Valuation of Ambulatory Surgery Center

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Introduction (Part I of V)

Ambulatory surgery centers (ASC) grew dramatically until 2008 and during the growth period provided services previously only available at hospitals. In this five-part series, the authors first discuss the emergence and decline of ASCs, the forces driving growth and contraction, and how the ASC business model differs from that of hospitals. The remaining articles in this series discuss: 1) the regulatory environment of the ASC industry; 2) the reimbursement environment of the ASC industry; 3) the competitive environment of the ASC industry; and 4) the technological environment of the ASC industry. These provide a brief overview of factors valuation professionals will consider when called to value an ASC.

Until approximately 40 years ago, virtually all surgeries were performed in hospitals.[1] Patients spending several days in the hospital after surgery was common. Hospitals faced numerous restrictions such as limited operating room (OR) availability, scheduling delays, slow OR turnover, and restrictive hospital budgets and policies.[2]

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.[3] The facilities typically provide relatively uncomplicated surgical procedures in a non-hospital setting, and most ASC cases are non-emergency, non-infected, and elective.[4] ASCs typically specialize in one or two procedures/specialties (particularly related to ophthalmology, gastroenterology, or orthopedics).[5] If there is general anesthesia administered, the procedure does not usually exceed one hour in length, and requires less than a two-hour stay in the recovery room.[6]

Since the 1970s, the ASC industry has grown at a steady pace. In 1971, the American Medical Association (AMA) adopted a resolution endorsing the concept of outpatient surgery under general and local anesthesia for selected procedures and selected patients.[7] In 1980, Medicare began covering facility costs of certain ASC procedures to promote the use of ASC settings as a less expensive alternative to inpatient procedures.[8] In 1982, Medicare approved payment to ASCs for approximately 200 procedures; in 1987, the ASC list was modified to use specific CPT codes and expanded to over 1,535 approved procedures.[9] As of 2017, more than 5,600 ASCs in the U.S. performed 23 million surgeries annually, and Medicare has expanded the list to over 3,500 procedures that may be performed in ASCs.[10] The rapid growth in the ASC sector is, in large part, a product of regulatory policy attempting to encourage innovation. As illustrated above, the federal government has consistently stabilized and strengthened the ASC industry over the years to ensure equal access and safety by regulating prices through its reimbursement policies and by controlling licensing and certification.[11]

ASCs are generally owned by physician investors who derive revenue from the ASC.[12] During the beginning of ASC development, physician-hospital joint ventures were uncommon; however, as of 2015, 17% were physician-hospital joint ventures.[13] Currently, 93.8% of ASCs are for profit and 92.9% are located in urban areas.[14] ASCs are subject to far less regulation and require less capital to develop than a hospital.[15]

The growth in the ASC industry has significantly declined since 2008; since supply now far exceeds demand, and ASCs are experiencing declining same center case volume. These market forces will likely lead to industry consolidation.[16] Hospitals' decisions to increase their outpatient surgery capacity may have been influenced by the higher rates that Medicare pays for ambulatory surgical services provided in hospital outpatient departments (HOPDs) relative to ASCs (in 2019, Medicare's rates are 94% higher in HOPDs than in ASCs) and have further compounded problems for ASCs.[17] Oversaturation is an apparent problem for the industry, likely due in part to: the low market entry barrier for physicians as a result of relatively fewer regulations; the absence of, or less stringent, certificate of need (CON) requirements; and, lower capital requirements than most healthcare ventures.[18] Medicare and managed care have also created incentives for patients to use the ASC setting. Lower procedure costs, more convenient locations, and higher quality have led

many managed care plans to insist that minor procedures be performed in ASCs; however, there is a paucity of empirical evidence to support this preference.[19] Physicians are increasingly choosing to be employed by hospitals rather than work in an independent practice, which may lead to fewer physicians choosing to engage with ASCs.[20] ASCs opening in the past year have been adjusting to the changes by including fewer ORs than in previous years, an average of 2.7 ORs compared to 3.1 ORs in 2012.[21]

Many of the future challenges for ASCs will come from the regulatory and competitive environments, expounded upon in parts two and four, respectively. There are serious concerns regarding whether the proliferation of ASCs has outpaced the regulatory capacity to inspect them; whether the ASC industry unintentionally discriminates based on race and income; and, whether physician ownership creates an incentive to suggest unnecessary surgeries.[22] As the future of healthcare becomes increasingly more consumer- and convenience-driven, the ASCs' healthcare delivery model appears increasingly more promising. However, recent push-back from organizations such as the American Hospital Association (AHA) may prove formidable.

Future installments in this series will discuss: 1) the regulatory environment of the ASC industry; 2) the reimbursement environment of the ASC industry; 3) the competitive environment of the ASC industry; and 4) the technological environment of the ASC industry.

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