An intersection of benefits continues to make ASCs a good choice for clinics.

By Cathleen McCabe, MD, and Jeffrey Whitman, MD

Cataract surgery is one of the greatest success stories in medicine, with low complication rate and significant impact on the daily lives of patients. The majority of the 3.8 million cataract procedures performed annually in the United States are done in the approximately 1,200 ASCs specialized in the provision of cataract and other ophthalmic surgeries.

ASCs are Medicare-certified, state-licensed, accredited and highly regulated, and offer a cost-effective means to meet the growing demand of cataract surgery in a high-tech operating space overseen by ophthalmic-care professionals.

Outpatient Ophthalmic Surgery Society (OOSS) conducted an evaluation of surgical facilities that examined the following elements:

1: PATIENT HEALTH AND SAFETY

The cataract surgery OR is a comprehensive, high-tech environment housing phacoemulsification equipment (with or without femtosecond lasers), operating microscopes, delicate surgical instruments and sterilization systems that have been designed for the ophthalmic microsurgical setting. The ASCs may also contain sophisticated equipment such as head-up surgery technology or AI-driven intra-operative guidance systems. Staff are licensed and trained in ophthalmic care and the use of this specialized equipment. The surgeon, anesthesia professionals and clinical staff focus on emergent care needs, including patient monitoring equipment, medical gases (eg, oxygen), crash carts, defibrillators and all other airway and medication requirements. Creating this complex environment of trained professionals and costly equipment is an expensive endeavor and requires substantial attention to detail.

A survey of OOSS member and non-member ophthalmic ASCs confirms that virtually all facilities are Medicare-certified; 85% are accredited by a CMS-approved agency as an ASC, and 81% are licensed by their states as ASCs. Meeting these requirements enables facilities to receive Medicare facility fee reimbursement of more than $1,000 per cataract case.

For patient health and safety purposes, advocates for OBS note that their facilities are "accredited." However, these facilities are accredited as "offices," and they adhere to standards pertaining to infection control, life safety, environment, anesthesia, nursing and supervision that are not as strict as those applied to ASCs.

2: FINANCIAL PERFORMANCE

The ASC has proven economic strengths based on receiving a fair facility fee with suitable volume and a predictable cost structure. The investment in building a new ASC, furnishing it with the necessary technology and equipment in addition to operating it with professional, dedicated, trained staff, is significant. Some physicians prefer a multiple-owner ASC while other high-volume surgeons opt for an individually-owned ASC. Having multiple physicians invest in and use the ASC provides the opportunity for member physicians to share costs, to benefit from the growth of colleagues' practices and to optimize the use of the facility and resources. Individual owners assume all the risk, control and benefit of the ASC.

When a surgeon buys into an existing ASC, the investment can provide immediate return on investment (ROI) — possibly receiving distributions the next month based on proven operations, proven revenue stream and proven past distributions, ultimately resulting in an accelerated ROI. In contrast, an OBS' financial performance can be significantly limited by lower surgical volumes that generate minimal to no facility fees, with surgery performed exclusively by physicians of the practice — at least, in the current payer environment.

The ASC will likely obtain better pricing of supplies, implants, instruments and equipment given its higher volume, and will have a more robust and diverse lens/implant consignment, providing the surgeons with more flexibility in providing a variety of treatment options.

3: RISK ASSESSMENT – FINANCIAL/CLINICAL

Syndicating into an existing ASC costs less and may yield a bigger return faster than building

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Comparison of ASC and OBS business models

This comparison of business models includes data from ASC management companies AmSurg and Surgery Partners, and consulting firm MCG. It also includes information from marketing materials from iOR Partners.

Business model assumptions and rationale

- Approximately 45% of cataract patients are Medicare, eliminating them from OBS volume due to lack of existence of a facility fee.
- Approximately 30% are Medicare Advantage patients. It is speculated that OBS may secure half of such contracts, over a number of years.
- Approximately 25% of patients have private insurance. It is estimated that half of contracts may materialize over a number of years.
- 88% of patients have two or more comorbidities that could prevent them from having surgery at an OBS since these facilities are neither equipped nor have personnel (eg, anesthetists) to perform such surgeries.
- Consequently, based on empirical industry and market data from Am Surg, Surgery Partners and MCG, it is estimated that a maximum of 30% of a practice's cataract cases could be performed in an OBS.
- Syndication assumptions: Existing ASC with $1,000,000 EBITDA; Purchase 35% at a four-times multiple EBITDA; Accretive to existing surgeons meaning their remaining 65% of now $1,615,000 equals $1,049,750.

OBS case assumptions:

- Medicare pays no facility fee for cataracts, YAGs or any other procedure in OBS. Medicare Advantage plans and commercial plans rarely pay such facility fees in OBS, as well.
- Due to medical reasons, some patients are not suited for surgery in OBS.
- Insurance coverage will not cover devices and implants in an OBS.

	PHYSICIANS	BUILD NEW ASC	SYNDICATE IN ASC	OBS
Volume projections	**Total Volume**			
Cataract	1000	1000	1000	300
YAG Capsulotomy	300	300	300	0
Refractive Lens Exchange	300	300	300	300
Revenue Per Case Assumption				
Cataracts		$1,000	$1,000	$600
YAG Capsulotomy		$250	$250	$0
Refractive Lens Exchange		$800	$800	$800
Investment				
Build out		$1,119,800		$414,800
Equipment		$732,100		$417,500
Other Start-up		$189,600		$47,500
Syndication			$1,400,000	
Total Investment		$2,041,500	$1,400,000	$879,800
First 2 Year ROA in dollars		$N/A *	$1,232,250	$N/A**
First 7 Years ROA in dollars		$1,720,000	$3,943,500	$18,700
First 10 Years ROA in dollars		$4,975,500	$6,754,750	$317,600
Value of Investment in 12 years		$3,060,000	$2,261,000	Integral to Practice
Total 10-year return		$5,994,000	$7,615,750	$(562,200)

* The time of decision to build an ASC to opening facility takes 12-24 months, plus potentially 12 months to realize positive cashflow.

**From the time of decision to build out an OBS to opening the facility take six to 12 months, plus time to secure contracts; therefore, realizing cash flow likely takes 12-18 months.

a new one. For both new and existing ASCs, the financial risk can be shared by a group of physician owners. In a partnership scenario, the ASC revenue and productivity grow as each physician's volume increases. All partners benefit from each physician's use of the facility. The ASC can recruit new ophthalmologists to use the center, add sub-specialties and/or add new specialties to be performed to grow volume and revenue. The financial risk of owning an ASC is shared with the other owners also performing procedures. Any vacations, illnesses, long-term absences or closures due to external reasons (such as COVID-19) are absorbed and shared by the group of owners. In a single-owner ASC scenario, the physician can operate a very efficient, profitable, independent ASC while building a separate asset from the practice.

The surgeons' clinical risk is mitigated when performing surgeries in a Medicare-certified, state licensed or accredited (as an ASC) facility committed to providing optimal care in the ASC. An OBS may seek accreditation as an office, but these standards are less rigorous than those for ASCs.

4: AVAILABILITY OF AND ACCESS TO DESIRED TECHNOLOGY

ASC physicians-owners share costs helping them to invest in the latest innovative technologies. In an individual-owner ASC or OBS, the owner has the freedom to select desired technology but bears the full cost burden.

An additional consideration is that ophthalmic devices and implants such as minimally invasive glaucoma surgery, or MIGS, that clinically benefit the patients and provide an additional physician fee of $300 to $500 are approved in the ASC as the place of service.

5: DEDICATED PROFESSIONAL, TRAINED STAFF

With a dedicated professional staff at the ASC, physicians can perform the highest volume of procedures in minimal time, optimizing efficiency in the OR. The ASC staff is specifically recruited and trained for surgical environment as their unique focus. The staff is prepared for emergencies and complications. In an OBS, the staff has surgical duties such as scrub tech support and administering of anesthesia on a part-time basis, secondary to their primary clinic functions.

6: LIFE BALANCE

Spending less time to do a higher volume of surgeries in an ASC frees up more time for practice management, clinic or family. In an ASC, the physician is uniquely focused on performing surgeries, assisted with specialized staff dedicated to surgical care. Most surgeons will utilize multiple ASC ORs to optimize their efficiency. In an OBS, the surgeon is responsible for the care of patients, medical emergencies, anesthesia complications, management of staff and operations of practice and office surgical suite.

7: ASSET BUILDING

The ASC has the potential to generate significant ROI for the physician-owner. With the ever-changing health-care environment and reimbursement rates, it is in the physician's best interest to own two separate entities — the practice and ASC — and to align with a leading, progressive ASC. The physician who builds a practice that includes an OBS has one business yielding less flexibility and more risk.

For both new and mature surgeons, ASC-ownership is a key component of building long-term financial security. To enable new surgeons to own an ASC, current owners must prepare to sell ownership shares to them. Adding productive owners will increase the ASC surgical volume from new surgeons, grow the business and continue the high performance of ASCs. Mature surgeons have the opportunity to divest ownership shares in an accretive method that reduces their percentage of ownership while potentially increasing their distributions because of the incremental volume from new partners — building opportunity for the prosperity of new surgeons and rewarding experienced surgeons for their contribution over the years of ownership.

CONCLUSION

Cataract patients deserve safe, effective and affordable care. They expect limited risk of complications, and an improvement in their daily lives. ASCs and hospitals deliver the established cataract standard of care in appropriately accredited facilities tended by specially trained professional staff. The ophthalmic ASC remains, after decades of proven results, the best solution for patients and physicians. **OM**

For more info and resources, visit www.OOSS.org.