procedure, saving the Medicare and Medicaid systems more than 43 percent on average. I am an upper extremity specialist, so rotator cuff shoulder surgery is a common procedure in my practice. Utilizing CMS's tool, we can look at and compare the cost difference for arthroscopic rotator cuff repair in an ASC vs. HOPD. In an ASC, the total cost for arthroscopic rotator cuff repair is $3,918, Medicare pays $3,134, the patients responsibility is $783. In comparison, the total cost for the same procedure at a HOPD is $7,096, Medicare pays $5,677, the patient's responsibility is $1,419. The savings are clear, procedures performed in an ASC cost the payor and consumer less than if performed in a HOPD.

Medicare and its beneficiaries save $2.6 billion dollars each year as a result of ASCs and could save an additional $2.5 billion if just half the current HOPD cases were done in ASCs. Patient and private insurance companies save similarly. A review of commercial claims found US healthcare costs are reduced by $38 billion each year due to the availability of ASCs as an alternative for outpatient surgeries. Patients personally, through lower deductibles, realize $5 billion of those savings. Patients, employers, and insurers, therefore, appropriately remain very interested in care provided at ASCs. (California Orthopedic Association White Paper Expanding Services in an ASC Through the Addition of a Recovery Care Center 2017). (https://coa.org/newspublications/white-papers/)

Medicare this past year decided to discontinue the Inpatient Only List (IPO) of procedures. The IPO list was a list of procedures that could only be performed in a hospital inpatient setting, including common

procedures such as total hip and total shoulder replacement. Medicare previously would not pay for a procedure on the IPO list to be performed at an ASC. Medicare's decision to discontinue the IPO list proves that CMS values the ASCs as a cost saving alternative to traditional hospital care. This decision will lead to patients having the additional option of having a procedure performed in an ASC, that historically could have only been performed in the hospital.

The Covid-19 Pandemic has also highlighted the need for additional patient choice. In-patient hospital systems were severely challenged by staffing issues, procurement challenges, and patient volumes. Several of my patients rescheduled their surgeries due to the concern of the procedure being done in the hospital environment where patients with Covid-19 were receiving care. In addition, several of my patients were required to be rescheduled because the hospital was at capacity and could not guarantee they would have the staff available to provide appropriate post-operative care. This may seem like a simple inconvenience, but we care for people that have a narrowly defined timeline to heal and return to feeding their families. This is a significant challenge for a farmer or rancher who must recover before planting or calving, a patient trying to take advantage of already-met deductibles, or a WSI patient who wants to get back to work and off state assistance.

This leads us to discuss a new opportunity for our patients in North Dakota called an Extended Stay Center (ESC). Currently in North Dakota, patients are only allowed to stay in an ASC for up to 24 hours. The creation of the ESC would allow patients to stay up to 48 hours. Extended Stay Centers (ESC) are essentially recovery rooms for patients undergoing a procedure in an ASC. They are there for a patient who might need a little extra time and minor care to recover from surgery. The services included may be for pain management, physical therapy, or management of other bodily functions. Extended stay centers are not complicated, they are not meant to replace the hospital, and they are not a new concept. Other states, for instance Colorado and Arizona, have had convalescent care centers or recovery centers for many years. Reports from their experiences prove these centers are: 1) Patient centered, with very high

patient satisfaction, 2) Outcomes driven, with infection and complication rates being extremely low and 3) Cost conscious, with dramatically lower costs to the patient and the health care system. In other states, there have been collaborative joint ventures of an ASC/ESC model and their local health system partner, benefiting the entire regional health care delivery system. Oregon is the most recent state to pass ESC legislation allowing patients to stay up to 48 hours. This was a collaborative effort between the Oregon Association of Hospitals and Health Systems and the Oregon Ambulatory Surgery Center Association. (https://olis.leg.state.or.us/liz/2018R1/Measures/Analysis/HB4020)

The added advantage of an ESC for our North Dakota patients is related to our geographical footprint and population density. Most specialized orthopedic care, like total joint replacement, occurs in our population centers. Adding an ESC would allow our patients that travel a long distance the extra time they may need to recover prior to making the long trek back home. The hospitals, mandated by payors, typically have strict criteria for patients to qualify for a stay longer than 24 hours on some procedures. The ESC can give that patient with long travel distances, limited family support, or minor concerns the extra time needed to feel more comfortable before returning home. The additional time also allows physicians to care for their patients, without the pressure of having to send someone off to the hospital in an ambulance at 23 hours 59 minutes from admission to avoid penalty and burden to every party. The transfer alone is costly, the insurance companies will be charged for a hospital stay, tests will likely be run, and the patient's continuity of care may be disrupted.

In conclusion the ESC model is not a new idea, it is not a complicated building, and the idea is about being focused on patient care. This model improves patient choice, decreases the overall cost of care, and maintains or improves quality. SB 2334 came out of the Senate IBL committee 5-0 DO PASS and passed the full Senate 44-3. I would request the House Human Service Committee vote a DO PASS on SB 2334. I would like to thank Chairman Weisz, Madam Chairman Rohr, and the distinguished members of this committee for your time and consideration.

I would be happy to take any questions from Mr. Chairman and committee members.

Duncan B. Ackerman, MD

North Dakotans for Open Access Healthcare