

# A Primer For Surgery Center Investors And Lenders

Law360, New York (January 03, 2014, 5:42 AM ET) --

Before venturing into the ambulatory surgery center (ASC) industry, investors and lenders should examine key drivers and common misconceptions of the outpatient surgery center business to gain initial perspective on this growing area.

## ***1. The ASC market is fragmented.***

Generally, the ASC industry is more fragmented than other health care sectors. According to Hoover's, the top 50 companies generate only 30 percent of the industry's revenues. There are currently approximately 5,000 ASCs nationwide; 1,500 of those are owned in part by management companies and another 1,500 or so are partially owned by hospitals.

## ***2. Observe the ownership structure.***

As with other facility-level health care joint ventures, the most common model by which nonphysician investors participate is through direct equity ownership in a joint venture with physicians (and sometimes also a hospital). Investors will also often invest in a management company that takes a fair market value management fee in exchange for designated day-to-day administrative duties (either for a flat fee, percentage-based fee or a combination thereof depending on the services provided and state law restrictions).

## ***3. Profitability in a surgery center is a fairly simple formula.***

Revenue in a surgery center generally equals the number of cases multiplied by the reimbursement rate (i.e. typically the negotiated in-network rate, or the out-of-network rate as applicable), then adjusted for uncollectible amounts. Thus, assuming that there is a reasonable cost structure in place and a solid billing and collections approach, the profitability of the surgery center is largely driven by how favorable its commercial payor rates are, the total case volume in the center and the mix of cases (by procedure and payor).

## ***4. Compliance with the ASC safe harbor is a best practice.***

The federal Anti-Kickback Statute generally prohibits the offer or exchange of any form of remuneration with the intent to induce or reward the referral of federally-funded health care program patients. If all elements of an Anti-Kickback Statute safe harbor are met, then the arrangement is deemed compliant. If the arrangement does not meet all elements of at least one safe harbor, then the arrangement can be examined by regulators, who largely focus on the intent of the parties underlying the payment.

Anti-Kickback scrutiny applies to dividends received from physician investments in health care ventures such as ASC investments. For this reason, it is very common for surgery centers to attempt to comply with the ASC safe harbor to ensure immunity from prosecution. The ASC safe harbor has several important prongs that must be satisfied (which vary depending on whether the center is single-specialty, multispecialty and/or owned in part by

a hospital), and as noted above, every single element of the safe harbor must be satisfied in order for a financial relationship to be protected.

ASC safe harbor compliance is often memorialized in the governing documents of the entity (e.g., operating agreement) and is part of a robust compliance plan. However, although complete safe harbor compliance is typically an ASC's goal, even ownership structures that fall short of meeting every element can still be compliant with the Anti-Kickback Statute so long as the structure clearly demonstrates that it is not intended to reward or induce such referrals.

#### ***5. Primary care physicians are generally not investors in surgery centers.***

One of the fundamental aspects of the most compliance-oriented surgery center ownership structures is that the investing physicians are using the center as an extension of practice. The elements of the applicable ASC safe harbors are founded on this principle. By contrast, HHS's Office of the Inspector General has expressed a key concern of guarding against indirect referrals for federally funded health care program patients.

In a surgery center, rewarding "indirect referrals" refers to the practice of allowing a physician or hospital to invest or have another financial relationship in return for that party making referrals of patients to the surgery center without personally providing services to patients. Having an ownership structure with physician investors that are solely surgeons or other proceduralists is the most common structure for these reasons. Investors investigating a structure with primary care or other physicians in a position to refer, but not to personally perform services, should strongly consider the risks involved, as well as certain prophylactic steps to manage such risks.

#### ***6. ASCs do not generally employ physicians.***

In some cases, surgery centers are owned and operated solely within physician practices. However, most ASCs, including certainly those with a third-party management company or hospital as an investor, are legally distinct entities separate from the physicians' practice. Physicians from several local area practices may be co-investors in the same surgery center.

Regardless of the number of affiliated practices involved, physicians typically remain separately employed by their own medical practices and will continue to bill and collect for professional services through such separate practices. Although it is not common, some ASCs do employ physicians and bill and collect for such physicians' professional services (e.g., anesthesiologists and, even less commonly, surgeons). To the extent an ASC chooses to employ physicians, the arrangement needs to be structured properly to comply with state corporate practice of medicine restrictions.

#### ***7. Noncompetes are valuable but imperfect tools.***

Noncompetes in the surgery center investment context are typically viewed by courts differently than noncompetes in the employment context. Noncompetition covenants covering investment, ownership or management of competing facilities can be, in some states, more enforceable than employment-related noncompetes because they do not

typically restrict the practice of the physicians' profession. However, the enforceability will depend on both the scope of services as well as state-level laws and investors are cautioned to fully understand those state limitations when relying on a noncompete to protect the ASC.

#### ***8. Understand the impact of physician employment by competitors.***

For the past several years, there has been a strong national trend toward hospital employment of physicians. If there is an unfriendly hospital that competes with a surgery center, that hospital can cause significant problems for the surgery center by hiring away the main physician partners and placing associated restrictions on the physicians' use of the ASC. However, many hospitals make good partners in ASC joint ventures. Carefully constructed governing documents that address the parameters of physicians' employment by hospitals and cooperation with local hospitals when possible can both be useful strategies to help mitigate the risk presented by physician employment by hospitals.

#### ***9. Beware of non-obvious Stark Law risks.***

There is often confusion by investors and providers between the scope of the Anti-Kickback Statute and the Stark Law. The Stark Law regulates the appropriate circumstances for referrals for a specific list of "designated health services." Services provided at surgery centers generally are not included in the definition of "designated health services" and thus the Stark Law does not generally apply to an ASC's ownership structure or physician contractual relationships. However, there are other types of relationships that may be governed by Stark that are ancillary to the surgery center itself.

For example, the Stark Law will generally prohibit (except in extremely limited circumstances) the provision of imaging, DME, laboratory and other Stark services in the ASC. The ASC's arrangements with third parties for the provision of such services to ASC patients can also implicate the Stark Law. Finally, if there is a hospital investor in the surgery center, the hospital and physician relationships outside of the ASC (which will be governed by the Stark Law) can have implications for the ASC's own compliance programs and operational parameters. Investors in the ASC space are wise to understand how the Stark Law, limited as it may be to ASCs generally, is implicated by the specific facts and circumstances.

#### ***10. Ensure fully compliant ancillary physician agreements.***

Investors considering an ASC investment should carefully examine all physician ancillary relationships outside of the basic ownership structure, including medical director agreements, consulting agreements, physician-owned distributorship relationships, management agreements and space and equipment leases. Each such agreement, and especially any verbal/unwritten arrangements involving physician compensation, should be vetted very carefully to ensure full compliance with federal and state law. Critical aspects of such vetting process include ensuring that any service for which a physician is paid is fully needed by the hospital and that the compensation paid by or to the physician is fair market value.

#### ***11. Out-of-network reimbursement risk is significant.***

In the past, some centers have sought to take advantage of much higher out-of-network reimbursement rates offered by commercial payors. This can be a successful strategy for some ASCs, but in some states payors have taken aggressive steps toward curtailing the use of out-of-network strategies by providers, resulting in drastic reductions to both the amount paid on an out-of-network basis as well as the number of claims submitted by out-of-network providers. When evaluating a business such as an ASC, some adjustments may be necessary for potentially unsustainable revenue stream, depending on the state, payor mix and other factors of the specific ASC's operations.

### ***12. Taking health care receivables as collateral presents unique challenges.***

For some investors (typically lenders or other investors not taking direct equity ownership in the ASC), it often comes as a surprise that lenders and purchasers are not permitted to take direct assignment (and thus control) of Medicare and Medicaid accounts receivable. This is a result of the Medicare Anti-Assignment Rules. There are methods for structuring the participation of investors in such receivables to avoid running afoul of the Anti-Assignment Rules, while at the same time maintaining security in the underlying collateral.

### ***13. The ASC Medicare reimbursement rate is related to hospital outpatient rates.***

Currently, ASCs are reimbursed by Medicare at approximately 55 to 65 percent of the rate at which hospital outpatient departments are reimbursed for the same procedure, depending on the specific procedure and other factors. This can be a double-edged sword. Because their reimbursement is reflective of what hospitals are paid for the same procedure, they have the benefit of stability because hospital reimbursement typically does not fluctuate as wildly as some other sectors (e.g., lab reimbursement, imaging reimbursement or DME reimbursement). Yet at the same time, hospitals have a powerful lobby and the rates are generally less susceptible to broad cuts. The downside is that the percentage discount may be decreased over time, creating ongoing pressures on profit margins.

### ***14. Physicians cannot own in a hospital outpatient department.***

Physicians generally are not allowed to own directly in a hospital outpatient department (HOPD) where the hospital bills and collects for Medicare or Medicaid patients and such investment is in solely one department of the hospital as opposed to the "whole hospital" (and since the enactment of the Affordable Care Act in 2010, even investment in the "whole hospital" has become more restricted). Some parties have attempted to convert unprofitable surgery centers into hospital outpatient departments to take advantage of the higher reimbursement rates previously mentioned.

However, upon conversion, physicians are almost always required to divest their ownership due to the restrictions on owning in HOPDs. In a structure where an ASC converts to a HOPD, the hospital and physician can investigate options for maintaining physician relationships by implementing a co-management, medical director or other non-ownership arrangements. Parties considering such conversion should be aware that the OIG specifically discussed such conversions in the 2013 OIG Work Plan as an area of future investigation.

## **Conclusion**

These key legal and business issues must be examined by investors who are new to the ASC industry. Once these considerations are addressed, investors would be wise to further examine other key legal areas surrounding the ASC industry, such as physician-owned distributors, anesthesia arrangements and safe harbor compliance.