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BECKER'S ASC Review
PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Improving Your ASC's Billing And Collections – Five Important (And Sometimes Urgent) Areas To Address

By Judith L. English,
Vice-President Business Operations,
Surgery Consultants of America, Inc.

Are you doing everything you can to maximize your ASC's reimbursement? Investigate the following key financial areas in your center to pinpoint why reimbursement has decreased or is less that what was predicted.

These areas were chosen because of their ability to directly impact the center's revenue stream, but are certainly not all of the areas that need to be assessed on a regular basis for continued financial success.

Fee Schedule

In most ASCs, the fee schedule is established when the center is opened and essentially ignored from that point forward. Occasionally the Board may decide to do a cost of living increase, but rarely is the fee schedule reviewed.

- Do a spreadsheet and compare your fee schedule to reimbursement rates of your managed care contracts. **Be sure the fees allow the necessary margin to maintain your budget.**

- Assess your fee schedule in light of industry changes – changing Medicare reimbursement rates, increasing implant costs, competitive salary and benefit demands.

continued on page 8

Thirty Eight (38) Companies To Watch – 2007

By Scott Becker

In the past year, several new companies have entered the ambulatory surgical center marketplace. In addition, several existing companies have been sold or reduced their efforts in the industry. This article briefly highlights 38 companies that are active in the ASC industry.

If you have questions or concerns related to this list, please inform Scott Becker at 312-750-6016, sbecker@mcguirewoods.com. <u>This list is not an endorsement of any company.</u> The list is compiled by Scott Becker.

1. Acumen Healthcare. Acumen is a relatively small but competent management and development firm. It works with either physician centers or physician-hospital joint venture centers. It often provides management and development services on a non-equity basis. Two of its leaders, Tom Pritchett and Andy King, are very good people with whom to work. For more information visit www.acumen-healthcare.com.

2. Advantage Surgical Concepts. This is a newly formed company by Mark Kaufman, Andy Starr and a handful of other ambulatory surgical center veterans. They have established an initial center and are actively looking at additional projects and acquisition opportunities. The company is located in Texas. For more information visit www.advantagesurgicalpartners.com.

3. Alliance Surgery, Inc. Alliance Surgery, headquartered in Atlanta, owns and operates ambulatory surgery centers and specialty surgical hospitals in partnership with physicians and hospitals throughout the United States. Its typical model includes a minority ownership interest plus a development and management agreement. With ASC veteran Charlie Neal now at the helm of this company, Alliance is positioned for substantial growth over the next few years. For more information, visit www.alliancesurgery.com.

4. Ambulatory Surgical Centers of America. ASCOA, led by Dr. Brent Lambert, Dr. Tom Bombardier, Luke Lambert and Robert Westergard, continues to be one of the best managed surgery center companies in the ASC industry. It currently manages and owns approximately 30 surgical centers in twelve to thirteen different states. Its typical model includes a minority ownership interest plus a management and development agreement. ASCOA was founded by physicians and remains one of the most highly competent companies in the ASC arena. For more information visit www.ascoa.com.

5. AMSURG, Inc. Amsurg is one of the four pure play publicly traded ambulatory surgical center companies. Of the four companies, it is the most focused on single-specialty centers. Originally, Amsurg drew a great deal of its growth from ophthalmology and gastroenterology. Today, it is involved in many different specialties. It operates approximately 100 centers nationally. For more information visit www.amsurg.com.

6. Blue Chip Surgical. Blue Chip Surgical has its initial roots in Ambulatory Surgical Centers of America. A senior vice president of Ambulatory Surgical Centers of

continued on page 3

INSIDE

2 Letter from the Editor
10 Suffering From Success: ASC Buy-In Issues And Fair Market Value
16 The 5 Cardinal Sins Of New Development
20 The Return of Problematic Leases

Letter from the Editor

This first issue of 2007 includes a number of different items. First, we have included a list of 38 companies to watch in 2007. This is a relatively inclusive list that provides a short summary of a great deal of the companies that have made great strides in the ambulatory surgical center business. Second, we have included a terrific article from Judith English on billing and collecting for surgery centers. Judith helps to head up one of the leading billing companies in the country, Surgery Center Billing, and sheds light on a critically important subject. Third, Ron Lundeen and myself have authored an article related to ASC buy-in transactions. Because this is such a pressing issue for ambulatory surgical centers, we thought it would be a helpful addition to the first issue. Finally, we have an article that discusses developing ASCs from Robert Zasa.

As the year emerges, we see several interesting things on the horizon. Certain of these include the following:

1. GAO Reports ASC Costs. The Government Accounting Office recently reported ambulatory surgical center costs as being approximately 84% of the cost to perform the same surgeries in a hospital outpatient department. This is obviously a much higher cost level than was set forth in the 62% number suggested by CMS for reimbursement of surgery centers. In essence, that surgery centers would be reimbursed 62% of the payments made to hospital outpatient departments. It is expected that CMS will finalize their ASC payment plan this spring. We are hopeful, but not necessarily optimistic, that the number will be closer to the GAO number than the previously suggested CMS number.

2. Change in Politics. The changes in politics have already brought great threats to the surgical hospital industry. As part of a potential Medicare Reconciliation Act, there was some discussion of a push for a new moratorium on the development of physician owned hospitals. This is an issue that will be in close scrutiny in the next few years.

3. Nascent Enterprises, LLC. We have had the privilege to get to know Dr. Phil Davidson who works as a principal in Nascent. Nascent is a firm that specializes in helping physician driven and other types of medical companies and inventors move from idea to implementation to revenue generating. They work closely in the clinical regulatory, finance, business development, sales and marketing side, on the venture capital side, and in a variety of ways with developing medical device and other medical companies. For information regarding Nascent or to talk to Phil Davidson, please contact him at 727-347-1286 or at pdavidson@tampabayortho.com.

4. Ambulatory Surgical Center Conferences. We have two great conferences planned for this year. First, we have our Orthopedic, Neurosurgical and Pain Management Driven ASC Conference to be held June 14th – 16th in Chicago. Second, in connection with FASA, we have our annual Business and Legal Issues Conference being held October 18th – 20th in Chicago, Illinois. Each will be a terrific event.

Should you have any questions about either of the events or about writing for the ASC Review, please contact me at 312-750-6016 or at sbecker@mcguirewoods.com or please contact Michelle or Ken Freeland at 858-565-9921 or at michelle@pcmisandiego.com or ken@pcmisandiego.com.

Should you have questions or need assistance in the new year, please contact myself.

Very truly yours,

Scott Becker

The ASC Review is published 6 times per year. It is distributed to approximately 15,000 persons per issue with distribution of 20,000 issues for each the May–June issue and the September–October issue. For information regarding advertising or subscribing, please contact Ken or Michelle Freeland at 858-565-9921 or by email at ken@pcmisandiego.com and michelle@pcmisandiego.com.

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Thirty Eight (38) Companies To Watch – 2007 continued from page 1

America, Jeff Leland, founded Blue Chip Surgical approximately three years ago. Since that time, it has several projects underway including projects in Ohio, Maryland, Oregon and Pennsylvania. It focuses on spine and ear, nose and throat centers and is also opportunistic in its approach. It is a manager and equity owner in its projects. For more information visit www.bluechipsurgical.com.

7. Cirrus Healthcare. Cirrus has greatly expanded its growth and development over the past year. It has several hospitals and surgery centers in operation in Texas and California and is expanding quickly. Within the past twelve to eighteen months, Cirrus added a new chief executive officer Tim Parris and new president John Thomas. It is on a rapid growth pace. For more information visit www.cirrushealth.com.

8. Foundation Surgery Affiliates. This company was founded by Tom Michaud. It operates centers in many states, many of which are very successful. It has branched out into the business of bariatrics and the operation of hospitals. For more information visit www.foundationsurgery.com.

9. HCA. HCA, one of the largest for profit operators of hospitals in the country, continues to have one of the largest network of free standing ambulatory surgical centers. This network includes many centers that are "in market" as well as centers that are in markets that are not related to HCA. It remains one of the best operators of hospitals and health systems in the country. For more information visit www.hcahealthcare.com.

10. Health Inventures. Health Inventures was one of the original non-equity management and development companies focused in the ASC industry. While it is still one of the leading providers of management and development services to physicians and hospitals, it is now often an equity partner in joint ventures as well as a manager and developer. Wayne Lee, one of the initial founders of Health Inventures, retired this past year. He was a true leader in the ambulatory surgical center industry and a true gentleman. Richard Hanley and a highly qualified management team continue to expand the mission of Health Inventures. For more information visit www.healthinventures.com.

11. Healthmark Partners. Healthmark Partners is one of the true growth stories in the ASC industry. Over the past year, Healthmark Partners has added centers at a rapid pace. It also provides a very hands-on approach to management. While many of its transactions involve physician-hospital joint ventures, it also has several ventures in which Healthmark and physicians are partners. It is willing to own either minority or majority interest in centers. Bill Southwick serves as CEO and President of Healthmark Partners. For more information visit www.healthmarkpartners.com.

12. HealthSouth. HealthSouth remains perhaps the largest national operator and manager of ambulatory surgical centers. It also has a few small hospitals. Many of its centers achieve significant success. Its typical model includes both majority ownership as well as, in certain situations, minority ownership. This past year, HealthSouth announced that it plans to spin off its ambulatory surgical center division and is seeking bids to buy the ASC division as a whole. There are several competent professionals helping to lead HealthSouth's ASC division including Joe Clark, Mike Snow, Marc Goff and a host of others. For more information visit www.healthsouth.com.

13. Instantia. This is a company founded by Jack Amormino and Lisa Freeman to provide development services to surgical centers. Jack Amormino has long been involved in the ASC industry as CEO of American Medical Buildings, a turnkey facilities developer. Lisa Freeman was a long time leader with Aspen Healthcare. Instantia Health focuses on turnkey facility and operations development through Medicare certification and accreditation. Instantia develops centers with the goal of handing over a well conceived, efficiently designed surgery center that is managed by a center's own in-house administrative and clinical professionals. Instantia does not require an equity stake in its projects or a long term management agreement. For more information visit www.instantiahealth.com.

14. Medical Facilities Corporation. MFC is a Toronto Stock Exchange company. It was developed by the brilliant and tactical Dr. Larry Teuber. The company owns 50% or more of several small hospitals. It has been aggressively seeking acquisitions over the last year. It provides its member centers or hospitals with a liquidity option that does not involve giving up

management. For more information visit www.medicalfacilitiescorp.ca.

15. Meridian Surgical Partners. Merdian has completed the acquisitions of several centers in its first full year of operations. It was private equity funded and is looking to buy both surgery centers and small hospitals. Kenny Hancock, the founder of the company and its management team, has great experience with both surgical centers and with small hospitals. They have gotten out of the gate quickly and expect to make several more acquisitions in the next year. For more information visit www.meridiansurgicalpartners.com.

16. Mowles Medical Practice Management. Mowles Medical Management is one of the leading companies in the country with respect to the specialty of pain management. Whether helping to manage or consult on surgical centers or office practices, Amy Mowles has an expertise in pain management which is almost unequaled in the ASC industry. For more information visit www.mowles.com.

17. National Surgical Hospitals. NSH was founded by John Rexwaller. John and his management team have focused the company principally on owning and developing small hospitals with physicians. They have a very strong top management team. The company's COO, Jim Grant, has made an incredible contribution to the specialty hospital trade association (now Physician Hospitals of America). For more information visit www.nshinc.com.

18. National Surgical Care. NSC saw the loss of its founder and CEO, Tim Geary, with an unexpected and very sad death this past year. As a company, its long term leadership, including Rick Pence and Greg Cunniff, have done a wonderful job keeping the company on track and, in fact, expediting its efforts. It has acquired several centers this past year. For more information visit www.natsurgcare.com.

19. NeoSpine. NeoSpine is a company based in Nashville and was founded a few years ago. It focuses on neurosurgical and spine driven projects. NeoSpine is known for its focus on the neurosurgery community and spine ASCs. It has recently expanded its services to offer more comprehensive ancillary services to neurosurgeons with the addition of stereotactic radiosurgery partnerships. NeoSpine currently operates ten facilities and it is scheduled to open several more in 2007, a number of which include hospital partners. It has been particularly focused in Certificate of Need states. For more information visit www.neospine.com.

20. NovaMed. NovaMed is another one of the four pure play publicly traded ambulatory surgical center companies. It has enjoyed tremendous growth over the past year with a rapid pace of acquisitions. It added a new CEO, Thomas Hall, and includes a deep management team, many of which have been with the company for a long time. They are in the business of both developing de novo facilities as well as acquiring majority interests in existing ASCs. For more information visit www.novamed.com.

21. Nueterra Healthcare. Nueterra is one of the most prolific owners and operators of surgery centers that works with centers on a national basis. Its founder, Dan Tasset, has been very active in ASC industry trade associations and a real contributor to the industry. They currently have 39 surgical facilities in operation and development (ASCs and Surgical Hospitals). With the help of a team with years of outpatient management experience, they are planning substantial growth especially in the surgical

hospital sector. For more information visit www.nueterra.com.

22. Ortmann Healthcare Consultants. Ortmann Healthcare, founded by Fred Ortmann, is a very busy and active player in the ASC industry. It works with both physician hospital joint ventures as well as physician-only centers. For more information visit www.ortmannhealth.com.

23. Physicians Endoscopy. Physicians Endoscopy is one of the two or three best companies involved in the endoscopy area. It focuses solely on GI and endoscopy centers. It typically owns a minority interest in and manages its centers. It often also provides billing services to the centers. It has an outstanding core management team including Barry Tanner, John Poisson, Karen Sablyak and others. Physicians Endoscopy is actively involved in single practice centers, coalition driven centers, and physician hospital centers, as well as acquiring minority interest in centers. For more information visit www.endocenters.com.

24. Pinnacle III. Pinnacle III is quickly evolving as a leading provider of consulting and management services to orthopedic-driven surgery centers and small hospitals. It also works with practices on a wide range of other services. It has added greatly to its management depth in the last year with the leadership of Rob Carrera and Rick Dehart. Pinnacle III is on the short list of leading firms that provide both management and development services but don't require an ownership interest. For more information visit www.pinnacleiii.com.

25. Prexus Health Partners. Prexus Health Partners invests in and manages hospitals, surgery centers and imaging facilities. Their original growth was in the State of Ohio and driven by founder Ajay Mangal, M.D., M.B.A. Since that point, they have ventured out beyond the State of Ohio. They have almost no complaints from their physician partners and tend to do a very good job of managing and developing projects. They are very hands on and working to grow at a fast pace. For more information visit www.phcps.com.

26. Regent Surgical Health. In its five year history, Regent Surgical Health has expanded to own interests and manage physician-only centers, physician-owned hospitals, and physician-hospital ventures. It has operations in approximately ten states and is a leading operating company in the ambulatory surgical center industry. It was founded by Tom Mallon and it enjoys a deep and strong management team. Regent Surgical Health was one of the first companies to focus on helping to turn around surgery centers. For more information visit www.regentsurgicalhealth.com.

27. Resurge Hospitals. Resurge Hospitals, led by Rusty Shelton, provides consulting and management to both physician-owned hospitals and physician-hospital joint venture hospitals. For more information visit www.resurgehospitals.com.

28. Somerset CPAs. Somerset CPAs provides a broad range of consulting services to ambulatory surgical centers and specialty hospitals. It has traditionally been very actively involved in the development of ambulatory surgical centers and specialty hospitals on behalf of orthopedic and other physician-driven projects and practices. While it does not provide ongoing management or ownership in centers, it does provide development and consulting services for ambulatory surgical centers and small hospitals. For more information visit www.somersetcpas.com.

29. Surgery Consultants of America. Caryl Serbin, the founder of this company, is one of the most focused and best people in the ambulatory surgical center industry. She runs a company that is known for doing what they say they will do and providing excellent guidance. They work often

with physician-hospital joint ventures and also with physician-owned centers. They are often brought in to improve the billing and collections of centers and to provide turn around management for centers that have the capacity to succeed. They have a successful affiliate company which provides billing and collections services. For more information visit www.surgecon.com.

30. Surgical Management Professionals. ("SMP"). SMP specializes in the management and development of ASCs and surgical specialty hospitals. SMP has the unique history of being created by The Sioux Falls Surgery Center eight years ago and, as such, still has employees deeply involved in the clinical aspects of running a center. In recent years, the majority of their projects have been in the area of joint ventures between hospitals and physicians in CON states. These projects have served to integrate the medical communities in which they operate. SMP has a seasoned team of healthcare professionals led by industry veteran Doug Johnson. Doug is also the current President of Physician Hospitals of America (formerly known as American Surgical Hospital Association) in addition to SMP. This gives Doug and SMP a unique perspective on the politics of individual centers and the industry as a whole. For more information visit www.surgicalmanprof.com.

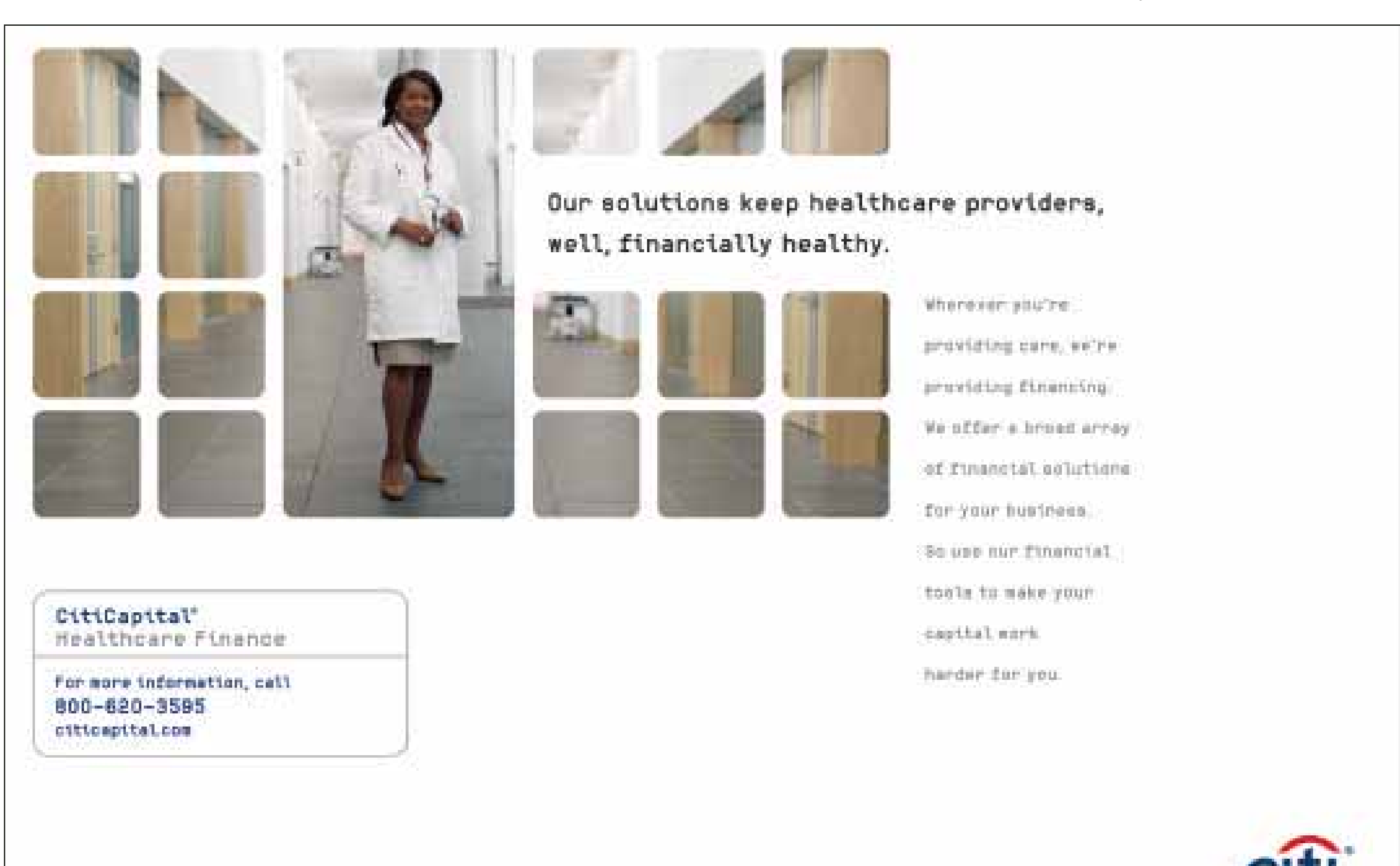
31. Symbion, Inc. This company went public in 2004. Since that time, it has enjoyed excellent growth through acquisitions and to a great extent through same store growth. It has a top flight internal management team and is growing at a very healthy pace. It has recently expanded its mission to actively acquire both surgery centers as well as small hospitals. They are a terrific company to work opposite of and they continue to increase the pace of their acquisition activity. For more information visit www.symbion.com.

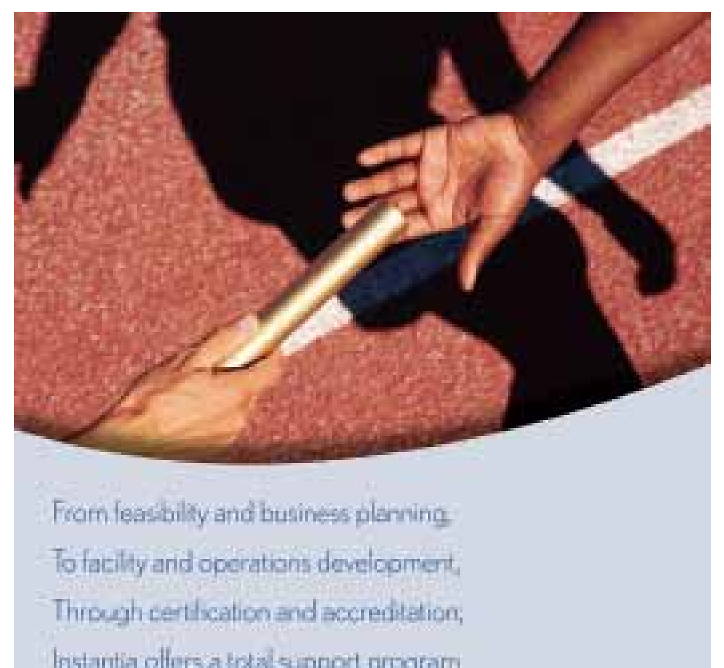
32. Tantis Health Care. Tantis Healthcare, a subsidiary of Nueterra Healthcare, offers a financial product to owners of profitable surgery centers who are considering selling a minority or majority stake in their center. The company which acquires and partners with profitable centers is led by Kevin Standefer. For more information visit www.tantishc.com.

33. Titan Health Corporation. Titan manages and develops specialty focused surgery centers on a national basis. It has an emphasis on orthopedics, spine and neurosurgery, and pain management. While it focuses principally on orthopedic, neuro and pain opportunities, it has a great variety of fully operational projects. It typically maintains a minority interest position and has a very nice reputation as a smart and trustworthy partner. For more information visit www.titanhealth.com.

34. TruMedical Partners. TruMedical Partners was founded this past year. It focuses on the development and ownership of hospitals as well as surgical centers. It was founded by certain former professionals who at one time were associated, in part, with Cirrus Healthcare. It started its business with the acquisition of a hospital in California. For more information visit www.trumedicalpartners.com.

35. TRY Healthcare Solutions. This company has been formed by industry leader Tom Yerden. Tom Yerden was the founder of Aspen Healthcare which was a long term operator and manager of physician-hospital joint venture ambulatory surgical centers. After departing from National Surgical Care, he has returned to the ASC industry to develop TRY Consulting. Tom is principally involved in consulting with ambulatory surgical centers. He is very talented.





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36. United Surgical Partners. USP is one of the four pure play ambulatory surgery center companies that is publicly held. It now operates more than 137 different facilities. Its facilities are principally surgery centers, though it has a good number of small hospitals. More than 50% of its centers have a not for profit health system as a joint venture partner. It continues to enjoy great same center growth through both increased cases as well as through increased reimbursement on an average per-case basis. It is one of the most strategically smart companies in the surgery center market. For more information visit www.unitedsurgical.com.

37. Universal Health Services. Universal Health Services has an ASC division to complement its much larger hospital operations. While principally a hospital company, it has done a nice job of expanding and growing its ASC business. For more information visit www.uhsinc.com.

38. Woodrum ASD. Woodrum ASD manages and assists physicians and physician-hospital joint ventures on a national basis. It has added some very significant and top notch professionals over the last couple years to its roster of senior vice presidents. These people have greatly helped strengthen the company. Joseph Zasa currently serves as president of Woodrum ASD and has done a great job of providing leadership to the company. Bob Zasa and David Woodrum, two of the founders of the company, remain very actively involved in growing the company and its efforts to serve and develop physician-hospital driven ambulatory surgical centers. For more information visit www.woodrumasd.com. ■

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 continued from page 1

- Medicare group-based fee schedules should have carve-out fees for procedures that are time and supply intensive or require non-reimbursable implants.

Revising your fee schedule is fairly straightforward and often results in amazing benefits. Review your fee schedule at least annually and update sooner if necessary.

Managed Care Contracts

Just complaining about low reimbursement rates will not fix the problem. The best way to improve reimbursement is to work with, not against, the managed care companies.

- Identify the representative that can make decisions about reimbursement rates and deal directly with them.

- Determine what areas you need to change, i.e.,

  - Carve-out higher reimbursement rates for high ticket procedures

  - Separate implant reimbursement

  - Multiple procedure allowances and discounts

- Reciprocity is the name of the game – know where you can afford to offer reductions to compensate for what you want increased.

- Be able to support your requests for increased rates by providing case costs.

Most importantly, don't just accept what they offer – negotiate!

Procedure Coding and Charge Entry

Employ certified and experienced surgical coders to optimize your reimbursement. Investing a little more in payroll can often result in thousands of dollars in additional reimbursement while remaining compliant with OIG requirements.

- Remind your surgeons they can assist in revenue enhancement with detailed operative notes demonstrating medical necessity and complexity of procedure(s).

- Claim submission requires knowledge of procedure and diagnosis coding as well as modifiers. In most centers coders perform charge entry and claim submission.

- Important reminders to keep your cash flow ongoing:

  - Timeliness – claims need to be out the door within 48 hours following surgery
  - Accuracy – recheck all areas of claim before submitting
  - State-specific guidelines, i.e., modifiers, form variances, etc.
  - Electronic submission wherever possible

Improving your revenue stream can often be as simple as setting specific goals for your coding and billing staff and rewarding them for meeting or beating those goals.

Payment Posting and Denial Management

Getting paid is one thing – getting paid correctly is another! The more experienced the reimbursement specialist is relates directly to getting paid <u>fully</u> for services rendered.

- Your payment poster needs full access to current managed care contracts. This is key in determining accuracy of payments.

- Start denial process immediately for errors or non-payments.

- Develop a denial log to track reasons for denials. Track trends by payer, by surgeon, by coder, etc.

- If correctly paid, change responsibility for balance owed to secondary insurance or patient and bill immediately.

Denial management is one area where problems often go undetected. Inexperienced or interrupted payment posters often do not identify incorrect payments or a trend in denials. If denials are not followed up immediately, timely filing clauses in your contract may become a reason for the payer to contest liability for the amount due.

Accounts Receivable Management

Accounts receivable is an asset, meaning it's money that is owed to the center that they anticipate collecting. When A/R is not managed properly it changes from an asset to bad debt. This is not a good thing! Again, experienced personnel are the key for good collections.

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- Contact the payer 15 days after submission of an electronic claim to determine status of payment.

- Measure days your claim remains in accounts receivable – recommended 50 days or less.

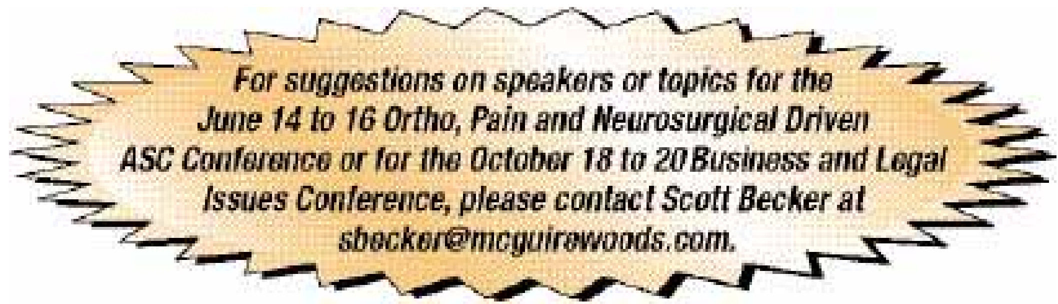
- Measure percentage of claims still unpaid after 120 days – recommend less than 15%.

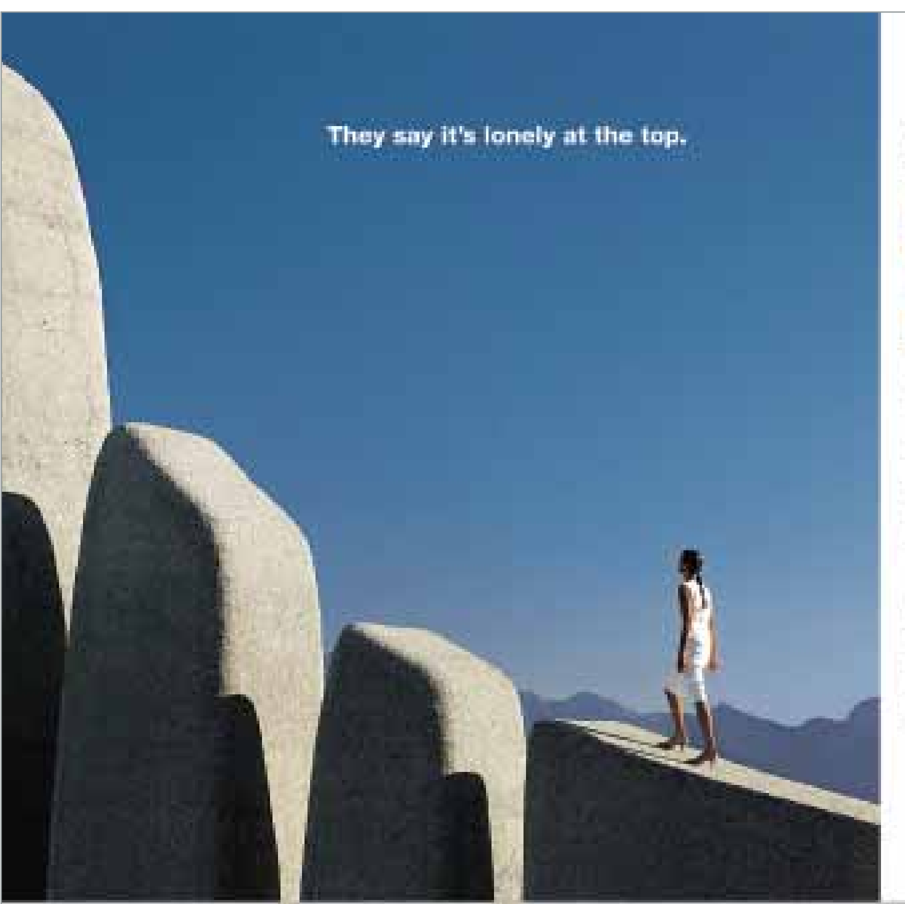
- Set achievable goals for your collector – how many accounts to touch per month? What percentage of collections in each area, 30 days, 60 days, etc.?

- Patient collections are often not worked because of time constraints. Evaluate the percentage of monies still owing at 120 days in patient accounts. A phone call to an overdue patient account often results in a credit card number or a promise of payment.

Because of the high percentage of managed care claims that are not paid on a timely basis or are paid incorrectly, collections are an important and sometimes daunting task. Don't expect payments to arrive by themselves – this just doesn't happen anymore – it takes constant effort to get the money you are owed.

Profitable centers don't just happen; they are usually the product of hard work and well-thought-out financial planning. If you are a new center, following these common-sense suggestions will assist you in meeting your financial goals. If your center is an existing center having financial difficulties, explore each of the areas referenced. Chances are you will find at least one area that can be improved. ■





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Suffering From Success: ASC Buy-In Issues And Fair Market Value

By Ron Lundeen and Scott Becker

A successful ambulatory surgery center can be a financial benefit to its physician owners. However, providing a way for new physician investors to join an existing successful ASC raises significant regulatory concerns. Most importantly, ownership interests must be provided to new physician investors at a fair market value. In a very successful ASC, the fair market value may be prohibitively high. This can be the case, for example, when the owners desire to add a younger physician that lacks the ability to make a large capital investment.

This article sets forth key regulatory considerations to be taken into account when offering ownership interests to new physician investors in an ASC. These regulatory considerations provide guidance to suggest certain improper and proper methods of structuring a physician buy-in.

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I. Key Regulatory Considerations

Due to the concerns of physician referrals set forth in the Fraud and Abuse Statute, 42 U.S.C. § 1320a-7b(b), and the Stark Act, 42 U.S.C. § 1395nn *et seq.*, physician investors must purchase membership units ("Units") in an entity that owns and operates an ASC ("Company") for the fair market value of the Units.

The Fraud and Abuse Statute prohibits the knowing and willful solicitation, receipt, offer or payment of "any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind" in return for or to induce the referral, arrangement or recommendation of Medicare or Medicaid business. Violation of the Fraud and Abuse Statute is a felony and may result in a fine of up to $25,000, imprisonment for up to five years or both. In addition, the Office of Inspector General within the Department of Health and Human Services ("OIG") may suspend or exclude providers from participation in the Medicare or Medicaid programs if it determines, in its discretion, that a provider has violated the Fraud and Abuse Statute. Federal courts have held that an arrangement violates the Fraud and Abuse Statute if any one purpose of remuneration is to induce the referral of patients covered by the Medicare or Medicaid programs, even if another purpose of the payment is to appropriately compensate an individual for his professional services. *U.S. v. Greber*, 760 F.2d 68, 71 (3rd Cir.), cert. denied 474 U.S. 988 (1985).

The OIG and the courts have generally taken a very broad view of what is considered "remuneration" under the Fraud and Abuse Statute. The offering of a discount of an item of value, particularly ownership interest in an ASC, may be considered "remuneration" for the purposes of the Fraud and Abuse Statute. Additionally, any gift, gratuity, relief from a financial obligation (such as an interest-free or guaranteed loan) or benefit conferred by one party on another, directly or indirectly, may be considered "remuneration" as well.

The OIG has promulgated several safe harbor regulations in order to clarify and narrow the scope of the Fraud and Abuse Statute. Compliance with the safe harbor regulations provides an absolute defense to prosecution under the Fraud and Abuse Statute. However, arrangements which do not fall fully within a safe harbor may also be lawful under the Fraud and Abuse Statute. Specifically, the OIG has recognized that arrangements which may not fall within the parameters of a safe harbor may still operate without the types of abuses the Fraud and Abuse Statute is intended to prevent.

The ASC safe harbor, 42 CFR 1001.952(r), provides that return on an investment interest in an ASC will not be considered "remuneration" so long as certain applicable standards are met. The ASC protects investment in four different categories of ASCs: surgeon-owned ASCs, single-specialty ASCs, multi-specialty ASCs, and hospital/physician ASCs. In each of these cases, the safe harbor standards include the following two requirements:

> The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity. [...]
>
> The amount of payment to an investor in return for the investment

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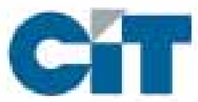

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> must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

The commentary to the ASC safe harbor regulations, 64 Fed. Reg. 63536 (1999), expands on the importance of a fair market value of investment interests:

> The gravamen of an anti-kickback offense is payment of remuneration to induce the referral of Federal health care program business. In the context of an ASC, our chief concern is that a return on an investment in an ASC might be a disguised payment for referrals. Two examples illustrate the potential problem. First, primary care physicians could be offered an investment interest in an ASC for a nominal capital contribution as an incentive to refer patients to surgeon owners of the ASC. The primary care physicians would not perform any services at the ASC, but would profit from any referrals they make. Second, physicians in specialties that typically refer to one another could jointly invest in an ASC so that they are positioned to earn a profit from such referrals or so that one physician specialty provides the ASC services and the other provides the referrals. In such cases, medical decision-making may be corrupted by financial incentives offered to potential referral sources who stand to profit from services provided by another physician.

In 1989, the OIG issued a "Special Fraud Alert" relating to health care joint ventures. In the Special Fraud Alert, the OIG identified the features of what it perceived as "suspect" joint ventures under the Fraud and Abuse Statute, including: (1) the selection of investors solely on the ground that they are in a position to make referrals to the joint venture; (2) offering greater investment opportunities to investors likely to make a large number of referrals; (3) actively encouraging investors to make referrals; (4) requiring only a small capital investment by physician-investors or loaning the investment capital to physician-investors; and (5) investments with disproportionately large returns compared to similar investments with similar risk. Office of Inspector Gen., *Special Fraud Alert: Joint Venture Arrangements* (Aug. 1989). This Special Fraud Alert was recently revalidated by the OIG in a communication dated October 6, 2006.

The OIG addressed broader concerns regarding joint ventures in its April 2003 Special Advisory Bulletin, and clarified that a discount is a form of remuneration for the purposes of the Fraud and Abuse Statute. The Special Advisory Bulletin also identified that safe harbor protection relies on the use of fair market values as determined in an arms length transaction. Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Special Advisory Bulletin: Contractual Joint Ventures* (Apr. 2003).

II. Improper Buy-In Strategies

Based on the regulatory considerations above, the following strategies are likely to be considered improper methods of allowing new physicians to buy in to an existing successful ASC:

1. *Less than Fair Market Value.* The price of Units in the Company should not be discounted from a fair market value. A discount due to minority interest, lack of liquidity, or any other reason may be applicable to the price of Units. If so, this reduction in value may arguably be reflected in the fair market value and the pricing of the Units. A nominal payment for an interest in an ASC or any health care entity is particularly suspect, as CMS identified in its commentary to the Fraud and Abuse Statute, 56 Fed. Reg. 35970 (1991):

   > Many of the more abusive joint venture arrangements of which we are aware offer only nominal investments to physicians. We believe that, in many cases, these nominal investment interests are designed to induce referrals or encourage the investor to otherwise generate business for the entity. In addition, by distributing the benefits of ownership to as wide a base of physician investors as possible, these joint ventures seek to lock-up their market, and thus operate in an insulated business environment largely free from normal competitive pressures such as pricing constraints. We believe that it is not useful to impose a minimum capitalization requirement [on all physician investment opportunities]. Because each joint venture has different capital needs, it is not possible to specify one level of capitalization that would represent a reasonable floor for all joint ventures. For example, requiring at least $500,000 in capitalization would obviously be viewed very differently by a laboratory joint venture than by a magnetic resonance imaging joint venture. We do believe, however, that it is useful to analyze joint ventures on a case-by-case basis to determine what the real capital needs of the project are, and whether the capital that has been invested is merely a sham to pay investors for referrals.

2. *No Related-Party Loans.* The physician investor should not receive any loans or other financial assistance from the Company or from any other member of the Company for the purpose of purchasing Units. Furthermore, loans should never be provided on an interest-free or other financially preferable basis. The investor should invest real capital into the Company. The OIG provided the following guidance to identify a potentially improper joint venture investment in a 1994 OIG Special Fraud Alert:

   > To help you identify these suspect joint ventures, the following are examples of questionable features, which separately or taken together may result in a business arrangement that violates the anti-kickback statute. Please note that this is not intended as an exhaustive list, but rather gives examples of indicators of potentially unlawful activity. [...]

- The amount of capital invested by the physician may be disproportionately small and the returns on investment may be disproportionately large when compared to a typical investment in a new business enterprise.

- Physician investors may invest only a nominal amount, such as $500 to $1500.

- Physician investors may be permitted to "borrow" the amount of the "investment" from the entity, and pay it back through deductions from profit distributions, thus eliminating even the need to contribute cash to the partnership.

- Investors may be paid extraordinary returns on the investment in comparison with the risk involved, often well over 50 to 100 percent per year.

3. *No Option to Buy Units.* Physician investors should generally not be allowed to purchase a small ownership interest for a fair price with a guarantee of the ability to purchase incremental ownership interests (such as one or two Units each year) at the same price. By providing a guarantee of additional Units at a set price, particularly when the fair market value increases or is expected to increase above the set price, the Company may be providing improper remuneration to the physician investor. Later offerings of Units may be made to existing investors, but not in a previously guaranteed number, at a previously guaranteed price, or based on the volume or value of business generated.

4. *No Additional Purchase for Higher Value Physicians.* When a subsequent offering of Units is made, the Company should not provide investors with the opportunity to purchase additional Units based on a physician's past or expected ability to refer patients to the ASC.

III. Acceptable Buy-In Strategies

The following strategies are likely to be considered proper methods of allowing new physicians to buy in to an existing successful ASC.

1. *Fair Market Value.* The fair market value of the Units in the Company must be determined. All sales of Units must be at this fair market value. When possible, this value should be established by an independent third-party appraiser. If applicable, the third-party appraiser may take into account lack of liquidity or minority discounts when establishing the value of the Units for a new investor. The nature and amount of such discount should be clearly documented in the appraisal. If the price is set by an internal analysis, the Company should have a clear, documented method of establishing the valuation.

2. *Loans for Units.* New investors may obtain loans from an unrelated party (such as a bank) in order to make an

investment in the Company. It may be necessary for new investors to pledge their Units to the bank as collateral for such a loan. If this method of investing will be allowed, the Company's operating agreement should specifically provide that such a pledge is permitted or the members of the Company should provide a written consent to permit such a pledge.

3. *Smaller Initial Purchase.* To reduce the cost of a buy-in from a new physician investor, the new investor may buy a smaller number of Units than existing investors own. For example, if existing investors each own 10 Units, then a new investor might buy only two Units in order to pay 20% of the fair market value of the ownership of the existing members of the Company. The new investor would have proportionately less ownership and receive proportionately less distributions than the other members. Further, if subsequent offerings are made, they should be made at a price which is the fair market value at the time of the subsequent offering. Furthermore, the later opportunity to purchase Units up to an amount of equal ownership should generally be provided to all physicians with less than equal ownership, regardless of the volume or value of referrals to the ASC.

4. *Distribution of Debt Proceeds.* Another method of lowering the price of the buy-in for a new physician is to recapitalize the Company, such as through an increase in the Company's debt. This can provide a means to make a large distribution to existing Members. It can also lower the value of the Company. Prior to the offering of new Units, the Company might obtain a loan or other debt. The Company then immediately distributes the proceeds of the debt to existing members. When a calculation of the fair market value of the Company is thereafter made for new physicians, the increased Company debt results in a lower valuation of the Company and therefore a lower fair market value of Units for new investors to purchase. In short, it is easier for new investors to purchase more Units because the Company as a whole has a lower value. The advantages of this strategy are that the existing physicians are provided with immediate cash, and new physician investors may purchase a larger ownership share. Disadvantages of this strategy include the increased debt burden on the Company which may take years to overcome. Furthermore, any substantial increase of debt reduces Company value, increases risk of default and decreases the Company's ability to obtain additional debt when needed. Paying down the principal of the debt also negatively impacts later Company distributions and will not generally provide corresponding tax deductions to the members of the Company. Finally, such an effort may be viewed as evidence that the Company does not genuinely need new capital.

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5. *Buy-In Price Need Not Equal Buy-Out Price.* At times, the Company may wish to redeem Units from existing members at or near the time Units are offered to new physician investors. There may be situations when the Company does not have the right to buy out members. For example, the Company may have been formed before the ASC safe harbors were adopted and thus the Company's operating agreement may not provide for buy-out upon non-compliance. In this case, to encourage the physician member to redeem his or her Units entirely, it may be appropriate to buy out the physician member at a premium.

   The buy-in price should never be below fair market value, as described here. In certain situations, the buy-out price is often calculated according to a valuation formula in the Company's operating agreement. This may result in a per-Unit buy-out price that is lower than the per-Unit buy-in price. Alternatively, the per-Unit buy-out price may in unusual situations be higher than the fair market value buy-in price. In this situation, the Company may redeem several Units at a higher price (as determined by the operating agreement) and bring in new investors at a lower price (as determined by a legitimate fair market valuation). If the per-Unit buy-in price will be lower than the per-Unit buy-out price, it is particularly important that the buy-in price be properly supported as reflecting the then-fair market value. ■

Should you have questions about any of these issues, please contact Scott Becker at 312-750-6016 or Ron Lundeen at 312-849-8106.

The 5 Cardinal Sins Of New Development

By Robert J. Zasa, FACMPE, MSHHA

Are you embarking on a new ASC development? I'd like to offer a few tips that our firm shares with physicians at the outset. In our experience, there are 5 cardinal sins that cause disaster.

1. Don't Overbuild

In the planning stage, many physicians underestimate the efficiency that an ASC is capable of, and plan for too large a space. Though well intentioned, the planners and architects they work with also tend to oversize the facilities to create attractive spaces with room to grow, then build the center to hospital grade construction specifications – the costs for which they will not have to live with. They don't factor in an ASC's operational efficiencies, such as just in time inventory, disposable anesthesia circuits, specialized surgical packs, reduced size medical records and space, anesthesia closets rather than rooms, reduced sterile storage, and electronic filing of records in the space planning.

Every extra 1,000 square feet costs the center $50,000 a year in operational costs—in rent, utilities, insurance, housekeeping and supplies, staffing, property tax, and the equipment, maintenance and repairs with additional HVAC.

The majority of existing ASCs in the U.S. have **not** had to increase their size due to increased case volume. Many centers are over sized and over built causing unnecessary ongoing fixed cost. This is exacerbated by the reduced reimbursement for ASCs. The building should have good flow, proper storage for equipment, proper sized clean up and sterile rooms. ASCs that are built too large result in a permanent overhead expense that owners will have to bear.

2. Don't Over-equip

Some fixed and much of the movable equipment does not need to be purchased brand new. Re-manufactured equipment with guarantees (there are many reputable resources) is much less expensive. You also don't have to equip and furnish every square inch just because you have the space. And, you can outfit the center in stages, since equipment can usually be acquired quickly once it is ordered. Because they purchase in huge volumes, equipment procurement companies working on a fixed fee, and not receiving referral fees from manufacturers, can save you a great deal of money. There is no reason to pay interest or lease charges on equipment that is not used routinely – hoping that some physician will use it someday. You can develop per-use agreements with equipment dealers for paying when the items are used, particularly helpful for expensive scopes, lasers and other infrequently used, specialized items. It is unwise to tie up your cash, especially for equipment, which can often be leased with an option to buy on a non-recourse basis (no personal guarantees required) for a reasonable interest rate.

3. Don't Over-staff

When opening the ASC, it is impossible to know how many cases the physicians will really bring to the center or how quickly the ramp-up will occur. At the beginning, staff new to the facility will not be as efficient either. Certainly, you want to provide excellent service even at the beginning, so we recommend to our centers that they hire at least one additional FTE nurse. This will be particularly important for pre-op/recovery where there is much patient contact, and where there will be impact on the ORs. However, the timing of bringing on the staff before Medicare certification and the extracted time it is now taking between occupancy, getting the State or AAAHC to come survey, getting the results back from Medicare, the time it takes to process and obtain the Medicare number and further time it takes to get the Medicare billing number (usually 4-6 weeks after getting the Medicare number in some cases) creates a cash flow issue. The number and timing of when the staff starts is a major issue. Staffing also needs to be planned well in bringing in the correct types of personnel at the proper time in the early development stages of an ASC.

Our guidelines for staffing a multi-specialty center performing 2,400 to 3,000 cases a year are to have total payroll not exceed 25% to 27% of net revenue for a multi-specialty ASC. This percentage will increase to 30% if there will be an inordinate amount of lower revenue cases performed at the ASC such as GI, Pain, or Cysto cases. Staffing usually runs 10 to 11 man-hours

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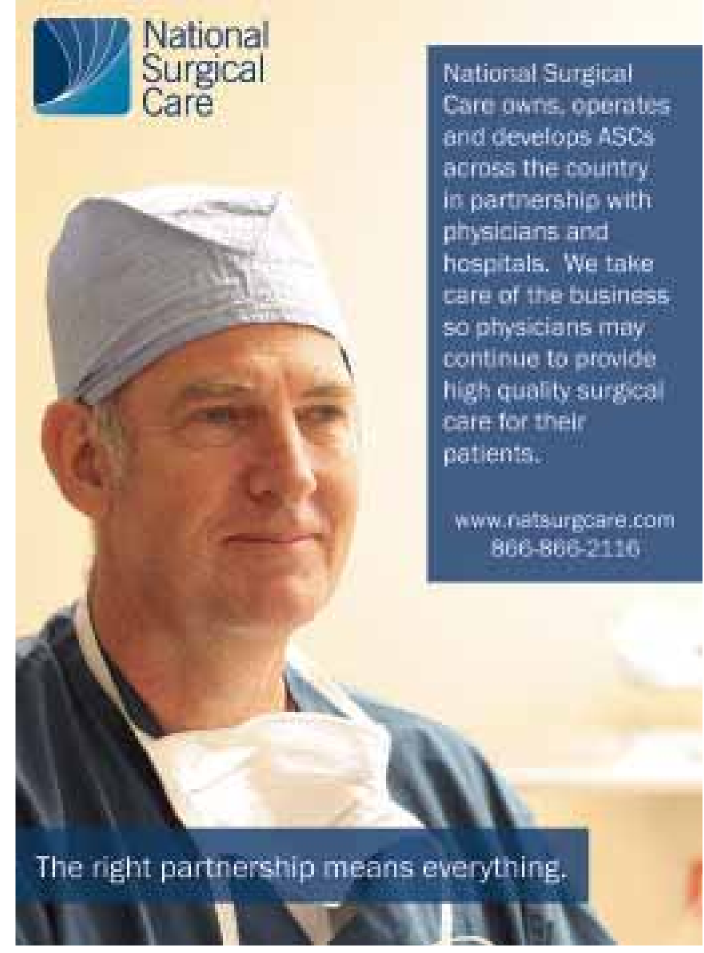
per total productive-hours per patient (not procedures) after the first three months of ramp up. It can be lower for ASCs where there are over 4,000 cases performed per year. In these cases the productive-hours per patient, including the business office, could run 8.5-9.5 hours per patient (not per procedure. Often there are multiple procedures per patient.) Total payroll includes salary plus benefits, and contract labor in business and clinical areas. Endoscopy and pain services in the surgery mix will lower the productive-hours per patient. More orthopedic, plastic and eye patients should be factored into the surgery mix.

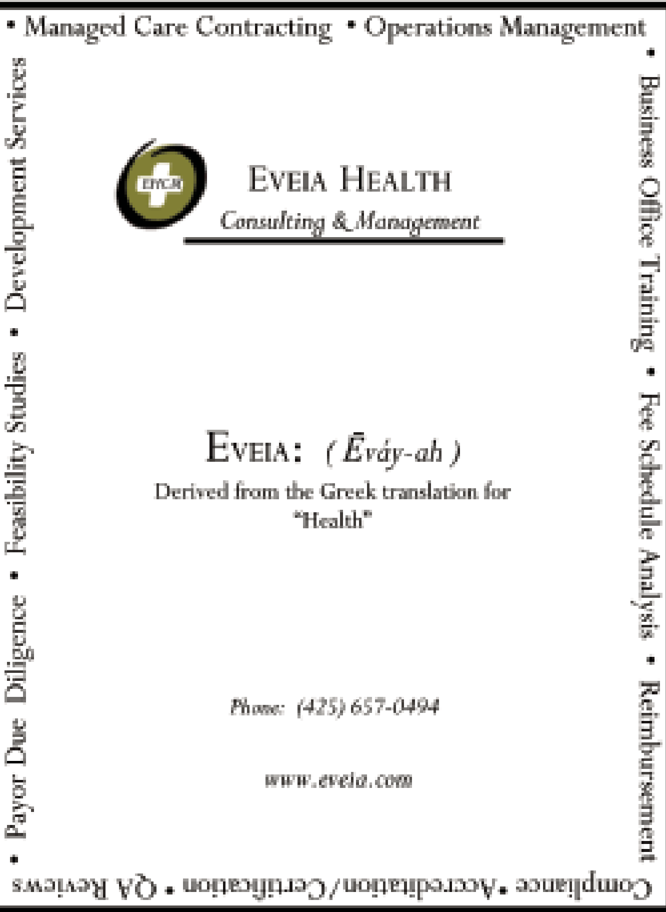
Staffing is the second largest variable cost in your operations. Too many staff causes undue financial burden. It is better to use flex staffing to meet variability in hourly caseloads. Permanent, part-time and PRN staff are critical at opening and as a long-term plan. However, under the guise of quality service, many centers carry 3 to 4 more staff members than are actually needed to meet that goal. It's critical for your center to set financial parameters based on reliable statistics to ensure staffing is adequate for providing excellent patient service. Remember, you can always hire staff – but it is hard to fire them.

4. Don't Under-capitalize the Business

For small businesses, like an ASC, cash is king. Many small businesses – including ASCs – fail because they run out of cash and have insufficient staying power for slow growth periods, paying problems for expenditures or time delays in the project. Proper cash flow is critical – and should be part of your formal business plan done at the outset to project the costs of pre-opening and expenses. Your plan should be conservative about case ramp-up to project prudent cash flow. Projections for accounts receivables less than 60 days for the first 6 months of operations are unrealistic. The rule of thumb is 120 days for the first 6 months, and then tightened down to 40 as operations move forward. Pre-opening rent is often overlooked since ASCs cannot usually bill patients at least 90-120 days after they move in due to the time it takes to obtain Medicare provider and billing numbers. Most third party payers will not even contract with an ASC until they have their provider number. The timing of this must be factored into the planning of a credit line and the amount of money invested by the owners into the business.

You must correctly calculate the current amount of investment in the ASC per share or per unit, if an LLC. Often, ASCs undervalue the per share per volume amount to make the deal more attractive to physician investors – only to find they have not raised enough cash to fund the project, construction, tenant improvements or delays. A good guideline is to raise 25% to 30% of the total project from the investors. This percentage is calculated from the costs for pre-opening,





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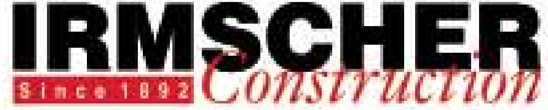


equipment and operations for the first 6 months. You should also arrange a credit line for the first 6 months in case of delays so the center never runs out of cash for its start-up 18 months (6 months pre-opening + year 1 operations).

5. Don't Allow 1 Entity or Doctor to Own Too Much

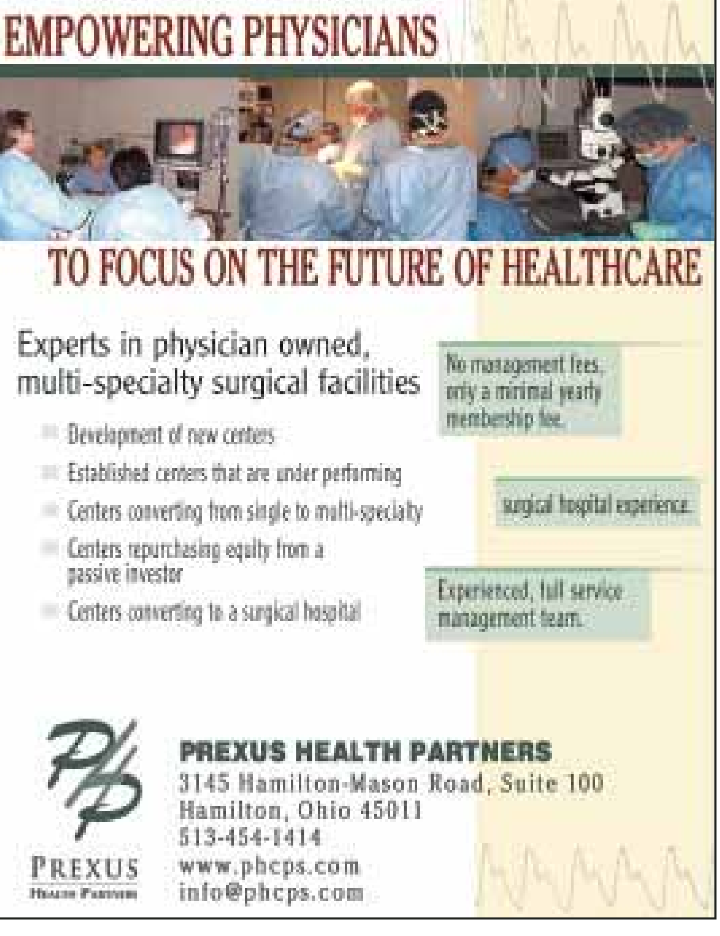
Most doctors don't want to bring cases to a center that is owned significantly by 1 or 2 doctors. They will refuse to "line the pockets" of another surgeon. Therefore, never allow 1 doctor or group to own too much of the center, unless the center is being developed for that practice alone.

It is important to properly remunerate founding surgeons. Certainly, those who conceive the center, take time away from their practices for development, who are first in the deal and take the risks, deserve to buy extra shares and/or receive development fees or management fees, if they will provide ongoing services. (Their commitment has nothing to do with their case volume.) Units or shares can be divided into founder and non-founder shares. We have found that "Class A" and "Class B" stock does not work well among surgeons (except in the case when the split is with a hospital). No surgeon wants to be considered a Class B surgeon. If your founder physicians want to create a different class of stockholders, you may want to create different risk levels or voting levels to differentiate the two types of stocks.

The issue of founder contributions – often intangible – is a very sensitive area when initially structuring the center, and needs guidance from legal counsel. The rule of thumb is to make sure that the services being delivered are tangible and visible in order to justify any additional fees or shares/units being purchased by the founding surgeons. We strongly suggest that the per-share costs of the founding surgeons be exactly the same as all other investors—not only for legal purposes, but also for political reasons. Undervaluing the shares for founders leads to numerous problems, which can be easily avoided by following these recommendations. This is practical advice we give our clients, and the surgeons should always consult ASC experienced, legal counsel to guide them in these matters.

This is just an overview of all the issues needing foresight and planning before embarking on your endeavor. It is always best to have a development partner that understands the ins and outs of all phases, and one that you will have confidence and trust in for the long haul. Here's to your success! ■

Robert J. Zasa is a partner in Woodrum/ASD, an ASC development, management and partnering firm focusing on new and existing centers. For more information, visit www.woodrumasd.com or call 626.403.9555.



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The Return of Problematic Leases

By Scott Becker and Elissa Moore

As profit margins in surgical centers become tighter and the reimbursement for physician services continues to erode, many surgery centers are again discussing equipment leases and variations on equipment leases as a means to reduce risk or increase business. This article briefly describes several issues that should be taken into account in developing equipment leases.

Key Questions.

There are five key questions that need to be addressed in developing an equipment lease for a surgical center. These include:

> **Q: (1) Is the landlord or lessor a physician owned entity or, alternatively, owned by a third party that does not include anyone that makes referrals to the center?**
>
> **Q: (2) Will the lease be a fixed fee annual lease or a per click or per use type of lease?**
>
> **Q: (3) If the lease is a per click lease, what would be the aggregate cost to acquire the equipment? For example, is the lease for a large ticket capital expenditure, in which case it may make sense to rent on a per click basis and avoid the risk of owning the equipment?**
>
> **Q: (4) Is the intent of the lease to reduce capital expenditures and reduce risk or, alternatively, is it to induce the referral of business from physicians who can utilize the center?**
>
> **Q: (5) Can the payments under the lease be readily defended as fair market value?**

General Case Concerns.

These are several of the questions that need to be addressed in developing leases with physician owned landlords. Leases that are entered into with referring physicians are particularly subject to scrutiny in that the Office of Inspector General and several regulatory authorities have regularly articulated concerns with situations

where centers buy or lease equipment from physicians. Typically, the concern is that the intent of the lease is to provide the physicians with an inducement to bring or refer cases to the center. Thus, leases where payment is made on a per click basis are particularly subject to concern. Further, leases that are on a fixed annual fee basis, can also create substantial concern if (1) the annual payment is more than fair market value, (2) the equipment can be obtained at a lower cost from another party, and/or (3) the lease payment, while fixed on an annual basis, is recalculated each year or periodically explicitly or implicitly related to increases or decreases based on some measure of activity at the center.

Per Click Leases.

Leases which are set on a per click basis cannot meet a safe harbor under the Anti-Kickback Statute. 42 U.S.C. § 1320a-7b(b). This does not necessarily mean that they are illegal. Specifically, a lease may still be legal if a party can clearly demonstrate that the lease makes sense from a financial perspective, regardless of the amount of volume or value generated by the physicians' referrals. Further, they tend to be easier to defend if the lease is related to a large piece of equipment. Where the capital cost to the center might be a $1,000,000 or more, it may very well make sense to rent the equipment on a per click basis. In essence, it helps the center avoid a very large financial expenditure and obligation. In contrast, where someone is renting on a per click basis, and it is a piece of equipment that can readily be purchased by the center, for example, at $30,000 to $40,000, it raises much greater concern that the real purpose of the lease may be to drive referrals to the center than to actually avoid an expenditure.

One of the reasons per click leases cannot meet the equipment lease safe harbor is because the equipment lease safe harbor regulations require among other requirements that the aggregate rental amount be set in advance each year. In 1991, the Office of Inspector General responded to comments requesting clarification as to whether percentage or per use arrangements are protected under the equipment lease safe harbor, stating:

These sorts of arrangements need to be examined on a case-by-case basis. For example, a lease to a hospital of major medical equipment, such as a magnetic resonance imaging scanner, may specify that higher rent is to be paid when more than a predetermined number of procedures is performed. Such an arrangement can be troublesome if the lessor is a partnership of radiologists on the hospital's medical staff, because the incentive for overutilization is clear. It is the nature of the relationship, if any, between overall volume of use and referrals, that triggers the statute.

For these reasons, we specifically decline to protect rental charges…where the aggregate amounts of payments are not set out in advance. This does not mean, however, that percentage or per use leases and contracts that are based on overall volume (including business from referral sources with no financial interest to motivate them) are per se violations of the state. We recognize that legitimate considerations, such as the depreciation of equipment, could result in some part of the payment to be based on

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a percentage or "per use" payment arrangement without these payments influencing or being influenced by Medicare or Medicaid referrals. However, the more the payments appear to reflect the volume of referrals from the financially interested party, the more suspect the arrangement becomes and the more likely we will need to examine it carefully. 56 F.R. 35952 (July 29, 1991).

Accordingly, per click leases, can be structured to reduce the risk by (1) setting an annual cap on the amount of payments from the center to the physician landlord, (2) assuring that the per click payment is supported and documented as fair market value for the equipment rented, and (3) having a record and reality that demonstrate that the per click method is not intended to drive or induce referrals.

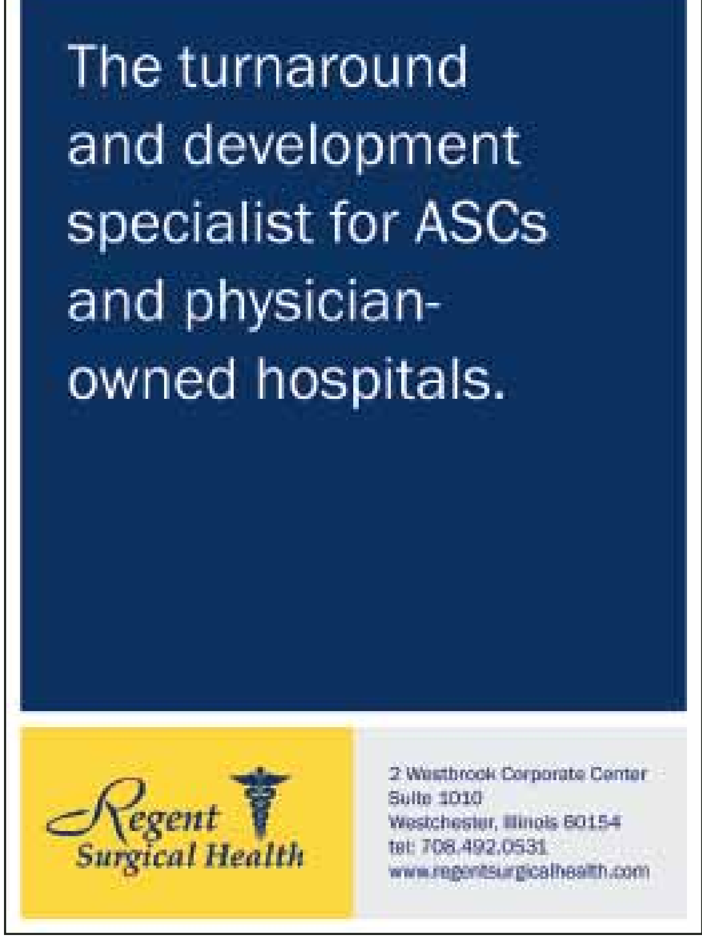
The Anti-Kickback Statute vs. the Stark Act.

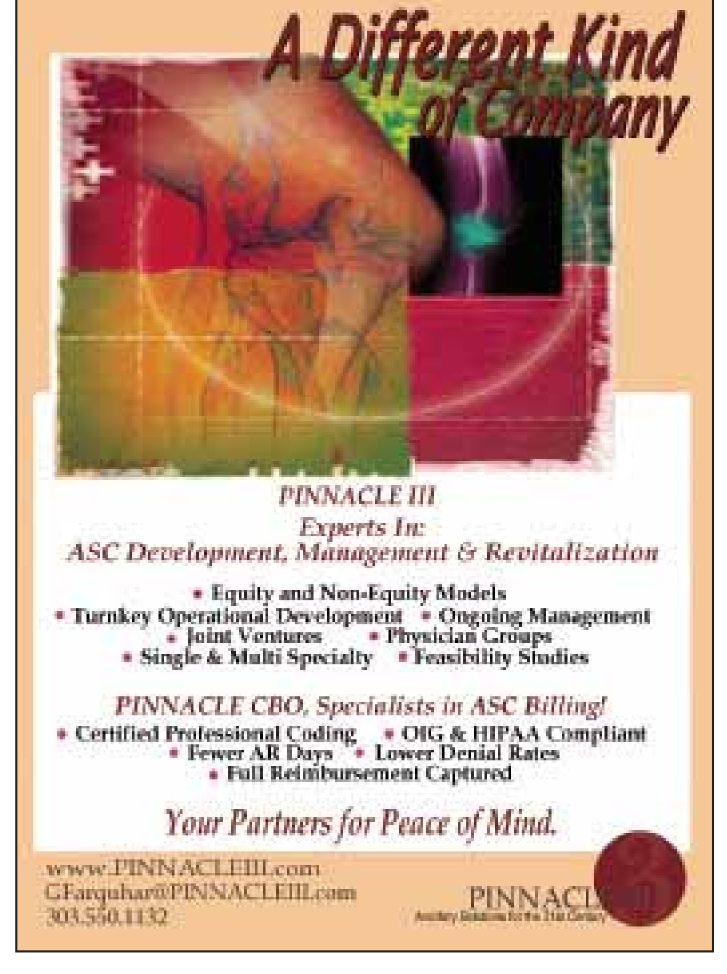
As noted above, the Anti-Kickback Statute equipment lease safe harbor requires that the annual aggregate amount of lease payment be set in advance for each year. Thus, a per click lease would not meet a safe harbor under the Anti-Kickback Statute. In contrast, under the Stark Act, which is generally not directly applicable to surgical centers, the Department of Health and Human Services has indicated that a per click lease can meet the equipment lease exception to the Stark Act. 42 C.F.R. 411.357(b). The equipment lease exception provides, among other requirements, that the rental charges over the term of the agreement are set in advance, consistent with fair market value, and are not determined in a manner that takes into account the volume or value of referrals generated between the parties. In essence, under the Stark Act, as opposed to the Anti-Kickback Statute, it is not a requirement that the aggregate annual fee be set in advance.

In addition, the Centers for Medicare and Medicaid Services has responded to comments requesting clarification of per-use based payment methodologies that do not vary with the volume or value standards:

> [T]ime-based and unit-of-serve based compensation will be deemed not to take into account the volume or value of referrals or other business generated between the parties *as long as* the time-based or unit-of-service based compensation is fair market value for services or items actually provided and the compensation does not vary during the course of the compensation agreement in any manner that takes into account referrals of DHS… We consider per use payments (also known as "per click") payments to be unit of unit-of-service based on compensation. 69 FR 16069 (March 26, 2004).

Parties should structure equipment leases to comply with all aspects of the equipment lease exception to the Stark Act. Moreover, parties should be particularly mindful of Anti-Kickback Statute risks with respect to any leases entered into where the physicians own all or part of the leasing company. This risk is further amplified when the lease is on a per click basis. ■





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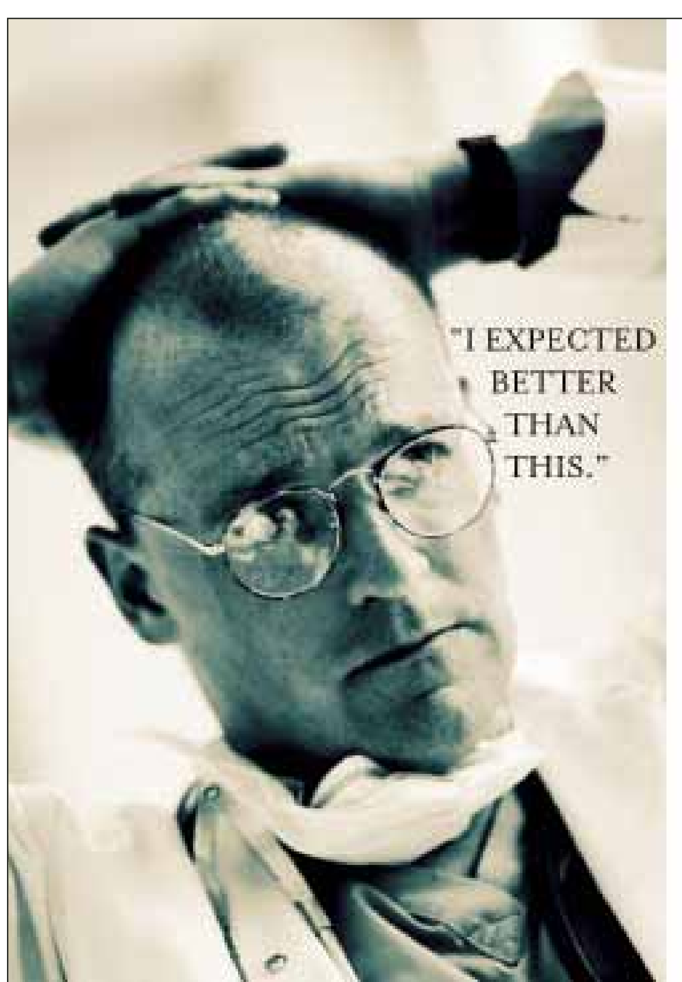

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