Developing an Ambulatory Strategy

A Q&A on the importance of considering an ambulatory surgical center or office-based lab to achieve your goals.

WITH ANNE BEEKMAN, RN; JACOB TURMELL, DNP, RN, NP-C, ACNS-BC, CCRN-CMC; AND MARC TOTH, CMAA

If you are a cardiovascular administrator or physician leader, you have likely been asked the question: "What is your ambulatory strategy?" It is an increasingly popular query in the cardiovascular world. Any ambulatory strategy will require the consideration of an ambulatory surgical center (ASC) or office-based lab (OBL) as a means to provide outpatient cardiovascular services. To better understand the required steps in considering and implementing an ASC or OBL plan, Anne Beekman, RN, Vice President of MedAxiom Consulting, spoke with Jacob Turmell, DNP, RN, Vice President of MedAxiom Consulting, and Marc Toth, CMAA, Chief Executive Officer of ACA Cardiovascular.

Ms. Beekman: Why is developing an ambulatory strategy such a hot topic?

Mr. Turmell: Every day, we see an increase in the shift to more of an ambulatory setting for many procedures that were once inpatient. The Centers for Medicare & Medicaid Services (CMS) is changing reimbursement to push certain procedures into the ASC or OBL, particularly in the vascular, electrophysiology, and cardiac space. With this change, cardiology practices are finding it to be a step in the value transition and a better patient and provider experience. The risk of not creating an ambulatory strategy for your practice is that someone else will, putting you in a position to potentially lose patients and market share.

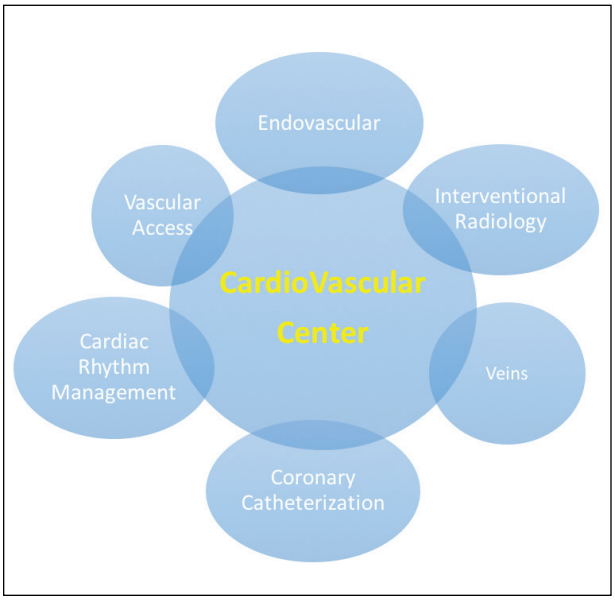
Ms. Beekman: What advice would you offer to a program or physician group considering an ASC or OBL?

Mr. Toth: Determine your outpatient strategy for the next 5 to 10 years; this will help identify what you should do today. Understand local, state, and federal regulations, and select the range of services you would like to offer, considering which subspecialties will be complementary to the case mix you offer. The scope of services at many cardiovascular centers is represented in Figure 1.

Next, you should work to understand the local market dynamics in terms of referrals and potential physician partners or a joint venture with a hospital. Also, what are the facility options and limitations you face when considering the options of an OBL in an office, de novo ASC, or timeshare facility with other subspecialties?

During the predevelopment strategy phase, it would be helpful to focus on the following considerations:

- Carefully assess patient volume based on expected physician participation and interest



Courtesy of Marc Toth, CMAA, ACA Cardiovascular.

Figure 1. Organizational structure of cardiovascular centers with subspecialties.

- With projected volume, estimate corresponding construction, supply, and staffing costs
- Choose a facility that is appropriately sized for today's and tomorrow's case load expectations
- Engage with a qualified architect and construction management firm with significant ASC experience to ensure that the facility is built to Medicare standards
- Develop a sound pro forma with expected volumes and realistic debt, with a business plan addressing key operational and governance issues including all key stakeholders
- Select a health care attorney with expertise in developing ASC structure

Ms. Beekman: How do you decide whether an OBL or ASC is right the path?

Mr. Toth: OBLs are relatively fast, easy, and inexpensive to start but are limited in the scope of care that they can provide. For example, an endovascular OBL can be opened in most states in a few months, with a relatively small capital investment, but it is essentially limited to peripheral artery disease, venous, and fistula maintenance procedures.

They are also at risk for CMS changes in reimbursement. Medicare's dramatic reimbursement reduction in fistula maintenance procedures in 2017 led to the closure of many office-based vascular access centers. This CMS reduction of the same fistula procedure was not realized in ASCs, resulting in this great variance in payment based on a different site of service. This has led to the conversion of many centers to hybrid OBL/ASC. You should consider whether your center can survive long term as an OBL with fluctuations in CMS reimbursement, such as the 2017 cuts highlighted in Table 1.

ASCs have a distinct set of requirements that requires thoughtful and thorough analysis, as well as expertise and guidance in development and management. This entails a slightly larger capital outlay and certification by Medicare. ASCs also have the ability to offer a broader scope of services and can be combined with an OBL as a hybrid center to mitigate variation in CMS reimbursement. Depending on the market dynamics, developing an ASC as a joint venture with a hospital may be a good strategy for risk sharing.

Ms. Beekman: Can certificate-of-need (CON) states participate in an ASC or OBL for cardiac devices and invasive coronary procedures?

Mr. Turmell: The simple answer is yes. There are many things that you must consider if you live in a CON state. Currently, there are 35 CON states, as well as Washington, DC. These states have laws and regulations that require approval before an organization can expand, offer new services, or purchase certain pieces of equipment.

Obtaining a CON, however, can be challenging. In the first quarter of 2018, we've seen three OBLs obtain CONs in notoriously difficult states in the Midwest. These CONs were obtained by applying for a single specialty (ie, a vascular CON rather than a multispecialty CON).

Mr. Toth: One effective strategy is to build your OBL to ASC Medicare standards and immediately begin performing as an OBL as soon as state licensure is achieved. Concurrently, the center can apply for the CON and get started with the application for Medicare certification. Although it may cost slightly more to construct, having a Medicare-certified center allows many more options.

Ms. Beekman: Are there regulatory, CON, or accreditation requirements that need to be considered? Are they the same for both an ASC and OBL?

Mr. Turmell: In general, ASCs are highly regulated facilities at both the state and federal levels. An ASC must meet state requirements and obtain a state license, as well as meet standards for Medicare and be approved by the federal government. For this, the ASC should be accredited to ensure that it meets established standards. There are several options for accreditation including the American Association for Accreditation of Ambulatory Surgery Facilities, The Joint Commission, the Accreditation Association for Ambulatory Health Care, and the Healthcare Facilities Accreditation Program.

All of these organizations have similar standards for ASCs. Additionally, CMS has specific requirements for them as well, including (1) it must operate to provide surgical services not requiring hospitalization; (2) services do not extend past 24 hours; (3) it may not share space with another entity during operating hours; and (4) it may not share space with a hospital or critical access hospital outpatient surgery center.

OBLs are often considered "just another department." OBLs are not as stringently regulated, but there might be certain standards state by state. There is the option to have the OBL accredited either through The Joint Commission or the Accreditation Association for Ambulatory Health Care. The concern for the lack of regulations and safety has led to the creation of the Outpatient Endovascular and

TABLE 1. CMS REIMBURSEMENT FLUCTUATIONS					
Procedure	2017 Bundled CPT Code	Office-Based 2017 Final FFS	Approximate ASC Rate	Approximate Variance ($)	Change (%)
Access angiography	36901	$580.70	$369.36	$211.34	-36%
Angiography with angioplasty	36902	$1,234.97	$3,119.32	$1,884.35	+153%
Angiography with stent	36903	$5,663.44	$6,025.55	$362.11	+6%
Thrombectomy	36904	$1,800.60	$3,119.32	$1,318.72	+73%
Thrombectomy with angioplasty	36905	$2,304.14	$6,025.55	$3,721.41	+162%
Thrombectomy with stent	36906	$6,867.55	$9,341.79	$2,474.24	+36%

Abbreviations: ASC, ambulatory surgical center; CMS, Centers for Medicare & Medicaid Services; CPT, current procedural terminology; FFS, fee for service.
Data from the Centers for Medicare & Medicaid Services.

Interventional Society (OEIS), which looks at OBL safety and accreditation, credentialing, registry data, compliance, and appropriateness.

Ms. Beekman: Which quality metrics should be monitored for an ASC or OBL?

Mr. Turmell: For an ASC, there are many quality metrics that you should report based on CMS guidelines. Some of these are continued from last year, such as wrong site/side/patient/procedure, rate of hospital transfer/admission, and status of personnel who have been vaccinated for influenza. Some new criteria have been added and some are voluntary; however, these have more to do with eye procedures and normothermia. Many ASCs report registry data if they are doing any electrophysiology device work.

For an OBL, there is no specific set of quality metrics that need to be reported. Most OBLs have internal quality metrics that are reviewed. For example, a group may look at patient flow, patient satisfaction, or process improvement measures to evaluate the quality of care being provided. Additionally, some OBLs will continue to report registry data for catheter-based procedures and percutaneous coronary interventions (PCIs).

Ms. Beekman: Can an OBL offer ASC-type services? If so, what is the cost?

Mr. Toth: First of all, if you're in a CON state, plan on $75,000 in attorney fees for the CON application. The cost of converting an OBL to an ASC is difficult to estimate because so much depends on your physical office space. Generally, buildings built before 2005 are going to be cost prohibitive to convert to a Medicare-certified ASC. Engaging with an architect who has significant Medicare-certified ASC experience is the best way to get an accurate assessment.

Ms. Beekman: Are there ways for employed physicians to participate in an ASC or OBL?

Mr. Toth: In anticipation of PCI becoming CMS approved in the ASC setting, we may see cardiac and vascular hospital administrators become more interested in partnering with physicians in their outpatient strategies. Joint ventures with physician groups and hospitals may become a great way to share risk and deliver high-quality, efficient, consumer-friendly, outpatient cardiovascular health care together.

Ms. Beekman: Some ASCs and OBLs may not be financially viable. What causes these failures?

Mr. Toth: The foundation for success—or failure—of an outpatient strategy is established during predevelopment. That's why the predevelopment phase must be a methodical process with careful planning and discussion of key issues that affect the entire process. Attention must be given to formulating sound financial projections, creating an equitable ownership and governance structure, creating an efficient design, obtaining financing, and ensuring that the project is well capitalized. During this phase, the very culture of the outpatient strategy begins to emerge. Errors in this phase have a tendency to be long lasting.

At the conclusion of predevelopment, the key operational governance and ownership issues are clarified for the participating members; investment equity is raised from the participants, financial feasibility is measured, the design is finalized, and financing is obtained. With a well-conceived plan, you will be on your way to making your vision a reality.

Most OBLs and ASCs are successes or failures before they're built. Planning is absolutely critical to long-term success. Developing an accurate and comprehensive business plan along with a thoroughly vetted

operational structure gives the outpatient center its best chance for success. Patient volume equals revenue. Therefore, it is critical to accurately predict volume by specialty and payer and assign reimbursement rates to these predictions to determine expected annual revenue.

Finalize the pro forma with the estimated patient volume and reimbursement, the corresponding staffing and supply matrix, plus estimated facility needs. Develop a multiyear projected income statement and projected cash flow, along with a solid business plan and revenue forecast to determine economic feasibility. Continue to verify these assumptions throughout the process.

Ms. Beekman: Thank you both for sharing your expertise and this detailed information on the changing landscape of outpatient cardiovascular procedures. It is an important conversation for cardiovascular physicians and leaders to be having. The opportunities that an ASC or OBL can bring are exciting, but according to the OEIS, as many as 25% of all OBLs fail. I hope that the information shared here will help programs avoid being part of that statistic. ■

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