Is there an ACO in your ASC’s future?

There’s a new abbreviation you will be hearing as part of health care reform—ACOs, or accountable care organizations. An ACO could be entering your ambulatory surgery center’s local market.

Encouraged under the health care reform bill signed in March 2010, ACOs are a strategy for curbing the rapid growth in health care spending, a source of alarm for economists and policy makers.

What is an ACO?

Under the health care reform law, (Section 3022), the government will set up a program by January 2012 to encourage ACOs to take accountability for coordinating care for a population. ACOs are networks of providers that work together to manage care for their population. These could be partnerships or joint ventures among hospitals and other professionals. ACOs will include at least 5,000 Medicare beneficiaries for at least 3 years and be accountable for the quality, cost, and overall care of the patients assigned to them.

The aim, policy makers say, is to get away from piecemeal payments for care, that is, separate payments to the surgical facility, physician, and anesthesiologist, and so forth. Instead, the ACO will be paid a package price for a complete episode of care and distribute the payment among the providers.

Mantra for reform

“Bundled payment is becoming a mantra for reform,” said Gerald Niederman, an attorney with Faegre & Benson in Denver, speaking at the Colorado Ambulatory Surgery Association meeting in Broomfield, Colorado, in May 2010.

Much of how these new organizations will function will be spelled out in rules and regulations, still to come.

ACOs aren’t limited to Medicare. Some large private payers like United Healthcare and Humana, and large health systems, like Catholic Healthcare West and Baylor Health Care System, are planning similar models.

Will ASCs be part of ACOs?

ACOs present both a challenge and an opportunity for ASCs, Niederman said.

In one sense, ASCs are ahead of the curve because they already know how to deal with bundled payments as part of current reimbursement, and they measure and benchmark quality indicators.

“ASCs with their lower cost structure and ability to measure quality are at the forefront of what health care reform is trying to achieve,” he noted.

But there is a risk ASCs could be left out of ACOs that form at the local or regional level unless they position themselves well.
“This won’t affect every community to the same extent,” Niederman said. “But if one allows only hospitals and physician groups to drive this, there’s the threat of being left behind.”

A live question

In another effect of health care reform, it’s estimated that half of the 30 million people who will be newly eligible for coverage will be covered by Medicaid, a poor payer.

Single-specialty ASCs may not be that concerned about Medicaid because they may have successful business models in spine care or cosmetic surgery, for example.

But for a large number of multispecialty ASCs, the issue of whether to participate in an ACO to enhance their reimbursement “will be a live question over the next 2 to 4 years,” he said.

Though it’s a discussion many physicians may not be eager to have, Niederman recommended that “you consider it more seriously than before.”

In many communities, ASCs are well positioned to have a seat at the table when ACO discussions occur.

“Many of you have the best doctors in your communities,” ones ACO planners are likely to want on board, he says.

ACOs may see benefits to including ASCs in their networks because of their track records for cost-effective care. Though it may seem unfair that ASCs receive only 59 cents on the dollar from Medicare compared with payments to hospital outpatient departments, an ACO might see an opportunity for savings in surgical care.

“Between 59 cents and a dollar is a huge opportunity for a system for savings,” he commented.

Time to expand the lens

Federal laws regulating relationships between physicians, hospitals, and other entities, such as antitrust and antifraud laws, have to be worked out. There is an area of antitrust law developing to provide for “clinically integrated” structures. The health care reform law also allows waivers from antifraud and abuse laws in certain limited conditions.

Unlike traditional managed care practices that focused on containing costs by rationing, the new networks will emphasize evidence-based care and quality measurement.

“I know how hard it’s going to be,” said Niederman but added, “I think there is a little too much fear about ACOs. It is happening. So once you get over that, there may be an opportunity.

“Whatever strategic or business planning you do, it’s a good time to expand that lens and consider ACOs and the other reforms that are upon us.”

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