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INSIDE

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Are Joint Ventures With Hospitals Beneficial to Surgery Centers?

Best-case scenario: Both sides gain

From a surgery center's perspective, the question about joint ventures should be: "How will it benefit us?" There might not be a simple answer. It all depends on how the joint venture is structured and why the ambulatory surgery center (ASC) and other organizations, such as a health system, want to engage in this arrangement. Certain industry trends complicate the issue further.

"The main reasons that ASCs partner with hospital systems is for assistance in getting access to various payer plans," says **Luke Lambert**, MBA, CFA, CASC, chief executive officer of Hanover, MA-based Ambulatory Surgical Centers of America (ASCOA), which is physician-owned.

In some markets, the health system dominates the market and controls an important payer. A surgery center might not have access to that payer's patients because the ASC is excluded from the plan, Lambert explains.

"So, they might partner with the hospital to get access to those plans," he says.

> "A LOT OF HOSPITALS ARE SEEING THAT THE MORE LUCRATIVE PROCEDURES ARE COMING OUT OF THE HOSPITAL TO AN OUTPATIENT SETTING."

Hospital-ASC joint ventures primarily are with nonprofit hospitals, although it can work with for-profit organizations, too, says **Robert Zasa**, MSHHA, FACMPE, managing partner with ASD Management, a consulting firm that develops and manages surgery centers for clients.

Joint ventures with ASCs started before the current trend of health

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systems' hiring physicians, Zasa notes. Hospitals often approach ASCs about forming a joint venture because they are drawn to the surgery center's success, such as in orthopedics, Zasa explains. *(See story on strategies to improve a joint venture partnership, page 123.)*

The hospital knows Medicare and other payers are approving more surgeries for the ambulatory setting to save on cost. Surgeons might perform a total joint replacement, for example, only as an inpatient procedure for Medicare patients because of Centers for Medicare & Medicaid Services (CMS) rules. But health system leaders know that this is changing. Soon, ASCs will receive these Medicare cases, so administrators should prepare for this shift, Zasa adds.

"They think, 'We'll lose those cases at the hospital, and orthopedics will do it on their own at their own surgery center,'" Zasa says. "It's a defensive move. A lot of hospitals are seeing that the more lucrative procedures are coming out of the hospital to an outpatient setting."

As employers increasingly turn to self-insured plans to reduce healthcare spending, they are steering patients to providers who can save them money. This has made ASCs particularly attractive to health systems in recent years. Health systems want to maintain contracts with big insurance carriers, but their own surgery centers could be too costly. Through a joint venture with an ASC, they have a lower cost option to offer carriers. The lower cost is shared by the hospital joint partner. The hospital also can reduce its own in-house staffing pattern and costs.

"Physician-hospital employment models have become bigger in the marketplace. We're seeing more of them," says **Tracy Hoeft-Hoffman**, MBA, MSN, RN, CASC, administrator of Heartland Surgery Center in Kearney, NE.

Hospital-employed physicians will bring cases to ASCs that are engaged in joint ventures with the hospital, she adds.

Another big benefit to a joint venture is that the health system has the clout ASCs lack when negotiating with payers. Sometimes, an area's biggest employer is the health system that controls its own health plan and steers its patients to providers that are either part of the health system or have an agreement with it.

"Doctors are looking and saying, 'The hospital has very strong relationships with Blue Cross and Aetna, and if we do the joint venture with them, then we may get a little higher fee,'" Zasa says. "That is driving it from the doctor's side to seek or be open to more joint ventures with health systems."

EXECUTIVE SUMMARY

Ambulatory surgery centers (ASCs) can benefit from a joint venture with a health system, depending on how it is structured.

- The main reason to partner with a hospital system is to get access to more payer plans.
- The joint venture also could boost an ASC's negotiating power in purchasing supplies.
- Health systems seek joint ventures to prepare for a future when more Medicare-covered surgeries move to the ambulatory setting.

Hoeft-Hoffman has found in her experience with a joint venture that a good joint venture agreement likely will result in better payment rates.

"If you have a good joint venture partner, they will help you negotiate to get a better rate, a percentage of billed, as opposed to a fee schedule," she says.

As an ASC that counts orthopedics as half its business, it's very important to know what carriers will pay for implants, she cautions. "If you have a good joint venture partner, they would be able to negotiate some of that."

Heartland Surgery Center is jointly ventured with CHI Health Good Samaritan in Kearney, NE. The ASC asks managed care companies to give the surgery center the same rates as the joint venture partner.

"The goal is to get a percentage of billed charges with implants in managed care contracts," Hoeft-Hoffman says. "CHI will get contracts and send them to us to see if we agree or not, and if we say, 'no,' they go back and renegotiate on our behalf."

For example, in one recent case, the insurer proposed a contract that would pay for implants that cost more than $5,000, but the ASC rarely performed implant procedures that were higher than that amount, she explains.

"We have 500 cases a month and 50% are orthopedics," she says. "If they didn't allow implants in the contract, then we wouldn't be able to bill for them."

The ASC let its joint venture partner know that the contract was not acceptable. The end result was the ASC and insurer went back to the previous contract, which was a percent of billed plus implants, Hoeft-Hoffman adds. ASCs also can benefit from the health system's purchasing volume.

"Sometimes, we get a better contract rate on purchasing," she says.

For example, with a health system's purchasing power, an ASC could obtain better prices on supplies, Hoeft-Hoffman says.

"I think it gets harder and harder to do this on your own without a partner," she adds. "There's hardly a new ASC opening that is not part of a joint venture with a hospital or healthcare management company." ■

After Entering Into a Joint Venture, Here's What an ASC Can Do

Sooner or later, some hospital or other organization will inquire about a joint venture with the local ASC. But will the ASC be ready when they do?

Surgery center administrators should know what to ask to ensure their ASC is well positioned in any joint venture agreement, says **Luke Lambert**, MBA, CFA, CASC, chief executive officer of Hanover, MA-based Ambulatory Surgical Centers of America (ASCOA), which is physician-owned. When considering a joint venture, first examine the market variables, including who the payers are, how predominant the payers are, reimbursement trends and issues, and what are the driving forces and competition, advises **Robert Zasa**, MSHHA, FACMPE, managing partner with ASD Management.

"Consider physicians' specialty areas in terms of their ability to control that particular specialty in that market," Zasa says. "These are the factors that tell you which way to go, who's going to own majority shares."

Physicians mostly own the majority interest, and the split is 51 to 49, if the hospital starts the process, Zasa adds.

ASC owners also should determine if there's enough upside to the joint venture that both parties will gain from it, he adds. These agreements typically are LLCs, for-profit joint ventures in which each partner is compensated based on the negotiated ownership. So, if the ASC owns only 10% of the joint venture, then they receive only 10% of the profits, Zasa explains.

"Sometimes, a hospital has a for-profit entity within a nonprofit that does investment in these organizations," he explains. "However it's structured, it's going to be reportable as profit, and everyone wants it to be profitable."

When structuring a deal, Lambert says, ask these three important questions:

1. How much will the hospital pay to buy in, and how much will they own?

2. How will the relationship affect the center's access to payers, and could the ASC improve payer rates at all?

3. Will the ASC see more patients because of the joint venture?

"Those three points are 80 to 90% of what's important," Lambert says. "The remaining things are governance types of issues."

For instance, will the ASC retain the right to govern its own operations? This one is very important, Lambert notes.

EXECUTIVE SUMMARY

When considering a joint venture with a health system, know which questions to ask and what type of agreement will work.

- Study market variables, payer mix, reimbursement trends, and driving forces.
- Ask how much the hospital will pay to buy in and how much they'll own.
- Make sure the ASC's role is defined clearly.

"Hospitals are used to dominating things they're involved with," he explains. "And, unfortunately, they tend to be dismal at managing outpatient operating rooms efficiently."

A typical hospital outpatient OR will do about a third of the cases in a given period of time, compared with a well-run ASC, Lambert says.

Lambert's advice is for ASCs to not let the hospital system be in charge of operations. "Surgery centers have to be more efficient because they get paid half or less what a hospital is paid for the same patients," he says. "If the hospital brings a hospital's inefficiency to the center, then they won't make money anymore."

When writing the joint venture agreement, ASCs should make sure their role is defined in the agreement, says **Tracy Hoeft-Hoffman**, MBA, MSN, RN, CASC, administrator of Heartland Surgery Center.

"Clearly identify the roles, and it depends on the hospital's percent of ownership," she says. "If they have a 20% ownership, it's very much a minority ownership. But many own 51%."

ASC leaders also should pay attention to possible philosophical differences between hospitals and ASCs. For example, surgeons typically start surgery centers to improve care quality and control their work environment, Lambert says.

"The number two benefit is they get two to three times more done in a day's work in their own facility, compared to the hospital," he says.

This productivity difference could be a deal changer for surgeons considering a hospital-ASC joint venture.

"It would really crush surgeons' practice productivity if they were reduced to a hospital-based outpatient department's type of speed in their surgery center," Lambert says.

Through more productivity and efficiency, ASC surgeons can complete as many surgeries in one day as a hospital-based surgeon can in two and a half days, and surgeons see the slower output as a waste of their own time, he offers.

"That would crush the throughput of the practice, and physicians would see a 30 to 40% reduction in profitability," Lambert says.

Hospital leaders might agree when the joint venture begins that the ASC could manage its operations. But ASC leaders should be alert to changes in the hospital's management. A new administrator could have a different view and change things, he notes.

"There's a lot of turnover in hospital administration," Lambert adds.

Some surgery centers will hire management development companies to help them protect the ASC's interests during and after a joint venture, Lambert says.

"It's very common for hospital-ASC joint ventures to also have a development management company that's part of the joint venture," he adds. "It provides some balance because a hospital can overwhelm what used to be a physician partnership, and physicians are at risk of having their desires ignored."

ASCs should walk away from a possible hospital joint venture when it appears the hospital's goal is to run everything their way or to simply buy-out the competition with plans to eventually close the ASC, Zasa and Lambert say.

"The onus is on the proposed joint venture partner to demonstrate why it will benefit an existing center that has heretofore been successful," Lambert adds. ■

Learn More About Payers to Improve Collections Success

Surgery centers must understand the payer landscape, compartmentalize payer categories, and create strategies for each one. Without this multimodal line of attack, they could leave themselves open to thousands of dollars in unpaid bills.

Medicare payments are predictable, so long as a surgery center submits claims correctly. Medicaid payments vary from state to state. Government healthcare payments do not pose the same issues for ASCs as private pay.

To determine ways to improve collections from private payers, learn what you can about each entity, advises **Lisa Rock**, president of

National Medical Billing Services. Rock speaks regularly at national conferences on the topic of how ASCs can improve their collections. She offers the following suggestions:

1. Look at each category of private payers: patient, self-funded, and fully insured.

ASCs usually will need to collect some portion of the procedure cost from patients due to copays, deductibles, and out-of-network costs.

Surgery center administrators must know the difference between self-funded and fully insured coverage. Self-funded refers to plans that employers pay for. They can be administered by Blue Cross Blue Shield and other payers, but the employers bear the costs. They are incentivized to keep their employees healthy to reduce healthcare spending.

"Health insurance premiums are really expensive, and employers feel they can save costs by cutting out the middleman," Rock explains. "It's true they can save significant money by paying their own claims and stop loss coverage."

Fully insured coverage refers to traditional healthcare insurance, and these plans are regulated differently than self-funded plans.

"If it's fully insured, the carrier is paying the bill," Rock says. "For fully insured plans, carriers hire actuaries and calculate premiums and give all different [types of] benefit packages."

There are numerous benefit configurations, depending on what the employer's preference. Patients pay the costs of surgical procedures that are not covered by their insurance. These can include high deductible amounts, copays, and the excessive charges from using an out-of-network provider.

ASC staff usually can find out whether a patient's plan is self-funded or fully funded by looking at their insurance card, which often states "self-funded" when that's the case.

2. Determine what patients and insurers will pay.

The difference between a surgery bill and what the insurance company will allow can be striking. For example, a patient with a self-funded employer who hires low-wage workers comes in for surgery. The employer's plan pays only 160% of Medicare for out-of-network services.

Suppose the ASC submits a claim for $10,000 for the surgery. Medicare would allow only $1,000 for the surgery, so the employer will pay only $1,600. On top of that, the patient carries a high deductible, and the employer ends up sending the ASC a check for $300 for the $10,000 bill. The rest of the bills are the responsibility of the patient, who likely will not be able to pay much of that outstanding $9,700, Rock says.

In this example, when the ASC receives the $300 check, the first instinct is to file an appeal. But that won't work because the self-funded employer paid exactly what their plans says they'll pay. "You're going to waste a lot of money when you're appealing and don't know what you're appealing," Rock says.

This is why it's crucial for ASCs to know these rules going into each and every case so they won't be blindsided by denials at the end.

"You can start the process to qualify patients [by knowing] what their coverage is and how it works," Rock says. "You'll be more successful that way."

"I used to work for an insurance company, and we had 800 denial codes," Rock says. "I would recommend converting all of your denial codes to one system so you can track them, and I'd recommend having a very specific appeals process and to understand whether the appeal goes under ERISA or under the fully insured product that is governed by the state or the patient."

3. Know how to handle appeals.

ASC directors should understand the three different categories so they can better understand what their options are if a surgical bill is underpaid or unpaid, Rock says.

"Let's say I have a denial, which is anything less than the full value of that claim because even a partial payment is a denial that needs to be worked out," she explains. "So, I'm sending in an appeal."

If the appeal is going to a self-funded plan, it's governed by one law (ERISA), and there are certain rules to follow, including the most basic one of gaining permission

EXECUTIVE SUMMARY

Learning more about the payer market can help surgery centers reduce denials and improve collections.

- Self-funded plans are offered by companies that pay to insure their own employees.
- Fully insured coverage is what people think of as traditional health insurance. These are regulated differently than self-funded plans.
- Patients must pay for their copays and deductibles.

from the patient to make the appeal, Rock says.

Under ERISA, ASCs and other providers are not entitled to appeal unless they have received permission from the patient in writing and include that permission with their appeal. If an ASC sends in an appeal without following the rules and submitting the patient's permission, then the appeal will not be accepted.

"You appeal differently for fully insured plans than for self-funded," Rock says. "Those are governed by the state insurance commission. ERISA plans, typically, do not have to abide by state laws."

Information about ERISA claims can be found at: http://bit.ly/2fnujCB.

4. Understand what your net revenue is.

Knowing net revenue can help with collections, Rock says. For example, if an ASC administrator knows that the center's patient base is all in-network and fully insured, then it's possible to determine reimbursement and revenue, she says.

It's more challenging to predict reimbursement and revenue when patients present with high-deductible health plans and self-funded employers with different policies or erratic reimbursement policies.

"Everyone is tired of paying high medical bills," Rock says. "Everyone is trying to figure out how to get control of that so people can get the care they need and providers are paid a fair price for their services. You have to understand how this business works to master it."

A surgery center is a business, and someone must lead it as such. "The number one problem I personally see is a lack of respect for the complexity of the revenue cycle," Rock says. "It is really complicated, and that's not just the collections, but everything leading up to it."

An ASC must stay on top of balancing, coding expertise, managing contracts, and knowing how to read the contract and pull it through the whole revenue cycle, she adds.

5. Avoid payer negotiation pitfalls.

There are multiple tricky aspects to negotiating with payers. For instance, an ASC could negotiate certain rates per CPT code. Then, the carrier could add a statement to the contract that says the carrier can bundle codes within a case. So, the ASC submits, for one case, two CPT codes to the carrier. The carrier pays only one, sending the ASC less than what was expected. The reason for the difference is the carrier says the additional CPT code was incidental, Rock explains.

"You get really busy, working at a surgery center, and the last thing on your list is doing due diligence of insurance verification," she says. "You could ask the patient to get a copy of what they're supposed to pay for in- or out-of-network, or see if they have it, but it's a lot of work. Some self-funded plan descriptions are 200 pages long, so you can check the benefits, but there is no guarantee of payment."

6. Make it easier for patients to self-pay.

Collecting from patients can be difficult, particularly if they were not prepared for a big bill. It's not that easy to write off the patient's debt, either.

"When patients owe a lot of money, you can't write it off unless they're financially or medically indigent or if it's a bad debt," Rock says. "If you can't write it off, then you have to attempt to collect, and it's expensive to send out statements."

Rock recommends ASCs create patient portals to reduce the overhead of people continually calling or writing to patients. "Go electronic with the statements, and this will help offset the cost of collecting," she offers.

These portals should be secure websites where patients can make payments. When ASCs create these portals, they typically see an increase in collections, she adds.

7. Watch for changes in payer trends.

ASCs are starting to see a trend in which some ASCs are sent more patients by carriers because of their tier rating, which is determined by their costs, Rock notes.

"We're starting to see this waiver of copay deductibles for tier one providers, and so they're driving the business to tier one providers," she explains.

The payer tells patients that if they visit an ASC or professional provider that is a tier three, patients will pay a copay and large deductible. If patients go to a tier two ASC, then the insurance will waive half of patients' out-of-pocket costs. But if patients visit a tier one ASC, the insurance will pay the whole cost, meaning the patient owes nothing, Rock says.

"Imagine your doctor says you need hernia repair, and you call your insurance company, and they say, 'If you go to this other doctor, you won't have to pay anything,'" Rock says. "It's an interesting way to attempt to control costs."

For ASCs that are designated tier two or tier three, this can affect both their volume and their collections. "Volumes are going down if you're a tier two or tier three, and it's just beginning to happen," Rock adds. ■

Follow These Steps for Analysis in Infection Investigations

Historically, ASCs demonstrate very low surgical site infection rates. One study found a surgery site infection rate that ranged from 0 to 3.2% for common procedures.[1]

Because ASCs experience high patient volumes, any lapse in infection control best practices at an ASC can create major problems. The way to prevent a post-surgery infection outbreak is to follow quality improvement steps in surveillance, detection, analysis, and process changes, says **Elethia Dean**, BSN, MBA, PhD, chief executive officer of ASC Compliance, an organization that works with ASCs on accreditation and regulatory compliance. Dean offers the following best practice steps in infection surveillance, control, and compliance:

1. Conduct active surveillance to identify post-surgery infections.

"The incubation period for bacteria is usually days or weeks after surgery, so it's not always possible to identify infections prior to the patient leaving the ASC," Dean says.

ASCs must actively identify these post-surgery infections, typically up to 30 days out.

One option for infection surveillance would be to ask the patients if they have experienced an infection after the procedure. Some ASCs call patients directly, but there is a drawback: "Some patients interpret redness as a sign of infection," she notes. "You get better data if you go directly to the physicians."

2. Look for infection trends.

There are a lot of potential trends, including two or more infections with a common medication, operating room team, specific surgical equipment, equipment sterilization methods, and recovery practices.

"Did you look at when the infections occurred, which day, week, month? Is there a trend where something is happening every Tuesday? Is there a particular physician who has infections?" Dean asks. "Look at everyone who [is involved with] the patient to see if there is a commonality. Look at all staff, instruments, medications given, anything and everything that touched the patient."

ASCs must ask these questions and investigate every single infection.

"What is required by CMS is that you do active surveillance, and then you will want to make that a part of your quality assurance/performance improvement [QAPI] program," Dean explains. "Every problem reported into QAPI should be investigated, and infections should definitely be part of QAPI."

The more data collected and reported, the easier it will be to find trends. For instance, there is not a regulation that requires someone record lot numbers of medications in the medical record. However, if there is an infection outbreak and the causative agent is a particular medication, it will be almost impossible to trace it to a certain lot number, Dean cautions. In this situation, the ASC is at higher risk of taking responsibility for the infection when the problem was actually caused by the medication manufacturer. Therefore, every ASC should keep up to date on medication recalls, regardless of whether patients exhibit infections, Dean recommends.

3. Take action, depending on findings.

If there is no discernible trend, then the ASC could look at differences between the patient who exhibited the infection vs. patients who underwent the same surgery without an infection. This assessment also might show a trend that could suggest better practices.

"Once a comparative analysis has been performed between infectious and noninfectious cases, changes can be made in order to achieve best practice," Dean says. "This may be a change in medication lot numbers, training of staff, housekeeping changes, etc."

Some of the usual infection control retraining strategies might include checking staff's hand hygiene practices as well as cleaning and sterilization procedures.

"Make sure staff are aware of cleaning the OR and know how to maintain a sterile field," Dean suggests.

4. Follow up on the QAPI process.

"Go back and check to see if there are any more infections and check for trends again," Dean says.

For example, an ASC might register one infection. Then, the next month, there is another one. The month after that, there's a third infection. "That's trending, and you have to look at commonalities between the three," Dean says. "It's not that once you finish it, you're done. Sometimes, you make a corrective action, and that may or may not solve the problem."

The QAPI process requires restudy of the problem to make sure the corrective action solved the problem

effectively. If it doesn't solve the problem, it could be that there was more than one factor that led to the original infection case, Dean notes.

Although there is not a national infection reporting requirement for ASCs, some states require reporting. When ASCs are inspected, most surveyors will look at reported infections to see if there is a trend and to make sure quality of care is maintained, Dean says. ■

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Surgery Center Finds Success With High-acuity Spine Cases

Start slowly with a test case

ASCs that are expanding their services might find that high-acuity spine cases can work well. Some strategies for expanding into spine cases are similar to expanding into total joint cases.

CMS still does not cover some spine cases, such as lumbar fusions, but ASCs can perform these for commercial payers, says **Lianne McDowell**, CASC, administrator at South Portland Surgical Center in Tualatin, OR. But it will only work if the ASC can control its costs, she cautions.

"It's good to have someone on staff who is savvy about costs and recovery times," McDowell says.

McDowell suggests taking the following steps when starting a high-acuity spine program:

• Step 1: Identify patients by checking data. Start with a checklist of patients who are healthy enough to undergo surgery in an ambulatory surgery setting and who are not on Medicare, McDowell says. Then, ask a spine surgeon to send information about one of these patients to review the case and payer. This first patient will serve as a test case to see how well the procedure will work, financially, for the ASC.

The patient's insurance and the patient — through copays — would spend more in a hospital outpatient setting, and the ASC administrator can use this as leverage when negotiating with the insurer, she suggests.

"Patients are becoming more savvy about costs, and this allows me to push with the payer to use their benefits to do a carve-out to get the procedure covered," McDowell says. "The patient wants to come to the ambulatory surgery center because he will pay less money and go home the same day."

When negotiating with commercial payers, be prepared with invoices to make them aware of the ASC's costs, she adds.

"I know they'll pay less if the patient comes to the ASC, and sometimes that can be a factor," McDowell says.

So far, the response to these requests has worked well. "It's a win-win-win: a win for payer, a win for facility, and a win for patient," she says.

• Step 2: Once approved, work on completing the contract. After an ASC receives approval, the next challenge is to move the case through quickly. The payer might have approved the surgery in a same-day surgery setting, but this doesn't mean they plan to pay enough to make the case worthwhile to the ASC. So, more negotiations are necessary.

"They might say, 'I'll give you $10,000,' and I say, 'I need $15,000,'" McDowell says. "Look at your costs and time involved and know the patient's benefits, too."

There likely will be a back-and-forth discussion on the amount paid to cover the procedure and on how to negotiate and approve the contract in a timely manner. They might ask for two months to push the contract through all the appropriate approval channels, and the ASC administrator can lobby for it to happen in three weeks, McDowell explains.

"The contract manager can negotiate, but will still need approval from someone higher up," she adds.

• Step 3: Manage the patient's time in recovery and expectations. The patient should know that he or she will go home on the same day of the surgery. Make sure the patient understands the time it might take to recover, whether it's four hours or 12 hours — in the case of ASCs that are authorized to offer 23-hour stays.

The ASC also must be sure the recovery period is manageable. For instance, if the patient experiences pain that is not well managed, then it's possible the ASC will have to transfer the patient to a hospital, which would be a poor way to start with spine surgery cases, McDowell says.

"You have all of these costs when patients stay longer, including staffing time," she adds.

A good strategy for managing recovery time is to work with surgeons, McDowell says. There should be some communication about the surgeon's expectations for the first high-acuity spine case. For example, the surgeon might request the patient stay for 23 hours, just for observation. If this occurs, the ASC must make two nurses available to staff the center overnight. This raises the procedure cost and could result in a financial loss for this test case, McDowell warns.

"If you feel you could afford that loss, then take that data back to the payer and say, 'Here's patient Jones, who stayed the night and went home, and, now, can we talk about getting this procedure carved out and doing more of them?'" she says.

• **Step 4: Push forward.** "Don't just do one case if you're successful at it," McDowell says. "Make sure surgeons are mindful of how we did this lumbar fusion, and it went great."

Talk about how it worked and what made it successful. Soon, other surgeons might be comfortable with cases like this one. Part of moving ahead is collecting solid data. McDowell has used data as part of renegotiations with payers.

"I got a spine surgeon involved because we wanted to get better payment because of the costs — even though we worked hard to bring down costs," she says. "We had real data showing how we were really bringing down our costs."

McDowell showed data on the ASC's costs in 2011 when it opened and compared these with current costs or a particular cost-intensive procedure.

"Costs decreased by 44% because we worked with vendors to bring down the costs," she explains. "We even brought disposable supplies down 28% for one spine procedure."

The ASC administrator also can show how some expenses, such as labor costs, will not decrease.

When McDowell engages in these discussions with payers, she starts with the highest-cost cases to show them that data.

"Once you get the contract, work to continue to bring it down to a lower cost," she offers. "I always start with the highest cost and most complex ones, like artificial disc replacement, and I show payers how we've worked to bring down costs."

Lowering costs also will help keep the ASC competitive should Medicare start covering these cases.

"Medicare pays less, but if you get your costs down, it will work," McDowell says. "What kind of opportunities do you have to make it feasible to bring down costs and add these cases to the center without losing money?" ■

SDS Manager

For Your Consideration: A Few Interesting FAQs and Answers

By Stephen W. Earnhart, MS
CEO
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Austin, TX

We receive several dozen questions per month from individuals via our website, texts, phone calls, or email. Our staff can answer most questions easily. For example: "What does Medicare reimburse for a certain CPT code," or, "What requirements does a certain state mandate for overnight stays?"

Fortunately, staff push some of the more interesting questions to me, which I enjoy. The more difficult the question, the more I like it. Over the years, I have shared (always anonymously, of course) some of my favorites. Here a few from the past month:

Question from a business office manager in a freestanding ASC: "We are struggling to find an effective way to communicate with our patients after they leave the facility. We have tried phone calls, text messages, emails, Pony Express — you name it. Any ideas?"

Answer: Since you are trying to reach them after surgery, someone in your center had the opportunity to ask the patient for the best contact information. If the patient offered the information but the patient doesn't respond when you try to contact them, then leave the patient alone. We all experience privacy violations via robocalls, spam, and

vendors. As important as we think we are, not everyone concurs. Many surgery patients see us as a place for some episodic event in their life and they don't necessarily want continued dialogue with us. Respect it.

Question from a surgeon investor in ASC: "I am an investor in a surgery center. Our management company is selling shares to an equipment vendor, not another surgeon. I didn't think that was legal, but I don't want to bring it up if I am wrong."

Answer: It is not "illegal," but there are two issues here. First, check your partnership agreement. Typically, when any partner in an ASC sells all or part of his or her shares, the person they sell it to has to be approved by the other members first. Also, those existing members usually have the "right of first refusal" to purchase those shares for sale.

Second, anytime non-surgeons purchase ASC ownership (i.e., anesthesia, management companies, or others who do not actually perform procedures in the facility), it can raise red flags with the "safe harbor" issues (which are too detailed to explain here). Check your partnership agreement, and ask your management company about any safe harbor issues.

Question from an RN who works in a hospital and moonlights in an ASC: "Our hospital has an electronic medical records (EMR) system that is not very good, but the surgery center I work part-time in doesn't have anything. Everything is paper and logged on Excel spreadsheets. As bad as the hospital system is, it is certainly better than the surgery center that has nothing. My boss at the hospital told me that the surgery center I work at is required by Medicare to implement this system and that what they are doing is against the rules of Medicare. I don't want to leave the job at the ASC because it is a fun place to work and I need the extra money, but I don't want to jeopardize my license by doing so."

Answer: Keep your part-time job. Medicare (CMS) does not require licensed ASCs to maintain an EMR (not yet, anyway). It is coming, and many freestanding surgery centers already put an EMR in place for the same reason you cited: It is better than paper. However, Medicare does have very specific regulations on documentation of data, which CMS monitors. Chances are that the surgery center you are working in is in compliance.

If you would like to ask questions, please feel free to send them.

Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575; Fax: (512) 233-2979; Email: searnhart@earnhart.com; Web: www.earnhart.com. ■

Making the Most of a High-deductible Plan Environment

One ASC achieved 100% cash collection

It was just in one summer month, but Bluffton Okatie Surgery Center in Bluffton, SC, logged a cash collection rate of 100.2%.

"We overcollected and then refunded," says **Terri Mahoney**, BN, CNOR, CASC, administrator of Bluffton Okatie. "We collect up front. Refunds seem to be a little higher, but we're OK with that."

That percentage rate might be exceptionally high, but the ASC typically collects from patients at a very high rate, Mahoney says. Here is how:

• **Always obtain an accurate preauthorization.** It takes time and staff effort, but it's well worth it, Mahoney advises.

"You need accurate information from the physician's office," she explains. "When they tell you the CPT code for the procedure, you can get an accurate preauthorization on that CPT."

This way, the ASC knows what its payments are and how much will be owed out of pocket. If the doctor's office sends the wrong code or information, it can create a major headache for all involved. The patient might already be booked for surgery, when the accurate cost estimate is discovered, and it means the patient will have to spend more out of pocket.

In these cases, the ASC will offer a payment plan for the patient. Everyone will make this kind of mistake at some time, but surgery centers can learn from their mistakes, Mahoney notes.

• **Engage in an up-front conversation with patients.** "High deductible plans have increased,"

Mahoney says. "We call patients as far in advance as possible."

The surgery center also uses a software system to help patients see how much of their deductible remains.

"We use software to find out what their financial obligation is three days in advance," Mahoney says. "You don't want to do it too far in advance."

It's possible a patient's recent hospital or doctor's visit had not yet shown up in the system, reducing the remaining deductible. It's best to wait as long as possible before collecting that information. Bluffton Okatie makes certain all patients know that the center expects them to pay what they owe before or soon after surgery.

"We expect to collect up front everything that is owed in the deductible and copay. It doesn't always work, but you go from there," Mahoney says.

Patients should know well in advance that they'll need to come up with a plan to pay for the procedure. Occasionally, a patient will say the timing doesn't work for them, financially, she says. At a minimum, the ASC asks patients to pay 50% of their bill on the day of surgery. Then, they have three months after the surgery to pay the remaining bill, Mahoney explains. "The majority of people want to pay their bills. People are pretty good with commitment and being realistic about what they can and cannot afford."

• Offer simple credit options. In addition to accepting several major credit cards, the ASC accepts payments from a healthcare credit card. Patients can apply for one and use it to pay their medical bill.

"We have noticed a large increase in how many people are using the card," Mahoney says.

Often, the card will give them a 12-month, interest-free loan. The ASC pays a fee for each bill that the card pays, Mahoney says.

"You have to be careful because the fees for the facility can be quite high," she warns.

Patients must be approved based on their credit rating. If approved, perhaps they could choose to pay off the balance in 12 months, 24 months, or 36 months. The surgery center is charged a fee that varies according to how long the patient's repayment time is. The longer the repayment time, the more the credit company charges the ASC.

"We only accept the ones that have to pay it off in 12 months or less," Mahoney says. ■

CME/CE QUESTIONS

1. **When an ASC structures a joint venture deal with a hospital/health system, which of the following is an important question to ask, according to Luke Lambert, MBA, CFA, CASC?**

   a. How much will the hospital pay to buy in, and how much will they own?
   b. How will this relationship affect the center's access to payers, and could the ASC get any improvement on payer rates?
   c. Will the ASC see more patients because of the joint venture?
   d. All of the above

2. **What is the difference between self-funded and fully insured healthcare plans?**

   a. Self-funded is when the patient pays without insurance. Fully funded means the patient carries third-party insurance.
   b. Self-funded is how health insurance plans are defined in 10 states. Fully insured is the terminology used in 40 states and the District of Columbia.
   c. Self-funded refers to plans that are paid by employers, but could be administered by Blue Cross Blue Shield and other payers. Fully insured coverage refers to traditional healthcare insurance, and these plans are regulated differently than self-funded plans.
   d. None of the above

3. **Which of the following is not a potential source of a trend in post-surgical infection?**

   a. Common medication
   b. Payer source
   c. Operating room team
   d. Equipment sterilization methods

4. **What is a good first step for a surgery center to take when the goal is to improve its rate of cash collections?**

   a. Set up a list of patient payment plans and terms.
   b. Always get an accurate preauthorization.
   c. Direct surgeons to call patients to remind them of their surgery bill.
   d. All of the above

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