

## **ACA will bring more patients to ASCs— but will profits follow?**

**T**he Patient Protection and Affordable Care Act (ACA) is affecting every part of the healthcare system, including ambulatory surgery centers (ASCs). Whether it will help or hinder ASCs, however, will depend on how adept they are at managing changes in the way they are paid and how they interact with other healthcare providers.

The ACA mandates a transition to payment based on care quality and patient outcomes. This is known as value-based purchasing or sometimes pay for performance, and it will gradually replace traditional fee-for-service rates.

The ACA also calls for coordination of care of Medicare patients, especially those with chronic conditions, through electronic health records (EHRs) and formal arrangements known as accountable care organizations (ACOs), where physicians, hospitals and non-acute care facilities share responsibility for care.

Those 2 changes—to value-based purchasing and accountable care—could have a major impact on the way many ASCs operate. At the same time, because of their long-term focus on quality and cost containment, ASCs may well emerge as star players in the new system. As senior consultant Jill Sackman, DVM, PhD, of Numerof & Associates in St Louis, notes, “ASCs stand alone, but they are concerned about costs and outcomes.”

### **ASC role expanding**

The most recent data is 5 years old, but it points to the growing role ASCs play in the US healthcare system. The Centers for Medicare & Medicaid Services (CMS), in its 2013 Report to Congress, notes that in 2008 there were 5,175 Medicare-certified ASCs, treating a total of 3.3 million Medicare beneficiaries.

These ASCs received Medicare-related payments totaling \$3.1 billion in 2008.

Between 2003 and 2008, according to CMS, an average of 331 new ASCs opened annually, and each year an average of 59 ASCs closed or merged with other facilities.

ASCs also have outpaced hospital outpatient departments (HOPDs) in patient volume growth. Both the actual percent increase in volume and the ASC share of Medicare patients “substantially exceeded the changes observed in HOPDs from 2003 through 2008,” CMS reports.

### **Joining an ACO**

Sackman, who consults for ASCs on financial strategies, says accountable care existed long before it was written into the ACA because academic health economists have long supported the concept. Most of the 32 current CMS demonstration projects, known as Pioneer ACOs, have been based in academic medical centers. Results, she notes, have been mixed.

However, the idea of sharing responsibilities and rewards across care settings, if not the name, is much older. Health Affairs blogger David Muhlestein counts 428 ACOs in 49 states, the District of Columbia, and Puerto Rico. More are located in high-population states, led by California, Florida, and Texas. The majority are private, and of those,

most are sponsored by physician groups. The rest are sponsored by hospitals, insurers, or (a very few) nonprofit community organizations.

Private ACOs may use various methods of allocating costs and distributing shared savings, but Muhlestein notes that many copy the model prescribed by CMS for Medicare.

An ACO, according to CMS, is a group of providers who coordinate patient care “to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.”

The reward for accomplishing that is a share of the money it saves for Medicare.

ACO participation is voluntary, even under Medicare programs.

To establish an ACO, the sponsoring organization must recruit other providers, especially primary care physicians. The physicians serve as entry points for patients and coordinators of care.

The ACO must then build a network of hospitals and specialists. This is easier in urban areas than in remote rural areas. For the less-populated places, an ASC with physician owners might be an ideal sponsor, Sackman says. “Rural providers tend to be independent, and they will need to learn to collaborate,” she says. “ASCs stand alone, but they are concerned about costs and outcomes, so they might be excellent partners in some rural ACOs.”

### **Getting ready**

When physicians began experimenting with ACO-type organizations in 2000 under an early Medicare program, the most frequent cause of delays was lack of data management and communication systems. Financial, purchasing, and clinical systems were limited to large hospitals.

“That’s evolving very quickly,” Sackman says of the outlook in 2014. A growing number of technology providers are specializing in systems—some of which are available online with no large initial investment—designed for ASCs and physician practices.

Other factors will influence an ASC’s decision to join an ACO and the effect it will have on the facility’s owners, staff, and patients.

Forming or joining an ACO may not appreciably change an ASC’s patient mix, volume, or administrative procedures if that facility:

- practices several specialties or general surgery
- is committed to tracking and reporting quality measures using electronic means
- has acquired information technology (IT), including EHRs
- has access to software for sharing data with other facilities
- maintains detailed revenue and cost records
- collaborates with other specialties and facilities to benefit patients and the community.

Becoming part of an ACO will increase the potential of additional revenue through shared savings. However, ASCs without those attributes will have a more difficult adjustment, regardless of whether they join an ACO. “They will have to become very conscientious about their IT capability, costs, outcomes, and variation in practice,” Sackman says. “Even without ACOs, that is the future of healthcare.”

### **Increasing patient volume**

Much of the discussion of the ACA’s impact on ASC revenue centers on the change from fee for service to reimbursement based on patient outcomes. Another impact—which seems largely taken for granted—is the inevitable surge in patient volume.

With the increase in patients who have insurance and the ongoing migration to

outpatient treatment, ASCs cannot help but see their volume increase.

According to an article by orthopedic surgeon Stuart Fischer, MD, "More people will be insured and able to come to our offices." Not only will surgeons have more business, they also will have to add nursing and administrative staff. "More private patients will be going to physician-owned MRI, physical therapy, and outpatient surgery centers," he says. "Clearly, there will be economic benefits."

Dr Fischer urges physicians to take an interest in their states' health policies, especially the new insurance exchanges. "The insurance exchanges will control what services will be covered and rates of reimbursement," he notes.

That's the good news.

The other side of increased volume, some experts note, is that ASCs must re-double their efforts to reduce expenses, increase efficiency, and raise public awareness of their quality and convenience. They will need to make the case to attract those newly insured patients.

According to Clint Hughes, vice president of marketing for MediGain in Plano, Texas, ASCs will need to monitor their cash flow more closely than ever. "With more patients signing on to Medicare and Medicaid, it will be necessary for ASCs to pursue all of the savings they can find," Hughes says in a commentary on MediGain's website, [www.medigain.com](http://www.medigain.com). They also should devote resources to billing functions, he adds, to ensure they are fully reimbursed by public and private insurers.

### **Meeting quality standards**

In its report to Congress, CMS outlines the elements of a value-based purchasing pay structure for ASCs. Paramount is the assessment of quality through the reporting system using Medicare claims and online databases. Portions of the Social Security Act, as well as section 3014 of the ACA, mandate selection of quality measures.

As implementation of the quality program continues, CMS will begin to develop "the structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for value-based bonus payments."

CMS also plans to start validating quality reports. Currently, reports consist mainly of G-codes on Medicare claim forms indicating the presence or absence of falls, burns, and so on. Section 3006(f) of the ACA instructs CMS to develop a method of verifying the accuracy of those reports.

CMS is considering an annual review of a random sample of ASCs. Another check could be a "targeted audit" that the CMS report states would allow the agency "to assess the overall quality of data submissions and minimize gaming."

According to the report, CMS has not yet decided how to distribute payments to ASCs based on their quality scores, though it is looking at its own proposed hospital and physician payment schedules as models.

One alternative would be making bonus payments and collecting penalties at the end of each year. Another would be withholding a portion of bonus payments in an incentive pool and dividing it among top performers.

According to a summary published by the Ambulatory Surgery Center Association, other provisions of the ACA that will most affect ASCs include the following:

- There will continue to be an annual reduction in payment updates to offset increased productivity at ASCs.
- Medicare patients will no longer have to pay deductible or co-pay amounts for colorectal cancer screening, a provision that may lead more patients to have the procedure.

- The law creates an Independent Payment Advisory Board. The 15 appointed members will recommend specific spending reductions for Medicare to meet savings goals. ASCs are likely to be included in any cutbacks. ❖

—Paula DeJohn

### **References**

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