

OBL, ASC, or Hybrid: Which Model Is Right for You?

Jim Melton, DO, and Michael Ferguson discuss ambulatory surgery centers and office-based labs for cardiac and vascular procedures and the emergence of the hybrid business model.



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An additional disruption in the hospital industry has been the implementation of CMS's new price transparency regulation, which was effective January 1, 2021. The United States Department of Health and Human Services now requires hospitals to publish 70 stipulated services and 230 others online or face a fine up to \$300 per day. This ruling does not yet apply to OBLs or ASCs, but it is best to be prepared. Ultimately, price transparency will benefit OBLs and ASCs in that it will enable patients to make more informed decisions regarding their care, highlighting the value proposition of high-quality care at lower costs in both sites of service.

In this article, two industry experts discuss considerations in determining which model might be best for your practice.

As more cardiovascular procedures are moved to an ambulatory surgery center (ASC) setting, we have seen the emergence of a “hybrid” business model, which combines an office-based lab (OBL) with an ASC. The Centers for Medicare & Medicaid Services (CMS) explains the difference between an OBL and an ASC in its Place of Service Code Set. An OBL is a location where the health professional routinely provides examinations, diagnosis, and treatment of illness or injury on an ambulatory basis, whereas an ASC is a freestanding facility, other than a physician's office, where diagnostic and surgical services are provided on an ambulatory basis.¹ In the hybrid model, an appropriately equipped facility typically operates as an OBL on certain days of the week and as an ASC on other days. This model allows a broader range of cardiovascular services to be provided in the hybrid facility.

Driven to reduce health care costs, insurers had started steering procedures to ASCs and OBLs instead of higher-cost hospitals before COVID-19. With infection concerns and a near halt in hospital-based elective procedures, the outpatient market has become an even more popular option for patients, and it is likely to remain so after the pandemic's end.

Can you tell us about your journey from a large hospital system to your current hybrid model?

Dr. Melton: We left the “big box” hospital system in 2015 because we wanted our patients to experience lower costs, reduced infection rates, and significantly higher satisfaction. My partners and I took a longer-term view of which model we wanted as our end state. Obviously, we saw the trend of increasingly more procedures moving out of the hospital into outpatient clinics. Additionally, we were hearing about a transition of reimbursement codes for a moderate number of cardiology procedures changing between the OBL and ASC settings. We believed that the hybrid model afforded us greater flexibility in managing our practice and higher efficiency in patient throughput.

Accordingly, we acquired a 40,000 square foot facility and built out a 10,000 square foot ASC on the first floor, while simultaneously operating as an OBL on the second floor. The 20,000 square feet on the second floor is office space, patient meeting rooms, and testing equipment. We operated as an OBL only for the first 8 months while we secured our license from the state to operate as an ASC. Our intuition in building the ASC

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immediately resulted in an overall cost savings versus retrofitting later and expedited our operations as an effective and streamlined hybrid model.

Which factors most impact the model that you select?

Dr. Melton: The decision regarding which model is best for you depends on your vision, risk tolerance, the makeup of your partners, and what you want your legacy to be. As a doctor, you need to put on your business hat when you make these decisions. You need to understand what procedures are reimbursed in each setting. For example, peripheral artery disease or critical limb ischemia pays much better in the OBL than the ASC, albeit 40% to 50% less than in the hospital. We are seeing many of those codes migrating to the ASC. That is why we did a hybrid model—to have the flexibility to adjust from a business perspective when CMS makes changes to reimbursement codes.

Mr. Ferguson: The most important thing to consider is your procedure mix today and where you want to see it in the coming years. Certainly, competitor research, environmental scanning, and staying abreast of proposed industry and technology changes are critical to your decision. The next consideration is where are your referrals coming from. Will you have enough business to sustain the practice?

We see more doctors looking closely at the codes when evaluating which model to adopt. For example, some specialists, such as a vascular surgeon or interventional radiologist, are choosing to operate solely as an OBL because their procedures are reimbursed at a higher rate within the OBL. On the cardiologist side, we see the majority move toward the hybrid model because they want the flexibility to do pacemaker implants on certain days of the week and peripheral vascular procedures on other days.

A word of caution: If you start with an OBL and believe you will eventually transition into a hybrid model, you should consider a buildout for the hybrid model specifications in the beginning, like Dr. Melton's practice. Although more expensive up front than just building an OBL, it is far less expensive than converting from an OBL to a hybrid a few years down the road.

Do you believe that an OBL-only model is too limiting?

Dr. Melton: I feel a standalone OBL has some business risk associated with it because you are limiting the number of procedures you can perform. The hybrid model, and especially a multispecialty hybrid, helps reduce risk, as you are not reliant on just one referral base. The downsides of starting a hybrid model from

the outset are the steep investment required to fund the build out to accommodate specialized equipment, mandatory patient requirements, and additional regulatory and Certificates of Need, among other capital and expense items.

Mr. Ferguson: In this outpatient market, we are seeing about 50% of our new customers operating as OBLs and the other 50% as ASCs or hybrid. Cost and state regulations appear to be the predominant drivers when deciding which model to adopt. You can operate an OBL almost anywhere, but an ASC has stringent state regulations that are expensive to implement. Rooms, hallways, and doorways must adhere to specific size standards, special accommodations for patients are required, and even the parking lot must meet code. So, the building, design, and initial investments are different for both models. You can build an OBL from the ground up in about 6 months, whereas it could take 12 to 18 months to build out a compliant ASC.

What impact has your hybrid model, the Cardiovascular Health Clinic, had on your patients and community?

Dr. Melton: Patient care is at its peak in our facilities and patient satisfaction is through the roof. With one-on-one nursing care, private rooms, and a comfortable environment, our patients feel like they are receiving concierge medicine, and their insurance companies are paying for it. From a care standpoint, it is very gratifying to know that we are making a difference. We are dedicated to limb salvage and amputation prevention. The ability to get people in immediately, conduct a procedure, and release them to go home the same day is incredible.

We also operate multiple locations throughout Oklahoma, enabling us to profitably serve the rural communities. We can travel when needed to see or evaluate patients and then perform the main procedures at the Cardiovascular Health Clinic in Oklahoma City. Satellite facilities are not a requirement when setting up an outpatient clinic. The decision for satellite offices should be driven by the physician group and where your referrals are coming from.

How did the COVID-19 pandemic impact the outpatient market?

Dr. Melton: I think that the COVID-19 pandemic has accelerated the transition to OBLs and ASCs. My state shut down the majority of elective surgeries, but they wanted us to stay open to take care of cardiac and vascular patients because hospitals didn't have the capacity.

Mr. Ferguson: Growth in the OBL/ASC market over the past 5 years has been slightly faster than anticipated. Of course, the pandemic caused an enormous uptick this past year, as hospitals could only treat essential patients. Physicians were actively searching for alternative options to see and treat their patients. Philips was able to help supplement a number of OBL physicians by bringing in mobile C-arms for patient diagnostic procedures. Recognizing the huge advantage of enabling patients with vascular and/or heart disease to come to the OBL, be seen, receive a diagnosis, and get treated in the same facility on the same day, many physicians committed to the hybrid model and started the process to build out ASCs, space permitting.

COVID also prompted CMS to take a closer look at the benefits of this outpatient opportunity. The alternative was forcing patients to wait for months for procedures because they couldn't get into the hospital. Patients are thrilled with the white glove experience from the time they walk through the front door to the time they leave. It is a completely different patient experience. As these cases move to the outpatient setting, it allows hospitals to focus on the more complex and urgent cases, allowing both hospitals and outpatient facilities to provide greater access to care for all.

What regulations are impacting the outpatient market?

Mr. Ferguson: CMS and reimbursement rates are certainly helping to shape the market. Additionally, technologic advances continue to induce CMS to approve new procedures that do not require hospital visits. I think this growth trend will continue as long as CMS sees the benefit, including high patient outcomes and satisfaction, and cost curves that maintain their current direction.

Currently in the United States, the hybrid model is not permitted in every state. Approximately one-third of all states do not allow an OBL and ASC to share the same location or operate simultaneously.² In order to help change state laws and guidelines governing the formation of ASCs, physicians and societies will need to continue organizing and engaging with state politicians for more changes to occur.

What are the benefits of transitioning from the hospital system to an outpatient hybrid model?

Dr. Melton: First, the biggest benefit for myself and my patients is the efficiency. I can see a patient who may be at risk of losing a leg in the next 24 hours, take them downstairs, and treat them the same day. That would be unlikely in a hospital. Working side by side with your staff each day, you can see the collabora-

tion, teamwork, and patient throughput all improve. Second, operating your own business and controlling your schedule and tempo has a tremendous impact on your quality of life. I still do some procedures at the hospital, but for the most part, I end my day at a reasonable hour and spend time with my family. Last, the autonomy in building a business that I control is professionally gratifying. I am able to recruit and mentor physicians who have the same work ethic and dedication to patient care, and ultimately, my business becomes my legacy within the community and an asset that will have tremendous monetary value at the point I decide to retire.

Mr. Ferguson: Physicians want to give their patients improved access to quality care, increased transparency, and a better experience. Physicians also want more control over their time so that they are not waiting until the end of the day to do a peripheral procedure at the hospital. With an ASC or OBL, they schedule procedures when they deem it prudent and finish their day with time left to enjoy their favorite pastimes.

What is the formula for success with the hybrid model?

Dr. Melton: You must have the right people—both within and outside your organization. If this is your first foray into running your own business, a management group can be invaluable in helping evaluate the market, plan the buildout, and even help deliver patient satisfaction. Which procedures are needed most? What is the best geographic location? What is the competitive landscape? What are the state requirements? Are you in a Certificate of Need state and how does that impact the process? What is the best model, footprint, and build out?

An industry partner, like Philips, can also be extremely helpful to a group starting out. In addition to their vast array of quality equipment and expertise, they can provide capitalization upfront by leveraging downstream product. This can be critical, as doctors may not have the capital or the ability to borrow the capital they need. It is an incredible program that has enabled this model to proliferate and is highly valued by participating physician groups.

What advice do you have for a physician interested in opening an OBL, ASC, or hybrid lab?

Dr. Melton: If they are entrepreneurial, want to build a legacy, and focused on providing the best patient care and experience, I would tell them to go for it. I would encourage them to adopt a hybrid model based on the increased flexibility in procedures and reduced longer-

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term risk. Last, don't go it alone. Secure the help of a management company or consultant to assist with those aspects of the startup or business processes that may not be your strength.

Mr. Ferguson: My first piece of advice is to understand your state's rules and regulations. Are you in a Certificate of Need state? What are the laws specific to your state? Second, you may want to designate a member of the team who can focus on the business side of things. Where will you locate your business? Who is overseeing the buildout, equipment, and other purchases? What about staffing? Under the hybrid model, a facility must ensure physical separation of the OBL and the ASC operations. The OBL and the ASC retain separate tax identification and national provider identification numbers. In addition, the operations must remain "distinct entities," which involves measures such as maintaining separate medical records and communicating to patients the different hours and policies of the OBL and the ASC.³ In addition, the administrative team needs to ensure the appropriate procedures are scheduled on the correct OBL or ASC operating days. There are a number of management companies that specialize in these type issues and are almost always worth the investment to get it set up right.

What are your predictions for the future?

Dr. Melton: We have seen a lot of the vascular and cardiac procedures transition out of the hospital. I believe we will see additional procedures, such as total joints and spine surgeries, transition to the clinic. The transparency issue will become a big deal in the coming year. We are already seeing patients shopping costs for procedures, with the hybrid model as a very attractive option to them.

Mr. Ferguson: I see less fear and resistance from the hospital side. Hospitals have witnessed that the OBL/ASCs are not taking business from them. I also see the rapid growth in rural areas continuing. The outpatient clinics are bringing valuable services into communities that had previously not had convenient access to these procedures.

I think that the market is going to continue to move forward with new procedures being opened up every day. New technologies are enabling additional pro-

cedures to safely be completed outside the hospital. In 2019, CMS's inclusion of "surgery-like procedures" added cardiac catheterization and coronary interventional procedures to the approved list, and in 2020, the addition of certain angioplasty and stenting procedures further expanded the range of cardiovascular services that may be performed in ASCs or OBLs. ■

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Dr. Jim Melton is a vascular surgeon and Cofounder of Cardiovascular Health Clinic, Advanced Cardiovascular Solutions, and Advanced Surgical and Research Solutions. He earned his Doctorate of Osteopathy at the Oklahoma State University College of Osteopathic Medicine. He performed his residency in general surgery and his fellowship in peripheral vascular surgery at Doctors Hospital in Columbus, Ohio. He is board certified in general and vascular surgery and has been instrumental in the advancement of vascular surgery and the treatment of peripheral artery disease in the state of Oklahoma throughout his career.

Michael Ferguson is the Vice President of Sales for Procedural Solutions within the Philips Image Guided Therapy Business Group (NYSE: PHG). In this role, he is responsible for managing OBL/ASC sales and customer relationships as well as leading strategy in hospitals for combining the sale of equipment and devices to create customer value. Mr. Ferguson is a strong leader with more than 24 years of interventional cardiovascular and peripheral vascular experience and is dedicated to both empowering care providers and ensuring that they have the resources they need to open their own OBL/ASC. Mr. Ferguson is recognized as an expert in the OBL/ASC field by physicians and industry leaders and is active on the Board of Directors for OBL/ASC societies, OEIS, and Cardiovascular Coalition.

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