

# ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

## Growing ASC Trend: Sell to a Hospital and Manage the Surgical Unit

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The historical growth of ASCs resulted from an increased emphasis on convenience, quality, physician leadership and financial performance. Today, with declining reimbursement for physician services and changing practice patterns of recent medical school graduates, hospitals and surgeons are looking for ways to continue these historical factors through strategic alliances in a rapidly changing environment. An increasingly common trend is the hospital purchase of the physician's interest in a freestanding surgery center and the subsequent engagement of a physician-owned organization to manage the ambulatory, outpatient, surgical or perioperative unit of the hospital.

Hospitals can pay for physician-led management services through either fixed monthly compensation or a combination of fixed monthly compensation plus incentive compensation based on the achievement of certain performance metrics. By preserving the ASC setting, both hospitals and physicians are realizing the benefits of working together in the ASC arena.

### Underlying factors driving these relationships and factors to consider before pursuing these ventures

Several factors are influencing the need for hospitals and physicians to more closely align. These factors include declining hospital margins, decreasing physician income, higher demand for value-based health care services, downward pressures on freestanding ASC reimbursements and the uncertainty associated with pending health care reform.

As the need for tighter integration between hospitals and physicians has increased, equity joint ventures, under-arrangements and other alignment tactics that have historically given physicians access to HOPD rates have come under regulatory scrutiny and, in some cases, significantly decreased reimbursement for services. The recent implementation of the Stark III laws now bans most under-arrangements for Medicare and Medicaid patients, which has caused many ASCs to rethink their long-term strategy. While some ASCs are able to mitigate these pressures by solely relying on existing commercial contracts, shifting to an out-of-network reimbursement model, increasing case volume in profitable specialties or hiring a for-profit management company; an increasing number of Charis Healthcare clients are turning to co-management or employment agreements to address these shifting market dynamics. However, since many surgeons are unwilling to give up the autonomy of independent practice, co-management agreements remain a viable long-term solution or initial bridge to an integrated delivery model.

Factors that should be considered prior to pursuing this type of venture include:

- Current and projected financial performance of the ASC
- Ability of the ASC to qualify for provider-status post-transaction
- Age composition and degree of loyalty of current physician owners
- Facility constraints (PACU space, consultation rooms, 23-hour stay capabilities, etc.) that could prevent current or future volume growth
- Shifting market dynamics (demographics, competitive landscape, pay-or pressures, etc.) that could change the ASC's current market position and performance
- Operational inefficiencies due to competing block schedule requirements at local hospitals, sub-optimized anesthesia performance, etc.

Prior to the execution of any form of management agreement, a number of hospitals are purchasing surgery centers.

### Purchase of surgery center ownership interest

Legally, a hospital can only pay "fair market value" for a physician's interest in an ASC. The definition of fair market value under the Internal Revenue Rulings and subsequently adopted in the International Glossary of Business Valuation Terms is as follows:

... the price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.

The valuation community has defined a hypothetical willing buyer as any likely buyer. Accordingly, the valuator must consider other purchasers besides the specific hospital to which the owners of the ASC might sell their interest. This prevents the valuator from considering any additional revenue the hospital might experience as a result of billing for services under the Hospital Outpatient Prospective Payment System (i.e., HOPD rates) or under its managed care contracts.

In addition, the valuator must only consider the control provisions of the interest purchased. If a hospital is purchasing the remaining interest in an ASC and that interest will give the hospital effective control, the hospital cannot pay a control premium if the interest alone (i.e. without consideration of the other interest owned by the hospital) does not have control prerogatives under the current operating agreement. However if the interest is a controlling interest (i.e., generally greater than 51 percent depending

on the governing rights as outlined in the center's operating agreement), the hospital may pay a control premium if warranted. Under valuation theory, control premiums are paid if the hypothetical purchaser has the ability to change the operation in a manner that will result in higher profits. An example would be the reduction of costs through a change in staffing or supply utilization.

Generally, the FMV purchase price for the equity in the center might equal what the owners can sell the center to any other third party. However, healthcare attorneys have raised concern about selling an interest based on projected cash flows not burdened by a management fee and then subsequently paying a management fee to the same owners from which the interest was purchased.

Once the ASC is purchased, the parties enter into a management agreement.

### Compensation under the management agreement

Management agreements are paid through either a fixed monthly fee or a combination of fixed and incentive base compensation. The incentive compensation is earned based on the achievement of certain performance metrics.

Management agreements are common within the surgery market. The most common type of management agreement exists between private management companies and ASCs.

Sinaiko's research indicates that management companies generally charge between 5-7 percent of net revenue for the provision of management services, although the appropriate fee is directly tied to the specific services provided under the specific agreement. These services might include managed care contracting or reduction of supply and equipment costs through access to a group purchasing organization.

In determining the FMV compensation payable to the physician organization, hospitals can rely on this market data as a base subject to certain adjustments related to the services provided to the hospital in comparison to the services provided by the management companies to the freestanding ASCs.

Typically, the infrastructure of physician-owned organizations do not mirror those of traditional ASC management companies, possibly resulting in the need to apply lower management fees as a percent of net revenue for the services. The overall range of management fees will depend on the scope of services, the overall revenue stream of the department managed and the actual or expected time requirements and costs of the manager.

The management fee should only be fixed if the revenue of the unit managed is comparable to that of a freestanding ASC. Once the revenue level exceeds this threshold, a portion of the management fee should be compensated based on the achievement of certain metrics. Certain management agreements are established with incentive compensation even if the revenue is in-line with freestanding ASCs.

### Examples of incentive-based compensation and issues related to administration

The incentive compensation is often based on:

- Clinical outcomes such as infection rates and antibiotic disbursement
- Patient safety including surgical site and death due to medical error
- Satisfaction including patient and employee
- Operations including case turnover and on-time starts
- Financial performance including costs per case and staffing ratios

Generally, it is advisable that no less than half of the total available management fee should be incentive based. Incentive metrics and targets should be jointly defined by the physicians and hospital leadership. Metrics should be targeted toward areas where potential improvement has been identified and meaningful impact on clinical outcomes, cost savings, operational efficiencies and patient safety is possible. Maintenance of certain targets is acceptable as long as targets fall within published clinical guidelines and national quality initiatives, such as SCIP protocols. Financial performance metrics can only target cost reductions and not incentive increases in volume or revenue. If financial or operational performance metrics are included, clinical and quality metrics should also be included to maintain the clinical integrity of the department. Target attainment should be reviewed annually to determine if changes need to be made to the metrics or thresholds and all such arrangements should be reviewed by legal counsel for compliance purposes.

Recent legal opinions favor agreements where there is an upside and downside risk. In response to this recent trend, some agreements now include payment deductions for the occurrence of never events or other preventable complications. The total amount of deductions cannot exceed the full value of the performance-based compensation component.

Optional provisions should also be considered to enhance the overall effectiveness of the agreement. The inclusion of optional provisions creates broad enough management oversight to effect significant change. With the elimination of under-arrangements in most markets, the provision of staff, equipment or supplies has become more prevalent in co-management agreements. Two of the three options may be included without triggering Designated Health Service designation. However, equipment cannot be provided with staffing.

### Issues related to integrating surgery centers into the hospital

Co-management agreements promote increased accountability, outcomes, efficiency and satisfaction, which are critical in the transient U.S. healthcare environment. Yet, as with any change initiative, careful attention should be given to critical success factors to enhance implementation efforts. These factors will vary by transaction but may include the following:

- Physician education and buy-in before the co-management relationship is established — This is critical. The physicians must understand the scope and importance of their proposed management tasks. In many respects, the physicians will have to change how they currently practice medicine, if for no other reason to allow time for their new duties in management.
- Maintenance of the ASC mindset — Patient, physician and staff satisfaction are largely driven by the ability of ASCs to provide high quality care in an efficient environment. These efficiencies cannot be lost as equity is shifted from physician owners to the hospital.
- Active physician leadership — Physicians must take an active leadership role with aligned incentives. As bundled payments and accountable care organizations become more of a reality, sustainable agreements will encourage strong physician leadership to enhance clinical outcomes and reduce non-reimbursable events.
- Appropriate physician governance and control — Physicians must maintain the appropriate level of governance and management control to create an efficient and physician centric environment. Without appropriate levels of control, the desired results of the co-management agreement may not be realized. While significant service line decisions (capital budget approval, service line direction, etc.) will require hospital approval, physicians must have enough authority to effect change.
- Appropriate scope — An effective agreement will allow for oversight beyond the ASC and potentially include hospital-based inpatient and

outpatient surgical departments. However, both hospital personnel and a motivated physician group must embrace this vision. There may be improvements and cost savings to be gained across multiple sites of care. Limiting the scope of the co-management agreement may limit its effectiveness. Some physicians and administrators may be resistant to such an agreement, but the inclusion of service line directors and managers in the LLC enhances the likelihood of successful implementation.

- **Dedicated surgical staff** — Staff incentives must be aligned with the overall objectives of the management entity. Incentive compensation is often found in ASCs, but is not typical of most hospital departments. In order to maintain the same levels of efficiencies and physician satisfaction, some agreements allow for the entire or critical pieces of the surgical staff to be directly employed or leased to the hospital by the management entity (only applicable for on campus locations). This creates a higher degree of alignment with the physicians and creates an avenue for incentive-based compensation without changing the hospital's global compensation structure.
- **Alignment with anesthesia** — Most agreements have performance metrics (e.g., on-time starts, efficient use of operating rooms, case turnover) whose achievement is heavily contingent on anesthesiologists. Anesthesia involvement will be critical to the agreement's success. This can be achieved through either informal or formal alignment structures. Examples of the latter include investment into the co-management agreement or a joint venture for anesthesia services, supplies and drugs.

- **Financial sustainability** — Partnerships that last are mutually beneficial for both parties and built upon trust. Co-management agreements should be avoided if they create unsustainable financial returns for either party. Medical directorships, call coverage stipends, subvention payments and other paid physician responsibilities should be evaluated against the terms of the agreement to avoid duplicative payments or other compliance risks.

The decision to proceed with this type of transaction is complicated. Both the purchase of the ASC and the compensation under the management agreement must be consistent with FMV. The management agreement should include metrics targeted toward areas where potential improvement has been identified and meaningful impact on clinical outcomes, cost savings, operational efficiencies and patient safety is possible. Overall, co-management agreements promote increased accountability, outcomes, efficiency and satisfaction, which are critical in the transient U.S. healthcare environment. ■

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