ASC Review
BECKER'S
PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Interview With John Poisson: A Temperate View of the GI Medicare Payment Cuts

By all accounts, GI as a specialty — and especially GI ASCs — will be hit the hardest by CMS's restructuring of the ASC payment system. But the situation is not as dire as it may seem at first glance, notes John Poisson, the executive vice president at Physicians Endoscopy, which works exclusively with the same GI facilities seemingly doomed by the ACG.

"We're in the process of going through a site-by-site analysis to determine the impact at each facility," he says. "You really need to look at all your payers and not just Medicare in determining what will be the real impact on your center."

And when Physicians Endoscopy does that calculation, "not taking into account payment increases from non-governmental payers over the next couple years, we're seeing an impact of only about 1 percent per year average reimbursement per procedure," says Mr. Poisson. For a center that does 11,000 procedures annually (34 percent of them being Medicare and commercial Medicare patients), the bottom-line impact is only $60,000 total (see "Breaking Down GI Cases" on page 3).

"That's only three endoscopes in the grand scheme of things," he notes.

Further, says Mr. Poisson, there are four key steps you can take to make up for this estimated result of the GI cuts in your ASC.

1. Stay on top of third-party payers. "Keep non-governmental payers on a regular renegotiation schedule," says Mr. Poisson. "Whenever we do that, usually every 18 to 24 months, the vast majority will provide rate increases. It may be 3 to 5 percent — though in some cases up to 10 percent — but any rate increases there will help offset increases in expenses and decreases in governmental reimbursement. If you haven't renegotiated in the last two years, do it."

2. Examine supply costs. "Another big-ticket item to take a look at is supplies," he says. "Are you part of a GPO? If not, look into it. On the expense side, you have to pay for the correct staffing levels, but you should be making every effort to get supplies at a good price."

3. Assess room utilization. This is a very important decision the board needs to make regarding what it will and won't require of utilizing physicians and physician-owners alike. "Clearly with GI cases, everyone would like to do them in the morning, but you're paying for the room all day," says Mr. Poisson. "So we tend to see very high utilization

rates in rooms in the morning, typically greater than 95 percent. But in the afternoon it often plummets to the mid-70s. Yes, it's hard to ask a patient on NPO to come in at 3:30; however, it's very important to examine whether you're running rooms at lower utilization for physicians' convenience or because you don't have the cases."

4. Bring in the cases. Are you getting all the cases into the center that you thought you'd get? "The biggest impactor there is not necessarily the physicians, but the schedulers in their professional practices," says Mr. Poisson. "It's by far the biggest barrier when opening a new center."

As a result, you have to network with their schedulers and make their lives as easy as possible, especially if the physicians are utilizers and not owners.

"The hospital takes all insurances and all acuity. Schedulers don't have to think, just schedule patients in. In the ASC, you have to deal with those things; there are more challenges in scheduling, particularly during the startup phase," he says. "Provide schedulers with a script that lists what to say and where to say it. [I need to remove the incentive language, sorry. Here is a substitute:] The schedulers truly want to do a good job, but its very easy to fall back into scheduling patients at the hospital because it's less work and less challenging. We encourage the physicians to monitor the scheduler's interactions with patients frequently in the first few months—you need to trust they are doing what they've been asked to do, however verification by management is critical."

Further, the four-year phase-in will help offset declining Medicare reimbursements, especially in GI.

"Reimbursement is clearly going down," says Mr. Poisson. "But you can't look at it in a vacuum; if you do, the situation is horrible. The average center's cases are two-thirds non-governmental payors. If you integrate Medicare payments with the rest of your payer mix, the situation is not nearly as Draconian as has been broadcasted."

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Breaking Down GI Payments

• 2007: $446 is the average per-procedure reimbursement across all procedures
• 2008: $441
• 2009: $439
• 2010: $437
• 2011: $439

According to Physicians Endoscopy's calculations (which are derived from using the AAASC calculator located at www.AAASC.org), which don't take into account any cost-of-living increases that may later be built into payments, there's only a $7 per-procedure average difference.

"That's why case-costing is so important," he says. "Say the center is doing 30 procedures a day, you're down $170. If you're able to schedule just one more patient in that day over your typical utilization, you're up.

"The profit-drivers in ASCs are always volume and utilization, those are always the biggest bang for you buck. No. 2 is the payer rates, third tier is expenses. Get the right staff, don't overstaff. Then you can focus on things like extending scope life, better purchasing power with a GPO, things of that nature. "