Going From OBL to ASC Takes Planning and Expertise

The rewards can be great if the essential factors point to “go.”

by Teri Yates

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In 2022, the Centers for Medicare and Medicaid Services substantially reduced Medicare payments for endovascular procedures performed in an office-based endovascular lab (OBL). Faced with these double-digit cuts, interventional specialists may wonder whether it would benefit them to develop an ambulatory surgery center (ASC) as an adjunct to or replacement for their OBL.

If an analysis of the regulatory environment and economics supports the development of an ASC, physicians must evaluate how to structure the entity to their best advantage.

Regulatory Considerations

The first step is to confirm with an ASC-experienced attorney that the proposed ownership group conforms to all legal requirements. For physician ASC owners to stay within a safe harbor of the federal Anti-Kickback Statute, they must:

- be qualified to refer to—and perform procedures in—the ASC
- derive at least one third of their practice income from performing those procedures.

To stay within the safe harbor criteria, non-surgeons may invest in the center if they are not in a position to refer patients. Other arrangements, such as permitting primary care physicians to invest in the ASC, could expose owners to liability under the statute.

State certificate of need (CON) regulations also play a role in who can invest in the center. Obtaining a CON can be costly, difficult, and even impossible if competing healthcare institutions oppose the project. Workarounds exist in some places, such as Georgia, where an ASC may be exempt from the CON requirement if the facility will only serve the patients of a single-specialty practice.

Capital Contributions and Financing

The ASC entity’s share price must be established based upon fair market value. The share prices cannot fluctuate from physician to physician based on the volume of cases they will bring to the center.

The owner’s initial capital contribution will typically range between $800,000 to $1,200,000, depending on the center’s size. That is not enough money to finance the entire project; owners will need an additional source of funds for construction, equipment, and working capital.

For this reason, physicians sometimes enter a joint venture (JV) with an ASC development and management company. In exchange for the right to purchase a significant percentage of the shares and hold a perpetual management services agreement, the ASC company will put up the additional capital needed to start the project. This arrangement also provides the physicians with the necessary administrative support to launch and operate the center.

Physician owners may find this approach attractive, initially, because they gain a partner with whom to share the

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economic risk. They also may be drawn to this structure because of the significant expertise needed to meet ASC licensure and accreditation requirements. Over time, however, this arrangement significantly limits the economic benefits to the physician owners because of their reduced equity and the high top-line fees charged for management.

Physicians willing to borrow (or self-fund) the additional start-up capital can increase their future returns by retaining all equity in their ASC. In this situation, the ASC owners address the need for expertise by engaging a consultant or management company on a contracted basis to provide start-up, management, and billing services for the entity. Owners then can periodically renegotiate these service arrangements to contain costs or address performance deficiencies, which provides a significant advantage over the JV arrangement where the contracts are perpetual.

Health System Strategic Partnerships

In some circumstances, sharing equity with a strategic partner can increase the ASC's success by generating more case volume. For example, if a physician relies upon a strong hospital relationship to direct referrals to their independent medical practice, creating the ASC as a joint venture with the hospital can protect that relationship. In these situations, physicians see the goodwill and potential for additional hospital referrals as a good trade-off for the possibility of less income.

Physicians can create a governance framework that allows them to maintain control of the ASC's operations. Frequently, the JV partners will appoint a third-party expert to oversee management, ensuring that each investor partner maintains an equitable level of control.

Optimizing Reimbursement

Will you need a JV partner for your ASC? Factors such as payer mix, geography, and patient demographics will heavily influence your answer. Large health systems and ASC management companies that contract on behalf of hundreds of facilities have greater negotiating power with payers. At times, the higher reimbursements that these partners bring in will offset the equity they take in the ASC.

Commercial payers are motivated to migrate as much surgical volume off the hospital campus as possible. For example, United Healthgroup published a research brief in 2021 demonstrating that the cost of surgical care in an ASC is 59% lower than a hospital outpatient department. This translates to an average savings of $680 per procedure for the patient.[1] In markets with limited availability of ambulatory surgery capacity, these potential cost savings can provide physicians the leverage to secure favorable commercial payer reimbursements for an independent, standalone ASC.

The benefits of having a JV partner to negotiate higher reimbursement will be reduced if most patients served in the ASC have a government payer. Endovascular specialists tend to be less constrained by these concerns than physicians in other specialties because cardiovascular disease is more prevalent in older patients.

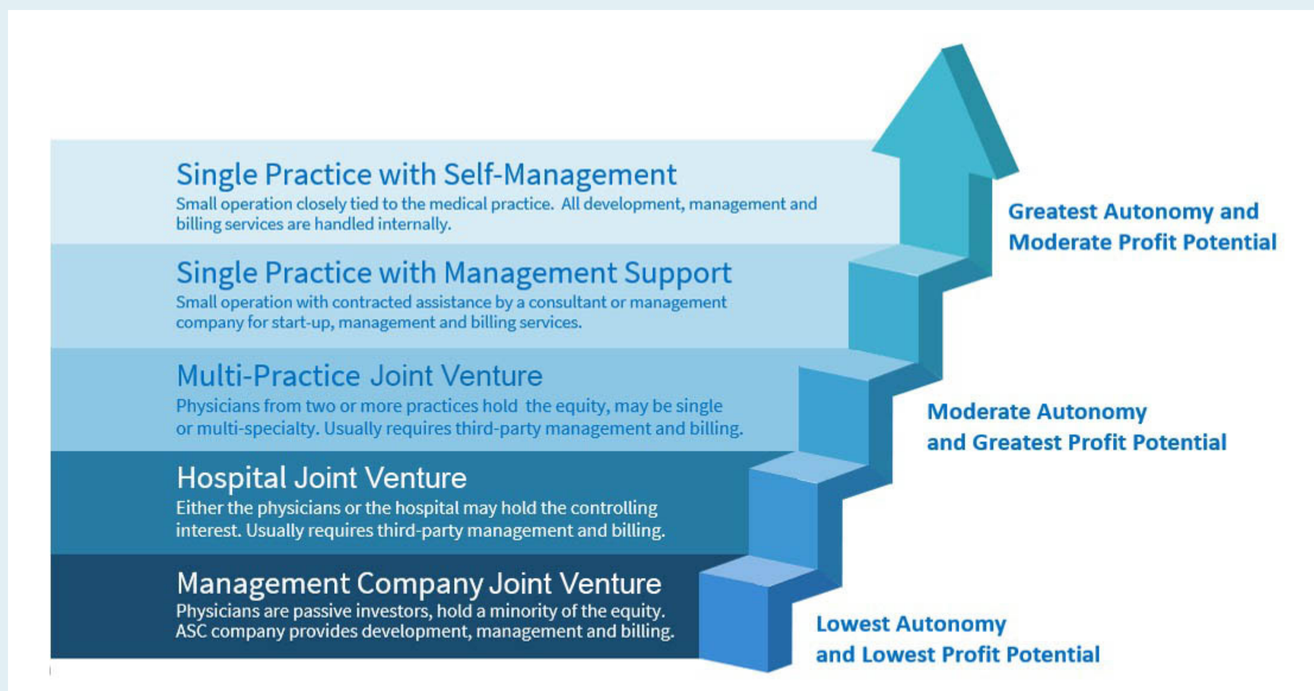

FIGURE 1. Many models exist when it comes to forming an ASC, each with pros and cons.

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The Feasibility Study

For a medical group that already operates an OBL, it may seem like the easiest strategy is to convert it to an ASC or hybrid OBL/ASC. However, few OBLs have been constructed to conform to the 2012 National Fire Protection Association 101 Life Safety Code (LSC) and the 99 Health Care Facilities Code (HCFC). All Medicare-certified ASCs must comply with these requirements, and the cost to retrofit an OBL to comply with LSC and HCFC is usually higher than designing the ASC in a new location.

Because construction costs are very high and the mechanisms for reimbursement are different in an ASC, it is critical to perform a careful feasibility study before proceeding with the project. The study should evaluate factors such as:

- regulatory requirements
- expected procedure volumes
- facility size
- construction, equipment, and operating costs
- reimbursement opportunities.

Be conservative when projecting case volumes and expenses. A pro forma based on realistic projections greatly improves the likelihood of achieving expected results under any reimbursement scenario.

Hire an Expert

Physicians should not expect their medical practice administrator to reliably complete the feasibility assessment unless they have prior experience in ASC management and operation. Lenders evaluating the pro forma and business plan to decide whether to extend financing will often request the qualifications of the individuals leading the project. Given the high consequences associated with making an error, the cost of engaging a qualified expert to perform the feasibility study is an excellent investment.

Reference

1. Shifting Common Procedures to Ambulatory Surgery Center Can Save Patients More Than $680. United Healthgroup. Published September 8, 2021. Accessed March 17, 2022. https://www.unitedhealthgroup.com/newsroom/research-reports/posts/2021-09-08-site-of-service-1010600.html

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