

Guidelines for Setting up an Ambulatory Surgery Center

Here's what you need to know for this endeavor.

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With today's changing healthcare landscape and the emphasis on lowering costs while bettering outcomes, physicians, payers, and patients are all embracing new methods to achieve both. Studies have continually demonstrated that outpatient surgery performed in an ambulatory surgery center (ASC) generally leads to excellent outcomes at significantly lower costs.

As a general rule, payers reimburse the ASC facility fees well beyond what they pay for surgeons' fees alone. For some cases, the addition of a facility fee to the surgeon's fee makes an otherwise minimal reimbursement significantly profitable. The surgeon is also able to control both safety and cost, utilize familiar assistants, and have more scheduling freedom. These efficiencies can allow the surgeon to increase his or her caseload without a significant change in work hours.

A prudent surgeon can take advantage of this to provide the best possible surgical experience for the patient and to do so in the most efficient and reasonably profitable manner. But given the fragile state of our economy and the uncertainty of healthcare, should you?

Financial Feasibility

When considering adding an ASC, the physician/surgeon and/or group must determine the number of outpatient cases performed and multiply that by the expected reimbursement for these procedures.

Preparing a pro forma income statement is the first step in the feasibility study. The pro forma analysis and feasibility study should be based on sound data regarding projected case volumes, case mix, and expected reimbursement rates. The greater the accuracy of the case volume and

of your patients would be considered "out-of-network" in your ASC, they will opt for surgery at the local "in-network" hospital. Early in the planning stage, you should attempt to discuss contracting with payers and obtain a real sense of whether contracts will be available and at what price.

Over the last decade, ASCs have faced increasing costs in areas such as labor and supplies. With no reimbursement increases for many years and increasing costs, surgery centers have been in a progressive margin

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reimbursement data collected, the greater the reliability of the pro forma projections.

Regardless of which specialties you foresee for the ASC, it is crucial to understand the surgical case volume represented by each. Determine the number of cases that would be transferred to the ASC, considering such variables as insurance contracts, regulatory issues, politics, convenience, scheduling, physician involvement, and surgeon behavior.

The Reimbursement Environment

Some insurance plans may not contract with ASCs. In some geographic regions, reimbursement may be below national standards. If many

squeeze over the past decade. So, clear expectations about timeliness must be established from the start by the surgeons and supported by the entire administrative and surgical staff. The more surgeries that an ASC can incorporate into the surgery schedule per day, the more likely it is that they will be profitable.

Capital Requirements

The typical development of a stand-alone ASC, with tenant improvements, requires a cost of approximately \$220 to \$250 or more per square foot to become operational. Additionally, money is also needed for equipment. In general, the cost to

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develop a new ASC is approximately a million dollars per operating room. Of the total budget amount, a substantial portion of the money can be provided through debt financing without guarantees. However, a certain portion of the debt (such as tenant improvements and working capital) may require personal guarantees. Moreover, a cash capital contribution of a substantial amount must also usually be contributed to an ASC venture. Typically, anywhere from \$500,000 (on the low side) to \$1,500,000 is required as an equity cash contribution in total by the owners.

One option is to have the ownership of the real estate and the ownership of the surgery center held by separate

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entities. This allows for additional investors to own a portion of the real estate holding company, thus making it less expensive for the investors in the surgery center entity. By separating the real estate from the operating entity that will run the ASC, investors can choose whether they would like to invest in the surgery center, the real estate, or both.

Expense Management

One of the current positive issues for ASCs is new legislation under consideration that would establish a value-based purchasing system that rewards ACS for high-quality outcomes.

The three biggest costs for an ASC typically are staffing costs (about 20% to 30% of revenue), supply costs (about 20% of revenue), and facility costs (about 10% of revenue). With staffing costs making up the majority of an ASC's expenses, it is critical to benchmark the hours per case to those at other similar centers to ensure your staff is working efficiently. Generally, multi-specialty cases will entail between 13 to 15 hours per case, and single-specialty cases will entail six to eight hours per case. These numbers are often translated in simple terms to approximately five full-time equivalents per 1,000 patients.

To control staffing costs, it is imperative to use staff efficiently by cross-training where appropriate, being open only as many hours as cases require, and, if possible, by sending staffers home when they are not needed.

Supply costs, to a degree, may be reduced by use of a group purchasing organization. Another common way to reduce supply costs is to implement standardization of

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certain common surgical supplies and reduce the use of nonessential supplies. These are both areas where a seasoned management company can help a surgery center achieve greater operational efficiency. While staffing and supply costs can be modified over time, facility costs, once a lease has been signed or construction has commenced, are much more difficult to change. It is very important to obtain expert advice relative to these cost items early and often.

Equity Ownership, Partner Issues, and Management Companies

Should you include a hospital or management company as an equity partner? Maybe. An experienced manager can help with financing, financial planning, analysis, certification, contracts, equipment, construction oversight, recruitment, and other aspects of the project that can

significantly reduce the likelihood of problems. An equity owner/manager will have a much greater level of concern for the project's success than a manager without an equity stake. However, with a management company as an equity partner, the profits must be shared.

Key items to negotiate with the management company include the percent of ownership, management fee, services provided, personnel employed or provided, length of the management contract, board rights, and reserve or veto rights of the management company. As when hiring anyone, a group should interview three to five management companies and talk extensively to other ASCs managed by the companies.

The number of investors is a delicate balance that requires significant forethought and planning. The average number of physician-owners in an ASC is approximately 15, according to Deutsche Bank's 2008 ASC report.¹

Too many physician investors can result in a dilution of responsibility and ownership interests. Too few mean a greater buy-in and a risk of lower case volume. In either instance, there can be resentment between productive and less productive physicians.

Approximately 25% of the surgery centers in the country have a hospital partner. Multi-specialty centers can take advantage of economies of scale for staff, supplies, and physical plant. They can also reduce reimbursement reduction risk through a diversification of reimbursement sources and a mix of physicians. A single-specialty center can be disproportionately affected if payers cut reimbursement for that specialty. However, with a single-specialty center, there are no turf wars or arguments over revenues, expenses, and profit sharing.

Hospitals as Willing Partners

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gery centers in the country have a hospital partner. In many situations, a hospital can add value through either helping with managed care contracting, making it easier to recruit physicians or otherwise reducing physician concerns regarding being excluded from privileges or having other types of retaliatory action taken against them by the hospital. It is good news for ASCs because many hospitals are viewing surgery centers as part of their strategic plan. Hospitals appear to be taking a more constructive posture toward ASCs because they are considering surgery centers as an opportunity to get into new market areas in the changing competitive marketplace.

The Building and Operational Issues

Should you rent, buy, or build? Centers can be leased from a third party, bought, or built from the

ground up. Often, it is quicker and less expensive to lease space and operate as a tenant.

Physicians planning an ASC should lease or purchase property that is suitable and cost-appropriate. High traffic and visibility are not necessary; a second- or third-tier commercial property that is level, safe, and accessible to your physicians and patients, and with easy parking will often be sufficient. However, a less expensive site may ultimately cost more due to unknown variables such as a lack of utilities, setbacks, zoning restrictions, or inability to meet codes.

Typically, a center requires one operating room per 1,000 to 1,500 cases. A typical two-room ASC can be housed in 7,000 to 8,000 square feet. An average-size ASC is approximately 13,000 square feet. The building should meet the group's volume and specialty needs as well as the financial parameters. Determine your case

numbers, staff needs (technicians, nurses, schedulers, office staff, etc.), and equipment requirements. Early in the planning process, consideration should be given to incorporating IT, fluid management, and anesthesia systems into the design.

Management information and other operational systems such as billing, materials management, and marketing should all be established early in the process. If established early and populated with appropriate information, then on opening, your clinicians, front office, and management will experience immediate efficiencies in scheduling surgeries, billing, performing collections, case-costing, and taking inventory, among many other tasks. If you choose to use an outside provider for billing, it should be involved early in the development stage so that billing and collections can begin on opening day.

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THE LEGAL CORNER

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Accreditation and State Licensure

Many states require ASCs to be licensed. In addition, ASCs should attempt to become accredited by the Joint Commission, the Accreditation Association for Ambulatory Healthcare (AAAHC), or another reputable accrediting agency such as the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). Accreditation means that the organization has undergone a thorough, independent survey of its policies and practices, which are compared against nationally recognized standards. The accreditation process involves self-assessment by the organization, followed by an on-site review conducted by surveyors who are themselves healthcare professionals.

Accreditation is a sign that the organization has committed to providing high-quality care and that it has demonstrated its commitment through an ongoing process of self-evaluation, peer review, and education to continuously improve its care and services. Accreditation often lets ASCs be deemed Medicare-certified, serve certain payers, and measure their services and performance against nationally recognized standards, thereby helping them to improve the quality of their care.

Accreditation organizations for ASCs provide standards of medical care, recordkeeping, and auditing.

Experienced RNs often make great ASC administrators.

Some of the goals of these organizations include continuous improvement of medical care in surgery centers and providing an external organization where the public can get information on many aspects of ASCs. These accreditation organizations require members to receive periodic audits, which occur every one to three years depending on the accreditation organization and the circumstances of the surgery center. In an audit, a team of auditors visits the facility and examines the ASC's medical records, written policies, and compliance with industry standards.

Speak with your state health department early on in your development process to learn your state's ASC licensing requirements, as each state is different. In all cases, you will want to have this conversation very early in the process to access state requirements and processes, and to help avoid unexpected delays in licensure requirements.

Staff

Hire the best people available because a great staff is crucial to an efficient and profitable ASC. It is far better to overpay a bit in order to hire outstanding help. You need not necessarily employ your staff full-time. However, you should pay your staff well and attempt to obtain the highest quality

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staff—even if highly paid on an hourly basis. It is also important to treat your staff extremely well so that you are able to recruit and retain the best possible employees.

High-quality management is critical to an ASC's success. Many management companies offer superior services. However, others are of little value. All management companies are not equal.

You will need to start by hiring an administrator and director of nursing. Experienced RNs often make great ASC administrators, if they are interested in the business side of ASCs. Generally, RNs are trained to be disciplined and dedicated workers—a work ethic that carries over to the administrator position. As such, RNs are often vibrant and willing to contribute in many ways to improve the surgery center. An administrator should typically be hired four to six months before a center intends to become operational.

Possible Problems

The biggest problem for most ASCs is the inability to effectively recruit the right number of physicians and cases or the inability to obtain appropriate commitments from their physician partners. The most successful centers are increasingly built around a core group of physicians. This approach lessens certain risks related to the center and clarifies the level of physician commitment. One recent concern is that the number of surgeons is decreasing due to hospital employment. The private practice of medicine is waning, and there is no

one to recruit for ASCs when surgeons retire or leave for other employment opportunities.

A second set of core risks includes overstaffing an ASC and building a facility that is too big. The desire of partners to have the latest and greatest technology and equipment can quickly kill a budget. It is often useful to have third-party input in

well-managed and well-thought out. A failure to do so can lead to significant financial problems for the entity.

Conclusion

With astute advisors, committed surgeons and colleagues, and a firm grasp of projected volume, expenses, and reimbursements, the surgeon owner/shareholder of an ASC will

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these decisions to help inject some rational, efficiency-minded thought into the process.

Despite their growth throughout the country (there are 5,500 to 6,000 ASCs in operation), a substantial number of ASCs still fail. The failures occur mostly due to bad management, low-volume of cases, poor reimbursement, or overbuilding. Knowing the risks involved in developing an ASC can help to ensure that your ASC will prosper and not fail. Working with experienced managers in developing a center can also help prevent failures.

Many centers also face significant risks related to reimbursement, managed care exclusion, poor billing and collection practices, and failing to contain supply and equipment costs. In essence, because the reimbursement for procedures is becoming less predictable, there is an extensive need to ensure that the project is

find that both gross and net income can rise substantially. This derives from several sources. More favorable contracts can improve revenues for the surgeon's office overall. "Downstream income" can improve dramatically with the typical improvement in efficiency experienced by surgeons participating in ASC ownership/use. While there is no doubt that there will remain ongoing management challenges, ASCs still remain a viable option to increase your surgical patient base. But remember that all of your decisions should be supported with data and benchmarking tools.

The information in this article is just the first step in considering whether or not to proceed with the project. Complete your due diligence. Obtain additional information from the resources listed in the box.

Any legal information is not to be considered legal advice, which must be tailored to specific circumstances for each practice. Further, since healthcare regulations are in flux and can vary by jurisdiction, it is advised that readers seek legal counsel to review their ownership structure and billing practices for compliance. **PM**

Reference

¹ Ambulatory Surgery Centers: Annual Survey Shows Growth Continues to Slow. Deutsche Bank. February 4, 2008.

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Resources

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF): www.aaaasf.org/

Accreditation Association for Ambulatory Health Care, Inc., (AAAH): www.aaahc.org/

The Joint Commission: www.jointcommission.org/accreditation/ambulatory_surgical_center.aspx