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The Role of ASC's in the New Healthcare Marketplace

2011 National Conference

Agenda

- ASC Facts and Implications
- ASC's and Accountable Care
- Physicians and ASC's – Alternative Delivery Models

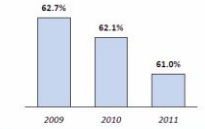
What's Changing? Everything!

- Reimbursement
- Care Delivery
- Access
- Insurance coverage
- Quality incentives

HOPPS Price Growth Continues to Outpace ASCs

Stagnant Payments Require ASCs to Improve Efficiency

ASC Payment as Percentage of HOPPS Rates



2011 Conversion Factor Change

Outlook for ASC Medicare Payments

- Reform legislation institutes productivity adjustment to encourage ASCs to control costs
- In 2011, a 1.3% negative productivity adjustment applied to ASC payment as codified by PPACA, largely offsetting 1.5% payment increase
- Secondary budget neutrality adjustment applied to ASC relative weights to ensure hospital payment changes do not increase or decrease aggregate ASC payments
- Medicare ASC payments "frozen" for seven of the last eight years

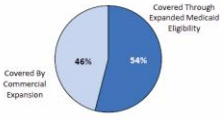
Coverage Expansion a Mixed Bag

Volume Increases at Less Favorable Rates

Newly Insured Americans by Source of Coverage

Children, Adults, and Adults Without Dependent Children

n=31.7 Million



Key Implications of Coverage Expansion

- Medicaid will account for majority of ASC volume from newly insured
- Increased Medicaid volume and declining Medicare payments to result in slight decrease in overall per-case economics
- Commercial rates, primarily from national payers, to be tied to rebased Medicare rates
- PPACA waves coinsurance for preventive services such as colonoscopy

ASC Market Consolidation in Advance of ACOs

Key Challenges

- Declining Medicare reimbursement
- Private payer scrutiny of medical necessity
- Recession-driven decline in case volume
- Decreased access to capital

Anticipated Market Responses

- More independent ASCs for sale
- Increased use of management companies
- Increased hospital acquisitions
- Reduced physician investment

Implications of the Debt Ceiling

- Lower average price per case
- Stage 1 – benign (relatively) for physicians
- Stage 2 (Super Committee) – up to 2% of Medicare and Medicaid programs can be cut including physicians, ASC's, hospitals etc
- Things at risk over next few months
  - ✓ Independent Payment Advisory Board
  - ✓ Permanent fix to sustainable growth rate methodology (SGR)
  - ✓ Managing costs of dual eligibles (placed into Medicaid managed care)
  - ✓ Increases in Medicare cost sharing
  - ✓ Increase in Medicare eligibility age

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ASC Quality and Access Act of 2011

- 1. Prevent the widening gap between ASC payment and HOPD payment for identical procedures
- 2. Create a value-based purchasing system for ASC's
- 3. Implement an appropriate reporting system to measure the high quality care that is prvided in the ASC setting
- 4. Allow Medicare patients to receive surgery on the same day they schedule a surgical procedure.

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Implications Already Playing Out

- Physicians and hospitals must be more tightly linked – legally and clinically
- Physicians are running towards employment because there are few other choices they feel are "financially safe"
- Hospital revenues and expenses need to be optimized now – especially in historically high revenue areas like inpatient and outpatient surgery and specialty practices and in high expense areas like labor and productivity and supply chain
- Ambulatory surgery and ambulatory care in general will grow exponentially due to continued downward pressure on inpatient reimbursement
- Some hospitals will continue to need cash and will expect their "partners" to bring some or be dis-intermediated

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Bottom Line

- Growth of "new" ASC's has slowed significantly
- New product lines (pain, GI, ortho) have grown significantly
- ASC's remain profitable but physicians are still looking for better partners
- Healthcare reform provides new opportunities for physician and hospital partnerships and ventures
- ASC's must maximize productivity and revenue capture and clinically operate efficiently and effectively
- In-patient peri-operative services are still chaotic and inefficient in most hospitals – physicians are begging for a partner to assist them in making inpt. OR's operate like ASCs
- Supply chain is still a large opportunity in most systems
- ACO development will force hospital systems to look for close partnerships with organizations that can help them become more cost effective

Accountable Care

Some Key Points

- The regulations favor PCP's as the "leader" of patient's healthcare
- ACO agreements are relatively short term – 3 years + one year performance measurement period
- An ACO must have a minimum of 5,000 beneficiaries
- Two shared savings models – 50% and 60% based upon willingness to take risk (2% savings threshold)
- ACO's are subject to a 25% withhold of shared savings to "insure" against future losses
- PCP's may only participate in one ACO – surgical providers and hospitals can participate in more than one ACO

How does this impact ASC's?

Details. Details, Details

- If you are not already organized as an ACO or don't have the pieces/parts required to be successful, you won't make it by January 2012
- ACO reporting standards will be very exhaustive – your organization will become an open book to consumers
- Payout of bonuses requires meeting BOTH cost and quality standards
- The quality and cost measures overlap with VBP, readmissions prevention etc
- Patients will be attributed to an ACO retrospectively based upon PCP billed charges over the previous year. The baseline comparison population will be those from the 3 yr period prior to the inception of the ACO start date.

- So – incurred costs will be compared to a benchmark of patients who would have been assigned to the ACO over the prior 3 years. This will be updated yearly by projected growth in per capita expenditures
- Quality reporting – all or nothing for 1st year….if you report performance on all 65 measures, you receive your cost-based bonus. If you miss 1, you get nothing!!! In the future, high quality ratings with lower than expected cost savings could get you a higher bonus and vice versa
- Only ACO requirement – having enough PCP's to serve at least 5,000 Medicare patients annually
- ACO's must save 2-3.9% compared to benchmark before it is entitled to bonus payments
- PCP's can only join 1 ACO but hospitals/specialty groups can belong to many

Accountable Care Organizations
Value Drivers & Issues

The charts below illustrate some high-level challenges and value drivers associated with ACOs.

Value Drivers

- Balanced quality and efficiency principles
- Shift from FFS, volume driven success factors to improved population health & accountable care
- Opportunity for providers to re-engage clinical values
- Facilitates successful capitated systems serving FFS & PPO patients
- It's "doing the right thing".
- Enables healthcare professionals to be stewards of healthcare funds.

Value Issues

- Inadequate primary care providers and delivery structures
- Most organizations don't have the core assets in place, so building these assets must occur
- Changing patient behavior & provider culture
- Legal obstacles (e.g., Stark, corporate practice of medicine, antitrust)
- TRUST between hospital and physicians (both employed and affiliated)
- FFS volume mentality among hospital leadership

Our Opinion

- Highly integrated delivery systems with care coordination and proven clinical / financial risk management capabilities will be the most likely candidates for early success within an ACO model.
- New entrants with minimal integration / care coordination face a learning curve consisting of cultural change and required investments before reaching a ROI, but this depends heavily on the payer environment.
- **Physician engagement/leadership and experienced risk management are vital for success.**

Risk / Complexity	🔴
Reward / ROI	🟢

Journey to an Accountable Care Organization

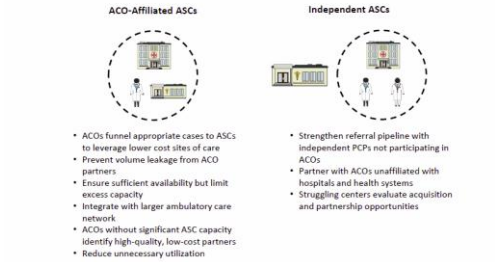
- **Clinical Integration** – Focused on the review of high priority health outcomes and associated tracking metrics, with emphasis on the integration of established and emerging methodologies such as Disease Management, Case Management, Medical Therapy Management and "Medical Home" models..
- **Provider Network –** Develop targeted physician recruitment plan and ACO physician network criteria that can be differentiated from the current provider contingent and provide a compelling value proposition for participation
- **Operating Model** – Focused on developing a proposed operating model for the ACO that defines criteria for participation, governance structure, regional care councils, management / reporting, and technology enablement
- **Technology Architecture / Integration** – Review pre-existing plans for technology (EMR/EHR, Care Management, Referral Management and Administrative Support Systems, Decision Support) that may be leveraged to support the ACO. Review the client's plans to technologically support an ACO, while offering recommendations for further enhancements or purchase of required functionality.
- **Financial Strategy** – Develop forecasted operating budgets for the ACO as well as analyze the expected financial benefits that the organization will provide to the client. Design an incentive plan to reinforce physician work efforts in support of driving costs while improving quality.
- **Organizational Alignment & Communication** – Address issues related to branding of the ACO as well as socializing consistent messaging across targeted key stakeholders and change management opportunities.

ACO Shared Savings Opportunity Hinges on CMS Rule-Making

- How will beneficiaries be assigned to ACO's?
- How will historical Medicare costs be calculated for purposes of calculating savings?
- How will risk adjustment be carried out?
- How will historical costs be adjusted based on estimated expenditure growth?
- What level of savings below historical Medicare costs will trigger eligibility for bonus payments?
- What percentage of savings will be shared with the ACO?
- What quality standards will the ACO have to satisfy?

Adapted from Accountable Care Organizations, Manatt, Phillips and Phelps, LLP, June 2011

Accountable Care Strategy for ASCs



Alternative Delivery Models

The emerging models of the future are "value-driven" and predicated on physician integration.

Future

New payment models
- Pay-for-performance (P4P)
- Bundled payments
- Value Based Purchasing (VBP)
- Accountable Care Organizations (ACO)

Clinical integration partner
"essential partner in achieving quality and cost thresholds"

- Healthcare Reform
- Employment is back!

Pay-For-Performance (P4P)
… rewarding physician groups or hospitals with additional financial incentives for achieving quality care based on specified performance criteria (Medicare demonstration project and private payer programs).

Accountable Care Organizations (ACO)
… encourages physicians and hospitals to integrate care by holding them jointly responsible for quality and costs (2012 in Reform Bill).

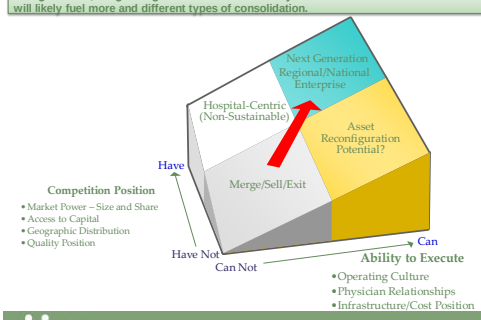
Value-Based Purchasing (VBP)
… reimbursement based on holding providers accountable to reduce inappropriate care and to identify and reward best-performing providers (2012 reform bill demonstration).

Bundled Payments
… single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings (2013-2015 in Reform Bill).

Common Thread:
Clinical Integration Between Hospitals and Physicians

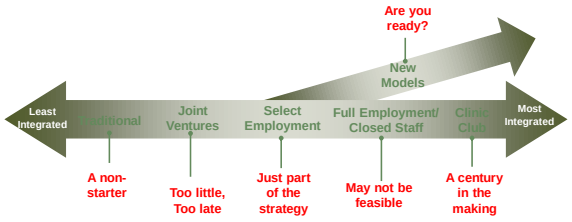
Consolidation

Going forward, the growing divide between health system "Can / Cannot's" and "Have / Have-Not's" will likely fuel more and different types of consolidation.



Alternative Delivery Models

Over the past few years, we have seen more providers use employment to achieve greater integration yet new models expand the scope of integration possibilities.



Summary Implications for ASC's

- The Joint Venture as a mechanism for tighter physician and hospital collaboration and clinical integration
- Cost containment – doing the "right" surgery in the "right" place
- Payment reform – bundling transfers the risk to the provider for overall cost per case
- Decreasing inpatient reimbursement pushes appropriate cases to an outpatient setting
- ASC partners that want to OWN and manage have hospital customers that need and want the cash
- New technologies allow more and more surgeries to be done safely in the lower cost outpatient setting
- With falling reimbursements, physician efficiency and productivity becomes even more important

What You Should Focus on NOW!

- Maximize revenue capture through clinical quality and coding/documentation accuracy
- Rationalize labor and productivity
- Standardize clinical pathways that reduce supply cost, minimize care variation, and improve outcomes
- Maximize patient throughput and rationalize the use of inpatient vs outpatient facilities
- Develop and effective ambulatory care network that can handle low CMI care while increasing capacity for profitable procedural cases

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ASC Prognosis

- Bullish!
- Further ASC consolidation and/or roll up
- Acquisition of additional ASC's by hospital partners
- Utilization of joint venture models seen as successful in ASC's
- Rationalization of outpatient vs inpatient surgical care sites
- Increasing efficiencies in the face of decreasing reimbursements
- ASC's are not going away……

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Questions?

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