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AMBULATORY SURGERY CENTER SAFE HARBORS - THE CURRENT ISSUES

By: Scott Becker

This article addresses two issues that are commonly raised. First, it discusses the issue of whether an ambulatory surgery center ("ASC") may redeem a physician who does not technically comply with the ASC Safe Harbor to the Federal Fraud and Abuse Statute. Second, it discusses the issue of how an ASC may address a situation in which a physician is unable to generate one-third of his or her medical practice income from the performance of outpatient surgical procedures because his or her specialty does not permit him or her to meet such standard.

1. Redemption of Non-Compliant Physician Investors

A. Background

The traditional rule under the Federal Fraud and Abuse Statute has been that a health care facility cannot require physician investors to perform cases at the facility as a condition to allowing such investors to maintain an ownership interest in the facility. The ASC Safe Harbors, which were issued in 1999, spurred a great deal of debate regarding the application of this rule in the ASC industry.

The ASC Safe Harbors include qualitative and quantitative requirements. The qualitative requirements include, for example, that: (a) physician investors must disclose their ownership interests in the ASC to patients who they refer to the ASC, (b) physician investors must not discriminate against Medicare or Medicaid patients, (c) the ASC must provide physicians an equal opportunity to purchase interests in the ASC, without regard to the volume or value of referrals that the physician may generate, (d) distributions to investors must be based on ownership, and (e) a number of other requirements.

There are also two quantitative requirements of the ASC Safe Harbor. The first requires physician investors to generate not less than one-third of their medical practice income from the performance of outpatient surgical procedures. The second requires physician investors to perform not less than one-third of their outpatient surgical procedures at the ASC in which they are investors. These requirements are sometimes referred to as the "two one-third tests".

When the Office of the Inspector General ("OIG") issued the ASC Safe Harbor in 1999, it used the two one-third tests as a means to prevent ASCs from encouraging indirect referrals sources to invest in the ASC. In its commentary to the ASC Safe Harbor, the OIG expressed its principal concern with ASC joint ventures as a concern that the ventures might serve as a means to reward physicians for indirect referrals (e.g., referrals to other physicians who actually perform the services at the ASC). Specifically, it stated as follows:

In the context of an ASC, our chief concern is that a return on an investment in an ASC might be a disguised payment for referrals. Two examples illustrate the potential problem. First, primary care physicians could be offered an investment interest in an ASC for a nominal capital contribution as an incentive to refer patients to surgeon owners of the ASC. The primary care physicians would not perform any services at the ASC, but would profit from any referrals they make. Second, physicians in specialties that typically refer to one another could jointly invest in an ASC so that they are positioned to earn a profit from such referrals or so that one physician specialty provides the ASC services and the other provides the referrals. In such cases, medical decision-making may be corrupted by financial incentives offered to potential referral sources who stand to profit from services provided by another physician.

64 Fed. Reg. 63,518, 63,536.

B. Analysis

Notwithstanding the OIG's intent behind including the two one-third tests in the ASC Safe Harbor, many ASCs have explored ways in which they can use the two one-third tests as a rationale for redeeming physicians who do not perform cases at the ASC. It is important, however, that an ASC follow the guidelines discussed below when redeeming physicians based on non-compliance with the two one-third tests, so that its decision to redeem the physician is not viewed as violating the Fraud and Abuse Statute.

First, the ASC's reason for redeeming the physician must be based on compliance concerns. For example, an ASC cannot redeem a physician investor solely because the investor does not perform cases at the ASC. Rather, the ASC must equally apply all of the ASC Safe Harbor requirements, both quantitative and qualitative, to all of the physician investors of the ASC. Thus, an investor who refuses to treat Medicare or Medicaid patients or who fails to disclose to patients his or her ownership in the ASC should also be redeemed.

Second, because the litigation in this area is just starting to unfold, we advise ASCs to proceed cautiously when redeeming investors based on non-compliance with the ASC Safe Harbor. For example, an ASC may provide an investor several months or a couple of years to become compliant before redeeming the investor. This is particularly true if the investor is not an indirect referral source, because the two one-third tests were primarily created to prevent investment by indirect referral sources.

Third, if an ASC plans to redeem an investor because of his or her non-compliance with the two one-third tests, we recommend that the ASC offer the investor fair market value for his or her ownership interests. In essence, the ASC should not "punish" the investor for not meeting the two one-third tests by redeeming the investor's interests at a discounted or below fair market value price. If the documents provide for the failure to meet the requirements as an adverse event and at a reduced price, this should be to avoid the person having a right to "put" their shares and not to penalize the person for not bringing in cases.

Fourth, an ASC considering redeeming physicians due to their non-compliance with the two one-third tests should keep in mind the following two caveats. First, an ASC and its members may arguably be convicted under the Fraud and Abuse Statute and subject to criminal penalties if a regulator can successfully establish that the ASC redeemed investors because the investors were not performing cases as the ASC, as opposed to regulatory compliance concerns. Second, in at least one case where an ASC redeemed an investor because he was not performing cases at the ASC, the court awarded the investor substantial punitive damages (i.e., approximately $4 million), as well as compensation for the improper redemption.

2. Addressing Non-Compliant Physician Investors Based on Specialty

An issue often arises where a physician investor is unable to meet the two one-third tests due to his or her specialty. An ASC must decide whether to permit such physicians to invest in the first instance, and whether to allow such physicians to retain their ownership after they demonstrate an inability to comply with the two one-third tests.

As discussed above, the OIG included the one-third tests in the ASC Safe Harbor in order to discourage indirect referrals sources from investing in ASCs and to ensure that physician investors were actively involved in the ASC. Through advisory opinions, the OIG has provided some comfort to joint ventures owned by physician investors who do not meet the two one-third tests, as long as the intent behind allowing such physicians to invest was not to encourage indirect referrals. However, an ASC may be exposed to significant legal risks in situations involving physicians, if such physicians are encouraged to invest in the ASC so that they will generate referrals for other surgeons who use the ASC. In essence, we would feel quite comfortable with an ASC allowing a physician to become, or remain, an investor in an ASC if the physician has a significant outpatient surgery practice, yet is unable to precisely meet the one-third tests.

Again, we caution ASCs to proceed carefully with redemptions based on non-compliance with the two one-third tests in light of the fact that the law involving these cases is still evolving and that such redemptions could potentially be viewed as illegal or contrary to the spirit of the Fraud and Abuse Statute.

FAST FACTS ABOUT ENDOSCOPY DRIVEN AMBULATORY SURGERY CENTERS

By: Scott Becker

1. There are two national companies that focus heavily or specifically on endoscopy centers: Physicians Endoscopy, LLC (Barry Tanner; 215/589-9005) and AmSurg, Inc. (David Manning; (615/665-1283).

2. GI procedures remain among the top two or three types of procedures performed in ASCs.

3. Endoscopy centers are probably more concerned about Medicare using a hospital outpatient department charge system than other ASCs in that GI procedures are among the few which are paid a lower rate in hospital settings than ASCs.

4. Average revenues for GI procedures can be $550 to$600 in a reasonable reimbursement market. Medicare payments are typically in the $420 to $440 range.

5. An endoscopy center that performs 5,000 to 6,000 procedures can generate $1,000,000 plus net income if operated on a very prudent and economical basis.

Should you have questions, please contact Scott Becker at sbecker@mcguirewoods.com.

EASC TRENDS

By: Barry Tanner

Two emerging trends that are being seen in the development of endoscopic ambulatory surgery centers ("EASCs") are 1) the formation of physician coalitions to achieve economic feasibility and to ensure long-term success, and 2) the formation of hospital physician joint ventures for much the same reason. These trends signal several important changes that are taking place, and also set the stage for a different type of expertise that is required to successfully develop and manage EASCs over the long haul.

For GI physicians today, ownership of an EASC is a near necessity for numerous reasons – preservation of income, physician recruitment, meeting the time constraints of patient care, and reducing the inefficiency often associated with hospital based care are but a few of those reasons. Many large groups of GI physicians developed their EASCs several years ago beginning in the early 1990s. Today, it is estimated there are approximately 400 single-specialty EASCs in the United States. Successful EASCs can range from those that are quite small, around 1,800 to 2,200 annual procedures, to those that are quite large, 7,500 annual procedures and up. One thing that is quite clear is the fact that larger, higher volume facilities tend to have greater profit margins and cash flow than smaller low volume facilities. This, of course, comes, as no surprise since the fixed costs associated with developing and operating an EASC are high relative to the variable costs. Therefore, once the procedure volume increases to a point where the fixed costs are covered, the incremental contribution margin per procedure is quite significant. For larger GI practices who build a facility that is "right-sized" for their expected volumes, financial success is more likely to be sustainable even as the inevitable reimbursement squeeze cuts into historical profit margins. For smaller groups of GI physicians, or those who operate solo within a small community of about four to six GI physicians, a significant entry barrier exists for EASC development. To overcome these barriers, GI physicians are seeking to form coalitions and/or to joint venture with the local hospital. Either can be a successful strategy if caution is exercised throughout the planning and implementation steps.

Building physician coalitions requires a high level of leadership, exceptional communication and data sharing, and the adoption of and adherence to a strategic set of protocols that will promote a pathway for gathering and analyzing data and using that data to make informed decisions.

Group dynamics play a very important role. The benefits that GI physicians can realize from forming a coalition are many. First of all, there is strength in numbers. This strength is tangible both from an economic standpoint and also often from a political standpoint. By forming a coalition, community based GI physicians may be able to assemble sufficient procedure volumes to more than justify sharing the costs associated with EASC development and operation. Spread the risk. Too much reliance upon any one or two physicians can lead to long-term disaster if something should change with any one practitioner. Politically, a coalition represents a unified group of physicians with a singular purpose and goal. From the hospital's perspective, this unification of physicians who operate with a decisive business plan and demonstrate financial sophistication, represent a formidable and, in the physician world, unusual challenge. Faced with this sort of organized and well-capitalized group, the hospital often sees the "train leaving the station" and focuses not on seeking restitution from the physicians but on finding a way to amicably participate in the venture.

Including the local hospital in the process of exploring a possible joint venture can also add another significant layer of complexity. While there are several very good reasons to team up with the hospital, e.g. payer contracting, political harmony and even financial stability, often the hospital's view of the world is to "protect their turf" by controlling and managing the delivery of outpatient GI services. Economically "sharing the wealth" with the GI physicians is a rare and typically foreign concept. When considering a hospital physician joint venture, GI physicians would be well advised to establish several important ground rules right up front. The GI physicians should at all times maintain majority ownership of the EASC. The hospital can participate by playing an active role in facility management, however, extreme caution should be exercised to ensure that the desired levels of efficiencies in terms of physician block scheduling, staffing and patient flow can and will be achieved. Facility management by the hospital is often accompanied by "creeping control" over all operational decisions. In determining EASC ownership, the GI physicians should carefully scrutinize the true economic value that the hospital can bring to the equation. Does the hospital control a significant patient population through third-party insurance? Will the hospital insist upon credentialing other non-GI physicians to utilize the EASC for procedures? Will the hospital insist upon utilizing hospital staff and managing the EASC just like a department of the hospital? These are just a few key questions.

Physician coalitions and hospital physician joint ventures are complex management situations with inflated chances for confrontation and power struggles. Physicians Endoscopy is one company that

specializes exclusively in the development and management of EASCs and has extensive experience with physician coalitions and with hospitals as equity and non-equity partners. John Poisson, Chief Operating Officer of PE stated, “While PE brings significant economic value to each of our physician partnerships, the value that PE adds when physician coalitions and/or hospitals are involved in EASC development and management, increases dramatically”. Mr. Poisson also states, “PE serves as both orchestrator, arbitrator and often as an independent voice of reason, while simultaneously doing all the leg work, research and data gathering necessary to enable the physicians to make informed decisions.”

There is still a very substantial need and a multiple of reasons for GI physicians to come together to develop their own EASC. To avoid missteps, minimize risk and to ensure that the long-term outcome is one of success and harmony, seek professional advice and counsel, and structure your EASC partnership to ensure that the physicians make the final call.

ADDING A CORPORATE PARTNER: PROS & CONS

By: Edward W. Staunton & Jonathan C. Vick

Adding a corporate partner to an ambulatory surgery center (ASC) is becoming increasingly popular as ASC owners seek to improve the financial performance and utilization of their surgery centers. Of the 3,700 Medicare certified surgery centers in the US, approximately 800 are partnered with ASC corporations, 200 are partnered with hospitals, and about 100 are in 3-way partnerships with physicians, an ASC corporation, and a hospital. Adding a corporate partner to a new or existing surgery center is relatively easy and can make good business sense in many cases. Presently, there is a wide selection of ASC companies competing to partner with good quality surgery centers with growth potential. This is an advantageous time to be seeking a corporate partner as the range of available corporate partners and the continuing consolidation of the industry has created a “sellers” market.

Why would physicians want a corporate partner? The primary reasons for selling an interest in a physician-owned surgery center to a corporate partner include:

- Improving financial performance (centers with corporate partners have higher utilization and average over $300 more revenue per case more than independent centers)
- Access to additional capital without personal guarantees or joint and several liability

- Professional management that results in higher profits
- A strategy to buy-out non-productive partners and add new physician-partners
- An exit strategy that allows the founding investors to sell their interest at a higher price than they could sell it for to new physician-investors
- A safety net to guarantee a buy-out at a pre-determined multiple in the event of legislation that limits or prohibits physician ownership

Choices for a corporate partner: There are three (3) different choices for a corporate partner, each with advantages and disadvantages.

For-profit ASC companies – These professional ASC management companies provide strategic sources of capitalization, skilled management services, and other ASC support resources. For-profit ASC management companies typically purchase either a minority or majority interest in the ASC ("buy-in" ranges between 20% to 51%). This model has shown remarkable growth in the last 5 years. There are now over 20 ASC companies seeking to partner with independent ASCs, providing proven growth strategies and "exit" plans for physician-investors.

Hospital Partners – Some surgery centers have a hospital as an equity partner. These are typically managed by the hospital. Hospitals usually require at least a 51% ownership interest to preserve their 501C(3) status.

3-way (Physician/ASC Company/Hospital) Partnership – These joint venture models are typically managed by the professional ASC management company. The most popular 3-way model incorporates equal or near-equal ownership amongst the 3 parties. The most common legal structure used is an LLC or limited partnership. These partnerships work best if the physician partners engage initially with the professional management ASC company to collaboratively determine the best strategic structure into which the hospital partner will be added. This first step of engaging the ASC company prior to approaching the selected local hospital is a very important "first step" in facilitating the development of an "optimal" 3-way joint venture partnership.

Pros and Cons of different corporate partners:

- For-profit company

o Pros – Reduced physician risk, more investment security, professional management and management systems, generally higher revenues and profits, contracting expertise, increased case volume and facility fees, access to capital, relevant benchmarking. Expedited turnover times. Higher facility fees than independent centers. Corporate-partnered ASCs tend to be the most profitable of the models due to the management expertise and focus on utilization and profitability.

o Cons – Shared control; loss of independence; business-like management; shared profits; profit orientation.

- Hospital

o Pros – Potentially convenient location; supply and services contracting; access to hospital's payer contracts; hospital provides capital; access to a CON, if needed.

o Cons – Hospital usually wants majority ownership and control; managed like a hospital; competing uses for capital; physicians lose leverage.

- 3-Way

o Pros – Three parties to provide capital; balanced and less adversarial; professional management; managed like an ASC, not a hospital; risk spread between 3 parties; facility fees similar to hospital model.

o Cons – Profits split 3-ways; physicians have less ownership; delicate partnership structure; hospital must bring value or ownership will be diluted without value.

How to add a corporate partner: The following steps are necessary to identify and negotiate a surgery center partnership that will meet the needs and goals of the physician-partners:

- Identify the needs and goals of the physician-partners
- Identify the type of partner that best suits the needs of the physicians
- Identify the potential partners that will achieve the goals
- Solicit partnership proposals from all the potential partners
- Negotiate the proposals so that the goals and needs will be satisfied

The physicians' tolerance for risk, operating goals, time and availability to manage, and return on investment expectations are essential criteria that will drive the selection of the most appropriate ASC partner. Therefore, it is important for physicians to develop a clear understanding of their long-term ownership goals prior to pursuing a partner.

Questions to ask: Here are some questions that should be answered early in the search for a corporate partner to arrive at the best partnering alternatives for any surgery center:

- Which partner(s) has the experience necessary to meet the unique needs of our center?
- Which companies are paying the highest multiples?
- How much is our center worth?
- How do we get the best terms and value for our center?
- Should we sell a minority or a majority interest?

It is very important to identify and solicit potential ASC partners based on long-term ownership goals. The surgery center market remains highly fragmented with over 20 corporate partners to choose from, and it is important to identify the most qualified partners and leverage the competition among these partners to achieve the most attractive partnership deal. An independent opinion of the fair market value of the new or existing surgery center adds to the leverage that the owners will have when entertaining partnership proposals.

About the authors: Edward W. Staunton and Jonathan C. Vick are Partners in ASCs Inc., a consulting firm that specializes in strategic partnering: helping physicians find the right partner and negotiate the best deal for their ASC, providing ASC merger & acquisition services, and ASC valuations. Over the last 20 years they have assisted over 150 groups of physicians, hospitals, and corporations form successful partnerships.

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