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Valuation of Ambulatory Surgery Centers (ASCs): Competition

As noted in the first installment of this five-part series, an *ambulatory surgery center* (ASC) is a distinct entity that primarily provides outpatient surgical procedures to patients who do not require an overnight stay after the procedure.[1] The facilities typically provide relatively uncomplicated surgical procedures in a non-hospital setting, and most ASC cases are non-emergency, non-infected, and elective.[2]

ASCs compete in an increasingly crowded industry for patients. The industry is fragmented, highly competitive, and rapidly changing with technological advancements. ASC's main industry competitors are hospitals. While the ASC industry is seeing more capital investments, indicating the profitability and attractiveness of the industry, this adds another layer of competition for existing ASCs.

This second installment in this five-part series on the valuation of ASCs will discuss the competitive environment of ASCs, by competitor type.

Hospital Outpatient Departments

ASCs compete with *hospital outpatient departments* (HOPDs) for the technical component revenues resulting from procedures and diagnostic testing provided in these facilities. HOPDs, while typically not "*freestanding*," offer many of the same services provided by ASCs and other types of freestanding outpatient enterprises. One reason that HOPDs function as significant competitors to ASCs is the financial attractiveness beholden to HOPDs. Significantly, in contrast to ASCs and other freestanding outpatient enterprises, HOPDs typically have access to the market leverage maintained by the parent hospital organization, and are reimbursed under the *Hospital Outpatient Prospective Payment System* (OPPS), which allows them to receive a "*heightened reimbursement differential*" for the same services or procedures provided in an independent freestanding facility.[3] Over the past couple of years, ASCs have received approximately 58.5% of what HOPDs receive for comparable services.[4] However, it is important to note that the demographics vary for HOPD and ASC settings.[5] ASCs primarily treat Medicare patients aged 65 to 74, and perform less complex treatments than HOPDs.[6] A study from the *American Hospital Association* (AHA) claims that HOPD clinics treat poorer and sicker (i.e., more acute) Medicare patients compared to patients treated at ASCs.[7] Further, the AHA claims that HOPD costs are higher than physician offices, due in large part to heightened regulatory requirements for HOPDs.[8] These two significant factors may diminish the role that HOPDs play in the future.

Significantly, the *Bipartisan Budget Act of 2015* (BBA)[9] prohibits off-campus HOPDs created after November 2, 2015 from collecting Medicare reimbursement for non-emergency services under the OPPS starting on January 1, 2017.[10] Effective January 1, 2017, these facilities receive reimbursement under an alternative fee schedule, such as the *Medicare Physician Fee Schedule* (MPFS) or the *Ambulatory Surgical Center Fee Schedule* (ASCFS).[11] In passing the BBA, Congress mandated site-neutral payments for all services and items furnished at new off-campus HOPDs.[12]

Overall, the ASC industry provides more low-cost services compared with HOPDs, enticing many insurers to implement more favorable reimbursement rates, and other insurers to enact policies stating that they will not pay for certain surgeries performed in HOPDs unless the site is found to be medically necessary.[13] On average, Medicare saves $2.3 billion each year due to the lower costs for procedures at ASCs than HOPDs.[14] These cost savings have incentivized insurers to increase procedure volume at ASCs.[15] Moreover, Medicare beneficiaries may also realize significant out-of-pocket savings from choosing ASCs over HOPDs.[16] A cataract extraction provided by a HOPD may cost $496 in out-of-pocket costs, whereas it may cost about $195 at an ASC.[17] Increased scrutiny by the *Centers for Medicare & Medicaid Services* (CMS) of HOPDs' high prices resulted in CMS attempting to cap payments of all HOPDs to the same as other off-campus payments.[18] However, after a legal challenge from the AHA, the rule change was struck down in court.[19] This attempt by CMS recently is likely just the beginning of their increased scrutiny of HOPDs, which will affect the financial future for HOPDs.

General Short-Term Acute Care Hospitals

Some general, short-term acute care hospitals may have competitive advantages over ASCs, including their established managed care contracts; community position; physician loyalty; and, geographical convenience for physician inpatient and outpatient practices. However, ASCs compete favorably with general, short-term acute care hospitals on the basis of cost; quality; efficiency;

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and, responsiveness to physician needs in a more comfortable environment for the patient.

ASCs have been able to compete better than community hospitals for more profitable patients by: (1) concentrating only on specific *diagnosis-related groups* (DRGs); (2) treating far fewer Medicaid patients, who may cost more to treat and generate significantly lower reimbursement yield; and, (3) opting out of emergency room departments and services.[20] It is expected that health systems will increasingly work to differentiate their ambulatory services provided from their inpatient services, driven by technological benefits, financial advantages, and patient service expectations. Less invasive diagnostic and therapeutic procedures will continue to transform inpatient procedures into outpatient ones, while also improving outcomes, decreasing patient discomfort, and decreasing convalescence length.

Physician Practices

ASCs may also face competition from physician practices that perform office-based surgeries and other technical component revenue producing services, e.g., cardiac catheterization services, onsite at the practice. Competition among these providers is likely to further grow as: (1) reimbursement for these services becomes increasingly based on *quality* versus *quantity*; and, (2) the market for these providers evolves due to increased integration and affiliation among hospitals; physician practices; and, other outpatient providers who become affiliated with an *accountable care organization* (ACO).

Market Rivalries, Competitors, and Consolidation

Gains by ASCs in the outpatient surgery market share has generated opposition from hospitals, who have traditionally commanded this market share generally and/or through their HOPDs.[21] Many hospitals argue that their survival is in danger because of loss of profitable revenue streams to ASCs.[22] Although ASCs do tend to exit markets in which there are high levels of ASC competition, there is no evidence that ASC exit rates are affected by hospital density.[23] On the other hand, hospitals tend to exit markets with high levels of ASC density.[24]

In some states, hospitals have been lobbying for stricter entry laws such as *Certificate of Need* (CON) laws.[25] CON laws were originally passed in many states in the 1960s and 1970s, with a significant push from hospital lobbying and federal encouragement, in part to prevent investments that could raise hospital costs.[26] However, the *Federal Trade Commission* (FTC) has found that there is no evidence that CON laws have led to resource savings and may actually raise hospital costs.[27] ASCs located in a state with a CON law must complete a regulatory review process in order to obtain a certificate. Currently, 35 states maintain some form of CON program, and 27 of those states have CON laws relating to ASCs.[28]

The consolidation in the ASC industry is driven in part by hospitals, which are increasingly developing freestanding facilities under joint ventures with physicians, adding increased competition for existing ASCs.[29] However, the arrangement does bring benefits such as managed-care contracts and purchasing power to newly-formed ASCs.[30] Hospitals are warming to the arrangement because of the lower operating costs and convenient locations.[31]

Aside from physician joint ventures, overall consolidation among outpatient centers has been modest over the past five years.[32] Currently, the rate of new entrants offsets the amount of consolidation occurring in the industry.[33] A very small percentage of companies own 10 or more ASCs, because there are few benefits to having a large operation in the ASC industry.[34] Ventures that operate in multiple states face significant challenges because every state has differing Medicaid coverage and regulation, adding complication to running consistent business models.[35] There are some advantages to larger operations, such as instituting best practices that improve patient care or cut costs, efficiency in payment processing, leveraged purchasing power, and better analysis or sample size of claims data for billing.[36]

Excess capacity could incentivize further consolidation in the ASC industry. Overall, the industry operates with a low level of market share concentration, due to many ASCs being single specialty enterprises, and catering to local and regional markets.[37] In 2019, the four largest ASCs are expected to generate less than 15% of total revenue.[38]

Future Growth in ASCs

The number of ASCs has continued to increase over the past decade, healthcare industry participants have significantly incorporated ASCs into their business strategies.[39] A series of ASC acquisitions in recent years suggest that ASCs are highly valued assets for hospitals systems, private equity firms, and insurers.[40] In general, hospital systems are turning their attention away from inpatient settings, and toward investment in ASCs and other outpatient settings.[41] Continued hospital system acquisition of ASCs is predicted as these systems attempt round out their continuum of care in order to meet value-based reimbursement requirements and provide procedures in lower cost settings.[42]

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1 "Chapter 5: Ambulatory surgical center services" in "Report to the Congress: Medicare Payment Policy" Medicare Payment Advisory Commission, March 2019, http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch5_sec.pdf?sfvrsn=0 (Accessed 9/23/19).
2 "Ambulatory surgical centers: Development and management" By Thomas R. O'Donovan, Aspen Systems Corp, 1976, p. xiv.
3 "HOPDs vs. ASC: Understanding Payment Differences" By David McMillan and Anderson Payne, Healthcare Financial Management Association, April 1, 2019, https://www.hfma.org/topics/hfm/2019/april/hopds-vs--asc--understanding-payment-differences.html (Accessed 10/11/19).
4 Percentage calculated by dividing the ASC Conversion Factor by the HOPD Conversion Factor (published in the CMS ASCFS and OPPS) for calendar year 2018, 2019, and 2020.
5 "IBISWorld Industry Report 62149: Ambulatory Surgery Centers" By Jack Curran, IBISWorld, May 2019, p. 8.
6 *Ibid.*
7 "Comparison of Medicare Fee-for-Service Beneficiaries Treated in Ambulatory Surgical Centers and Hospital Outpatient Departments" Berna Demiralp, et al., KNG Health Consulting LLC, April 4, 2019, https://www.aha.org/system/files/media/file/2019/04/kng-health-aha-analysis-of-hopd-vs-asc-report.pdf (Accessed 10/11/19), p. 6.
8 "Hospital Outpatient Department (HOPD) Costs Higher than Physician Offices Due to Additional Capabilities, Regulations" American Hospital Association, 2014, https://www.aha.org/system/files/2018-09/info-hopd.pdf (Accessed 10/11/19).
9 "Bipartisan Budget Act of 2015" Public Law 114-74, § 603 (November 2, 2015).
10 *Ibid.*
11 *Ibid*; "Section by Section Summary of H.R. 1314" House of Representatives (November 2, 2015) http://docs.house.gov/meetings/RU/RU00/CPRT-114-RU00-D001.pdf (Accessed 10/11/19), p. 6.
12 Public Law 114-74 § 603(2)(B) (November 2, 2015).
13 "IBISWorld Industry Report 0D5971 Ambulatory Surgery Centers in the US" By Dmitry Diment, IBISWorld, August 2019, p. 8; "UnitedHealthcare outpatient surgery policy threatens hospital revenue" By Shelby Livingston, Modern Healthcare, October 17, 2019, https://www.modernhealthcare.com/payment/unitedhealthcare-outpatient-surgery-policy-threatens-hospital-revenue (Accessed 10/31/19).
14 Diment, August 2019, p. 8.
15 *Ibid.*
16 *Ibid*, p. 16.
17 *Ibid.*
18 "Judge Tosses HHS Scheme Lowering Hospital Outpatient Payments" By Lydia Wheeler and Tony Pugh, Bloomberg Law, September 17, 2019, https://news.bloomberglaw.com/health-law-and-business/judge-tosses-hhs-scheme-lowering-hospital-outpatient-payments (Accessed 10/11/19).
19 *Ibid.*
20 "Could U.S. Hospitals Go The Way Of U.S. Airlines?" By Stuart H. Altman, David Shactman, and Efrat Eilat, Health Affairs, Vol. 25, No. 1, (Jan/Feb 2006), p. 19.
21 "Measuring Welfare from Ambulatory Surgery Centers: A Spatial Analysis of Demand for Healthcare Facilities" By Ellerie Weber, The Journal of Industrial Economics, Vol. 62, Issue 4 (December 2014), p. 592.
22 *Ibid.*
23 "Ambulatory surgery center and general hospital competition: Entry decisions and strategic choices" By Mona Al-Amin and Michael Housman, Health Care Management Review, Vol. 37, Issue 3 (July/September 2012), p. 223.
24 *Ibid.*
25 "State certificate-of-need laws weather persistent attacks" By Lisa Schencker, Modern Healthcare, January 23, 2016, https://www.modernhealthcare.com/article/20160123/MAGAZINE/301239964/state-certificate-of-need-laws-weather-persistent-attacks (Accessed 10/11/19).
26 The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis" By Daniel Sherman, Staff Report of the Bureau of Economics, Federal Trade Commission, January 1988, p. iv.
27 *Ibid.*
28 "CON-Certificate of Need State Laws" National Conference of State Legislatures, February 28, 2019, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (Accessed 10/11/19).
29 Curran, May 2019, p. 7.
30 *Ibid.*
31 *Ibid.*
32 *Ibid*, p. 7-8.
33 *Ibid.*, p. 7.
34 *Ibid.*, p. 8.
35 *Ibid.*
36 *Ibid.*
37 Diment, August 2019, p. 19.
38 *Ibid.*
39 Medicare Payment Advisory Commission, March 2019, p. 146-147.
40 *Ibid*, p. 142.
41 *Ibid.*
42 *Ibid*, p. 143.

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