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## HEALTH CARE LAW

### Physician-Owned Surgical Centers Face Uncertain Future

New laws and regulations may dim the operating room lights

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For the past 15 years, investing in a same-day surgical facility has been some of the best medicine for physicians suffering from the managed care malaise — that is the loss of income to tight-fisted health insurers and health benefit plan administrators. Although same-day surgical facilities (commonly referred to by the Medicare program designation of “ambulatory surgery centers” or “ASCs”) are subject to a number of regulations at both the state and federal levels, and physicians’ financial participation in ASCs trigger concerns about compliance with anti-kickback and self-referral laws, physicians who are candidates for these investments have become fairly comfortable with the regulatory risks, and very pleased with the profits. The toughest problem for many of these physician-investors was agreeing on how the ownership interests are allocated and the profits divided (which, as

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any health care lawyer can tell you, is much harder than it sounds).

A bill that moved swiftly through the New Jersey Legislature at the start of this past summer, and was signed into law on June 29, imposes an assessment on the gross receipts of licensed ambulatory care facilities (other than facilities that are licensed to a hospital). This assessment drains a significant part of the profitability from many ASCs, and is viewed by many physicians as symbolic of a turning of the favorable tide that has carried their surgical facility investments thus far. When this new gross receipts assessment is viewed in combination with the existing regulatory hurdles for establishing and owning a surgical facility, along with a simultaneous clamping down on payments to physician-owned ASCs by health insurers, the legal-political-economic landscape seems far less hospitable to physicians than it has in the past.

The following is a summary of the background of the ASC boom, and the regulatory scheme that once fostered it and now seems poised to slow its growth in New Jersey.

#### The ASC Boom

Improved medical technology and

techniques developed over the past several decades have made it possible for physicians to perform some traditional surgery and other invasive medical procedures using various types of scopes, in an outpatient setting that uses far less overhead than a traditional hospital. When ASCs were still relatively new, they competed primarily with higher-priced hospitals that blended their outpatient surgery rates with their charge structure for sicker patients who need more facilities than an ASC could offer.

On the legal and political front, ASCs were initially prized and promoted by government agencies as a rare innovation that could simultaneously improve the quality and experience of health care and lower its ever-mushrooming cost. For years New Jersey’s certificate of need regime granted approval to essentially all applications to establish new ASCs, and in 1998, ASCs were “deregulated” — i.e., a certificate of need was no longer required to establish a new ASC.

Government rate-setting methodologies were new and not overly restrictive, and concerns about overutilization and self-dealing by physicians were alleviated by the federal policy of encouraging the establishment of new ASCs that led to a safe harbor regulation under the federal anti-kickback law. New Jersey’s Board of Medical Examiners also responded favorably to inquiries as to whether physician-owned ASCs were compatible with New Jersey’s self-referral law, which is commonly known in the health care community as the “Codey Law,” after our state’s new governor.

But in the new, less hospitable landscape, ASCs are under siege. Competition is much greater, as many more free-standing ASCs have been built, fueled by investment by physicians, hospitals and entrepreneurial health care businesses. Competition also comes from hospitals that have changed their outpatient surgery rates to compete. Payments to ASCs are reduced by insurers, and assessed by the state, and rumors are heard in the medical staff lounge about moratoriums on processing new licensure applications.

#### Facility Assessment

N.J.S.A. 26:2H-18.57(b) imposes an assessment of 3.5 percent on the gross receipts of licensed ambulatory care facilities in New Jersey. The assessment is probably more of a hardship on other types of licensed outpatient facilities that typically have lower profit margins than ASCs, such as magnetic resonance imaging, computerized tomography and lithotripsy facilities.

The assessment does not apply to facilities with less than \$300,000 in gross revenues, and the maximum assessment in any year is \$200,000. The assessment is based on receipts from two years prior (i.e., 2003 receipts are the basis for the 2005 assessment), and is payable in quarterly installments commencing in October of the preceding year (i.e., the first installment was due Oct. 1). Facilities subject to the assessment are required to submit annual reports to the New Jersey Department of Health and Senior Services with data on visits, charges and, of course, receipts.

The assessment is doubled for facilities that are not licensed. One source of anxiety for a number of single-operating room, unlicensed ASCs was whether this double assessment would apply to them. However, the NJDHSS has indicated that the assessment does not apply to entities that are exempt from licensure.

#### Licensure and Exemption

Physician-owned ASCs in New Jersey are treated as "health care facili-

ties," and are subject to licensure by the NJDHSS. However, single operating room facilities that are owned by physicians, and used only by the physician-owners, are exempt from the licensure requirement.

Obtaining a license can add months to the process of opening a new ASC, and complying with the licensure requirements increases overhead, mostly because of physical plant requirements that are incorporated in the licensure standards. With the addition of the new assessment on licensed ambulatory care facilities, there is a fairly significant financial advantage to a single-operating room, unlicensed facility.

At the time this article is being written, there are few rulings or regulations with regard to the assessment. However, it appears that when a physician-owned ASC provides other services (in addition to surgical services) that, alone, would not require NJDHSS licensure, the assessment will attach to all of the revenue of the "facility." In other words, if a group of physicians has set up a licensed ASC in its regular practice office, the assessment would apply to all of the revenue from the office.

#### Self-Referral and Kickback Laws

When representing physicians in any health care-related business venture, health care attorneys are always concerned about compliance with self-referral and anti-kickback laws. While the application of these laws is sometimes overlooked, they carry some of the harshest penalties for violations. The federal False Claims Act allows whistleblowers to share in awards to the government under these laws, making the threat of enforcement greater.

The notorious federal self-referral law, commonly known as the "Stark Law," does not apply to physician ownership of a basic ASC that (1) is only used for procedures for which Medicare permits an ASC facility fee, and (2) does not charge for any ancillary services. The federal anti-kickback law, on the other hand, could very well apply to physician investment in an ASC if physicians are allowed to invest in order to induce or reward their referrals

to the ASC or cross-referrals to the other investors. A safe harbor regulation allows physician investment in ASCs under circumstances that limit the possibility of rewards for cross-referrals but leaves in place significant financial incentives for physicians who perform procedures at the ASC in which they have invested.

While there is no regulatory exception for physician investment in an ASC under New Jersey's self-referral law, the New Jersey Board of Medical Examiners has indicated, in response to inquiries from attorneys, that under certain circumstances the BME does not view a physician's ownership and use of an ASC as a violation of the New Jersey self-referral law.

Complications can arise under both the federal and New Jersey self-referral and kickback laws when investors want to provide other services at their facility, such as clinical laboratory testing, pathology or diagnostic imaging services, or when the investors participate financially in the professional anesthesiology services provided to patients of the ASC.

#### Insurance Limits on ASCs

Many physician-owned ASCs, including many of the most profitable ones, do not participate in managed care networks, or participate very selectively. ASCs that are not participating providers in a managed care network have charges that are significantly higher than the discounted rates paid to participating ASCs. Even after applying the increased deductibles and copayments that patients must shoulder when using an out-of-network ASC, third-party payers may still pay more than double the in-network rate to an out-of-network ASC. Compounding the problem for payers, in some cases, physicians who do procedures at the ASC are participants in a network in which the ASC does not participate. This gives the physicians the improved access to patients that network participation entails, while only discounting their professional fees, and not the ASC facility fees.

In order to hold down payments to ASCs, some insurance companies and

health benefit plan administrators are seeking to reduce the use of out-of-network ASCs or reduce payments to out-of-network ASCs for the services they provide. This trend has been in the offing for several years and appears to be taking hold.

There are several techniques being used to accomplish this. Some insurers have sent letters to physicians who participate in their networks, warning that referrals to an out-of-network ASC violates such physicians' obligations as participating providers to refer to other participating providers whenever possible. Some insurers have paid claims from ASCs at a lower rate, claiming that the ASCs' charges were beyond the "usual and customary rates" covered by their benefit plans. Any attempt to limit or reduce payments to out-of-network ASCs is likely to be contested on the

grounds that it deprives the beneficiary of a benefit that is covered by their health benefit plan, not to mention the fact that it deprives the ASC of a substantial amount of revenue. Without actual modifications to the benefit plans that are being marketed by insurers, out-of-network ASCs can be expected to put up a fierce fight on this issue. However, the potential for eventual reductions in payments will impact the anticipated profit projections of many ASC projects that are in development, as well as many existing ASCs.

#### Conclusion

A question to keep in mind is whether and how the new and increasing pressures on ASCs discussed above might affect a physician-owned ASC project. Clearly financial projections

prepared in the past will have to be adjusted. This may winnow out less hardy, more risk-averse physicians from the pool of participants, leading to pressure for more aggressive business and legal structures, and attracting the attention of regulators to a sector of the health provider community that has been relatively free from scrutiny.

Looking to the future, there is probably a need for greater discipline and more careful attention to details in structuring physician investments in ASCs and in disclosing both the legal and financial risks to potential investors. Attorneys who represent physicians who have invested in an ASC or are planning to invest in an ASC will need to have extensive knowledge of the health care laws and regulations discussed above, as well as the trends in this area. ■

