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Valuation of ASCs and OBLs
Part III: ASC Value Drivers

Introduction

As discussed in the first and second installments of this four-part series, the shift to outpatient care in the healthcare industry has resulted in the advent of a growing number of diverse outpatient office-based facilities tailored to meet the accelerated growth in demand for healthcare services, leading to the establishment of, among other enterprises, *ambulatory surgery centers* (ASCs) and, more recently, *office-based laboratories* (OBLs).

Part 1 introduced and defined ASCs and OBLs, while Part 2 detailed the regulatory environment in which both of these outpatient facilities operate. This third installment will discuss valuation considerations (i.e., value drivers and investment risk factors) for ASCs, while the fourth installment will discuss the value considerations specific to OBLs. While the value drivers of ASCs are similar to those of other healthcare outpatient enterprises, there are several specific dynamics related to ASCs that should be taken into consideration during the appraisal process.

Scope of Services

The scope of services provided by a particular freestanding outpatient enterprise is a key element impacting the overall indication of value attributed to that enterprise. For example, multi-specialty ASCs allow for diversification of risks if one specialty receives a reduction in reimbursement.[1] Additionally, simply offering more than one specialty may create more volume and revenue for all of the providers involved.[2]

Advancements in technology and clinical practice have expanded the provision of surgical procedures in ambulatory settings.[3] The specialization of ASCs that billed Medicare in 2019 are shown below in Table 1.

Table 1: ASC Specializations, 2019[4]

	Type of ASC	Number of ASCs	Share of All ASCs
1	**Single Specialty**	3,356	65%
2	Gastroenterology	1,082	21%
3	Ophthalmology	1,057	21%
4	Pain management	619	12%
5	Dermatology	209	4%
6	Urology	134	3%
7	Cardiology	88	2%
8	Podiatry	83	2%
9	Orthopedics/ Musculoskeletal	32	1%
10	Respiratory	26	1%
11	OB/GYN	13	<1%
12	Neurology	6	<1%
13	Other	7	<1%
14	**Multispecialty**	1,787	35%
15	**Total**	5,143	100%

Capacity

Capacity is another key element that impacts the value attributable to ASCs. One measure of capacity for ASCs is the amount of physical space utilized in the provision of services. For example, the number of operating rooms (ORs) available, as well as average turnover rate, can be used as measures of ASC capacity. These metrics can be compared to normative industry benchmark survey data related to comparable enterprises and ASCs.

Revenue Stream

ASCs have a low to moderate level of revenue volatility.[5] This is due in large part to the indispensable nature of medical procedures, wherein demand for surgeries is not subject to revenue fluctuation based on economic climate.[6] Moreover, as healthcare costs continue to rise, many insurers and patients will view ASCs as a cost-effective, yet high-quality, option.[7] As a result of these factors, it is reasonable to assume that the ASC industry will exhibit a slight uptick in revenue over the next five years, driven in large part by demand from the rapidly growing elderly population.[8] However, an increase in demand is likely to lead to increased revenue volatility.[9]

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Since 2010, ASC growth has slowed, due in large part to revenue issues such as the proliferation of high-deductible health plans.[10] The cost-shifting mechanism has contributed to patients behaving far more cost-consciously with regards to their healthcare purchases. However, because patients are taking an increasingly active role in their healthcare, ASCs may benefit from offering a more economical (yet high-quality) option to patients, as ASCs have long led the way in cost-effective, quality care.

Additional considerations may include the implementation of a bundled payment system, which currently exists under the Ambulatory Surgical Center Fee Schedule (ASCFS), whereby the integral services and items utilized within the primary service being provided are reimbursed via a single payment. Bundled payments may be implemented through the various measures of productivity; for example, the Outpatient Prospective Payment System (OPPS) bundles items and services within a single Ambulatory Payment Classification (APC).[11] On the surface, bundled payments may seem to depress revenue for ASCs, but the payment model may actually benefit ASCs the most in the increasingly competitive value-based environment.[12] ASCs are well positioned to participate in bundled payment models because they provide similar procedures as hospitals at a lower cost, while also tracking expenses more easily than hospitals.[13] Further, bundled payments encourage patients to choose ASCs for surgeries and encourage payors to move patients to ASCs, thereby potentially increasing an ASC's volume.[14] Bundled payments can also ensure that ASCs are paid faster and can encourage even greater price transparency.[15]

Other considerations regarding reimbursement yield that are likely to impact the revenue streams of ASCs include:

(1) Quality reporting programs;

(2) Method and frequency of payment rate updates;

(3) Stability of payment rates – for example, reductions in reimbursement to curb utilization and spending are applied more often to certain billing codes;

(4) Referring physician utilization trends – such as increased scrutiny of physician referrals under fraud and abuse laws may impact patient volumes; and,

(5) Dependence on payor mix.

For ASCs, where reimbursement yield for certain services (e.g., surgical procedures) is subject to continuously changing payment rates, the projection of revenue streams by individual modality, instead of for the enterprise as a whole, may be more appropriate.

While payors have driven their beneficiaries to greater ASC utilization because of the potential cost savings,[16] a wide Medicare reimbursement gap still exists between ASCs and *hospital outpatient departments* (HOPDs), which gap ASCs have been fighting to reduce over the past years.[17] Although the *Centers for Medicare and Medicaid Services* (CMS) cut reimbursement rates for many physician specialties beginning in 2021,[18] ASCs were able to avoid some of the COVID-19 elective surgery restrictions that targeted only inpatient settings and, subsequently, some of the huge losses in revenue experienced by hospitals nationwide.[19]

Payor Mix

The typical payor mix for ASCs in 2019 (by percent of total revenue) is set forth in Table 2.

Table 2: Typical ASC Payor Mix[20]

	Payor	% of Total Revenue
1	Commercial	40.3%
2	Government (Medicare, Medicaid, Worker's Compensation, etc.)	33.4%
3	Other	17.5%
4	Out-of-Pocket Payments	8.8%

The reimbursement yield of a given ASC is significantly impacted by whether the particular facility bills on an in-network or out-of-network (OON) basis for a particular insurance plan. Under certain insurance coverage plans, patients are given financial incentives – e.g., lower deductibles and co-insurance payments – to see providers that are considered to be "in-network," referring to a contractual relationship entered into by the provider with the payor to offer services at a discounted rate.[21] In an effort to mitigate higher reimbursement rates for OON services, certain payors have instituted internal fee schedules that cap the allowable charge that these payors will reimburse providers for OON services.[22]

Further, many states (as well as the federal government) recently have passed, or have been attempting to pass, bills on the ability of providers to "balance bill" and have set forth caps on the pay for OON care at a regional insurer's typical negotiated rate.[23] At the end of 2020, Congress passed the *No Surprises Act*, which contains consumer protections against surprise billing, including: requiring that health plans cover surprise bills at in-network rates, prohibiting balance billing, banning OON providers from sending patients bills for excess charges, and giving states and the federal government more enforcement powers, among other provisions.[24] These attempts to cap OON charges may result in a decreased reimbursement yield for those ASCs that rely on an OON strategy.

Operating Expenses

ASCs generally have a much higher share of expenses for medical supplies and drugs than hospitals and physician practices.[25] Similar to other industries in the healthcare sector, wages represent one of the largest expenses,[26] although they comprise a much smaller share of expenses than an average hospital.[27] Rent and capital costs also comprise a smaller share of ASCs' expenses than those costs would be for a physician office.[28]

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Additional considerations regarding the operating expenses incurred by an ASC include:

(1) The size of the facility; e.g., the number of operating rooms and the number of cases;

(2) The ability of the ASC to manage supply costs;

(3) Whether the management of an ASC is performed by a third party; and,

(4) Whether the ASC employs a medical director.

In addition to the types of operating expenses incurred by an ASC, the amount of *fixed* and *variable* expense should be considered when performing an appraisal, as each type of expense is projected differently.

Capital Structure

ASCs incur significant expenditures for depreciable assets, including highly advanced surgical tools and equipment.[29] Various regulations require ASCs to keep electronic records, have tools for disposal, and comply with costly building regulations.[30] As a result of these factors, access to capital is a significant concern for ASC operators. Due to anticipated rapid advancements in medical technology, ASC operators will likely need to continue to invest in advanced medical technology to keep long-term costs down and to compete with other ASCs and hospitals.[31] Overall, capital investments have cancelled out wage growth in the ASC industry.[32]

The implications of the capital structure decision for freestanding outpatient enterprises, including ASCs, are similar to those of physician professional practices:

(1) The mix of debt and equity financing affects the risk-adjusted required rate of return for investment in the subject enterprise.

(2) Debt financing is typically cheaper than equity financing.

(3) Financing costs reflect the risks associated with each type of capital provided. For example:

   (a) Debt financing typically considers the four C's of the obligor: **c**redit risk (default risk) of the borrower, **c**apacity of the borrower to make timely repayments of both principal and interest (short term liquidity and interest coverage), **c**ollateral to cover the lender in case of borrower default, and an analysis of the **c**ovenants included in the indenture agreement.[33]

   (b) Equity financing considers the risks associated with an investment in the residual ownership interest (subordinate to any debt holders) of the subject enterprise.

Note that the amount of debt utilized by a specific freestanding outpatient enterprise will likely be impacted by: (1) the age of equipment and other technology utilized by the enterprise; and, (2) the enterprise's dependence on technology; for example, an ASC will have higher capital needs related to obtaining and maintaining surgical equipment.

Data and information pertaining to the most probable capital structure of an ASC can be derived from normative industry benchmark survey data, as well as comparable publicly traded company data, for those ASCs that have comparable publicly-traded companies. Additionally, the capital structure can be determined through techniques such as the iterative method. For the purpose of establishing the fair market value of an ASC, it is important to utilize formulas based on market values of equity and debt, rather than book values.[34]

Overall, it appears that ASCs currently have adequate access to capital because the number of ASCs has continued to increase (change in the number of ASCs is the best available indicator of their ability to obtain capital[35]), and hospital systems and other providers have significantly incorporated ASCs into their business strategies.[36] Further, the industry's continued growth indicates that capital is not difficult to obtain for such ventures.[37]

The successful and profitable business model of ASCs has attracted significant capital investment from investors, including hospitals, other physicians, and non-healthcare industry parties, e.g., venture capital and private equity.[38] Interest from these parties stem largely from the ongoing shift of services from the inpatient to outpatient setting and the potential profitability of ASCs.[39] Capital investment in the industry is expected to remain stable in the future even as industry profit, measured as earnings before interest and taxes, is expected to decrease slightly in the future from its current place at 19.7% due to pressured reimbursement rates.[40]

Suppliers

Suppliers in healthcare can include pharmaceutical companies and medical instrument companies.[41] In general, enterprises such as ASCs achieve a significant amount of their bargaining power from their size, as larger enterprises, with greater patient populations, represent a larger portion of business for vendors, and therefore, have more negotiating power than smaller enterprises. In addition, those larger ASCs that are able to reap the benefits of this increased market leverage may be able to lower operating costs by negotiating lower supply prices, thereby improving profit margins, which may increase the indication of value of the enterprise.

Subject Entity Specific/Non-Systematic Risk

While investors in a particular ASC would have additional investment opportunities available to them—e.g., government bonds, equity indexes—the discount rate utilized to present-value all the expected future net economic benefits should consider these opportunity costs as well as any idiosyncratic risk associated with an investment in the specific subject enterprise. This subject-entity-specific/non-systematic (idiosyncratic) risk for freestanding outpatient enterprises such as ASCs would include the various risk factors that are inherent and specific to the enterprise being valued, as well as the enterprise's operational performance compared to the most probable performance of similar enterprises as reported in normative industry benchmark survey data.

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Subject-entity-specific/non-systematic risk factors for most ASCs include, but are not necessarily limited to, the following:

(1) The uncertainty related to the continuity of the projected revenue stream based on the probability of achieving the projected productivity volume and the efficacy of the projected reimbursement yield utilized in the analysis;

(2) The risk related to the probability of achieving industry-indicated operational and financial benchmarks utilized in the analysis;

(3) The competitive marketplace within which the ASC operates; and,

(4) The historical operations of the ASC in comparison to the industry benchmarks.

Examples of subject-entity-specific/non-systematic risk considerations related to the valuation of an ASC include, but are not necessarily limited to:

(1) The diversity of specialties and services offered at the enterprise being valued;

(2) The percentage of OON patient volumes;

(3) Capital needs related to the facility and equipment;

(4) Operating performance;

(5) The stability and relative size of current and future reimbursement revenues; and,

(6) Relationships with independent surgeons/referring physicians in the market service area of the subject enterprise.

Conclusion

ASCs are performing an increasingly wider array of complex procedures and ancillary services, which present important revenue opportunities for industry operators. Changes in federal requirements with respect to reimbursement and site(s) of service for specific offerings can prove detrimental to operators focused on these segments. Talent and specialized physicians are required and largely determine the amount of payor and consumer demand for the provision of these services in the outpatient setting.

Revenue for ASCs is likely to be driven by cost-conscious patients seeking to have procedures performed at a lower cost.[42] Health systems have continued to invest in ASCs because of these low costs, despite lower reimbursement rates, and the potential to free up inpatient capacity for other patients.[43] ASCs will likely continue to form joint ventures with hospitals and other healthcare systems to retain high-quality physicians and ensure the capacity required to meet high patient volumes.[44] ASCs have also received high scores in patient and physician satisfaction that will only add to their viability.[45] As more insurers prefer the use of outpatient settings for procedures, ASCs will likely see sustained growth and valuation prospects going forward, but profitability, by contrast, is expected to fall over the next several years.[46] Nevertheless, the portion of providers planning on increasing their investment in ASCs rose from 44% in 2019 to 67% in 2020, a clear sign of continued interest and commitment.[47]

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(Continued on next page)

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