



Is There an ACO In Your Future?

Forecasting your facility's role in accountable care organizations.

How will accountable care organizations impact ambulatory surgical centers? ACOs — essentially HMOs with open networks — won't be game changers for ASCs, but they could be nice fits if they catch on.

The Patient Protection and Affordable Care Act, signed into law last year, lets accountable care organizations “manage and coordinate care for Medicare fee-for-service beneficiaries.” ACOs that successfully lower healthcare costs while satisfying specified benchmarks will receive a cut of the money that Medicare saves. The 1,400 pages of legislation and 400 pages of regulations (with more surely to come) that make up the healthcare reform law blueprint ACOs as follows:

- Each ACO has to submit an application to CMS detailing how it plans to deliver high-quality care at lower costs to the Medicare beneficiaries it serves.
- Each ACO must agree to accept responsibility for 5,000 beneficiaries.
- Patients can choose to receive services from outside an ACO, and can opt out of its data-sharing arrangements.
- In order to share in Medicare's savings, ACOs are accountable for meeting or exceeding 65 CMS-developed quality performance standards.

Barriers to banding together

Provide better care, reduce overall healthcare costs, share in the savings. Sounds like a great idea, right? Providers nationwide, primarily hospitals, are scrambling to position themselves for the advent of ACOs.

Not so fast. Technical deficiencies in the proposed regulations and practical challenges to implementation raise significant questions as to whether ACOs will take over the healthcare landscape. For example:

- Patients cannot be controlled. Each one has the ability to opt out of an

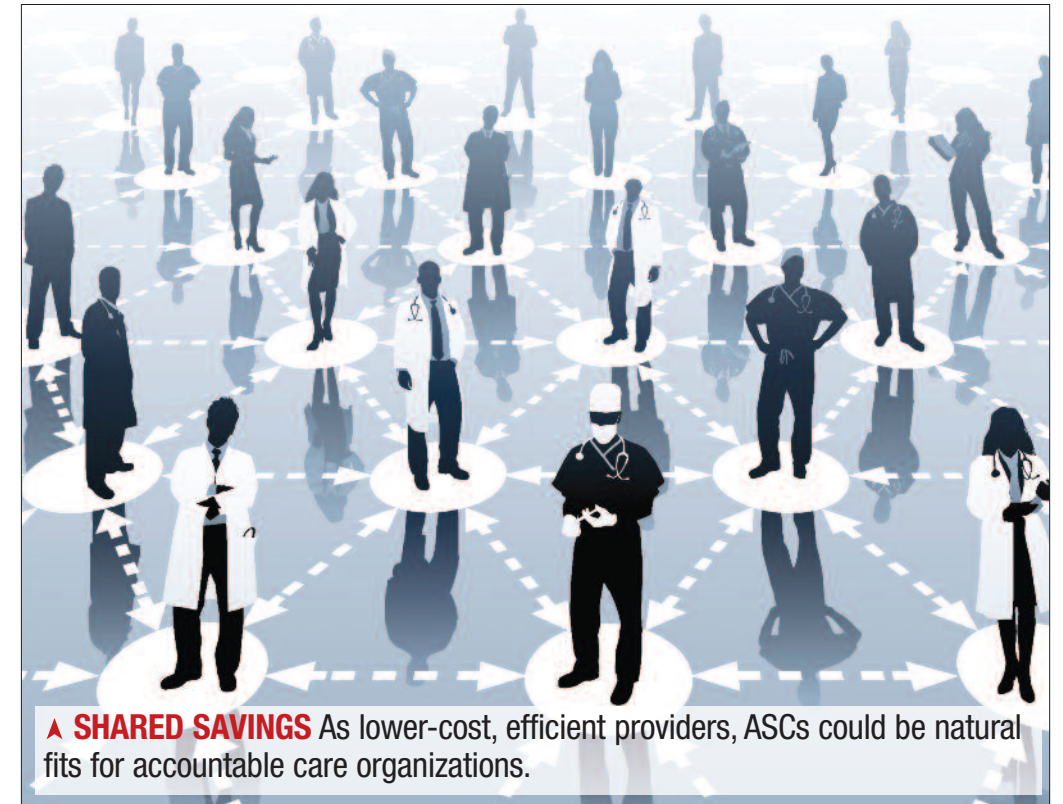
ACO and to decline to participate in its data-collecting reason for being. If you can't control patients, how can you control costs?

- It's not yet clear how patients will be assigned. CMS is proposing a retrospective method, but is also seeking

comments for its final rule on whether a prospective method would be more effective. Patient assignment could end up quite messy, especially since ACOs will have to accept any high-risk beneficiaries assigned to them for care, or else face penalties.

- Establishing an ACO will require significant organizational and information technology investment with no guaranteed upside.
- The proposed ACO rule imposes 65 performance metrics, making it almost impossible to track real financial or clinical outcomes.

It's also not clear whether federal agencies will be able to reconcile a myriad of conflicting rules and regulations that could hinder the ACO concept. The Federal Trade Commission and Department of Justice don't appear totally comfortable with the potential anti-competitive aspects, for example. CMS and the Office of Inspector General are still formulating policies relating to



the Stark Law, the Federal Anti-kickback Statute and civil monetary penalty laws. And the IRS is requesting comments on whether existing guidance over tax-exempt organizations planning to participate in ACOs and Medicare's shared savings program is sufficient or more guidance is needed.

The healthcare reform legislation driving the creation of ACOs faces its own hurdles, casting doubt as to whether it will ever be fully implemented. Several state lawsuits currently challenge its constitutionality, with federal judges so far splitting the decision. The U.S. Supreme Court has denied a request to immediately review the Virginia case, *Cuccinelli v. Sebelius*, and it will proceed through the intermediate federal appeals process, but it will likely reach the high court within the next year.

Plus, healthcare reform will most likely be a major issue in the 2012 presidential election, with Republicans gunning to dismantle it in the meantime. Even if President Obama is re-elected, the opposition will continue, especially if Republicans maintain control of the House of Representatives and gain seats or a majority in the Senate.

An ACO role for ASCs?

If these obstacles can be cleared and ACOs become prevalent, there will without question be a role for surgical centers in ACOs. As a lower-cost, more efficient provider of care, ASCs are a natural fit for a model emphasizing economy and quality. The question is how they would fit in. It seems unlikely that ASCs would remain independent. Why would hospital or primary-care-physician-driven ACOs direct cases to ASCs in which they didn't

have a financial interest?

The recent increase in hospital-physician joint ventures is partly in response to healthcare reform. But it's likely that real change in the ASC business comes not from federal mandates but from innovation in the private sector, through gain-sharing and other risk-shifting arrangements. ASCs will always have a role in the system — though who will own and control them is a fair question to ask.

Current ASC owners should position themselves for the future. Specialists should form large practice groups to protect their position in the market and, by extension, their ASCs. Development and management firms holding clusters of centers in a given area would be wise to encourage the consolidation of practices.

The benefits of consolidation are twofold. First, larger groups have more leverage to deal with ACOs in both the medical practice and ASC components of care delivery. Second, even if federal healthcare reform and ACOs fall by the wayside, larger groups will be positioned to make deals within the current system, whether that means traditional managed care contracting or more creative risk-sharing arrangements in the commercial market.

Additionally, larger groups can more readily provide ancillary services, share in the revenue generated from those services and pool resources to upgrade electronic medical records, billing systems and other management infrastructure. **OSM**

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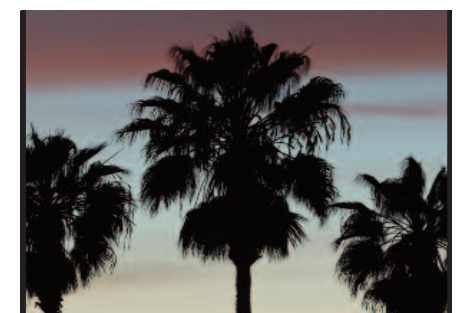
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