

# ASC PHYSICIAN FOCUS

AN ASCA PUBLICATION >>

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## Message from the CEO



During October, The Leapfrog Group announced plans to begin collecting and reporting data about quality

and safety in ASCs and hospital outpatient departments (HOPDs) using a voluntary survey that will be available across the country beginning in April 2019.

Leapfrog, a national nonprofit organization driven by employers and other purchasers of health care, has been reporting comparable data about hospital inpatient care for 20 years.

To enhance the value of this new program, Leapfrog has been talking with ASCA and inviting individual ASCs to participate and provide feedback during the program's pilot testing phase.

If your ASC would like to participate, I encourage you to [contact Leapfrog's Help Desk](#).

**Bill Prentice**  
Chief Executive Officer

## Most Important ASC Business Trends in 2019

Four ASC leaders discuss the business trends they expect to drive ASC prosperity in 2019.

**Chris Bishop, Chief Executive Officer, Regent Surgical Health in Westchester, Illinois:** The bundled payment trend is growing. Providers and payers recognize the opportunity to reduce the cost of certain high-volume, high-cost procedures like total joint replacements and spinal fusions. Structuring the bundle to ensure every partner is aligned and executes is extremely complicated. Fully understanding risk factors and how everyone interacts is crucial to developing a successful program.

For organizations still in the research or concept phase of bundles, it is likely time to accelerate efforts. According to research, bundled payments are the fastest growing payment type, with projected growth of six percent over the next five years. This would place bundled payments at 17% of all medical payment types by the year 2022.

**Tony Kilgore, Chief Executive Officer, Surgical Care Affiliates in Deerfield, Illinois:** Value-based care will be increasingly important to the viability of ASCs and in refocusing our health care system on the quadruple aim of cost, quality and patient and provider satisfaction. While value-based contracting offers many benefits, it can present a challenge for ASC operators that are unprepared to manage value-based reimbursement on their own.

The number of facilities with value-based agreements will continue growing over the course of the next year. The key to successful contracting is having the right value levers and potential paths to risk arrangements. We're continuously evaluating how to support our facilities in pursuit of the quadruple aim and to improve health care in America.

**Lori Ramirez, Chief Executive Officer, Elite Surgical Affiliates in Houston, Texas:** The landscape of ASCs is changing rapidly. There are fewer players in this space each year and consolidation is rampant. National players are acquiring small ASC operators for financial stability and leverage with managed care payers. In an effort to create efficiency and "work smarter, not harder," ASC operators are building smaller and more specialized surgical centers of excellence.

In addition, technology is surpassing all expectations as robotics, smart systems and virtual reality become more prominent. These systems will soon also affect routine tasks such as direct patient care. The use of analytics and quality outcomes data will define the success and growth of companies in this space in the next 10-20 years.

**Peggy Wellman, Market President – Pacific, United Surgical Partners International in Addison, Texas:** There are several trends worth watching. Physician-owned medical groups are taking on more capitated risk for facility services and working with physician networks to expand ASC use. Health systems that manage capitated risk are also focusing on reducing costs and expanding ASC use.

Payers are focusing more on appropriate site of service. Traditional payers are changing benefit designs to promote ASCs where clinically appropriate. Large employers are using bundled arrangements to reduce cost and improve quality.

Recent developments are also expanding the ability for ASCs to safely care for more patients. As the Medicare-approved ASC procedure list expands, this validates the ability of ASCs to support new cases, such as those in cardiology, spine and total joints.

# 10 Lessons from Running a Cash-Based ASC

By Keith Smith, MD



I posted bundled pricing for all of the procedures performed at the Surgery Center of Oklahoma almost a decade ago and have learned many lessons. Here are 10 of them.

**1. Single-payer or “Medicare for all” socialized systems are predictable failures.** Lesson #1 is self-evident as the first patients to take advantage of our online pricing were Canadians. These patients—victims of predictable bureaucratic rationing—had discovered that the only single payer upon whom they could rely was themselves.

**2. Domestic patients are willing to travel.** Patients have traveled for years within the United States to secure specialty care of all kinds. This willingness to travel is primarily due to perceived differences in quality. A quality facility that also provides value pricing can very effectively attract patients from all over the country, particularly those who are paying the entire bill. Patients from all 50 states travel to our facility for their care.

**3. Insurance carriers do not value high-quality or reasonable pricing.** No carriers want or have ever wanted to work with our facility. While this sounds paradoxical, our transparent pricing denies the carriers the ability to skim the transaction (securing a portion of the fictitious discounts they apply to claims for themselves). When a \$100,000 bill is “discounted” to \$20,000, an employer group, for instance, pays a commission to the carrier for the \$80,000 “saved.” Working with our facility represents an opportunity foregone for the carriers due to our price posting.

**4. True market pricing can never be imposed on those providing the medical service.** Market prices emerge from a competitive environment and fluctuate continuously, sending appropriate signals to buyers and sellers in the marketplace. Imposed prices are always wrong—either too high or too low—resulting in predictable surpluses or shortages of care.

**5. Transparently priced medical service models are not for everyone.** Fastidious and inefficient surgeons, for instance, do not fare well in an environment containing low-maintenance and efficient competitors. Surgeons with unusually high implant use or those involved in fee-sharing arrangements with implant manufacturers also do not fare well in a transparent and competitive environment. Market discipline, when allowed to function, cleanses the market of the inefficient, incompetent and unethical.

**6. Supply and equipment representatives are more price accountable in a cash-based environment.** Abusive pricing practices by a vendor that might repel buyers results in the exclusion of that vendor from the facility. Deducting the abusive overcharges of implant reps from a surgeon’s professional fees (in order to

stay true to our advertised and online prices) has been an effective way to keep implant charges in check.

**7. Patients save 50% to 90% at our facility compared to their next best price at a non-cash-based facility.** Self-funded employers save \$1,000 to \$3,000 per employee per year by carving outpatient surgical services out of their self-funded plans and purchasing through direct contracts. This move eliminates carrier payment-skimming practices. Waiving all out-of-pocket expenses for employees paradoxically provides the greatest savings to employers as the employees are more likely to patronize the cash-based, “no-out-of-pocket” option. Physician-owned facilities have the greatest opportunity to thrive in a cash-based environment as this model allows for the disintermediation of the process, eliminating the abusive institutional charges typically inflicted on the buyer.

**8. Paying patients are the happiest patients.** Cash buyers have done their homework about the doctors, facilities and prices. The “too-good-to-be-true” skepticism harbored by many patients quickly transforms into a gratitude that is fulfilling to all the members of the team.

**9. Cash-based facilities work well together.** While insurance carriers and hospital systems typically function as an anticompetitive cartel and represent the enemy to independent facilities, cash-based facilities work well together and coordinate with each other, as the synergies provided to various buyers are enhanced with this cooperation.

**10. Patients are savvy.** There are two economic models of care delivery in the United States: one seeks to maximize revenue and the other—the growing, market-based model—seeks to maximize the delivery of value. Buyers in the marketplace know the difference and exhibit extreme loyalty to facilities and physicians who have abandoned their price-gouging ways.

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The advice and opinions expressed in this column are those of the author(s) and do not represent official Ambulatory Surgery Center Association policy or opinion.

## Make Plans to Attend 2019’s Largest ASC Conference

Join thousands of ASC professionals and physicians from throughout the country at the [ASCA 2019 Conference & Expo](#), May 15–18 in Nashville, Tennessee. Meet with industry leaders, hear from government officials and find solutions to the challenges facing your ASC every day. This year’s program features more than 50 sessions designed for administrators, nurses, physicians, business office staff, human resources and the rest of your ASC’s staff. Topics include strategic planning, finance, insurance, economic trends, leadership, Medicare payment policy changes and succession planning. Physicians can earn up to 24 *AMA PRA Category 1 Credit(s)*<sup>™</sup>, commensurate with the extent of their participation in the meeting. Register by December 31 to lock in the early bird registration discount. [Learn more and register today.](#)

# Achieving Effective Medical Director Leadership

By John D. Brock



The medical director position is a vital but often underappreciated role in an ASC.

Having served as an ASC administrator for nearly 13 years, I believe there are several key factors that contribute to the effectiveness—and ultimately the success—of a medical director.

**Reasonable length of term.** There's something to be said for continuity. There's also something to be said for change. I'm of the opinion that ASCs should set term limits of two or three years for medical directors. This is enough time for a new medical director to settle into the position, maintain a high level of energy and engagement, participate in some significant decisions and transition the position to a new medical director.

With that said, I believe there is one significant caveat. An individual tapped to serve as medical director must be passionate about the position and willing to devote the time necessary to effectively fill the role. Assuming an ASC has multiple solid and interested candidates to serve as medical director, setting a term length makes sense. However, if such candidates do not exist, an ASC is better served not by making a change for change's sake but by keeping an effective medical director in the position until a viable successor comes along.

**Importance of specialty.** I'm of the school of thought that anesthesiologists often make good medical directors for multiple reasons.

They tend to be on site more than other physicians. In a multi-specialty center, they are likely to possess a better understanding of the dynamics playing out in all specialties and not favor one specialty over another. If there's no appearance of bias, all physicians and staff will feel more comfortable approaching the medical director with questions or concerns.

There are a few caveats here as well. I believe an individual serving as medical director should be an investor in the ASC, as this naturally enhances the connection to the center and its success. In many ASCs, anesthesiologists are not investors. If an ASC chooses to go with a non-anesthesiologist as medical director, this individual (besides exuding the passion already discussed) must be very accessible—essentially on call. If a question arises at the ASC that requires insight from the medical director, this individual—if not at the ASC—must be prepared to step away from other work to fulfill his or her responsibility.

**Mentor to director of nursing (DON).** The medical director should be willing to serve as a resource for the DON and be prepared to offer guidance and direction concerning clinical issues. This can include matters such as how to effectively run an operating room to decisions about clinical staff promotions. A medical director who is approachable and embraces the role of mentor will elevate the performance of the DON. Considering how closely a medical director and DON should work together, I recommend involving the medical director in the hiring of a DON.

**Clinical resource to non-clinical administrators.** Some, but not all, ASC administrators possess a clinical background. For those who do not, the medical director should serve as a clinical resource. I've worked in health care for more than 30 years, but there are clinical intricacies that I will never grasp particularly well because I am not a clinician. The medical director who served as my clinical resource when I was an administrator was of tremendous help when I was making decisions that would impact our ASC's clinical operations.

**Separation and balance.** As noted earlier, a good medical director is approachable. A good medical director can also help serve as a mediator, addressing any barriers to success and building consensus around important clinical issues.

But a medical director must also walk a fine line, avoiding any appearance of favoritism. A medical director must be careful not to accept the responsibility of representing the interests of an individual physician, physician group, specialty, staff member or department. The medical director's responsibility is to champion the greater interests of the ASC as a whole and the center's mission of delivering safe, high-quality care.

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## ASCs Win Big with Medicare's Final 2019 ASC Payment Rule

In November, the Centers for Medicare & Medicaid Services (CMS) released its final 2019 payment rule for ASCs and hospital outpatient departments. It included significant changes, many of which benefit ASCs.

Most notable is the decision to update ASC payments using the hospital market basket inflation factor. This represents a much more realistic indicator of rising costs in the ASC space than what CMS used before, the Consumer Price Index for All Urban Consumers (CPI-U), which focuses on prices for a broad range of consumer goods. ASCA has fought for this change over the past decade.

This rule also reduces the threshold definition of device-intensive procedures in ASCs from 40% to 30%—another policy change ASCA supported. This rule change effectively grows the list of device-intensive procedures ASCs can provide to Medicare patients from 153 to 277 in 2019.

Other policies in the rule allow for several new cardiac procedures in ASCs and introduce positive changes to the ASC Quality Reporting Program. The credit for achieving these goals goes to all ASC supporters who have supported ASCA's advocacy efforts for so many years.

[Access ASCA's final rule summary.](#)

# Addressing Physician Dynamics When Adding a New Specialty

By Chris McMenemy, CASC



Does this equipment advertisement sound familiar? "Like-new microscope for sale. Very limited use. Purchased for

a physician who joined our surgery center but left after only three months. Great buy! Contact me with questions."

Selling new equipment shortly after its purchase is probably not what this ASC had in mind when adding a new specialty to its surgery center. And although a physician's three-month stay may be a more extreme case, it's not unusual to recruit and lose physicians within a year of the union. How can your organization ensure that adding a new specialty will be a winning experience rather than a waste of time and money?

**Don't rush to bring physicians onboard.** The vetting process is as important as the recruiting process. While it's easy to get excited about the new specialty and physician group that can bring additional cases and revenue, don't become so involved in selling the center to the new physicians that you forget to ask the physicians to sell themselves to you.

**Get to know the potential physicians.** Do their values and practices align with your surgery center and its physicians? Is patient care and patient safety a priority? Do the physicians have a reputation of treating staff appropriately and complying with a facility's standards of practice? Does the new group seem like it will mesh with the center's existing physician(s)? Rely on your own impressions but also ask others who have practiced or worked with the new physicians. Communicate to the new group the practices and values of your center and its medical staff. You don't want to be faced with staff or other physicians leaving because of a difficult work environment.

**Assess the new group's commitment.** Adding a new

specialty requires investments: equipment, instruments, supplies, staffing education and possibly infrastructure improvements. It's reasonable to expect the new group's commitment to your surgery center's success.

Here is where communication is so important. The new group should understand investments will be made on its behalf and be willing to spend the time necessary to carefully communicate its needs. It's a bad omen when a group will not share preference cards and equipment needs or is unwilling to perform mock cases with the staff before day one of surgery.

**Prepare current physicians for change.** Existing physicians must be prepared for the changes a new specialty can bring to the center before the new group begins working at the center. These physicians must be part of the decision to bring the new specialty group into the center. As noted, adding the new group will likely require an upfront investment. Owners need to be prepared for these costs and supportive of decisions made concerning these investments. Shifts in block schedules may be necessary, with preferred staff members possibly shifting to other operating rooms (ORs). Delays may occur as staff adjust to new procedures and workflows.

Existing physicians need to be prepared for these challenges and come across as welcoming to the new group, despite any initial issues. If resentments or irritations show during the first weeks of the new specialty launch, it may take months before things settle down.

**Make sure staff members are also prepared.** Some staff will likely be moved to areas that present unfamiliar workflows and require training. Education will need to cover everything from patient care, organizing ORs, preparing case carts to speaking with patients and families on new procedures. The ASC's leadership must also define expectations for staff behavior and practices. The new group should feel the center is organized and adequately prepared for its arrival.

Without preparation and communication, bringing a new physician or group into the center can turn chaotic quickly. Remember, you only get one chance at a great beginning.

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## Online Tool Provides Average Medicare Prices for ASC and HOPD Procedures

The Centers for Medicare & Medicaid Services (CMS) recently launched a new, free online tool that provides a comparison of Medicare payments and copayments for certain outpatient surgical procedures performed in ASCs and hospital outpatient departments (HOPDs).

Required by Congress as part of the *21<sup>st</sup> Century Cures Act*, which ASCA championed and was signed into law in December 2016, the [Procedure Price Lookup tool](#) displays the national averages for the amount Medicare pays a hospital or ASC and the national average

copayment amount a beneficiary with no Medicare supplemental insurance would pay the provider.

While CMS states that the tool, part of the agency's eMedicare initiative, is intended to help consumers weigh cost differences when selecting the settings for their care, ASCs can leverage the information in marketing to help further differentiate themselves as a high-quality, low-cost option for surgery.

[Access the search tool.](#)