Orthopedic–Driven Ambulatory Surgery Centers and Specialty Hospitals—A Physician and Hospital Perspective

By:
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This article provides an overview of several issues facing the orthopedic-driven ambulatory surgery center and specialty hospital development industry. The article specifically then reviews certain key business drivers to industry growth, examines key risks related to ASC and specialty hospital projects, and provides a brief review of certain legal issues related to the same.

I. Overview.

There are currently approximately 4,400 to 4,600 operational ASCs in the country. In addition, there are approximately 100 to 120 operational specialty hospitals, of which nearly 70 to 80 have some form of physician ownership.

Approximately 30 to 40% of ASCs involve orthopedics in one manner or another, and 20 to 30 of the 100 to 120 specialty hospitals involve a significant amount of orthopedics or are specifically orthopedic-driven. Further, approximately 1,200 to 1,400 ASCs include a hospital partner whereas a smaller percentage of surgical hospitals involve a hospital partner.

Over the past few years, there has been substantial growth in the number of ASCs that include a hospital partner. This is true with regard to both joint venture ASCs involving orthopedics and those without orthopedics. In contrast, there has been somewhat slower growth in ASCs owned solely by physicians. This distinction is due in part to the fact that by this point in time a great number of large physician driven specialty practice groups, or such groups’ individual physicians, already own equity interests in an ASC and the ability for growth in solely physician-owned ASC is a bit more limited. In contrast, only approximately 25% of the country’s hospitals currently own interests in ASCs.

There has been revitalized growth in surgical hospitals since the end of the moratorium on the development of surgical hospitals owned by physicians. The moratorium expired on June 8, 2005 but was extended in part extended by a CMS moratorium suspending the issuance of provider numbers to specialty hospitals until January 1, 2006. Notwithstanding this moratorium, we have seen a significant amount of new surgical hospital projects arise.

There are currently several publicly-traded companies pursuing development of orthopedic-driven ASCs, including United Surgical Partners International, Inc, Symbion Inc., AmSurg Corp and several privately held companies. Additionally, there are a growing number of large not-for-profit hospital systems that are attempting to develop and acquire ASCs, and, to a lesser extent, specialty hospitals.

II. Key Risks To Orthopedic-Driven ASCs and Specialty Hospitals.

Many parties viewing the potential upside of orthopedic-driven joint ventures do not properly assess the potential risks involved. Key risks related to orthopedic-driven joint ventures include the following:

1. An orthopedic-driven ASC or surgical hospital is not nearly as immune to certain contracting problems with managed care payors as ASCs and surgical hospitals are which are focusing on other specialties. For example, orthopedic-driven ASCs and surgical hospitals rely heavily on payors other than Medicare

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2 For example, the GAO issued a Specialty Hospital Memorandum on May 19, 2005 in which it noted that AHA, FAH and others have tentatively identified 52 facilities as potential physician-owned specialty hospitals under development as of that time in anticipation of the expiration of the moratorium.
for their business. Unlike ophthalmology, where 80% or more of the business may come from Medicare, orthopedic ASCs and surgical hospitals run the very real risk of exclusion from commercial payor contracts and a resulting inability to serve large populations of patients. This has proven fatal to some orthopedic-driven ASCs and surgical hospitals.

2. Orthopedic-driven ASCs and surgical hospitals can be heavily reliant on a small portion of their patient population for a large percentage of their profits. For example, in many states, orthopedic-driven ASCs and surgical hospitals have done very well due to high payment rates for worker’s compensation or out-of-network business. Increasingly, these above-market reimbursement payors have reformed their payment systems and significantly reduced the amounts of money payable for their services. These reductions substantially erode the bottom line at many ASCs and surgical hospitals.

3. There are still some markets in which orthopedic-driven and other ASCs and surgical hospitals receive a percentage of their billed charges. In many markets, this type of payment methodology is something that the ASC or surgical hospital should enjoy while it can but should not count on for several years into the future. In the current market, a disproportionate percentage of profits may come from a small percentage of cases. For example, 20% of the cases may provide for 60% of the profits.

4. Parties contemplating such joint ventures should recognize that there is a vast difference in the productivity of different orthopedic physicians. The orthopedic doctors in one community may make for a very robust ASC or surgical hospital. In another community, where the physicians do not maintain such a rigorous caseload or where there is a great deal more competition, joint ventures with orthopedists may not be nearly as profitable.

5. A certain number of orthopedic-driven joint ventures, particularly those owned in part by hospitals, tend to be overstaffed. On average, ASCs often employ five to six full-time equivalents per 1,000 patients. In contrast, one often comes across ASCs averaging a much higher employee to patient ratio. These staffing levels place significant financial pressure on the ventures themselves. Moreover, in orthopedic-driven ventures, particularly, there is a risk of building a facility in excess of real needs, which can be due to either the equipment company’s or the architectural or building firm’s attempt to inflate the required size and amount of building and equipment. This leads to a long term problem that cannot easily be rectified.

6. Finally, there are situations where orthopedic physicians are heavily competitive with each other. This can lead to a very difficult dynamic in which key orthopedic physicians cannot all be kept happy. This type of tension can grow out of the fact that the physicians were initially in the same practice or some other factor that leads to long term animosity and even potential legal issues between the physicians. These types of situations can create debacles for the stability of ASCs and surgical hospitals.

III. Orthopedics Remains the Best Specialty for ASCs and Surgical Hospitals.

Orthopedics, notwithstanding the risks to orthopedic-driven ventures outlined above, remains probably the best specialty for ASCs and surgical hospitals to build around for a variety of reasons.

Orthopedics as a practice involves reasonably complex procedures and is coupled with a very high percentage of patients that need orthopedic services. For example, with respect to patient use, when compared to cardiovascular-driven ventures or neurosurgical-driven ventures, orthopedics enjoys two or three key advantages. First, the percentage of patients who self refer to an orthopedic physician is much higher than those who self refer to a cardiologist or a neurosurgeon. Second, the percentage of the overall population that require care involving procedures is much higher with respect to orthopedic services than it is with cardiovascular or neurosurgical services. The reimbursement per procedure for orthopedics is generally less than the reimbursement for typical neurosurgical and cardiovascular procedures. That stated, the advantages set forth above usually outweigh this negative.

Additionally, compared to gastroenterology, ophthalmology and certain other procedures, the reimbursement is much higher and the cases are sufficiently more complex. This means that the procedures are likely to continue to be performed in ASCs and surgical hospitals for many years to come. In contrast, some payors are aggressively trying to push gastroenterology-driven business into office-based sites. Further, the reimbursement for ophthalmology
driven centers is largely set by Medicare. Thus, there are few opportunities for excess profits.

IV. Benefits and Limitations to A Hospital-Physician Joint Venture Approach.

The pursuit of hospital-physician joint ventures for the ownership of ASCs and specialty hospitals and the use of this strategy provides a number of benefits as well as a number of limitations. The benefits include: (a) increased congruence in relationships with physicians as both parties have an interest in the profits and losses of the venture, (b) a less expensive method of developing loyalty than employing specialists, particularly as the cost to employ and retain specialists has proven to be very expensive in many markets, and (c) tremendous freedom for the physician as well as the hospital — a physician is able to maintain his or her independent practice outside of the joint venture.

There are also several limitations to the use of a joint venture structure, including, for example, (a) the difficulty of extricating the parties from, or dissolving, a joint venture, (b) due to Medicare and third-party payor pricing an ASC joint venture’s receipt of lower reimbursement than the hospital would otherwise receive, (c) due to the shared ownership in the ASC or surgical hospital, the hospital’s decreased share of profits when compared to sole ownership of an outpatient surgery department, and (d) significant limitations on the amount of physicians that can be involved in the joint venture and retain the joint venture’s economic viability and general attractiveness.

V. Current Legal Concerns.

There are a number of legal issues currently under significant discussion within the orthopedic-driven ASC and surgical hospital industries. Certain of the key issues include the following:

A. Surgical Hospitals.

As stated above, the moratorium on surgical hospitals expired on June 8, 2005. This has now been extended to January 1, 2006 by regulatory action which states that CMS will not issue new provider numbers for specialty hospitals until that time.

During this interim period, there are a handful of leading senators who are trying to take action to extend the moratorium. Further, there are many states which are considering the implementation of rules making it harder to develop a surgical hospital owned by physicians. In some states, the difficulty applies to all hospitals and surgical hospitals, not just physician-owned hospitals. Thus, the building of a new surgical hospital (as well as the expansion of those currently under existence), remains subject to significant legislative risk on a federal and state level.

B. Inclusion of Non-Safe Harbor Physicians in ASCs.

The safe harbor for ASCs includes both qualitative and quantitative tests. On the qualitative side, there are rules aimed at assuring that returns are based on units owned and not referrals made, requirements that physician disclosure be made to patients of ownership in the ASC, that Medicare and Medicaid patients are not discriminated against, and several other requirements. In addition, on the quantitative side, there are requirements that a physician must receive at least one-third of his practice income from performing outpatient surgery and, in the case of multi-specialty ASCs, that one-third of his or her ASC procedures must be performed at the ASC in which he or she is an owner.

For larger orthopedic practices, these rules often create significant challenges. For example, in a larger orthopedic practice, there are often physicians that still focus on significant inpatient procedures such as hip or knee replacement procedures and other physicians that focus heavily on procedures (such as spine procedures) that are not on the Medicare or Medicaid list. Accordingly, those practices must decide whether or not to permit the orthopedic physicians who will not meet the “safe harbor” to own interests in the ASC. In general, in the right joint venture structure, with significant efforts to employ prophylactic measures, we believe there are strong arguments to allow the inclusion of such orthopedists in an ASC that is truly a group practice extension of an ASC. The guidance for structuring such joint ventures is beyond the scope of this article.
C. Spine Procedures in ASCs.

ASCs are increasingly allowing spine surgery to be performed in ASCs. Here, it should be noted, that these procedures will not be reimbursed by Medicare in ASCs. Additionally, each state has its own requirements as to the licensure needed and whether such care is permitted in the ASC for such procedures. The movement of these procedures from hospitals to ASCs is saving payors a great deal of money. At the same time, ASC spine cases must be handled appropriately in accordance with state and federal law.

D. Magnetic Resonance Imaging and Other Imaging Services.

Increasingly, orthopedic-driven practices are looking to profit from the provision of imaging services. This can be permissible for orthopedic practices under the in-office ancillary services exception under the Stark law. Compliance with such exception is critical for practices. Notwithstanding the exception, certain states prohibit the in-office provision of imaging services by orthopedic practices. Further, payors are increasingly denying reimbursement of imaging in practice-based imaging facilities.

E. Medical Staff Issues and Economic Credentialing.

Hospitals are increasingly taking retaliatory action against those physicians that develop their own hospitals and ASCs (for example, through credentialing policies allowing the denial of privileges based on economic conflicts of interest, etc). The case law on this type of activity is quite mixed. While it tends to favor to a small degree the hospitals over the physicians, there are a number of situations where the physicians have had positive outcomes in combating such retaliation. Generally, the more that the hospital completely controls the market, the better chance there is that a physician group who is being attacked will have a chance to bring legal action against the hospital. In contrast, if the physicians have multiple other options for privileges, it is less likely that antitrust challenges to such hospital actions will be successful.

F. Relationships with Medical Device Implant Companies.

Increasingly, regulatory authorities are closely examining orthopedic physicians to assess whether they are receiving monies from implant and other companies in exchange for causing the use of such implant company products. As implants are a very significant cost for surgical hospitals and ASCs, it is in the best interest of the hospital and ASC to help assure that the physicians are not receiving any sort of improper incentive to use one vendor's products over another. Further, parties are increasingly looking at gain-sharing and other types of efforts to help provide incentives to standardize and drive down costs of implants and other equipment. The issues of payments from device companies and gain-sharing arrangements are expected to receive a much greater level of attention towards the end of this year and in 2006.

Should you have questions about any of the issues raised in this article, please contact Scott Becker at 312.750.6016 or Amber Walsh at 312.750.3596.

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3 For example, hospitals may retaliate by altering the credentialing process to deny privileges based on economic conflicts of interest, pressuring commercials payors to influence them not to contract with the ASC, and/or pressuring primary care physicians to change their referral patterns.

4 For example, the U.S. Attorney General recently issued subpoenas to at least five major orthopedic device manufacturers in an investigation of the companies' financial arrangements with surgeons for consulting and other personal services.