2009: A Game Changer? Maybe.

BY JOHN POISSON

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Recently, we watched with eagerness and an open mind to President Obama's prime time address to Congress and the American people on the need for health care reform legislation to be passed. Following the address, all the talking head pundits hit the airwaves with the pros and cons of health care reform. I imagine this debate will continue for quite some time, and while I'm certainly not much of a policy wonk, it does seem clear "something" will happen in this legislative cycle.

There have been signs all around for months. For example, on July 1, 2009, CMS released two new reimbursement proposals. The first was to increase the ASC facility fees by 0.6% in 2010. That one actually sounded pretty good to me all things considered. The second was disturbing—a decrease of 21.5% in professional fees across the board in 2010. Since 25% or so of the typical gastroenterologist's patients have Medicare as their primary insurance, this isn't a minor bump in the road. Conclusion: CMS thinks physicians are paid too much money and health care institutions shouldn't be paid any more than they already get, as a matter of fact, since the medical services CPI exceeds 2% in most sectors of the country, this 0.6% increase in facility fees actually equates to a further cut in reimbursement on top of the pre-existing cuts to GI next January resulting from the third year of the GI facility reimbursement phase-in. So what does this all mean, assuming these July 1st CMS proposals hold true? I did the math on the back of a napkin at the USAir Club this morning: for an average GI physician, his or her cumulative fees (both professional and facility) will decrease by at least 15% from 2007 to 2010 on a per procedure basis. Maybe that is part of the $600B President Obama referenced in wasteful Medicare spending.

An even earlier sign in 2009 was the June 1st New Yorker article by Atul Gawande, "The Cost Conundrum,"describing the phenomena and cost savings of "accountable care organizations." There is no question this article galvanized the Obama people and garnered the attention of policy wonks. On the surface this concept appears sound—regional networks of physicians and facilities focused on providing quality medicine while driving down costs and unnecessary medical tests. Of course, there may be a dark side, too. In terms of how these ACO's get paid, the old capitation concept appears to be rising like the phoenix. Will that lead to rationing of services or further cuts in provider compensation? That is a crystal ball question for the pundits.

What is clear is that health care has, does and will always evolve. 2009 has been a wild rollercoaster ride for health care, our nation and the world in general. Monumental change may be coming in health care reform, but I would propose that 2009 has already been a game changer in many ways.

2009 SO FAR: WHERE WE ARE TODAY

Currently, it's not even close to being as bad as the critics would lead one to believe. We've examined the same store growth in procedural volume across our partnered endoscopy centers, and there are some interesting conclusions:

- The 2009 year started out very slowly in January and February, while June, July and August have been record months.
- Overall, there is a clear west to east distinction in relative procedural volume changes versus 2008.
    - Eastern US: all centers demonstrate strong same store growth
    - Central US: mixed results yield slower growth; only one center shows a decline in volume
    - Western US: the centers are basically flat YTD
- Income trends across our partnered centers, while variable on a site specific basis, average a strong 6% growth rate in 2009.
- On the **potential** down side, many board members at our various partnered centers still believe their local health care market has yet to "bottom out" and predict this won't occur until the first half of 2010

(unless the economy really does start adding new jobs). Let's hope for jobs soon.

PHYSICIAN-HOSPITAL JOINT VENTURE GROWTH

There are some other interesting trends we are seeing play out nationally as well in 2009, the first of which is a spike in interest within *de novo* hospital Joint Venture (JV) endoscopy centers. Our sites in development are very heavily weighted with hospital JVs. This makes some degree of sense as we are finding that the hospital can be a valuable ally in the ever shifting health care landscape:

- Having a hospital partner during the initial payer contracting process for a new center has definitely yielded better overall reimbursement
- In those states with certificate of need programs, our applications that include a hospital partner undoubtedly move at a faster pace through the process
- In today's talk of accountable care organizations, there is no question the JV makes sense—high quality outcomes at a much lower cost structure than the HOPD

COALITIONS CONTINUE TO GAIN MOMENTUM

Let's face the facts, in many parts of the country the large GI practices have already developed their ASC(s). However, we are seeing an increasing number of smaller practices combining with solo GIs in the area to consolidate enough procedural volume to successfully develop a new endoscopy center. This approach often works well when combined with a hospital joint venture project. The keys to developing a successful coalition are relatively straightforward, and the following questions ought to be considered:

- Are the potential physician participants quality clinicians and of sound character?
- Will each physician continue to actively provide clinical services for 5+ years?
- Are the volume representations real? Is the commitment real?
- Can the group of various physicians, who traditionally may have seen each other as competitors, play in the same sandbox? The coalition physicians don't have to merge their practices necessarily (although they might in order to take advantage of some ancillary service opportunities), but they do need to reasonably get along with each other. A high procedural volume physician who is a known problem (either clinically or character-wise) is of little use to developing a quality endoscopy center project.

HOSPITAL ACQUISITIONS OF PHYSICIAN PRACTICES

We are also seeing a second generation effort by hospitals to acquire the local Primary Care Providers (PCPs) and, quite often, many surgical specialties in town. Part of this is clearly fear driven as the comfort of a stable salary package may appear more palatable than erosions in professional fees which will eventually lead to lower income for many physicians. The outcomes of these physician practice acquisitions remain unclear. Will hospital management be able to create solid accountable care organizations like those envisioned by the President, or will hospitals repeat the unprofitable and often disastrous mistakes of the 1980s when the initial round of PCP acquisitions generally were labeled complete failures? Only time will tell.

GENERALLY HIGHER PATIENT FINANCIAL LIABILITIES

Gone are the days of low patient co-pays and deductibles. In most of the markets we serve we are seeing considerably higher patient financial liabilities for procedural services. It is not uncommon to see $200 to $500 co-pays or deductibles in most markets for at least a small portion of the payers, even when the center is "in-network." Part of this is undoubtedly due to an even higher percentage of employers converting to self-funded benefits plans and other non-traditional health insurance instruments.

We are often asked by our physician partners about "writing-off" these higher patient liabilities. Although we are not lawyers and wouldn't ever presume to provide legal advice of any kind, I would strongly suggest that one seek qualified regulatory guidance before assuming that "write-offs" are permissible in a broad sense. We are seeing more patients going on payment plans (directed by our billing department) that assist them with extending their payment terms over a longer cycle with reasonable interest rates. There are also several national companies that provide full payment of the patient financial liability upfront to the ASC, if the patient agrees to utilize their payment plan; however, if the patient misses a payment or is late, the interest rates often skyrocket.

Related to this increase in patient liabilities, we are also recommending that your ASC consider collecting Time Of Service (TOS) payments upfront at reception whenever possible. Many ASCs have avoided collecting these payments in the past because it wasn't usual and customary in their local marketplace. In many parts of the country that mood is changing. And there is clear evidence that your ASC will collect more on the front end than waiting to bill on the back end after service has been delivered. This is something to think about if you don't currently perform TOS collections at your ASC.

Patients have also become more aggressive in seeking discounted health care. In the past, many patients were reluctant to ask upfront for financial consideration, almost as if that were a stigma of some sort. That has all changed in the past year. We see a great example of this in our southeast Michigan market. The state of Michigan has an overall 19% unemployment rate and Detroit proper now exceeds 33% unemployment. Our partnered facility there has seen a five-fold jump in self-pay patients in 2009 (the trend is still climbing). These patients don't have health care insurance, but they are continuing to seek GI services, although they tend to be far more assertive in seeking discounted care than ever before.

MEDICARE SURVEY BACKLOGS INCREASE

Until recently, when one opened an ASC, you could expect to get your Medicare visit fairly quickly after treating your first patients. Those days are generally gone. In the latter half of 2008 and certainly in 2009, the normal wait time for the critical Medicare review is now 60-90 days, irrespective of whether or not you seek "deemed status" through an accredited third-party such as AAAHC. The impact of this elongated timeline is clear: more upfront working capital needs to be raised than ever before. If you are developing a new ASC, keep this in mind.

This delay in the Medicare review also dramatically impacts the vast balance of commercial payer contracts as well. Generally, these plans won't finalize their agreements with your ASC until you receive your Medicare PIN or PTAN number. As a result, even after waiting 90 days for the Medicare survey to occur, you still may be waiting another 45-60 days before the MC PIN is in place. The end result is a five month potential delay in getting those other commercial contracts aboard. Plan cash flow carefully.

REGULATIONS INCREASE IN 2009

Medicare red flag rules…conditions of coverage…HIPAA electronic security audits…etc. There is no question that governmental regulations are advancing faster than most ASC boards can keep pace. In 2009 alone there have been several major Federal rule sets issued while in many states the regulations have crept forward as well, too.

One strong suggestion for any ASC today is to conduct an independent third-party operational audit of your facility to ensure you are in compliance with all these new regulations and guidance requirements. It is really quite easy for one to take the position that some of these "rules" are trivial or even counterproductive to providing quality care. However, it is a near certainty that the surveyor won't adopt that same attitude during his or her next licensure or accreditation visit. Consider this operational audit a new type of "insurance" plan to help protect the ASC, yet another cost of doing business.

WHAT ABOUT 2010? SOME PREDICTIONS…

Prediction #1: The recession tide begins to turn in early 2010 and net new jobs begin to be created in your local marketplace by the middle of the year. An economy on the rebound creates opportunities in business and the practice of outpatient medical services is no exception. March 2010 may well serve as a terrific opportunity to aggressively promote colon cancer awareness—more than your practice or facility has ever done so in the past. There may be some pent-up demand out there as many may have pushed off screenings during the past months.

Prediction #2: The business fundamentals to manage a successful endoscopy center will remain. Effective utilization, contracting, resource management and an eye on quality remain critical items to monitor and proactively steward. Endoscopy ASCs will continue to thrive if we focus on the fundamentals as well as continue to actively recruit new providers to the medical staffs of each center. As a result, professional management of these endoscopy centers is seen as more important than ever.

Prediction #3: Professional fees are cut by Medicare, but not as bad as 22% that has been publicized. However, this does lead to more GI physicians recognizing that an ever growing percentage of their personal income is derived from their ASCs and related ancillary services. For those that don't yet have an endoscopy center, the time to build is now.

Prediction #4: Health care reform succeeds, although maybe not exactly as President Obama expected. Irrespective of whether a bill is signed into law or not, health care reform has already arrived simply by the fact of becoming "the topic of 2009" on every patient's mind. Consumers are becoming more and more educated every single day, and they know what they want from their health care professionals. Quality, service and timeliness along with value are the watch words for the future.

All in all, 2009 may have been a "game changer" year in health care. And our journey continues…

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