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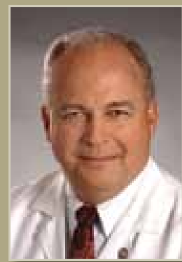

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Ask the Experts

A QUESTION & ANSWER EDITORIAL ON ISSUES RELATED TO ASCs

IS DEVELOPING AN ASC IN THESE ECONOMIC CHALLENGING TIMES STILL A GOOD IDEA FOR THE GI PHYSICIAN?

CAMERON: Developing a new ASC today requires close attention to your business model. Value, payor mix, and overhead must come together for a new venture to make sense. A center with high fixed costs and low volume will have a difficult time putting together a pro forma that makes sense. On the other hand, a high-volume of procedures that is hampered by a preponderance of poor third-party payors will also be a non-starter. Therefore, one room centers that are limited in their ability to increase volume or centers that have a large percentage of government sponsored programs with their artificially low reimbursements will have a difficult time.

JOHNSON: As long as the ASC can be a profit center this still makes good business sense. Key is efficiency and cost effectiveness for provision of these cases. As the emphasis on quality will continue to grow as a key benchmark for endoscopists, the certified ASC should continue to be a quality location for provision of endoscopic services.

BROWER: There are a lot of challenges today facing the GI physician investing in an ASC. Reimbursement continues its downward spiral: insurers try to steer patients away from out-of-network facilities; financing is not as readily available; and no one knows where health care reform will eventually land. On top of that, hospitals continue to cry foul over what they perceive to be the unlevel playing field and look for ways to close the door on more physician-owned ASCs. As such, this may be one of the last great opportunities to get into an ASC before things get worse. Owning an ASC allows the physician to control operations and the quality of services provided, as well as share in the benefits of the facility fee. Moreover, if physician ownership of ASCs is further restricted, there is a good chance that existing physician-owned ASCs will be grandfathered. Thus, the questions to ask are: can you get a facility up and running quickly and secure the necessary financing? Do you have the requisite volume to make it work? If so, now is the time to act.

THOMPSON: Yes, ASCs continue to be a viable and important practice setting for GI physicians. The combination of physician equity and physician control promotes an efficient and cost-effective setting for the delivery of GI services—just what patients and payors want. In addition, ASCs are relatively stable from a regulatory standpoint and office-based reimbursement for GI procedures is in jeopardy. Still, the ASC must be sized right, staffed right, and utilized right, and supported by a managed care contracting strategy that optimizes reimbursement and volume. These fundamentals hold true regardless of the economic climate—it's just that these fundamentals become more acute during an economic downturn.

WHAT CAN THE GI PHYSICIAN EXPECT THE NEAR FUTURE HOLDS FOR ASC REIMBURSEMENT AS WELL AS PROFESSIONAL FEES?

CAMERON: The gastroenterologist can expect to see lower reimbursements on both the technical and professional side. We have already seen a widening of the gap between the HOPD and ASC from the recently mandated 65% to approximately 59% over the last two years as HOPD reimbursements rise and ASC reimbursements do not keep up. Medicare professional reimbursements are scheduled to be reduced by 21% as of January 2010 if Congressional action is not forthcoming.

JOHNSON: The likelihood is that GIs can expect professional cuts as will be likely for all specialists. Given the Draconian cuts that the ASC reimbursement has taken, it would be hard to imagine that this could be cut further—without risking of "reverse migration" of patients back to the HOPD which is a more expensive place to provide care.

BROWER: ASC fees are under attack from the government and the private insurers. More and more ASCs are being challenged over their out-of-network rates which are usually a multiple of their in-network rates. Government payers will also be looking to further challenge reimbursement of facility fees. The same holds true for professional fees—it is unlikely that either governmental payers or private insurers are going to be increasing fees significantly, if at all, in the near future. Unfortunately, as physicians have had to face over the last decade, they will continue to have to work harder in many instances to make the same kind of money. Volume is going to continue to be key.

THOMPSON: There is little likelihood that reimbursement will increase for physician services. Most likely, reimbursement will decrease—all the more important for GI physicians to be part of an efficient and cost-effective delivery model. Also, an increasing percentage of reimbursement will be at risk based on certain quality and outcome measures. Given that the system of ASC reimbursement was materially changed in 2008 by tying ASC payments to the HOPD rate, I would not anticipate any major changes in the *method* of ASC reimbursement for the foreseeable future. Still, the divide between ASC payments and HOPD payments will likely widen, given the different annual inflation updates applied between the two systems of reimbursement and the rescaling of the HOPD weights. With no changes in the reimbursement methodology, ASC payments for GI services could be as low as 50% of the HOPD payment in five years. Similar same downward pressures will apply to the physician fee schedule for professional services.

THERE ARE MANY GI PHYSICIANS ACROSS THE COUNTRY CURRENTLY PERFORMING AND FINANCIALLY BENEFITING FROM OFFICE-BASED ENDOSCOPY. WHAT DOES THE FUTURE HOLD FOR THIS TYPE OF REIMBURSEMENT, AND SHOULD GI PHYSICIANS CONSIDER ALTERNATIVES TO PROTECT THEIR ECONOMIC FUTURE?

CAMERON: Current cost cutting and rising overhead trends will not spare the office-based endoscopist. Medicare cuts due to the unworkable SGR formula will profoundly affect the office-based endoscopist. New York has recently completed its requirement for accreditation of office-based endoscopy and we can expect this trend, that ultimately increases overhead, to continue across other states.

JOHNSON: Office endoscopy will come under increasing scrutiny as the emphasis on quality of care grows. Many of the endoscopies provided at present are by primary care doctors who do these in their office and who would/could not be certified at an ASC or hospital. Office endoscopy, if done, will have to be in locations that are certified as safe and acceptable and on par with standards for ASCs and HOPDs. This could include certification by AAAHC, JACHO or Medicare. For gastroenterology, the primary bulk of office endoscopy is done in states where the GIs cannot get a certificate of need (CON) because of state law restrictions which are biased towards protecting hospital services. Recognizably, this CON legislation is not evidence based and there are only a few states that still have this legislation—many of which are currently being challenged.

BROWER: The future of office-based reimbursement may be as uncertain as the future of ASC reimbursement, although market forces may suggest that investing in an ASC may make more sense going forward. For one, opportunities to invest in physician-owned ASCs may become less available in the years ahead either due to regulatory restraints or market conditions (due to a saturation of ASCs or worsening market conditions in general). Secondly, much also depends on the anesthesia component and certain payer strategies suggest that reimbursement for this service within an ASC setting is more likely and profitable than in the office based setting. Finally, regulation of GI procedures in the office setting is increasing each year. An ASC already is subject to regulation and can spread the cost among the investors, especially if you have multiple groups joining into one center.

THOMPSON: Not long ago, office-based GI procedures made economic and operational sense for the GI physician. However, declining reimbursement from both governmental and commercial payors, coupled with increasing regulation of office-based procedures, have had a negative impact on the financial viability of the office-based setting. Some payors have reduced or eliminated separate fee-for-service anesthesia billing for endoscopies which will have the effect of lowering total reimbursement for these procedures, further jeopardizing the economic feasibility of office-based procedures. Thus, it is likely that GI procedures increasingly will move to the ambulatory surgery center setting.

WHAT ARE THE BENEFITS AND DOWNFALLS FOR AN INDEPENDENT GI PHYSICIAN SELLING HIS/HER PRACTICE AND CENTER TO THE LOCAL HOSPITAL AND BECOMING AN EMPLOYED PHYSICIAN?

CAMERON: The answer to this question ultimately comes down to a local issue. If the physician sells to a hospital system he loses control of his patient base, charts, and usually his front office. Once this deal is made it is difficult to undo. Referral patterns will shift with new lines of business opening and some old dependable support drying up. If the employment contract called for straight salary this may not matter, but if the physician reimbursement is based on RVUs/collections this may have a chilling effect on the physician's bottom line. On the other hand, the new lines of business may substantially increase patient flow and, therefore, reimbursement. Your new hospital partner may increase your marketing budget substantially. Ultimately, you have to ask if the hospital considers you an asset or whether they are purchasing your practice to sideline a competitor.

JOHNSON: Lack of autonomy always has a price! Although the local hospital may offer a "carrot," from our experience in seeing this around the country, there is a "stick" not too far behind. Policy changes for your personnel, scheduling, quotas, flexibility, capital expense, programmatic growth, and referrals are among many of the issues that may emerge with transition to employee status.

BROWER: There are a number of pitfalls in selling a practice and becoming an employee of a hospital. You lose control over many aspects of your practice (you are no longer the boss). You are also subject to a list of priorities set by a health care system and GI may not be at the top of that list. However, with the trends in reimbursement and the current economic situation, a well negotiated deal might make sense, although the first avenue to explore may well be a joint venture.

One potential downfall that should be taken very seriously is the stability of the buying entity. There are hospital systems that are failing across the country, some that had been strong only a few years ago. Single hospital systems are struggling even more in many instances and may be desperately reaching out to do deals as a last ditch effort to survive. You may negotiate a good sale price and a long-term employment agreement, but what happens when that hospital goes bankrupt? The painful reality may be that the GI center you sold turns a profit, but the hospital fails for a whole host of other reasons. Your employment agreement is only as good as the hospital itself. You could be in the position of having to start all over again.

THOMPSON: Timing is everything. GI physicians always want to sell their practices and centers when they are at their highest and best values. The problem is, you often never really know when that peak has been reached. Over the last year or so, selling prices for GI centers, expressed as a multiple of EBITDA, have decreased a point or two from their highs of 6-8 times EBITDA. Still, money isn't everything, and the GI physician must consider the other pros and cons of selling his or her practice to the hospital. Pros include a more stable environment in terms of reimbursement and compensation, along with a built-in referral system. Hospital employment also provides the opportunity to shed some of the administrative and managerial responsibilities attendant to owning and operating a practice. Cons include giving up control/autonomy over the operations of the practice and tying yourself to the success of one hospital or health care system—the proverbial basket holding all of your eggs. Still, I believe we will see an increasing number of GI physicians (and other specialty physicians) interested in an employment model with a hospital, health system, or medical foundation. Reimbursement and regulatory policies seem to favor that model.

WHAT CAN A SOLO OR SMALL GROUP OF PHYSICIANS DO TO IMPROVE THEIR CURRENT ECONOMIC SITUATION, ESPECIALLY WITH FUTURE EXTENSIVE CUTS TO THEIR PROFESSIONAL FEES?

CAMERON: Solo and small groups will find it increasingly difficult to deal with rising overhead and falling reimbursements. They must have enough volume to take advantage of multiple income streams. They will find it increasingly difficult to make a living on E+M codes and the professional component of endoscopy. The addition of other lines of business such as ASC technical fees, pathology, anesthesia, CT colonography, and pharmacy all require a threshold volume to satisfy the fixed costs of setup and operation. This threshold patient volume can only be reached by forming larger groups of motivated physicians with the same goals.

JOHNSON: Carefully analyze your business plan. Know your costs for providing each service—in particular for endoscopic services. Develop ways that justify that you and your practice provide quality care—this will be a huge area for insurance providers over the next few years. Practices should benchmark their care against national standards. An excellent example here is the project being championed by the ACG and ASGE for endoscopic benchmarks with a national data registry. It is anticipated that those physicians who participate in these types of registries will be recognized as "quality" providers, and at least for the near future should receive higher payments. Ultimately outcomes will define quality. But this is extremely complex, and, at least for GI services which are primarily outpatient care, will take a long time before the databases are sophisticated enough to accurately analyze the information. Another thing for GIs to do is to look at alternative revenue streams for their GI practice. This may include clinical research or developing new areas of interest. One example here is for the treatment of hemorrhoidal disease. We have been extremely impressed by a new banding technique which has been safe, effective and offers a new improved care provided to our patients as well as an alternative revenue stream which makes great economic sense!

BROWER: While some areas of the country have been slow to embrace the group practice concept, that is the future and the future is now. It is going to become increasingly difficult for a small group of doctors in just about any specialty to survive with the ever increasing costs of running a practice coupled with lower reimbursement. Forming a larger group that is managed effectively should save on costs and bring more to the bottom line. Likewise, diversifying the practice (i.e., bringing your GI practice into a multi-specialty group) also increases the ability to bring more revenue to the bottom line. And, as most physicians know, a group practice properly structured can help you realize the benefits of revenue from different specialties without violating Stark and Federal Anti-Kickback laws.

THOMPSON: Revenue Cycle, Revenue Cycle, Revenue Cycle! Paying attention to the revenue cycle of a practice is probably the single most important thing a GI doctor can do to improve his or her economic situation. The revenue cycle starts with a solid managed care contracting strategy and progresses through to scheduling, registration, coding, billing, collection, and claims denial management and appeals. Improvement in any one of these processes can significantly impact a practice's economic status. This is an area where I often suggest GI physicians engage the assistance of a consultant or other outside expert to critically analyze the practice's revenue cycle. An independent view can pay dividends.

HOW CAN THE GI PHYSICIAN LEARN MORE ABOUT HEALTH CARE REFORM AND THE AFFECT ON HIS/HER CURRENT CENTER, AS WELL AS WHAT HE/SHE SHOULD BE DOING NOW TO MINIMIZE ANY NEGATIVE IMPACT?

CAMERON: All three GI societies publish practice management articles on a regular basis and produce practice management courses. Industry publications such as *EndoEconomics* and *Becker's ASC Review* are excellent sources of information and can refer the physician or practice manager to competent professional help.

JOHNSON: The key is to look to the national societies which represent his/her type of clinical practice. Everyone needs to pay attention and as well respond to requests for communication with their legislators. Having been involved for a long time in medical political issues, I have learned a key lesson—effective politics is local! A grassroots connection for state and national legislators that can be orchestrated by each physician as well as his/her friends, employees and patients are all ways to make issues heard when decisions are being made. Never underestimate the power you have if you mobilize your influence when it comes to providing the best care for your patients!

BROWER: Unfortunately, no one knows for sure where health care reform is going and even less how it will affect particular specialties. Keeping current is difficult because most news coverage is more about the "politics" of health care reform than it is about the substance of the proposals themselves. Publications like *EndoEconomics* which focuses on the GI specialist, as well as other leading health care journals, are important educational tools as to the substance of the proposals. Professional societies also need to take the lead in keeping the members of their specialty current and informed as the laws develop.

THOMPSON: There are a number of resources a GI physician can access to learn more about health care reform and its effect on his or her practice. These include the American Gastroenterological Association, the Ambulatory Surgery Center Association, the Institute of Medicine, MedPac, and local Congressional offices. These many sources notwithstanding, at this point in time, it is difficult to ascertain the framework of any true health care reform, let alone the details. Sifting through the rhetoric, what does seem apparent is that reimbursement policy will continue to drive health system change. Anything a GI physician can do (or any physician for that matter) to improve quality and outcomes, reduce cost, and enhance the patient experience, all supported by the deployment of health information technology, undoubtedly will be responsive to any ultimate health reform legislation, no matter its form.

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