How Healthcare Reform Impacts ASCs and Physician-Owned Hospitals – 10 Observations

By Scott Becker, JD, CPA, Leigh Page and Rob Kurtz

For physician-owned hospitals, the healthcare reform bill and its impact are very clear and very negative. For ASCs, there is much less direct impact and the long-term impact is much less clear.

To Sell or Not to Sell: A Guide for Orthopedic Practices Eyeing Deals With Hospitals

By Barbara Kirchheimer

Orthopedic surgeons contemplating turning over their practices to their local hospital may view such a deal as a way to lock in lifelong profits while saying goodbye to all of the administrative hassles of managing a practice. But seller beware: If money is the primary motivator, the strategy could well backfire, according to physicians who have entered into such deals.

9 Reimbursement and Business Concepts for Orthopedics in ASCs

By Lindsey Dunn

1. New CMS ASC payment system has generally increased orthopedic reimbursements. The transition to the new CMS ASC payment system, which pays centers at a percentage of HOPD rates, has increased the reimbursement rates of most orthopedic procedures, says Jay Rom, president of Blue Chip Surgical Center Partners. The system, which went into effect Jan. 1, 2008, and was designed to be phased in over a four-year period, continues to benefit orthopedic service lines as the percent of the payment formula determined by the new system is phased into the overall ASC reimbursement rate.

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Publisher’s Letter

Healthcare Reform; Is the AMA the Worst Trade Association Ever?; Orthopedic, Spine and Pain Management Driven Ambulatory Surgery Center Conference: Improving Profitability and Business and Legal Issues – June 10-12, Registration Discounts Available

It has been an incredibly interesting couple of months in the healthcare world.

1. This issue includes several items related to healthcare reform and its impact on physicians, hospitals, physician-owned hospitals and surgery centers. This issue also includes several articles related to orthopedic- and spine-driven ASCs.

2. For a copy of an article entitled “Is the AMA the Worst Trade Association Ever?,” please contact sbecker@mcguirewoods.com.

3. Finally, we have our 8th Annual Orthopedic, Spine and Pain Management Driven Ambulatory Surgery Center Conference on Improving Profitability to be held June 10-12, 2010. This includes great speakers on the future of healthcare, future of orthopedic- and spine-driven surgery centers, a talk by healthcare futurist Joe Flower, a talk by the National Political Director of the Atlantic Media Company Ron Brownstein and a great deal of physician leaders speaking. Overall, it has 90 sessions and 112 speakers. The deadline for early registration is May 1. If you register by May 1, you will receive an additional $200 discount if registering for the entire conference. To register, call (703) 836-5904 or send registration via fax to (703) 836-2090. To register online, go to https://www.ascassociation.org/june2010.cfm.

A full copy of the brochure is also enclosed herewith, beginning on p. 15.

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How Healthcare Reform Impacts ASCs and Physician-Owned Hospitals – 10 Observations (continued from page 1)

1. As to physician-owned hospitals, the bill will preclude new facilities which are not Medicare-certified by Dec. 31. The bill doesn’t include any similar provision for ASCs nor do observers expect any such prohibition.

2. For existing physician-owned hospitals, it places immediate limits on expansion of operating rooms, beds and procedure rooms, limits aggregate increases in physician ownership and imposes immediate disclosure requirements. Hospitals are also prohibited from conditioning physician ownership on the physician referring cases to the hospital. This can create challenges even for hospitals that are acting in a wholly appropriate manner.

3. Many planned physician-owned hospitals that are under construction will be able to meet the Dec. 31 deadline and breathed a sigh of relief. Others will not be able to meet the deadline for Medicare certification and will need to assess a new strategy as to how to complete their projects and operate. They are assessing multiple different options.

“Obviously, these provisions are extremely harmful,” said Molly Sandvig, JD, executive director of Physician Hospitals of America, in a press release. “They virtually destroy many of the hospitals that are currently under development, and leave little room for the future growth of the industry.”

4. As to ASCs, the legislation will have little in it that directly relates to ASCs. From an ASC industry perspective, this is largely very good. It will provide new incentives for preventive care which include, in part, a waiver of copayments for procedures like colonoscopies. It avoided an impact on the pricing of ASC services and the ASC payment system. It will require CMS to work with ASC industry stakeholders to develop a report to Congress by 2011 describing how Medicare could incorporate value-based purchasing strategies for ASCs, according to Andrew Hayek, CEO of Surgical Care Affiliates and chair of the Ambulatory Surgery Center Advocacy Committee, in a press release.

It also avoided a requirement for ASCs to file Medicare cost reports. The original House version of the bill required ASCs to submit reports so CMS would have data to determine ASC reimbursements. Nothing good could have come out of the reporting, says Marian Lowe, senior vice president of federal health policy for Strategic Health Care. “Because the data would not be used as the basis for payment, CMS would not audit the cost reports, calling into question the accuracy of analysis based on reported data,” she says. “Despite ASCs’ role in creating savings for the healthcare system, there is a significant gap in payment rates between HOPDs and ASCs. ASCs offer CMS and patients savings opportunities, yet continued pressure on ASC payments could shift care to return to more expensive surgical settings.”

5. Longer term, the providing of authority to an independent MedPAC type of board — the new Independent Payment Advisory Board taking effect in 2015 — may give ASCs much greater concern as it would have unprecedented powers to reduce Medicare payments for ASCs, physicians and other providers, except hospitals. “The board is a really worrisome thing for ASCs,” says David Shapiro, MD, a partner in the Ambulatory Surgery Company. “Will it have overarching authority over reimbursement?” If the board’s powers are left intact, Dr. Shapiro says the ASC industry will have to work closely with it, as it currently does with MedPAC, to make sure ASCs’ views are heard, a sentiment shared by Mr. Hayek.

“Our team of advocates in Washington will remain at the table to ensure that ASC interests are protected as the administration begins the complex task of implementing the new law,” said Mr. Hayek in the press release.
“We will be vigilant throughout the implementation process to ensure that ASCs can provide services for the newly insured patients at rates that keep the industry economically viable.”

6. ASCs may also take some comfort on the addition of 30 plus million covered lives to the insurance pool. Many of these patients are expected to be on Medicaid, which pays low in many states. “That would be painful and put new pressures on efficiency of management within an ASC,” says Barry Tanner, president and CEO of Physicians Endoscopy. “But I believe ASCs could handle it. Most of them have at least some excess capacity that could take on a certain amount of patients without losing money, even at Medicaid-level rates, without losing money.”

7. It remains to be seen long-term whether the legislation will discourage the independent and smaller group practice of medicine versus very integrated systems. This is a key issue for ASCs in that a large proportion of ASC users and owners come from small to midsize independent group practices. Some trends are already stacking up against this segment, which makes physician recruitment more difficult as less independent physicians are available. A huge question is whether the long-term impact of this legislation will be to further discourage the small- and mid-sized practice of medicine.

8. The second great long-term concern of the ASC industry may be whether and to what extent the health insurance industry remains viable and a better payor for ASC services. In many situations, commercial payors are the source of most ASC profits.

9. A final large, overriding concern is whether reimbursement will be threatened from Medicare due to the overall cost of providing coverage to a much larger pool of people.

10. Overall, the results for physician-owned hospitals are very negative. The results for ASCs are very uncertain.

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**To Sell or Not to Sell: A Guide for Orthopedic Practices Eyeing Deals With Hospitals (continued from page 1)**

Some orthopedic surgeons interviewed say they are satisfied with deals they struck with their local hospitals and would do so again if given a chance. There are others who prefer to remain independent. But all agree that such deals are not get-rich-quick schemes, nor do they come without significant compromises and complications. That means surgeons should think long and hard about what they want to gain from aligning with a hospital before making the leap. They should also engage legal and financial experts to help make the most of the relationship, say those who have been through the process.

**Alignment can bring financial gains**

Several years into working for a hospital, Melvin Deese, MD, an orthopedic surgeon with Summit Sports Medicine & Orthopaedic Surgery in Brunswick, Ga., says he does not regret the decision to turn over his six-physician independent practice to Southeast Georgia Health System in 2007.

With payors pitting hospitals against physicians and an unclear regulatory environment in the state that made it difficult to predict expansion possibilities, the physicians decided it was time to side with the local hospital instead of going against it, Dr. Deese says.

Here’s what he says the physicians gained: the strength of the hospital system’s backing from a marketing and financial standpoint, greater leverage with insurers and a compensation model that allows them to care for all patients regardless of who is paying the bill.

On the flipside, here’s what they gave up: the autonomy of making decisions regarding the daily management of their practice, ownership of the practice’s real estate and surgery center and the ability to act nimbly to improve the efficiency of their operations when they see opportunities to do so.

“We were a successful and profitable practice,” Dr. Deese recalls. “We had as much chance as anyone to succeed. I just felt like what we did was the right thing to do long-term for delivery of care in our community. It allowed us to focus not so much on the changing administrative side of the delivery of orthopedic care, but more on the practice of orthopedics, with the hospital handling administrative components.”

While there have been a few challenges along the way, the practice’s physicians have been satisfied with the arrangement, he says.

**Less practice oversight, more practice of medicine**

Rocco Monto, MD, a Massachusetts orthopedic surgeon who turned over his private orthopedic practice to Nantucket Cottage Hospital in 2008, was feeling some of the same pressures as Dr. Deese. “When I felt like I was spending more time running the practice and less time being the practice, that’s when I knew I had to make some sort of change,” Dr. Monto says. His options, as he saw them at the time, were seeking out employment from a hospital, joining a larger orthopedic group or trying to revamp his practice to keep up with the changing times. Currently 49 years old, the mid-career physician wanted to stay put and do whatever he could “to get to the finish line in 15 years,” he says.
“What I found out, to my dismay, was that my practice wasn’t worth what I thought it was worth,” he recalls. “As physicians, we fundamentally believe that, like other businesses, we have a goodwill value, but there really was no goodwill.”

After overpaying for physician practices in the 1980s and 1990s and losing money on the deals, hospitals have become savvier about negotiating with physicians, Dr. Monto says.

Looking at his options realistically, Dr. Monto says he felt he had the greatest leverage with his local hospital system, which is part of Partners HealthCare in Massachusetts. He struck a deal to work for the Nantucket hospital with a salary and bonus compensation arrangement, with the hospital paying the lease on his office space. The arrangement allowed him to return his focus to what he enjoys most: taking care of patients. “What it’s allowed me to do is the best I can do,” he says. “But there’s no pot of gold at the end of the rainbow anymore; there really isn’t.”

**Type A’s need not apply**

Both Dr. Monto and Dr. Deese say letting a hospital take over is not for everyone. There are some surgeons whose personalities make it difficult for them to yield control to a hospital, and if they work in a larger urban environment where income is steadier, they may never have to. However, Dr. Deese says he is fielding an increasing number of calls from other physicians interested in exploring the option. “The uncertainty of [reimbursement] year in and year out is more than most of them want to deal with at this point,” he says, referring to changing reimbursement rates, which are less of a threat to a physician’s income under a hospital employment model.

Dr. Monto’s advice to other surgeons contemplating turning their practice over to a hospital includes the following:

- Be honest in understanding where you stand in your market. This will help you know how much leverage you have in striking a deal with a hospital.
- Know what the hospital wants to get out of the deal.
- Be clear and upfront about what you want to get out of the deal.
- Try to envision a way to bring the hospital’s interests in line with yours.
- Negotiate with civility and respect because your reputation within the community is at stake.

**Physician-hospital alignment a growing trend**

Dr. Monto and Dr. Deese are not alone in opting to throw their lot in with a local hospital. Recent nationwide studies back up the idea that the relationships between physicians and hospitals are changing. In a study published in the Sept/Oct 2008 issue of *Health Affairs*, authors Lawrence Casalino, Elizabeth November, Robert Berenson and Hoangmai Pham found that from 2005-2007, hospitals’ employment of specialists accelerated in seven of 12 metropolitan markets studied, and 68 percent of 46 hospitals included in the study employed sizeable numbers of specialists. Of those hospitals, 84 percent increased specialist employment from 2005-2007.

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Roughly two-thirds of the orthopedic surgeons in South Carolina are now employed by hospitals, says Steven Poletti, MD, the president of the South Carolina Orthopaedic Association. He, however, is not one of them. At least not anymore.

In 1996, Dr. Poletti was part of a practice that was bought by Tenet Healthcare Corp., but the relationship was dissolved after the employment contract was up. “It wasn’t a bad relationship,” he says. “But I think the ultimate problem with the sale of medical practices was that, oftentimes, your productivity was tied to collections, which is a mistake for a doctor.” Now he is one of nine physicians at the Southeastern Spine Institute in Mr. Pleasant, S.C., and he prefers to remain independent. His reasoning is fundamentally one of control over patient care.

Working for a hospital limits a physician’s options, Dr. Poletti says. Under employed arrangements, hospitals dictate where the physicians operate, where they refer patients and where they order tests. The primary reason hospitals employ specialists is to gain control of their ancillary services, he suggests. “By giving up that control, we lose part of our voice in doing what we think is best for our patients,” he says.

“Right now I wouldn’t want to become employed by a hospital because I don’t have to be,” Dr. Poletti says. “I think the doctors that are becoming employed by a hospital are doing it because they have to be.”

Declines in reimbursement, the drying up of credit to physicians and a less receptive Wall Street all are driving this trend, suggests Michael Farris, chairman and CEO of Navvis & Co., a St. Louis-based management consulting firm that provides consulting services primarily to health systems but also to physicians.

Employed physicians bring value to hospitals
Hospitals are beginning to see employing physicians as a “value proposition” that offers the physician a mix of income-related, lifestyle and professional satisfaction but also benefits the hospital by incorporating the physician into the success of the entire health system, through pay-for-performance structures and other opportunities for accountability. Under certain arrangements, specialists and hospital administrators can sit side by side on multidisciplinary councils that are tasked with managing a system’s performance, cost and quality, and the physicians might be rewarded financially when the council meets predetermined goals and objectives, Mr. Farris says.

That said, it is important for physicians negotiating deals with hospitals to weigh the pros and cons to them personally, and to structure a deal that works for them, says David J. Schiller, a tax attorney in Norristown, Pa., who handled Dr. Monto’s negotiations to turn over his practice to the Nantucket hospital.

Clinching the deal
One thing to consider, Mr. Schiller says, is the physician’s physical space. Is the office leased or owned? If so, what will happen if the physician becomes employed by the hospital? The hospital may want the physician on-site, or may not want to buy an office. For these reasons, physicians wanting to join a hospital might want to wait until they are near the end of a lease to begin negotiations in order to avoid getting stuck with the remainder of a lease.

If the hospital is actually purchasing a physician’s practice, there might be complications arising from the potential for double taxation. This will depend on the way the practice is legally structured and whether it is incorporated. There may also be restrictive covenants involved in a purchase if a hospital is interested in hiring one physician in a practice but not another.

Medical equipment can also be a source of headaches. If a hospital purchases a physician’s medical equipment for $50,000 as part of an employment deal, but then a year or two later decides not to extend the physician’s employment, that physician might have to go out and buy all new equipment at a significantly higher price unless a contract is negotiated that allows for the physician to purchase it back from the hospital at the price at which it was sold to the hospital or a further depreciated price.

Hospitals will typically compensate physicians based on productivity, with a base salary and a bonus linked to productivity measures, according to Mr. Schiller. Physicians may go into negotiations expecting to be paid based on what they were making on their own, which he says is legally irrelevant but may determine whether there is a deal.

“If I was working 75 hours a week and was making $1 million a year, who says I’m going to work 75 hours a week for them?” he says. “The real question that I would ask is what is fair-market value, not what have you been earning.” Mr. Schiller suggests coming to terms with what a fair salary would be, understanding the terms of a potential contract, and knowing how long the hospital is willing to guarantee income. “You have to figure out what’s reasonable,” he says.

Generally, Mr. Schiller says, a physician might be able to earn more being self-employed, but the trade-off comes in the form of steadiness of employment, reduction in administrative hassles and more reasonable work hours. “I think physicians are just sick of getting paid less and less, having staff issues, and they’d rather just be employed,” he says.

For physicians who are interested in selling their practice to a hospital, Dr. Monto suggests beginning negotiations while still in a strong position financially. Deals can take many months to hammer out. Dr. Deese adds that it is important to hire an accountant experienced in physician practice valuation who can help get the most value for your practice and an experienced healthcare attorney to represent your concerns.

“You can’t wait until you’re in trouble,” says Dr. Monto, “but you always have the nuclear option of walking away.”

Contact Barbara Kirchheimer at barbara@beckersasc.com.
The 2010 Medicare unadjusted base rates for a few of the more popular ASC orthopedic procedures are as follows:

- Arthroscopy, shoulder (CPT 29806) — $1,588.70
- Arthroscopy, knee (CPT 29875) — $1049.62
- ACL repair, arthroscopically (CPT 29888) — $2,785.52

2. Medicare payment increases can lead private payors to increase their payments. “CMS’s revamped reimbursement methodology significantly increased orthopedics, and we’ve been able to use that with other payors,” says Mr. Rom. “If Medicare is recognizing that reimbursement needs to increase, in many cases, other payors will follow suit.”

Additionally, because many commercial payors negotiate payment rates at a percent of Medicare, increases in Medicare reimbursement could potentially lead to increases in rates from commercial payors, says Eric J. Woollen, vice president of managed care for Practice Partners in Healthcare.

3. Increased payments have allowed more orthopedic cases to be performed in the ASC setting. Rising reimbursement has allowed physicians to bring cases to the ASC over the past few years that traditionally may not have made sense to perform in the ASC setting, says Mr. Rom. “Implant-heavy procedures and more complex cases, as well as some fracture work, now make sense financially for the ASC,” says Mr. Rom. “However, the challenge is that not all payors will reimburse adequately, so what makes sense financially needs to be determined on a payor by payor basis.”

4. Regularly evaluate contracts with private payors. ASCs must stay on top of their contracts to ensure the payment rates cover their costs and provide adequate profit.

Mr. Woollen says an ASC should never pass up an opportunity to renegotiate a contract upon renewal. “You always want address these because cost structure changes every year, such as changes in case mix and changes in overall costs,” he says.

Mr. Rom recommends ASCs administrator work with payors to negotiate rates that cover costs and provide a reasonable profit. If these negotiations fail, administrators should educate their physicians about which cases from which payors are not financially feasible in the ASC because the reimbursement is less than the cost, he says.

Mr. Woollen echoes his sentiment. “Our challenge is to demonstrate to payors that we’re providing value and costs savings for plans and for the patients because our setting is more cost-effective than the hospital,” he says. “Because of co-insurance, rising deductibles and increased cost sharing, we’re ultimately saving both the payor and the patient money.”

5. Case costing is fundamental. In order for ASCs to know which procedure and payor combinations are profitable, ASCs must understand the cost of each procedure performed by each surgeon, says Mr. Rom.

“If ASCs don’t understand case costs, they don’t have the knowledge to know which cases they’re losing money on, and they lack the ammunition to go to payors to explain why their payment rate doesn’t make sense,” he says.

6. Payor contracts must address implant costs. Implant costs are a critical component of any contract negotiations, says Mr. Woollen. ASCs should carve out procedures with expensive implants to ensure they are adequately reimbursed for implant costs.

“Payors are generally receptive to carve-outs because of implant costs and the time required for certain procedures,” says Mr. Woollen. “ASCs can validate these high costs by showing payors their implant invoices and demonstrating the need for payors to negotiate fair reimbursements that build in some profitability.”

Ralph Gambardella, MD, an orthopedic surgeon and president of Kerlan-Jobe Orthopaedic Clinic in Los Angeles, which also operates an ASC, says that carve-outs are crucial to orthopedic profitability. “As more and more orthopedic surgeries are done in the outpatient setting, more and more surgeries will require implants. Because of the high cost of implants, these procedures have to be carved out or you’re dead, financially,” he says.

7. Work with physicians and vendors to reduce implant business. ASCs can tap their physicians and vendors to bring down the costs of implants.

“Make the vendors compete for implant business,” says Mr. Rom. “Once you know you’ll start a new procedure or service that requires a new type of implant, work with the physicians to minimize variation of implant price and negotiate with vendors to find the one offering the most cost-effective pricing.”

Although encouraging physicians to use the same implants can save an ASC money, Dr. Gambardella warns it can also negatively impact physician satisfaction. “The challenge of providing only one brand of implant in order to negotiate a better price is that you are still dealing with multiple physicians who prefer different products,” he says. “You could potentially lose a physician’s business to another center if that center offers the implant he or she prefers.”

8. Consider adding additional, profitable orthopedic procedures. ASCs should also consider adding profitable orthopedic procedures, such as spine cases and partial knees, which are growing in popularity in the outpatient setting, says Dr. Gambardella.

Mr. Woollen agrees. “Adding these procedures, if implants are covered, can be fairly profitable and provide a better experience for the patient, but you need to carve them out so it makes sense for the ASC to perform them,” he says.

Alejandro Badia, MD, FACS, founder of the Badia Hand to Shoulder Center in Miami, a fully-integrated orthopedic facility, which includes an ASC, says some orthopedic trauma cases can also be profitable in the ASC. “We’ve been doing trauma cases in our ASC for about a year-and-a-half,” he says.

9. Unaffiliated orthopedic surgeons are still available in some markets. The surest way to increase profitability in any service line is to add additional cases, which can be done fairly easily by bringing in a new physician user. While it is difficult in some markets to find orthopedic surgeons that are not already affiliated with an ASC, these physicians are quite available in other markets.

“The challenge is convincing other surgeons to change their habits,” says Dr. Badia. It’s starting to happen as cases trend more and more to the ASC setting, but many other surgeons continue to operate at hospitals, which are largely inefficient operations, out of habit. I personally don’t see how they do it.”

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For Physicians:
1. Increased demand for physicians. With 32 million more Americans expected to enter the health insurance market, demand should rise, especially for primary care physicians, the Philadelphia Inquirer reported. This occurred when Massachusetts passed its statewide universal healthcare in 2006. However, the expansion in coverage will not happen for a few years, until 2014.

2. No permanent fee fix. The reform legislation does not permanently repeal the Medicare sustainable growth rate formula, which is again set to trigger a 21.2 percent pay cut for physicians at the end of the month. “It’s really unclear what pathway the House is considering to change the situation,” Robert Bennett, a government affairs representative for the Medical Group Management Association told HealthLeaders this week. “Now we are looking toward the April deadline, and then Congress will have a recess, and they are really running out of days.”

3. New independent panel setting reimbursement rates. The new Independent Payment Advisory Board “could unilaterally reduce Medicare payments without any public input,” said James Goodyear, MD, president of the Pennsylvania Medical Society in the Carlisle (Pa.) Sentinel. “The current IPAB framework could result in misguided payment cuts that undermine access to care and destabilize healthcare delivery,” added AMA President J. James Rohack, MD, in a release.

4. More bureaucracy. “The health system reform bill creates more government bureaucracy” and “installs mandates too numerous to list,” Dr. Goodyear told the Sentinel. “We see no reduction in administrative burdens for physicians and no reform in the way healthcare services are paid under the Medicare program,” added Joseph Reichman, MD, president of the Medical Society of New Jersey, in the Philadelphia Business Journal.

5. No tort reform. “The legislation does not include any medical malpractice reforms that would lower physician costs and prevent defensive medicine practices,” Dr. Reichman told the Philadelphia Business Journal. Without tort reform, physicians “are forced to practice more defensive medicine than is necessary,” the Pennsylvania Association of Health Underwriters told the Philadelphia Business Journal. The AMA and other organizations would like a cap on non-economic damages, but all the bill offers is $50 million in grants to states to explore alternative means of resolving medical liability claims.

6. Elimination of new physician-owned hospitals. The bill would prevent any new physician-owned hospitals from opening after the end of the year and, except for a very limited exception involving physician-owned hospitals with a high Medicaid patient population, prevent existing hospitals from growing. The provisions “virtually destroy many of the hospitals that are currently under development, and leave little room for the future growth of the industry,” said Molly Sandvig, executive director of Physi-
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Hospitals

1. More paying patients. The addition of 32 million paying patients will benefit hospitals that treat great numbers of uninsured, such as Grady Health System in Atlanta. The reform bill “should take some of the operational pressure and the near-death experience Grady faced in 2007,” Grady CEO Michael Young told Channel 11 in Atlanta. The bill’s expansion of Medicaid in particular would erase most hospitals’ bad debt within five years, Dan Mendelson, president of the consultancy Avalere Health, told the Associated Press. However, the expansion wouldn’t take effect until 2014, and in the meantime, hospitals will look for mergers as a way to lower expenses, Paul H. Keeckley, executive director of the Deloitte Center for Health Solutions, told Bloomberg News.

2. Reduced Medicare reimbursements. Hospitals are giving up $155 billion in Medicare funds over the next decade, or about an 8 percent cut, but they are expected to gain $170 billion because of fewer uninsured patients. Some are skeptical, however. Michael Walsh, CFO at Abington (Pa.) Memorial Hospital, told the Philadelphia Inquirer it would be a “leap of faith” to believe that there would be enough new revenue to cover the cuts. He decried the notion that “poof, we have this healthcare legislation and now there’s coverage and the problems go away.”

3. Quieter EDs. With more people going to physicians for care, the hospital ED shouldn’t be as busy, Jim Krauss, CEO of Rockingham Memorial Hospital in Harrisonburg, Va., told WHSV TV. However, it could be that “there’ll be more demand than there is supply of doctors, which puts a potential risk on filling up ERs,” Mr. Young at Grady said. “I think there’s going to be strain getting into an internal medicine doctor’s office or a family doctor just as [there will be] this big push for more service.”

4. Pressure to be more efficient. Hospitals will need to “identify waste and be even more cost efficient,” David Shulkin, MD, president-elect and COO of Morristown (N.J.) Memorial Hospital told the Daily Record. “Redoubling our efforts in this area will not be easy, nor comfortable, but it must be done to effectively serve our community.” Cyril Chang, a healthcare economist at the University of Memphis, told the Commercial Appeal that “hospitals, physicians and other providers will be asked to work harder and provide more services for more people.”

5. More cooperation with other providers. Health reform will require hospitals to collaborate more closely with physicians and other providers. “Going forward, success will require sustained effort and unparalleled cooperation from everyone on whom Americans rely for their healthcare, including hospitals, physicians and other caregivers, and insurers,” Chip Kahn, president and CEO of the Federation of American Hospitals, said in a release.

6. Advantages for hospitals with tax-exempt insurance plans. While insurers have to pay a new fee, it will represent only half of premiums for tax-exempt insurers such as Kaiser Permanente and Geisinger, according to the Associated Press. Other hospitals that own small, not-for-profit health plans should benefit, too.

7. More Medicaid payments at lower rates. Stephens Mundy, president and executive director of CVPH Medical Center in Plattsburgh, N.Y., told the Press-Republican the hospital will see an annual decrease in federal reimbursement rates for Medicaid patients in the next 10 years and an increase in eligibility for Medicaid. While the cuts in Medicaid happen immediately, the expanded coverage won’t take effect for several years, he said.

Orthopedics

Gross Charge and Revenue Statistics by Number of ORs

Here are the median gross charges and net revenue per orthopedics case by a surgery center’s number of operating rooms, according to VMG Health’s 2009 Intellimarker.

**Gross charges**
- All facilities — $8,026
- 1-2 ORs — $7,768
- 3-4 ORs — $7,633
- More than 4 ORs — $9,657

**Net revenue**
- All facilities — $2,453
- 1-2 ORs — $2,111
- 3-4 ORs — $2,482
- More than 4 ORs — $2,383

Information comes from VMG Health’s Intellimarker benchmarking study. VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of VMG Health’s 2009 Intellimarker, visit www.vmghealth.com.

Contact Leigh Page at leigh@beckersasc.com.
20 Orthopedic- and Spine-Driven ASCs to Know

By Lindsey Dunn

Here is a list of 20 orthopedic- and spine-driven ASCs to know. To view profiles of and learn more about these facilities, visit www.BeckersOrthopedicandSpine.com. Note: ASCs are listed in alphabetical order.

Houston Orthopedic Surgery Center (Warner Robins, Ga.)
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Loveland Surgery Center (Loveland, Colo.)
Orthopaedic Surgery Center of San Antonio (San Antonio)
Mayfield Clinic Spine Surgery Center (Cincinnati)
Midland Surgical Center (Sycamore, Ill.)
Missoula Bone and Joint Surgery Center (Missoula, Mont.)
New Mexico Orthopaedic Surgery Center (Albuquerque, N.M.)
The Orthopedic Surgery Center of Arizona (Phoenix, Ariz.)
Orthopaedic Surgery Center of La Jolla (La Jolla, Calif.)
Orthopaedic Surgical Center of the North Shore (Peabody, Mass.)
Parkway Surgery Center (Hagerstown, Md.)
Peak One Surgery Center (Frisco, Colo.)
Ravine Way Surgery Center (Glenview, Ill.)
Reading Surgery Center (Wyomissing, Pa.)
Rockford Orthopedic Surgery Center (Rockford, Ill.)
St. Louis Spine Surgery Center (Creve Coeur, Mo.)
Surgery Center of Reno (Reno, Nevada)
Tucson Orthopedic Surgery Center (Tucson, Ariz.)
Wildwood Surgical Center (Toledo, Ohio)

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5 Things Orthopedics and Spine Practices Can Do Immediately to Improve Profits

By Renée Tomcanin

Here are five changes and improvements orthopedic and spine practices can make immediately to improve profits in their practices.

1. Involve physicians in creating business policies. Solid business fundamentals are more important than ever in running a successful practice. It has also become more important for physicians to understand how the business component of their practice is operating in order to make necessary adjustments to counteract rising overhead costs and payment cuts. Involving physicians in the process can also help to ensure new policies are integrated into your practice's culture more quickly.

William R. Pupkis, CEO of Capital Region Orthopaedics in Albany, N.Y., says keeping physicians involved in making policy can ensure your practice can easily identify problems affecting profits and make changes to improve them. “We meet with the board as a whole and identify and present statistics on problems, such as billing errors,” Mr. Pupkis says. “I make one or two suggestions, but the physicians ultimately make decisions on what path we should take.”

2. Consider adding ancillary services. Many orthopedic and spine practices benefit from adding ancillary services, including imaging services and durable medical equipment, and joining or opening ASCs. Leveraging the services of partners within a multispecialty group can also benefit the practice in this area.

Ken Austin, MD, an orthopedic surgeon with Rockland Orthopaedics & Sports Medicine in Airmont, N.Y., says providing services such as physical therapy and pain management in addition to orthopedic care can have its benefits. “It is a move classic to orthopedic practices to reach out and become multispecialty. We have benefited by opening small, efficient satellite offices so that gives us more outreach in the community and we can convert that into more patients in our offices,” he says.

Mr. Pupkis says DME is one service most practices should consider as it is relatively simple to add for even smaller groups. “Practices will need one key individual to handle inventory. The billing can be done within the practice's current methods. If set up properly, practices can see good margins,” he says.

Practices can use Medicare to determine at what prices to sell DME. He also notes that practices should limit the number of larger, more expensive items they keep on hand. Physicians working at practices providing DME must also limit the amount of equipment they give away.

Another common ancillary service is MRI, but Mr. Pupkis notes that this can cost well over $1 million to set up and may not make sense for smaller practices. “You will need to invest in the MRI, hire someone to build the suite and then ensure you have the proper accreditation,” he says.

3. Improve outreach in your community. Establishing a strong presence and name recognition can result in more patient referrals for your practice. This does not mean that your practice needs to invest a lot of money on marketing or advertising. Mr. Pupkis recommends, at the very least, for practices to have a Web presence. “Search your local competitors and make sure that you have a site that at least matches theirs in quality and information,” he says.

Teaming with local athletes can also be beneficial to orthopedic and spine practices. Dr. Austin says, “We are in a small, tight-knit community, so we make sure we serve them in many ways. We take care of high school athletes, and we help to set-up and provide medical support to our local little league. This gets our name out in the community, and if any of the players need care, they usually come to us.”

Maintaining relationships with referring physicians is also a critical part of a practice’s outreach. Dr. Austin says a major challenge can be contacting new physicians. “In the past, we could spend some time talking with referring physicians in the hospitals, but recent trends show that hospitals are using more and more hospitalists and more referrers are staying in their offices. Now, we spend a lot more time on the telephone with our referring physicians,” he says.

Dr. Austin also says orthopedists should be sure they are not roadblocks when it comes to referring physicians providing care to their patients; rather, they should make it easier for physicians to send their patients to the orthopedic practice if necessary.

4. Drop your worst payor if necessary. Increasing legal struggles regarding out-of-network contracts have provided more impetus for practices and their ancillaries to stay in-network. However, practices should not be afraid to drop payors that are no longer profitable for them.

Mr. Pupkis says practices should consider their managed care contracts as an “investment portfolio.” He says, “Both provide economic returns, and the more diverse they are, the better. Both demand careful management.”

Payors can be tracked as a percentage of a practice’s total payments. Medicare should be the lowest payor in this model; commercial payors should represent a higher percent. Practices should then decide if payors who are closer to Medicare’s numbers are profitable for their businesses.

Mr. Pupkis warns that dropping out of a payor’s network can be a long, painful process for the practice, its physicians and patients, and the decision should be considered carefully. However, the practice needs to be dedicated the decision. “[The process] does not work unless you are willing to ‘fire’ a payor, because you will have no leverage in the process if you back down,” he says.

The process of dropping a payor requires a few major steps. Mr. Pupkis’ practice began its process by first sending out letters to patients and posting notices in their office saying they would no longer be in-network for the payor. This began well in advance of the contract termination date. In the notices, payor contact information was provided so patients could respond to the company directly and voice their concerns. In a few instances, this action resulted in the payor returning to the table willing to negotiate, resulting in a contract that worked for both the practice and the payor.

Not every attempt ends this way, however. Mr. Pupkis says the main fact to know before moving out-of-network is that practices must follow-up and attempt to collect payments from patients in order to avoid legal troubles. “In the past, many practices would only submit claims to the payors for their 80 percent of the payment, and then ‘forgive’ the patient’s contribution. Now, practices are legally required to make rigorous attempts to follow through on outstanding patient payments,” he says.

5. Leverage EMR to the best of your ability. An increasing number of orthopedic practices are investing in electronic medical records, and if used to its maximum potential, this costly investment can improve overall efficiency.

Dr. Austin says his practice has coordinated its EMR with its scheduling and billing components. By capturing patient data at the beginning of the process, the practice has been able to increase efficiencies by reducing the number of staffing hours spent entering information into a separate system. “Instead of spending extra time filling out forms, we are about to get in to the office and manage care better by making efficient use of the staff’s, physician’s and patient’s time,” he says.

Contact Renée Tomcanin at rennee@beckersasc.com.
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Becker's ASC Review/Becker's Hospital Review Names 100 Best Places to Work in Healthcare

Becker’s ASC Review/Becker’s Hospital Review has announced its list of the “100 Best Places to Work in Healthcare.” The 2010 list was developed through nominations and research, and the following organizations were selected for their demonstrated excellence in providing a work environment that promotes teamwork, professional development and quality patient care. For a variety of reasons, the editors ultimately determined to exclude certain categories of companies from the list and thus didn’t include any companies from the following categories: valuation firms, billing and collections companies and minority ownership ASC companies. Clearly certain companies in these areas were also worthy of inclusion.

To view profiles of and learn more about the 100 Best Places to Work in Healthcare, visit www.BeckersOrthopedicandSpine.com. Note: Organizations are listed alphabetically by name.

Access MediQuip (Lake Mary, Fla., and Houston)
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Advocate Health Care (Oak Brook, Ill.)
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Alexian Brothers Hospital Network (Arlington Heights, Ill.)
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B. Braun Medical (Bethlehem, Pa.)
Banner Health (Phoenix)
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Baptist Health South Florida (Coral Gables, Fla.)
Barnes-Jewish Hospital (St. Louis)
BayCare Clinic (Green Bay, Wis.)
Baylor Medical Center at Frisco (Frisco, Texas)
Beaumont Hospitals (Royal Oak, Mich.)
Borland-Groover Clinic (Jacksonville, Fla.)
Brigham and Women’s Hospital (Boston)
California Pacific Medical Center (San Francisco)
Cedars-Sinai Medical Center (Los Angeles)
Centennial Surgery Center (Voorhees, N.J.)
The Center for Outpatient Medicine (Bloomington, Ill.)
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Covenant Health System (Lubbock, Texas)
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Duke University Hospital (Durham, N.C.)
Ephrata Community Hospital (Ephrata, Pa.)
Garden City Hospital (Garden City, Mich.)
Genentech (South San Francisco)
Gifford Medical Center (Randolph, Vt.)
HCA (Nashville, Tenn.)
Heart Hospital of Austin (Texas)
Holy Name Hospital (Teaneck, N.J.)
Indiana Regional Medical Center (Indiana, Pa.)
Jersey Shore Ambulatory Surgery Center (Somers Point, N.J.)
Johns Hopkins Hospital (Baltimore)
King’s Daughters Medical Center (Ashland, Ky.)
Lakeland Surgical + Diagnostic Center (Lakeland, Fla.)
Laser Spine Institute (Tampa, Fla.)
Lehigh Valley Health Network (Allentown, Pa.)
Lifebridge Health (Baltimore)
The Lippy Group for Ear, Nose & Throat (Warren, Ohio)
Massachusetts General Hospital (Boston)  
Mayo Clinic (Rochester, Minn.)  
MedHQ (Westchester, Ill.)  
Medline Industries (Mundelein, Ill.)  
Meridian Health (Neptune, N.J.)  
Meridian Surgical Partners (Brentwood, Tenn.)  
The Methodist Hospital System (Houston)  
Mid-Columbia Medical Center (The Dalles, Ore.)  
Midwest Orthopaedics at Rush (Westchester, Ill.)  
Missoula Bone & Joint and Surgery Center (Missoula, Mont.)  
Nebraska Orthopaedic Hospital (Omaha)  
NewYork-Presbyterian University Hospital (New York)  
North Bay Regional Surgery Center (Novato, Calif.)  
NorthShore University Health System (Evanston, Ill.)  
NovaMed (Chicago)  
OhioHealth (Columbus, Ohio)  
OrthoMaryland (Baltimore)  
Orthopedic South Surgical Center (Morrow, Ga.)  
Parkway Surgery Center (Hagerstown, Md.)  
Providence Health & Sciences Alaska (Anchorage)  
Rex Healthcare (Raleigh, N.C.)  
Sage Products (Cary, Ill.)  
St. Joseph Health System (Orange, Calif.)  
St. Vincent Health (Indianapolis)  
Scripps Health (San Diego)  
SourceMedical (Birmingham, Ala.)  
South Texas Spine & Surgical Hospital (San Antonio, Texas)  
South Texas Surgical Center (Seguin, Texas)  
Southern Ohio Medical Center (Portsmouth, Ohio)  
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Why Patient Selection Matters to Spine-Focused ASCs: Q&A With Dr. Thomas Forget

By Cole Ollinger

Thomas R. Forget, MD, is a neurosurgeon with St. Louis Spine Surgery Center in St. Louis.

Q: Do you foresee continued growth in outpatient spine surgery volumes?

Dr. Thomas Forget: I don’t think there’s any doubt that outpatient spine will continue to grow. In neurosurgery, we’ve moved past the perception that all procedures required inpatient settings. Obviously, that’s true for brain tumors and very complex surgeries, but we were trained to think everything had to be done in the hospital, including routine spine cases. This traditional thinking created a barrier to the development of outpatient spine ASCs, but today it’s much less of an issue.

Advances in technology and techniques have enabled us to safely deliver quality care, and that’s why more neurosurgeons are comfortable performing spine cases in outpatient environments. Because of the nuances and need for specialized staff, I think neurosurgeons in general prefer spine-focused ASCs over multi-specialty facilities.

Q: What do you see as the major challenges facing outpatient spine ASCs?

TF: Obviously, healthcare reform legislation may have a large impact on the overall market, but it remains a black box for now. I think another significant challenge for neurosurgeons in particular is to resist the temptation to automatically do every case at their ASC. Just because you can do a case on an outpatient basis doesn’t mean you should. Lumbar decompressions and basic cervical cases generally don’t pose significant risks, but the more complex spinal procedures must be evaluated very carefully. It sounds like a basic concept, but there’s some risk for spine-focused ASCs and patients in doing these complex cases in an outpatient setting.

Q: Your ASC, the St. Louis Spine Surgery Center, includes both neurosurgeons and orthopedic spine surgeons. How have you built a partnership between the two groups?

TF: It was a very natural progression for our team. We all knew each other from the hospital and wanted to go into business together. We also had very candid discussions about the exact types of procedures we wanted to do at the surgery center, and defined those cases carefully.

The initial planning effort has contributed significantly to our success. If there was any conflict, it was around OR time. Of course everyone wanted to schedule surgeries in the morning, but we’ve managed to work that out.

Q: What other factors have been critical to your success?

TF: Being able to hand-pick our staff. We formulated a team of skilled and experienced nurses who know how to identify potential problems and handle any complications that arise. Having OR nurses who grasp the nuances of neurosurgery gives our surgeons confidence that pre-, post- and intra-op care are all delivered at the level of quality we expect. I know my patients are well screened before surgery and properly monitored afterward.

The efficiency of our ASC is another key element. The fact that I can do three or four spine procedures in the morning and still be in my office for clinic by early afternoon gives me a great deal more control than if all of my surgeries are scheduled at the hospital.

Q: What advice would you give younger surgeons considering involvement in an ASC?

TF: It’s important to work with partners whom you respect and trust. That includes your OR nurses and support staff, as well as your business partners and fellow surgeon-owners.

But, the most important idea is to be completely honest with your patients, and yourself. Patients should understand clearly the financial interest you have in the ASC, as well as why you perform the procedures there. The good news is that patients like many of the same aspects of surgery centers — namely comfort and convenience. It all comes back to patient selection: For every single case, you have to ask yourself, ‘Is the ASC the best place to perform this surgery?’ The good news is that in many cases it will be.

Thank you to Blue Chip Surgical Center Partners for arranging this article. Blue Chip developed St. Louis Spine Surgery Center, along with Dr. Forget and other surgeon-owners. You can learn more about Blue Chip and read more surgeon stories at www.bluechipsurgical.com/insights.

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SCB CAN MAKE YOUR MONEY GROW
6 Reimbursement and Business Concepts for Spine in ASCs

By Lindsey Dunn

1. Negotiations with payors can be more difficult for spine than orthopedics. Since Medicare does not reimburse spine cases in the outpatient setting, negotiating ASC rates for spine cases with private payors can be more difficult than other specialties because payors often set rates at a percent or multiple of Medicare rates.

“Negotiating for spine is much more difficult than orthopedics because payors don’t really know how to pay for spine — Medicare doesn’t reimburse it in the ASC,” says Jay Rom, president of Blue Chip Surgical Center Partners. “You should negotiate off of what payors are paying the hospital. You want to be less expensive than the hospital and sell that to the payors.”

Mr. Rom suggests administrators check payor Web sites for information on estimated costs for spine procedures at the hospital. This will give them a better sense of current payor costs as insurers are increasingly making cost estimates available to their members.

Blue Chip ASCs are typically able to offer a 30-40 percent discount over hospital costs to payors while still covering costs and building in a profit, says Mr. Rom.

2. Don’t add spine before examining and renegotiating existing contracts. If an ASC is considering adding a spine service line, it should not add the services before closely examining its current contracts with payors.

“Because many contracts do not include codes that Medicare does not cover, existing payor contracts are not likely to include spine reimbursement,” says Mr. Rom. “A lot of contracts have a default category for cases not covered elsewhere in the contract, and this will almost never be feasible for spine. You have to start negotiations with the payor early, because the process doesn’t usually go quickly.”

3. Contracts with payors must address implant costs. Just as with orthopedic cases, considering implant costs are critical to profitable spine cases. In fact, they may even be more important for spine cases because implant costs typically run higher with spine — as much as $2,000-$5,000 per case — than in traditional orthopedic cases, says Mr. Rom.

Mr. Rom says spine cases must be carved out or the case rate must be built to assume implant costs. Since implant costs can vary from physician to physician — sometimes by as much as $3,000 — rates must also cover the most expensive physician, he says.

“While we do a lot of work trying to minimize cost differences, there are practice differences that are going to exist. Some physicians are trained with different materials that just cost more,” says Mr. Rom.

4. Allow 6-12 months for negotiations and don’t be afraid to walk away. Mr. Rom suggests existing centers allow six months to negotiate with payors, while new centers should allow up to a year. ASCs must also know their case costs and work from the cost up. “Understand your implant and facility costs and build in a sufficient level of profit,” he says.

“If an ASC already has a contract with a payor, it can move more quickly, but you may have to terminate the contract if the payor will not come around,” says Mr. Rom. “It depends on how important and how big of an opportunity it is to the ASC to bring the spine cases. Look at the termination provision and threaten to use it or use it.”

Physicians Surgery Center in San Diego, says his ASC had to be willing to exclude payors that didn’t offer good contracts as the ASC would only lose money on the cases. So far, Physicians Surgery Center has remained in-network with its payors, but Dr. Raiszadeh reports that other ASCs in the area performing spine procedures have found some success by going out-of-network. “The reimbursements are higher for out-of-network ASCs, but the volume is more variable,” he says.

Mr. Rom suggests ASCs be as active as possible in helping payors understand spine at ASCs and the cost-saving benefits of contracting with a center.

5. Reduce implant costs by negotiating with vendors. Since steeper discounts are offered on implants as more devices are ordered, ASCs should work to reduce the number of vendors they order from.

Mr. Rom says Blue Chip ASCs typically try to use only 1-2 major vendors, which allows them to negotiate exclusive contracts offering better pricing. ASCs may also find additional discounts by joining with other facilities to order implants. Dr. Raiszadeh says he is familiar with several ASCs that have joined together to order implants and receive bulk pricing as a result. He also said that ASCs with hospital partners may benefit from using the hospital’s volume to its advantage.

6. Pursue workers’ compensation cases. Worker’s compensation cases traditionally reimburse well for spine in the ASC setting, so physician-owners should consider performing these cases in the ASC, when appropriate.

Dr. Raiszadeh says many of his workers’ compensation cases, including most anterior cervical and lumbar discectomies and some fusions, can be performed in the outpatient setting. These cases bring additional revenue to an ASC, and building relationships with workers’ compensation representatives can be beneficial.

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