

BECKER'S ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

10 Key Legal Issues Facing Ambulatory Surgery Centers

By Scott Becker, JD, CPA, Elissa Moore, JD, and Elaine Gilmer, JD

Between healthcare reform, increased enforcement under the Anti-Kickback Statute, less patience on the part of physician leaders for underperforming surgery centers and increased pressure from payors on out-of-network arrangements, it is an interesting time to write about legal issues in the ASC sector. This article briefly discusses 10 legal issues, although any article on this subject could include many more. We hope you will find this a helpful overview of certain key legal issues being faced by surgery centers.

1. Healthcare reform. No one knows exactly what the ultimate impact of healthcare reform

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13 Major Changes Facing ASCs

By Brent W. Lambert, MD, President of ASCOA

Brent W. Lambert, MD, president and owner of Ambulatory Surgical Centers of America, discusses 13 changes for ASCs in the next few years.

1. More reliance on government payors. Look for a big increase in government-paid healthcare under health reform, particularly in Medicaid. For ASCs this means low reimbursement rates and a rigid bureaucratic approach with no option to negotiate contracts as in the private sector. "Right now, about one-third of all patients are government-paid," Dr. Lambert says. "Under health reform it's going to double or even triple, depending on how this all falls out."

2. Reimbursements continue to fall. Reimbursements have been declining as out-of-network opportunities with private payors become less common and Medicare reimbursements fail

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A Review of OIG Self-Referral and Antikickback Cases:

5 Categories of Non-Compliant Physician Relationships and 8 Recent Cases

By Scott Becker, JD, CPA, and Lindsey Dunn

From 2001-2010, there were nearly 100 different HHS' Office of Inspector General physician self-referral and kickback settlements. In just the last two years (2008-2010), there were more than 20 such settlements. At the same time, there has been an upswing of interest by hospitals and other healthcare entities to align more closely with physicians. Many of these 20 or so more recent settlements involve alleged improper at-

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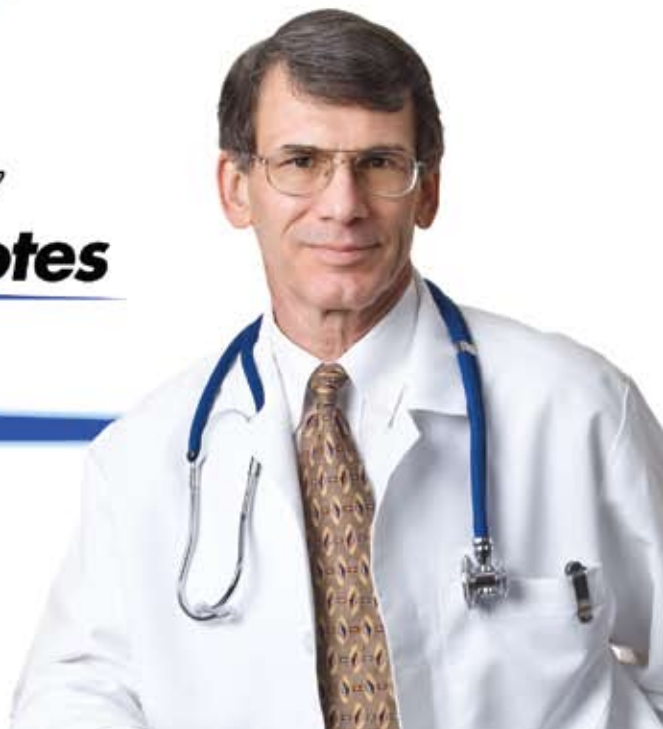
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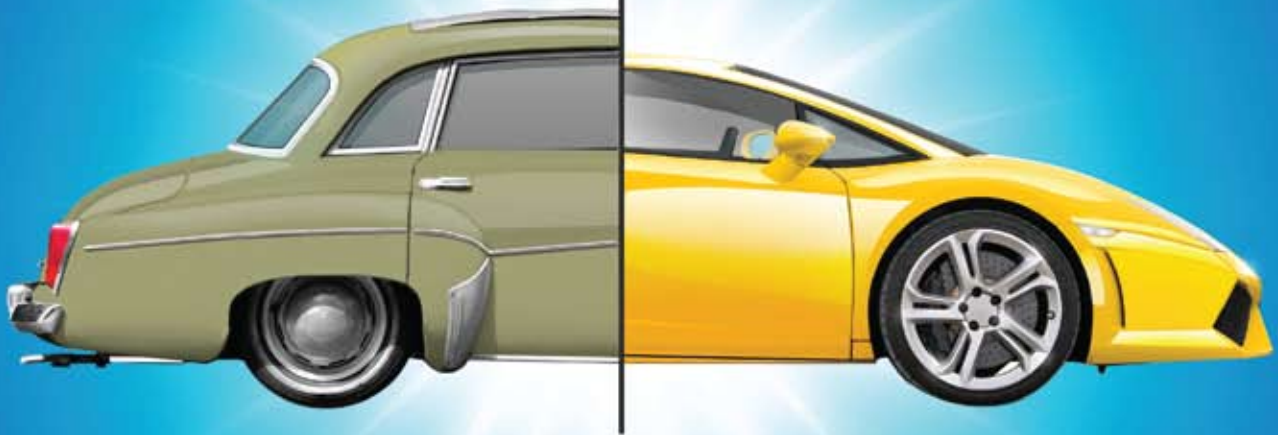
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Publisher's Letter

Improvements at ASC Communications; Tucker Carlson and Bobby Knight to Speak at October Conference (Oct. 21-23; Chicago); New Channels Added to Sites

By Scott Becker, JD, CPA

We are taking several steps to improve the offerings of ASC Communications. A few of these we want to note are as follows.

1. 17th Annual Fall ASC Conference. This fall we are bringing in new keynote speakers including Bobby Knight and Tucker Carlson as well as 95 other business, physician and political speakers to make the fall conference — October 21-23 — our best event ever.

2. ASC Website. We have added channels on 1) healthcare reform, 2) ASC turnarounds and ideas to improve performance, 3) gastroenterology/endoscopy, 4) ASC valuations and transactions, 5) coding, billing and collections and 6) anesthesia. Please visit www.BeckersASC.com.

3. Hospital E-Weekly. In addition to the Becker's Hospital Review E-Weekly, we have added a Daily Hospital and Health Care Alert for those who have interest beyond surgery centers. We have also added channels to the hospital site as follows: 1) anesthesia, 2) healthcare reform, 3) 30 Best Hospitals, 4) 100 Best Places to Work, and 5) Stark Act and Anti Kickback Issues. Shortly, we will add channels on 1) increasing volume, 2) financial issues, 3) staffing issues and staffing efficiencies, 4) physician practice performance and physician specialties, and 5) cancer care programs and cancer drug costs. Please visit www.BeckersHospitalReview.com.

4. Orthopedic and Spine. We will be adding an orthopedic and spine device and implant insights section to all magazines for the rest of 2010. We are also adding two additional channels to the Orthopedic and Spine site as follows: 1) How to build a spine ASC channel and 2) an orthopedic and spine device news channel. Please visit www.BeckersOrthopedicandSpine.com.

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Scott Becker

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10 Key Legal Issues Facing Ambulatory Surgery Centers (continued from page 1)

will be on ASCs. However, almost everyone expects that it will lead to an incremental increase in the number of governmental and lower paying patients. In the short run, healthcare reform does not appear to have a very immediate negative impact on surgery centers. In fact, because the reform legislation provides certain incentives for preventive efforts, such as colonoscopies, and because there is no public option, the immediate negative impact is not clear.

However, over the long run, there are three big concerns. First, there are concerns that a substantial number of additional patients will be added to the coverage pool at what is expected to be very low rates. A second concern is whether the current healthcare reform is actually an intermediate step on the way to a more national public option and other efforts to significantly reduce costs and put pressure on commercial payors to further reduce costs. These efforts will likely, in the longer term, mean lower reimbursement for surgery centers. A third long-term concern is to what extent there will be an impact on the independent practice of medicine.

Certain of the concepts set forth in the healthcare reform initiatives involve integrative efforts between hospitals and physicians to develop accountable care organizations and other efforts that allow the joint packaging of care. These efforts, together with other payment incentives for hospitals often lead to more employment of physicians by hospitals. This reduction in the pool of physicians means a reduction in the lifeblood of surgery centers.

While the overall verdict on healthcare reform is not yet in, certain of the long term trends do not favor surgical centers despite the fact that ASCs generally reduce the cost of care.

2. Anti-kickback issues. The government over the last few years has initiated huge increases in the funds allocated to healthcare fraud enforcement, which enforcement focuses on billing and collection issues, as well as physician-hospital relationships. In the past, fraud enforcement focused heavily on billing and collections issues. Now, significant fraud and abuse resources are also put towards review of Stark issues and anti-kickback relationships between hospitals and physicians. The surgery center industry has just begun to see some level of investigation of fraud and abuse on the physician relationship side. We believe the surgery center industry is ripe for more investigative resources to be directed toward it.

We continue to see the evolution of different types of possible anti-kickback situations. These relate to situations where parties are trying to sell shares to physicians at prices that may be below fair market value, situations where facilities are leasing equipment on a per-click basis from physicians¹ and situations where parties want to sell different quantities of shares to different physicians or pay different types of medical director fees to different physicians.

Over the next few years, as the government allocates more money to anti-fraud initiatives, it will be important to keep an eye on what types of activities people are engaging in and what types of activities the government is particularly targeting.

(a) Safe harbors — Non-compliant physicians. Over the past few years, parties have become more aggressive in trying to redeem physicians who are not safe harbor compliant as existing physicians are increasingly less patient with non-safe harbor compliant physicians. In many situations, the parties may offer the non-compliant physicians full value for the shares, even if such full value is not required under the surgery center's operat-

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ing agreement. The parties may also give such non-compliant physicians a long notice period in which the non-compliant physician may come into compliance with the safe harbor. In addition, it is important that safe harbor concepts not be applied in a discriminatory manner. Rather, the safe harbor concepts should be consistently applied to all physician members if the center is going to enforce the concepts and use them to redeem parties. Further, there is at least one significant case where the use of the safe harbor concepts was challenged by a physician. While the case was dismissed on other grounds, it has provided additional comfort to parties who are looking to redeem physicians based on lack of safe harbor compliance. Again, it is critical that redemption be truly based on safe harbor compliance.

(b) Safe harbors — Indirect referrals. The government continues to express great discomfort with indirect referral sources and non-safe harbor compliant physicians. That said, the government is very cautiously but intelligently handling cross-referral relationships, as evidenced by the extreme caution exercised by the Office of Inspector General in issuing a positive advisory opinion to a hospital-physician joint venture where only a small number of the orthopedic physicians were not safe harbor compliant (i.e., four out of 18 physicians were not safe harbor compliant), but were potential referral sources. There, in fact, the OIG prohibited the referral of cases from the non-compliant physicians to parties that would receive such referrals and then use the surgery center for those cases. In reaching its conclusion, the OIG said:

“In the circumstances presented, notwithstanding that four Inpatient Surgeons will not regularly practice at the ASC, we conclude that the ASC is unlikely to be a vehicle for them to profit from referrals. The Requestors have certified that, as practitioners of sub-specialties of orthopedic surgery that require a hospital oper-

ating room setting, the Inpatient Surgeons rarely have occasion to refer patients for ASC-Qualified Procedures (other than pain management procedures, which are discussed below). Moreover, like the other Surgeon Investors, the Inpatient Surgeons are regularly engaged in a genuine surgical practice, deriving at least one-third of their medical practice income from procedures requiring a hospital operating room setting. The Inpatient Surgeons are qualified to perform surgeries at the ASC and may choose to do so (and earn the professional fees) in medically appropriate cases. Also, the Inpatient Surgeons comprise a small proportion of the Surgeon Investors, a majority of whom will use the ASC on a regular basis as part of their medical practice. This Arrangement is readily distinguishable from potentially riskier arrangements in which few investing physicians actually use the ASC on a regular basis or in which investing physicians are significant potential referral sources for other investors or the ASC, as when primary care physicians invest in a surgical ASC or cardiologists invest in a cardiac surgery ASC.” Advisory Opinion No. 08-08 (issued July 18, 2008).

Here, the arrangement did not meet every requirement of the safe harbor in question. However, certain other factors led the OIG to conclude that, although the arrangement posed some risk, the safeguards put in place by the parties sufficiently reduced the risk of illegal kickbacks to warrant granting the positive advisory opinion.

(c) Buy-in pricing for junior physicians and new physicians.

Parties continue to look for ways to reduce buy-in amounts for junior physicians. Increasingly, there are arguments for lower valuations based on the impact of the changing economy on surgery centers and the uncertainty of profits going forward. It is also possible for junior physicians to buy

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fewer shares, to obtain loans from companies that are in the business of providing financing for physician buy-ins (provided such buy-ins are not guaranteed or supported by any other investor or the surgery center) and to engage in opportunities like recapitalizations to further reduce the cost and value of the center. Again, a key issue is ensuring the center is not selling shares to junior physicians at below fair market value to induce the referral of cases or the retention for cases.

(d) Can we kill a partner physician? One question that ties closely into the safe harbor concepts is, "Can I kill a physician who does not perform cases at the center?" The answer, briefly stated, is you cannot kill such physician. However, there are possibilities to work with the safe harbors and compliance guidelines to see if the party is someone that should be redeemed pursuant to not complying with the safe harbors or other operating agreement terms.

(e) Sale of additional shares to highly productive physicians.

We often see situations where a physician who produces proportionately more than he owns wants to buy additional shares in the surgery center. In general, it is very hard to facilitate this. It is possible for that physician to try to buy additional shares from other partners. Here, the other partners cannot sell their shares to the high producing physician simply to help keep his or her cases at the center. If existing partners want to sell shares, for reasons unrelated to retaining volume, it is not illegal for them to sell shares to such high producing physicians. The sale of shares should be at fair market value.

(f) Profiting from anesthesia and pathology. Increasingly, we see situations where centers and physicians are looking for ways to profit from ancillary services such as anesthesia, pathology or other areas. Again, there are certain ways in which an ASC can lawfully profit from anesthesia in a legal manner. However, there are certain other ways, such as setting up an anesthesia management company, which are of more significant concern with respect to the legality of profiting from anesthesia. This area has recently come under attack by the American Society of Anesthesiologists.

The laws with respect to profiting from pathology are somewhat murkier. There is an ability often for gastroenterology practices related to surgery centers to perform pathology services in their own office and profit from these. However, there is a whole range of analysis that has to be performed to ensure that such efforts comply with the Anti-Kickback Statute, the Stark Act and the Anti-Markup Provisions.

(g) "Per-click" relationships. There have traditionally been several different types of "per-click" arrangements for such items as gamma knives, lithotripters, lasers, CT and MRI scanners and other types of equipment. However, the government has now outlawed most per-click relationships (at least in the Stark context). Although the changes to the Stark Act and the accompanying regulations do not necessarily apply to surgery centers, the analysis and concerns are applicable under the Anti-Kickback Statute to surgery centers. CMS offered an explanation of its position in the commentary to the new rules:

"At this time we are adopting our proposal to prohibit per-click payments to physician lessors for services rendered to patients who were referred by the physician lessor. We continue to have concerns that such arrangements are susceptible to abuse, and we also rely on our authority under sections 1877(e)(1)(A)(vi) and 1877(e)(l)(B)(vi) of the Act to disallow them.

"We are also taking this opportunity to remind parties to per-use leasing arrangements that the existing exceptions include the requirements that the leasing agreement be at fair market value (§411.357(a)(4) and §411.357(b)(4)) and that it be commercially reasonable even if no referrals were made between the parties (§411.357(a)(6) and §411.357(b)(5)). For example, we do not consider an agreement to be at fair market value if the lessee is paying a physician substantially more for a lithotripter or other equipment and a technologist than it would have to pay a non physician-owned company for the same or similar equipment and service. As a further example, we would also have a serious question as to whether an agreement is commercially reasonable if the lessee is performing a sufficiently high volume of procedures, such that it would be economically feasible to purchase the equipment rather than continuing to lease it from a physician or physician entity that refers patients to the lessee for DHS. Such agreements raise the questions of whether the lessee is paying the lessor more than what it would have to pay another lessor, or is leasing equipment rather than purchasing it, because the lessee wishes to reward the lessor for referrals and/or because it is concerned that, absent such a leasing arrangement, referrals from the lessor would cease. In some cases, depending on the circumstances, such arrangements may also implicate the anti-kickback statute."²

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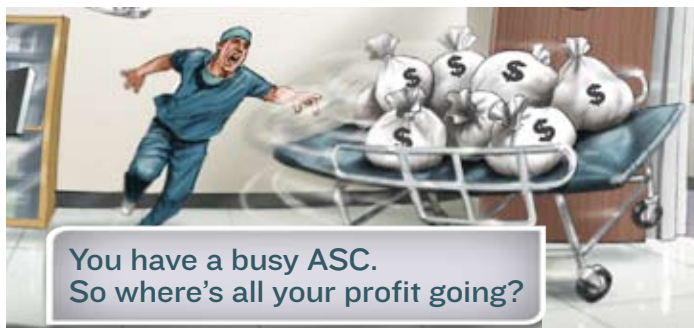
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(h) Medical directorships. Recently, we have been asked about the use of medical directorships for ASCs. In short, medical directorships should be used only if the medical director is providing true medical direction. If a typical center has one medical director who is an anesthesiologist and/or another surgeon truly involved in that direction, that should be the core model a surgery center should consider. When looking at other situations, for example, having a medical director for each specialty, there must be a legitimate reason for the need for multiple medical directors, the fees must be fair market value and such arrangement must not be intended to provide a kickback in exchange for cases.

3. HIPAA. The Health Insurance Portability and Accountability Act continues to be updated in a manner that adds additional burdens. One of the biggest burdens in the most recent HIPAA amendments require that a patient be notified of any sort of inadvertent breach of disclosure of confidential information. Previously, centers and healthcare providers could decide, on a case-by-case basis, whether or not to notify the patient of an inadvertent breach. Now, patients must be notified of any breach. Further, under the newly revised HIPAA, the patient has the right to receive medical records with little cost even if the surgery center must incur costs to provide the medical records.

4. Antitrust issues. There are two antitrust issues most prevalent in the ASC industry. First, there is a question as to whether a hospital and physicians can jointly contract to try to obtain better rates from managed care payors. Here, the key issue is ensuring that two entities can be considered one entity for purposes of the antitrust laws, which makes them legally incapable of conspiring with each other. There is a significant difference in legal interpretations on this across the country. For example, if a hospital owns 80 percent or more of the surgery center and has substantial control of the surgery center, there are very strong arguments that conspiring together is not possible from an antitrust law perspective (i.e., the hospital and surgery center are one). When the ownership is between 50 percent and 80 percent, the determination differs from district court to district court, which is to say by region of the country. Further, the amount of control the hospital has over the surgery center is a critical component of the ultimate determination. Where a hospital owns less than 50 percent of the surgery center, it may still be possible for the hospital and surgery center to be considered one entity, but the hospital must have very substantial control of the surgery center.

The other common antitrust issue arises when a surgery center is excluded from certain payor

contracts due to aggressive hospital competition. Here, the challenge for the surgery center is showing that the hospital provides more than simple competition but rather has conspired to harm the physician-owned surgery center or has made an effort to monopolize the market. This can be a very expensive process of gathering facts to prove such conspiracy exists.

5. Medical staff bylaws. Medical staff bylaws issues constantly arise in the surgery center context in several distinct contexts. First, determining whether or not to waive a provision to the medical staff bylaws in order to allow a physician to remain on or join the medical staff even though he or she does not technically meet a specific qualification. There are pros and cons to periodic waivers of provisions as to specific physicians. Second, the issue of how to remove a physician from the medical staff due to some sort of medical conduct issue or other issue. Here, to obtain the protections of the Healthcare Quality Improvements Act (HCQIA), it is critical that a surgery center exactly follow its medical staff bylaws procedures and also follow the rules of HCQIA.

A third issue related to medical staff bylaws is how removal from the medical staff under the bylaws impacts redemptions from the surgery



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center as an owner. Here, there is commonly a requirement in the operating agreement that a member must be on the medical staff in order to be an owner in the surgery center. It is critical that the two efforts be somewhat divided from each other. In essence, this means that the effort must be made first to make sure that the decision under the medical staff bylaws be handled separately and not tied to ownership. Then, once the medical staff issue is completed, the operating agreement redemption issues can be addressed.

6. Hospital outpatient department transactions and "under arrangements" deals.

Over the last few years, "under arrangements" — a type of transaction where an infrastructure company provided all surgery center services to a hospital — became very popular. This was because it allowed the hospital to continue to charge hospital outpatient department rates and allowed the physicians, in part, to own the infrastructure company and stay aligned with the hospital. In addition, physicians were getting paid as well as they would typically do in a surgery center (i.e., billing their professional services). In essence, this type of structure abrogated the benefit to CMS of the lower payment rate for ASC services. The Department of Health and Human Services, as part of the most recent Inpatient Prospective Payment System, changed

a number of related Stark Act provisions. In that regard, they specifically outlawed this type of arrangement.

As the government has outlawed under arrangements transactions, we are revisiting situations in which a surgery center sells to a hospital and develops what is titled a "co-management" relationship. This provides the physician or physician group compensation for managing the service of the hospital but allows the hospital to really be the owner and provider of the services and to provide the services at hospital outpatient department rates. The great challenge in these relationships will be assuring that they are fair market value and paying physicians for reasonably needed services and not just a means to get money to physicians in exchange for business. The further great challenge of these relationships will be how they look three to five years after a transaction is completed. In essence, there is nothing as congruent in terms of interests as a true joint venture. Over time, there is a great likelihood that case volumes will be reduced and that the glue of the relationship will be not as strong as it was when first formed.

7. Out-of-network reimbursement. The ability to profit substantially from out-of-net-

work patients continues to decrease. While many parties profit from out-of-network payments, payors are increasingly aggressive regarding recoupment, collection of appropriate co-payments from patients and increasing co-payment and deductible responsibilities. Thus, the ability to make outsized profits or have serious negotiation leverage through the use of out-of-network continues to be hampered.

On the out-of-network side, we are seeing increasing situations where payors either issue audit letters to surgery centers, develop no pay policies on out-of-network, or pay surgery centers just a fraction of what they expect to get paid. Surgery centers, on their end, are increasingly making efforts to work with state departments of insurance to explain how the cutting off of out-of-network precludes patients from accessing true PPO benefits. There are a handful of cases that discuss whether or not payors have responsibilities to pay providers when providers are serving patients out-of-network and in some situations reducing co-payments. This is an evolving area that we expect to get uglier.

8. Physical plant relationships. Increasingly, third-party accreditation firms and CMS surveyors are taking a much harder approach

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towards grandfathering in outdated physical or non-compliant plant conditions. In many situations, these physical plant conditions may have preexisted certain changes in certification rules that now require different structures, sizes and other types of accommodations. Notwithstanding the fact that many older facilities pre-dated such rules, surveyors are demanding that such facilities be brought up to code immediately. This can provide real challenges to existing surgery centers.

9. Physician-owned equipment companies. One of the interesting new scenarios is where physicians own an equipment company and sell equipment to the surgery center. In essence, the physicians become

a middleman between the surgery center and the equipment provider. This allows the physicians to profit on the sale of equipment used in any cases that they perform. ASCs should be cautious regarding these relationships.

10. IOL relationships. Increasingly, there are situations where physicians buy intraocular lenses, specifically the premium lenses, and sell them to their patients. Here, the physicians may or may not buy these lenses from the surgery center itself and some physicians may have a relationship where they directly buy the lenses and sell them to patients. Either way, these transactions raise issues as to how much money goes back and forth between the surgery center and the physicians as to the IOLs and whether the surgery center is improperly allowing the physician at the center to profit from the sale of equipment. There are also issues as to the proper pricing of such lenses sold to patients. We are also aware of certain situations where two lens manufactures may provide free sample lenses to physicians and the physicians may sell these lenses to patients. This is likely improper. ■

This is intended as a brief summary of 10 key legal issues facing surgery centers today. Should you have additional questions, please contact Scott Becker at sbecker@mcguirewoods.com, Elissa Moore at emoore@mcguirewoods.com or Elaine Gilmer at egilmer@mcguirewoods.com.

References:

¹While not necessarily illegal, the lease fees must be fair market value and there must be very strong arguments to defend the practice as not intended to induce referrals under the Anti-Kickback Statute.

²73 Fed. Reg. 48713-48714 (Aug. 19, 2008).

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13 Major Changes Facing ASCs (continued from page 1)

to keep pace with inflation. One modest improvement is a recent increase in Medicare orthopedic reimbursements. However, "every week I'm seeing two or three failing centers that need help," Dr. Lambert says.

3. Decline in the number of ASCs. Medicare figures show the number of ASCs last year rose by the smallest amount than at any time in the past 25 years, and Dr. Lambert predicts the number of ASCs will actually decline for the first time this year. This is due to declining reimbursement and a growing unwillingness of physician-investors to cover shortfalls of unprofitable ASCs, which now make up about half of all surgery centers.

4. Fewer surgeons for ASCs. While normal retirement rates would produce an attrition rate for surgeons at 15 percent in the next five years, some estimates put that rate at 40 percent because many older physicians are alarmed about health reform and want to retire early. "I see it all the time, physicians saying, 'I'm getting out,'" Dr. Lambert says. "The impetus is health reform."

5. Not enough physicians overall. The law is giving coverage to 32 million more Americans, but "how are they going to accommodate them?" Dr. Lambert asks. Even if Congress lifted its freeze on residency positions funded by Medicare, it would take years for enough primary care physicians to get through the training pipeline, and even longer for surgeons.

6. Emergence of a two-tier healthcare system. Government-paid healthcare will increasingly diverge from private-paid healthcare. While Medicaid rolls grow, physicians will continue to shun these patients, meaning they will have to depend on care from nurse practitioners, physician assistants and nurse anesthetists. Dr. Lambert also sees physicians dropping

out of Medicare, fleeing a possible fee cut. In his hometown of Naples, Fla., "you're starting to see doctors not taking Medicare," he says. "That is a watershed event."

7. ASCs are ratcheting up lobbying efforts. The ASC Advocacy Committee, founded last August, may raise as much as \$2 million within the next 12 months, which would be an unprecedented war chest of funds. The committee is lobbying the federal government for higher ASC reimbursements and to collect data on quality benchmarks, demonstrating ASCs' outcomes are superior to hospitals'.

8. Hospitals' political power is scary. The political power of the hospital lobby in Washington was blatantly demonstrated by Congress' passage of bans on new physician-owned hospitals and expansions of existing ones in the health reform law. That's troubling because hospitals might use that power to block some pro-ASC initiatives in Congress, Dr. Lambert says.

9. But hospitals actually need ASCs. If all ASC cases went back into hospitals, they wouldn't have the capacity to cover them all, much less make any money on them. For example, most hospitals are too inefficient to now perform cataract operations profitably.

10. An inattentive Congress. It's a bad sign for physicians that Congress still hasn't provided a permanent Medicare fee-fix, even though organized medicine made this a priority. "The government is showing its hand," Dr. Lambert says, adding this does not bode well for other reimbursement issues affecting physicians.

11. But Congress needs ASCs. As the enormous costs of health reform become apparent, Congress will be under strong pressure to save

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money. That may mean raising reimbursements so that more ASCs can survive. Medicare reimbursements for ASCs are 59 percent the rate for HOPDs. "We're the low-cost, low-complication surgical delivery system in the United States," Dr. Lambert says. "The government doesn't want ASCs to go away. If the number of ASCs fell dramatically, the federal budget would be more expensive."

12. ASCs can point to higher quality.

ASCs have low infection rates, 10 times lower than hospitals. "Infection rates, that's where we have hospitals nailed," Dr. Lambert says. "We want the government to start measuring all outpatient programs in the United States. We want outcome studies of HOPDs."

13. Many reforms could be repealed. Republicans stand to win solid majorities in both houses of Congress this fall, but their quest to repeal health reform would be vetoed until 2013, the earliest date a GOP president could take office. But even at this late date, a big chunk of the law could be repealed because many provisions don't take effect until 2014. ■

Contact Dr. Brent Lambert at blambert@ascoa.com.
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A Review of OIG Self-Referral and Antikickback Cases: 5 Categories of Non-Compliant Physician Relationships and 8 Recent Cases
(continued from page 1)

tempts at aligning with physicians. Thus, a review of these settlements demonstrates a number of the tactics that hospitals and other groups are currently using to align with physicians.

1. The settlements can roughly be divided into settlements that are for less than \$100,000 and those that are more than \$100,000.

2. The settlements that are less than \$100,000 generally have several things in common. They often reflect technical issues, they were often self-reported, and they often involve situations in which there is little implication of illegal intent. For example, this type of settlement may involve technical violations, a failure to sign some sort of document or some other single error.

3. The settlements of more than \$100,000 may or may not be self-reported. They also often seem to demonstrate a clear intent to help physicians and suggest an intent to generate and strengthen business relationships.

4. Among settlements that demonstrate intent to strengthen relationships with physicians, there are five general categories of kickback and self-referral relationships. They are as follows:

- The first category involves the provision of free services or staff to a practice of physicians. This may include administrative assistants, physicians assistants, athletic trainers or information technology.
- A second category includes paying for services not really needed. This may include paying for medical directorships, paying for vice presidents or providing part-time employment. In many situations,

these can be wholly proper relationships. It is those relationships that are entered into that don't have a true purpose other than to reward physicians for referrals which are problematic.

- A third category includes situations where one is paying too much for a service such as for leased space or medical directorships or for other assets.
- A fourth type includes providing discounts on things such as insurance or other items, such as leased space.
- A fifth category involves paying physicians under contract different amounts than are contracted. For example, a hospital may contract a physician at a fair-market rate for a medical directorship but then actually compensate the physician at a higher rate.
- Finally, a sixth set of claims involves recruitment arrangements which are not structured to fully comply with recruitment exceptions in the Stark statute or found to have improper intent in regards to the Antikickback Statute.

5. Nearly all of these categories of relationships have appeared in recent OIG cases and/or settlements. A few examples of some of the larger cases include:

- **Spartanburg Regional Healthcare System (Spartanburg, S.C.).** In this case, the government alleged that the hospital provided IT technology resources to 10 different non-employed practices without billing the practices for the service. Because the hospital was providing the services for free without a contract with the physicians, the services allegedly served as a kickback to the physicians. The hospital settled for \$780,000.



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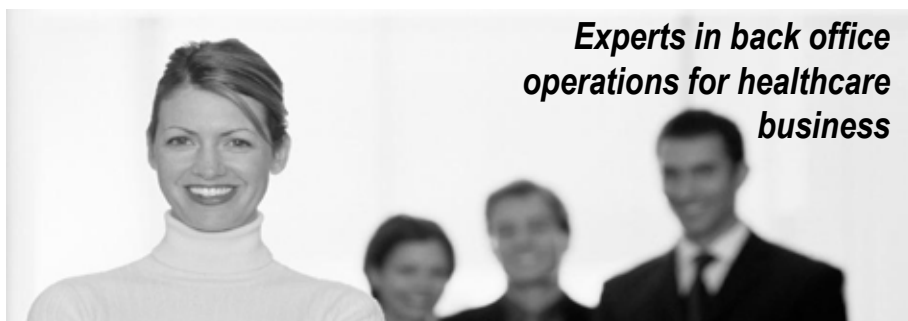
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- **Tuomey Hospital (Sumter, S.C.).** This case involved the providing of a number of part-time employment arrangements which were found to have no more purpose than to induce referrals. In essence, the hospital paid physicians for part-time employment services that were not needed. A federal jury found the hospital guilty of violating the Stark Act for the contracts, which it began offering to physicians in 2004. Here, the hospital faces nearly \$45 million in damages for its Stark violation.
- **St. Joseph Medical Center (Towson, Md.).** This case involves a situation where a large hospital in Maryland, St. Joseph, was attempting to more strongly align with the largest cardiology group in the area, MidAtlantic Cardiovascular Associates. Here, the group was deemed to control \$70-\$80 million in business. The government's investigation intended to examine if any improper financial relationships existed between the hospital and the practice. Specifically, the government was looking into the hospital's hiring of two of the practice's physicians, which resulted in the withdrawal of a nearly \$25 million offer from competing Union Memorial Hospital in Baltimore to acquire the practice. The investigation led to three of the top executives of St. Joseph resigning from the system, and the hospital settled with the government in July 2009 to resolve the allegations without admitting liability in order to, according to the hospital, avoid litigation costs.
- **University of Medicine and Dentistry (Newark, N.J.).** Here, the government alleged the hospital illegally paid kickbacks to cardiologists in exchange for referring patients to the hospital thereby causing the submission of false claims to Medicare. The government alleged that the hospital experienced a drop in certain cardiac procedures that jeopardized the hospital's Level 1 Trauma Center status. As a result, the hospital allegedly provided local cardiologists contracts for part-time employment, which the government alleged only served as vehicles to provide illegal kickbacks. Here, the hospital settled with the government in Sept. 2009 for \$8.3 million, and a number of individual cardiologists have also settled with the government for accepting the kickbacks. The basic concept was the hospital employed physicians at various compensation rates for services that were essentially unneeded.
- **Covenant Medical Center (Waterloo, Iowa).** In this case, Covenant was alleged to have overcompensated five physicians in return for referrals. The hospital settled for \$4.5 million. Although the physicians were not named as part of the settlement, they were said to be some of the most highly paid physicians in the country.
- **King's Daughters' Hospital and Health Services (Madison, Ind.).** Here, the hospital self-disclosed its conduct involving contracts for employed physician bonuses based on services they were not personally performing. The OIG alleged that the hospital's contracts did not fully comply with the Stark Act. As a result, the hospital settled for \$391,500.
- **Oswego Hospital (Oswego, N.Y.).** In this case, the hospital self-disclosed its conduct to the OIG and agreed to pay more than \$2.1 million for allegedly violating Stark requirements in agreements with more than 20 physicians. The agreements included recruitment arrangements, office leases, professional service arrangements and the provision of discounted employee benefit plan premiums to non-employed physicians.
- **Ivinson Hospital (Laramie, Wyo.).** Ivinson Hospital was alleged to have provided kickbacks to physicians by providing free rent, equipment and furnishings; leases at less than fair-market-value; medical director services in excess of fair-market-value; and reimbursement at rates more than the requirements of an income-guarantee agreement. Here, the hospital also self-disclosed its behavior and agreed to pay \$635,000 to the government.

These cases highlight both the increased interest by hospitals to more closely align with physicians and the increased scrutiny by the OIG to ensure these relationships comply with applicable health and antikickback laws. Hospitals and other entities that enter into such relationships must be careful to ensure their agreements are compliant. ■



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Is the AMA the Worst Trade Association Ever?

By Scott Becker, JD, CPA

The American Medical Association has been in existence for 162 years now, making it the oldest trade association in the nation, but this organization doesn't have a clue anymore as to what a trade association is about.

A trade association promotes its members' best interests. From time to time, it can embrace higher causes, even a cause such as health reform. But if it strays too far from its core mission of delivering benefits for members, it ceases to be a trade association and becomes something else — maybe an officious advisory group, as when the AMA declared in 2008 climate change was real.

Last year, the AMA gave its support to a fledgling health reform process whose ultimate success was very much in doubt at the time. In return for that support, the AMA wanted at minimum two basic things: federal tort reform and a permanent fix of Congress' noxious sustainable growth rate. The SGR, promulgated in 1997, has been producing ever-higher proposed cuts in Medicare physician reimbursement, which constantly have to be patched but are never removed.

Now health reform has become law, and what does the AMA have to show for its early support? No SGR-fix, no tort reform and a number of new payment problems created by the new law. Here are just four examples.

- a powerful new advisory board that can lower physician fees with little Congressional oversight.
- an estimated 15 million previously uninsured people who will be covered at very low-paying Medicaid rates.
- the prospect of intra-professional conflict as Medicare reimbursements for some areas may be raised and, under the zero-sum game of Medicare spending, physician reimbursements will probably fall.
- the demise of physician-owned hospitals. No new facilities can be built after this year and existing facilities cannot expand upon the date of enactment.

That adds up to no wins and several losses for physicians, leaving Paul DeHaan, MD, an orthopedic surgeon and AMA member in McHenry, Ill., feeling frustrated. In the health reform process, "there are huge concerns that many critical items we've been asking for were ignored," Dr.

DeHaan told the *Chicago Tribune*. "I believe they [the AMA] lost much support and confidence from a large faction of members, and that will hurt them in recruitment and retention."

Who got the better of whom?

AMA President J. James Rohack, MD, has repeatedly said the AMA's early support of the health reform bills gave it a front-row seat at the bargaining table, where it would be able to finesse more physician-friendly provisions into the final law. Last August he characterized an early version of the House health reform bill as "a starting point for the health reform debate, and the AMA is committed to staying engaged to improve the final legislation."


But as it turned out, the chief benefit of AMA involvement in the process was to make it easier for President Obama to sell the bill to Congress and the nation. Urging the House to pass the reform bill in November, Mr. Obama noted that the doctors of the AMA were behind it, and "they would not be supporting it if they really believed it would lead to government bureaucrats making decisions that are best left to doctors."

Actually, the President needed the AMA more than the AMA needed him, according to Howard Smith, MD, a Washington, D.C., obstetrician-gynecologist. "Obama needed to get all the major actors on board to have any hope for it to pass," Dr. Smith

wrote last year in the blog, *DC Examiner*. "Knowing this, it stood to reason that it would be more to the advantage of the AMA to hold its support off until it could get the best deal possible."

As the AMA became more expendable in moving the bill forward, its influence over the process waned. The fate of the SGR-fix is a good example. "The flawed Medicare payment formula must be fixed," Dr. Rohack told *MedPage Today* in the summer, when things still looked pretty promising for this issue. The House passed an SGR-fix in its first version of health reform, but then things went downhill. The SGR-fix has a huge price tag — \$210 billion to \$230 billion over 10 years. That's the amount on paper, at least. In reality, Congress has always in the past staved off the cuts and the money is never realized. In the strange world of Capitol Hill, though, this fictional amount is real money — so real that it threatened to squeeze out the money Congress wanted to spend on expanding coverage to millions of uninsured people, while delivering net savings over 10 years. After the short-lived victory in the House, the Senate threw the SGR-fix out of its reform bill, introduced it as a separate measure and voted it down.

That was the end of the fee fix as part of health reform, but Congress was still assuring the AMA until the end that the SGR-fix had a chance, and the AMA believed them. As recently as last month, just before the final health reform vote, Dr. Rohack was still promising in a conference call to reporters




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he'd hold Congress' "feet to the fire" and make it pass a permanent fee-fix. But it was too late. "It becomes extremely difficult to do a fix now that health reform has passed with such a big price tag," Julius Hobson, the AMA's former chief lobbyist, told *Chicago Business* a few days after the final vote.

Why the AMA failed to have influence on health reform

Why, after being so tough on President Clinton's health reform proposal in the early 1990s, did the AMA roll over so easily for President Obama and the Congressional Democrats? Many personally blame Dr. Rohack. This cowboy-booted cardiologist from Texas entered the AMA's one-year presidency just when health reform negotiations heated up and he's pretty much been front-and-

center ever since. But even if Dr. Rohack shares some of the blame, the AMA's mistakes run deeper than one man who took office last June and will be gone from it this coming June.

One mistake was the organization's highly nuanced position on health reform, which nobody but the AMA got. The organization frequently said while it supported the proposed health reforms, it did not endorse them. What? 'Endorse' means you think it's perfect and love it the way it is; 'support' means there is enough there to keep it moving while realizing there are things that need to be changed," an AMA delegate explained to *Psychiatric News*. A good explanation, perhaps, but the headline always was the AMA supports health reform. In a December letter on

the Senate's reform bill to Senate Majority Leader Harry Reid (D-Nev.), the AMA said it "firmly supports critical aspects of the bill" but "there is still work to be done." What kind of negotiation tactic "firmly" supports a plan — even parts of a plan — and still demands changes? Do you even listen to the demands of a negotiating partner who has already agreed to the contract?

The AMA's biggest mistake, however, was getting so smitten with the prospect of health reform that pocketbook interests for members were put in the trunk. Even before the reform debate, "the AMA was traditionally cautious about advocating the interests of doctors because it feared that advocacy could be misperceived by the public as partisanship," Dr. Smith explained in his blog. This time around, AMA officials also appeared to have no appetite any more for always having to nix ambitious, well-meaning social programs in favor of pocketbook issues. Some delegates at the AMA's December meeting praised the organization's affirmative stance on health reform and criticized "the AMA's reputation over the years as a nay-sayer — voting against Medicare in 1965 and the Clinton health care reform proposal in the 1990s," the *Psychiatric News* reported.

Though Dr. Rohack and the rest of the AMA board set AMA policy through most of the health reform debate, the House of Delegates, the ultimate authority in the AMA, had a chance to redirect it at an interim meeting in Houston last December. Three former AMA presidents and 10 state and specialty societies came in open revolt against the board's stance, but delegates firmly rejected a motion to rescind AMA support of health reform by a vote of 315-199. (However, they did pass several resolutions condemning parts of the bill, such as the advisory board.)

The Houston vote was a validation for Dr. Rohack, giving the beleaguered board an endorsement from the entire "House of Medicine." "Our policy is created through our House of Delegates," he told *Analyst Wire* afterwards. "Our House of Delegates represents every state medical association, over 170 specialty societies, medical students, residents, faculty of medical students, faculty of medical schools. So our policy is created by the profession."

AMA policy was endorsed by the profession. The delegates might have made the endorsement, however, because they were handed a fait accompli with little choice but to accept it. Sure, they could have yanked the AMA board from its chosen path, but health reform already seemed to be well into its last lap (that is, until Scott Brown (R-Mass.) won the U.S. Senate race in Massachusetts and put off final passage for a couple of months).

While the House of Delegates true stance on health reforms seems a little unclear, polls of



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physicians are even hazier. A National Public Radio poll in September found that nearly three-quarters of physicians favored a public option for health insurance, but another poll the same month by *Investors Business Daily* found 65 percent of doctors opposed government expansion of healthcare.

No longer a membership-driven organization

The House of Delegates may still represent physicians to some degree, but the AMA definitely does not. AMA membership reportedly reached a peak of 70 percent of physicians in 1962 and now is generally pegged at about 17-20 percent of all doctors. (The number is fuzzy because members include medical students and retired physicians, who have relatively high membership rates because they pay discounted dues.)

While plummeting membership would cripple most organizations, the AMA makes up for lost dues income by relying increasingly on other income. Product endorsements have been out ever since the 1997 Sunbeam scandal, but publications like CPT coding manuals have filled in the gap. In 2008, dues made up only 16 percent of AMA revenues, or \$43.9 million, while books & products made up \$69.9 million in revenues, database products made up \$47.6 million and publications, \$64.6 million, according to the most recent statistics in the AMA's 2008 annual report.

Other trade organizations have to meet the needs of dues-paying members, but the AMA is in its own, strange orbit. While it is still regarded, for now, as a major force in national policymaking, whether it can remain so is an open question. It is no longer the tough-minded trade group that frequently went to the mat on payment issues with federal policymakers. Its membership is broad and too ill-defined to direct policy. And, in the health reform debate, at least, its leadership seems to lack the most basic negotiating skills.

"The AMA, when first established, represented the views of the doctors in the 'trenches,' but now they have capitulated to our government and are not interested in the needs of practicing physicians," wrote Harold Fields, MD, in a comment on the *HCP Live Network* last July. "The AMA is only interested in self-advancement and maintaining its position." ■

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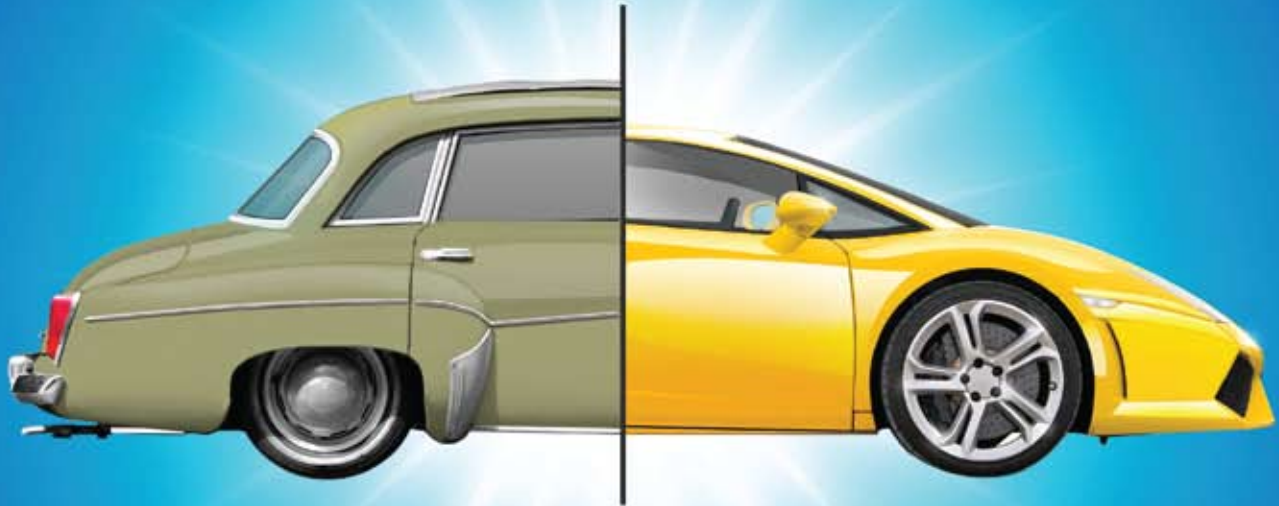
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4 Initiatives That Doubled Physician Distributions

By Sherry Hardee, RN, Administrator of Upper Cumberland Physicians Surgery Center

The Upper Cumberland Physicians Surgery Center in Cookeville, Tenn., grew distributions by 125 percent in 2009. This significant distribution growth was the result of accomplishing several strategic initiatives.

1. Increase capacity. To begin with, the center opened a second gastroenterology lab that doubled the center's capacity for GI patients. The majority of the center's GI physicians are not partners, so it is important for the center to accommodate these physicians' schedules to capture their patient volumes. Our center is very accommodating to all of our medical staff, but we are very cognizant of the contribution our non-partner physicians make to the center.

2. Take advantage of favorable Medicare rates. Management has worked hard to communicate what impact the Medicare reimbursement changes are having on our center. As

a result, our center's general surgery case volume has increased significantly, with a particular increase in lap chole surgery. Our physician partners have a renewed commitment to perform all appropriate cases at the center. Administration and scheduling continually communicate with physicians and their offices to avoid "holes" in our surgery schedule.

3. Reduce costs. We managed to reduce our medical supply cost from 26 percent of net revenue in 2008 to 20 percent of net revenue in 2009. We performed a detailed analysis of our medical supply cost under our existing GPO and under a proposed GPO. The proposed GPO offered significant savings; therefore, the center managed a GPO conversion and experienced significant supply cost savings.

4. Eliminate debt. Finally, the center aggressively paid down equipment loans and a line of credit in 2008. While this was painful in 2008,

the center has now paid off these debt obligations, freeing up additional cash flow for partner distributions. ■

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72-Hour Recovery Center Greatly Expands the Scope of an ASC

By Leigh Page

An overnight recovery area opens a whole new world for ASCs looking to build volume with a wider array of procedures, says Joseph Banno, MD, a urologist and founder of the Peoria (Ill.) Day Surgery Center, a four-OR, multispecialty ASC.

In Dr. Banno's opinion, when an ASC has no place for surgery patients to recover for up to a three nights, it cannot handle such cases as hysterectomies, sinus surgeries, many types of spine surgery, some gallbladder surgery, abdominoplasties and penile implants.

While Illinois and many other states generally don't allow ASCs to maintain three-night recovery areas, Peoria Day is an exception. It entered a state pilot program almost 14 years ago that allowed four ASCs in Illinois to build recovery care centers that can hold post-op patients for as long as 72 hours. Similar recovery centers are permitted in California and several other Western states.

Dr. Banno says 93 percent of all surgeries can be done in an ASC when patients have a chance to recover for up to three nights. The recovery center made his ASC more attractive. When the surgery center opened in 1997, 10 more surgeons signed up. Today, 53 physicians, including 44 investors, use it and the ASC has an infection rate of less than 1 percent.

The state pilot never led to implementation of a full-blown program, but Peoria Day and the other original pilots remain in operation. Dr. Banno says the recovery center itself currently does not break even. The state limits the charge to \$600 a night per patient and, under the current volume of patients, that doesn't pay for two nurses it has in each shift. However, the recovery center adds 38 percent more revenue to the ASC, representing cases that the ASC otherwise would not be able to accept.

Dr. Banno has petitioned the state to allow a higher charge, and he expects the recovery center's volume to rise. He also says more insurers are interested in contracting with the ASC.

Dr. Banno is pleased with his unusual recovery care center and owes a great deal of his business to it. He performs 100-150 penile implants a year at the ASC, knowing patients can always stay overnight in the center if necessary. Except when he is on call at the hospital, he almost never uses the hospital OR anymore. ■

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How One ASC Increased Its Annual Returns: Q&A With Dr. Joseph Stapleton

By Rob Kurtz

Joseph Stapleton, MD, is an anesthesiologist, pain physician and a partner at East Portland Surgical Center in Happy Valley, OR.

Q: Last year was a challenging financial year for many surgery centers. What were some of the key steps you took in 2008 and 2009 to see increases in annual returns?

Dr. Joseph Stapleton: In 2008 and 2009 we were in the process of adding additional spine surgeons and of course their cases to our center. This minimized the impact of the economic downturn. In addition we were very careful with our staffing levels and equipment purchases. We had our scheduling staff reach out to our partners and non-partners doing cases at the center to ease scheduling of their cases. We worked to decrease turnover and increase efficiency to create an environment that helped our physicians be more productive.

Q: Is there a single initiative your center has undertaken that you are particularly proud of and has proven to be financially beneficial to your ASC?

JS: The most important thing that we have done is to add spine cases to the center. It has been a part of our center for the last four years, but as our experience has grown and the comfort levels of our staff and physicians have grown we have been able to increase our volume in this area.

Q: What plans do you have this year to continue to grow profitability and improve efficiency?

JS: This year after partnering with USPI and Legacy Health System we are looking to add additional physicians and finish out an additional OR to increase our case load.

Q: What other exciting initiatives are you undertaking?

JS: We are developing a new program for outpatient total knee replacement modeled after the successful program at Duke University utilizing home health and continuous femoral nerve blocks for pain control.

Q: Many surgery centers do not have anesthesiologists as owners. As an anesthesiologist, along with a pain specialist, what perspective and expertise do you think you bring to the center that differs from the other physician-owners

and makes your ownership stake valuable to the success of the center?

JS: In the initial ramp up phase of a surgery center as an anesthesiologist I was able to provide back up for our anesthesiologists should there be problems in recovery or there was a need for assistance for intubations, etc. As the center has grown and we have three anesthesiologists, that need has diminished.

Q: You've had very strong returns over the past several years. What made you and the other owners in East Portland Surgical Center decide that it was still worthwhile to sell 50 percent of the ASC at the start of this year?

JS: We felt that partnering with a health system/national surgery center management company would be an opportunity to add additional health plans that could come to the center and since the buyers had additional shares to offer to new owners, we could add new partners at a level that we wouldn't have considered with our original partnership. It was also an opportunity to take some chips off of the table, and we are working to grow our volume so that we can continue distributions at the same level as before. Already we have gotten distributions at about 65-70 percent of pre-sale.

Q: As an ASC owner, what advice would

you offer other physicians interested in starting or investing in an ASC?

JS: The best advice regarding the surgery center business is to make patient care and satisfaction the number one priority and everything else will follow. Our original partner Blue Chip Surgical believes that, and it has proven true. ■

Learn more about East Portland Surgical Center at www.eastportlandsurgery.com.

Thank you to Blue Chip Surgery Center Partners (www.bluechipsurgical.com) for arranging this interview.

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ASC Association President Kathy Bryant Discusses Healthcare Reform's Impact on ASCs

By Lindsey Dunn

Kathy Bryant, president of the ASC Association, discusses the impact of healthcare reform on ASCs.

Productivity adjustment. The new law requires a productivity adjustment to be applied to annual inflation updates. This adjustment begins in 2011 and will reduce payment increases to ASCs for each year thereafter. Ms. Bryant says this provision will have the most direct impact of any on ASCs.

If it had been implemented in 2010, the productivity index would have resulted in a 1.3 percentage point lower update for ASC payments. "Essentially, the productivity index will cause payment updates beginning in 2011 and every year after to be lower," says Ms. Bryant.

The productivity adjustment is intended to encourage more efficient provision of services by a variety of providers, but Ms. Bryant says it has a disproportionate negative impact on ASCs. "Because of the ASC payment freeze and the method in which our inflation update is already factored, the productivity adjustment will have a disproportionate impact on ASCs," she says.

New fraud and abuse provisions. Ms. Bryant says there have also been significant changes in fraud and abuse requirements in the reform package. One of those changes includes the provision that providers who do not report overpayments in 60 days will be considered as having submitted a false claim.

"Obviously, providers have an obligation to return overpayments, but considering an overpaid claim a false claim after 60 days creates another burden on ASCs," she says.

Waived patient co-insurance for some preventative services. The new law includes a provision that would waive patient co-insurance and co-payments for certain preventative services, including colonoscopies. While this provision may provide some increased volume to ASCs performing these procedures, Ms. Bryant says this provision primarily benefits patients.

"I think certainly any provision that encourages people to get preventative services is obviously going to drive some new patients to receive these services. While there may be some increases in volume and eased efforts for collecting a co-pay, the direct benefit is to the beneficiary; it's more indirect for ASCs," she says.

Expanded health coverage. Healthcare reform is expected to expand coverage to 32 million uninsured Americans, which could benefit ASCs that treat those patients.

"While I don't see a lot of direct benefits to ASCs in the legislation, expanded coverage to uninsured individuals would perhaps reduce the costs of charity care provided by ASCs," says Ms. Bryant. "There is also some assumption on the part of healthcare economists that there will be more healthcare services provided as a result of reform, but only time will tell if that manifests."

Failure to encourage use of ASCs. "I think it was a big loss to Medicare beneficiaries that the new law does not encourage the use of ASCs," says Ms. Bryant. "President Obama and his staff went through the budget looking for

any way to save money, and they were certainly provided information on how ASCs could help do that. The role of ASCs was not addressed."

Ms. Bryant adds that the efforts of the ASCs industry and its advocates helped stop reform legislation from having an even greater negative impact on ASCs. "When it comes to this type of work, stopping certain provisions is equally important to achieving other things," she says. "Without the work of ASC advocates, it could have been a lot worse. For example, ASC cost reporting was not included in the final legislation and other health sectors, such as home health, have experienced huge reductions that we were largely able to avoid." ■

Learn more about the ASC Association at www.ascassociation.org.

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7 Statistics ASCs Should Look at Every Month

By Renée Tomcanin

1. Case volume. Monthly case volume is a good indicator of an ASC's performance; however, there are a few things to consider when looking at this figure. Brian Brown, regional vice president of operations for Meridian Surgical Partners, says preparing a "budget" for case volume can provide a better reflection of what your surgery center should be doing.

"In our budget process, we look at a two- to three-year period to get an actual reflection of what will happen in the next year. When we analyze case volume, we consider it in comparison to the budget and prior year," Mr. Brown says.

It is also important to consider the timeframe and account for oscillations in physicians' practices depending on the specialty and the state of the economy. "In the beginning of the year, many deductibles are reset for patients, which can lead to them putting off elective surgeries, whereas toward the end of the year, it is the reverse," Mr. Brown says.

2. Revenue per case. This statistic is affected by two factors:

- **Rate variance** — Reimbursements will vary depending on payor. Medicare and other federal programs will most likely be the lowest payors as compared with commercial payors, which will most likely

be higher. The greater the number of Medicare cases, the more fluctuation will occur in your rates because the lower Medicare rates may skew the average overall, according to Mr. Brown.

- **Volume variance** — The more intensive your cases, the higher your revenue per case will be, according to Mr. Brown. This will depend on the specialties and subspecialties at an ASC. "For example, ACL repairs in orthopedics require more OR hours, but are higher paying than arthroscopies. If one month sees 20 percent of all orthopedics cases as ACL surgeries, this will affect multiple levels of the ASC's operations," he says.

Mr. Brown says the important thing to consider if revenue per case is off budget in a month is to take a look at other metrics and consider the bigger picture of how the ASC was running. "More intensive cases can affect all expenses that fluctuate, such as salaries and supplies. If those seem to be on or under budget, then the ASC was able to effectively manage an upturn in more intensive cases," he says.

3. Salaries per case. Salaries and supplies are two expenses that can account for half of the cost of running an ASC and, as such, they can be major indicators of how ASCs are operating. They are also the two areas

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that can easily be controlled, unlike rent, insurance, etc., according to Mr. Brown.

ASCs will want to look at the budget and include areas such as scheduled bonuses and raises and employment taxes. Mr. Brown advises ASCs to make sure contract labor is kept low, as temporary workers usually are employed at a higher rate than full-time employees.

Watching this statistic will also be essential when planning for situations such as vacations or other absences. "If a physician is on a two-week vacation, you will want to adjust accordingly, such as flexing some staff members' hours. Otherwise, you will see a significant increase in salaries per case," Mr. Brown says.

4. Hours per case. This statistic depends on your ASC's specialty mix, according to Mr. Brown. ASCs heavy in orthopedics and spine will expect to see higher hours per case, whereas GI- and ophthalmology-driven ASCs will typically have lower hours per case.

"Each center is unique," Mr. Brown says. "It is also important to focus on your specific physician mix to determine what your target should be. Surgery times for like-procedures vary by physician. If your physician takes 30 minutes per cataract versus 10 minutes, your hours per case goal will be affected."

5. Supplies per case. As previously discussed, supplies are another significant line item expense ASCs can control. Mr. Brown notes that it is essential for ASCs to budget for supplies based on its case mix. Some important supply items to look at are implants, IOLs and pharmaceutical expenses.

Implants should be monitored particularly closely, and ASCs should make sure expensive devices are covered by payors. "ASCs need to break out implants and make sure payments have been received. Back-office employees should make sure patients have the proper authorizations when submitting claims, because margins can be affected if implants are not paid for," Mr. Brown says.

6. Days in A/R. The national average for days in A/R is around 35 days. Mr. Brown says ASCs should use this number as a baseline, but also consider the unique circumstances surrounding a particular ASC. "You need to set realistic goals based on your managed care contracts and what percentage of your business is in-network versus out-of-network," he says.

For example, an ASC that is 95 percent in-network can usually expect faster payment than an ASC that is 50 percent out-of-network. This can be the result of many factors. In-network ASCs have the benefits of agreed upon rates and can often process most of their claims electronically, which result in a more timely payment, according to Mr. Brown. "For ASCs like this, 15-21 days in A/R may be a better target. At one of our centers, most major payors pay in 7-9 days, when accounting for a 24-hour turnaround for dictation. If A/R would spike to 35 days, you will need to investigate what happened," he says.

Out-of-network ASCs, on the other hand, often cannot submit claims electronically and do not have agreed upon rates. Mr. Brown notes that insurance companies will often push out-of-network claims to the bottom of the pile before sending payment. "In this case, I wouldn't use 35 days as a target — probably closer to 40-42 days," he says.

Mr. Brown says out-of-network contracts are not an excuse not to be aggressive in collection processes. "Cash drives ASCs. It does no good to bring in cases if you can't collect on them, and if you can't collect, you are out of business," he says.

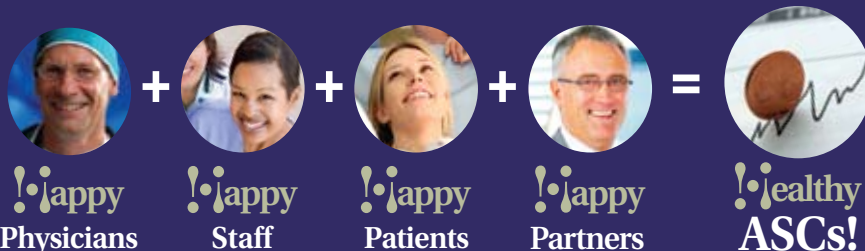
7. Collections goal per month. Mr. Brown says a good benchmark for collections should be based on the prior two months' net revenue. The average of the month should then be multiplied by 98 percent to account for 2 percent bad debt. "It's not a hard and fast method, but it gives the business office a number to shoot for and can drive upfront collections in the month," he says.

Using the goal, ASCs can examine how they did and then identify areas for improvement if the goal is not met. "Occasionally, it may be something big, like billing for implants that weren't covered, or it can another factor, such as an insurer is slow in paying that month," Mr. Brown says.

Another good technique to keep the business office incentivized to meet the goal is to provide bonuses or other perks if goals are met. ■

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Co-Management Relationships of HOPDs: 5 Things Your ASC and Hospital Should Consider Plus Legal Commentary and Key Concerns

By Leigh Page

Many hospitals are looking to buy up ASCs from physician-owners and convert them into hospital outpatient departments that command higher reimbursements than ASCs. Other hospitals are seeking to have HOPDs operate like ASCs. While physicians cannot directly own HOPDs, they can forge co-management relationships with the hospital to ensure they still have some control over operations and that these facilities remain efficient. Here are some suggestions on how co-management should be structured.

1. Hospital needs to commit to an efficient HOPD. The goal is that the HOPD should continue to function as much as possible as it did when it was a freestanding ASC, says John Smalley, a principal and co-founder of Healthcare Venture Professionals in Franklin, Tenn. "Make sure hospital officials are willing and able to minimize the red tape that tends to make hospital operations less efficient than an independent, physician-run operation," he says.

The agreement with the hospital should ensure the facility operates in an efficient, effective manner, with high quality and an excellent patient focus in such areas as scheduling, registration, pre-certification, product standardization and capital equipment selection, he says.

2. Create an oversight committee that includes physicians. An operations committee that includes physicians who use the facility should oversee the HOPD, Mr. Smalley says. The committee should be the de facto governing body of the HOPD, with representation about evenly split between the hospital and physicians. It should be involved in a wide array of issues involving the HOPD, including clinical, quality and peer review activities.

Joan Dentler, managing partner at ASC Strategies in Austin, Texas, says physicians cannot own the HOPD because CMS requires it to be an extension of the hospital to qualify for hospital reimbursement, but the committee should have the ability to choose equipment and advise on hiring staff.

3. Limit hospital services the HOPD uses. The requirements of various hospital departments such as human resources, purchasing, healthcare IT and general policies and procedures, can make

the HOPD less efficient, Mr. Smalley says. He asks: "Is the hospital willing and able to minimize its inherent bureaucracy and red tape so that the ASC continues to function like a freestanding ASC to the extent possible as an HOPD?"

For example, Ms. Dentler says some hospitals are burdened with "IT overkill," when there are so many IT requirements that it slows down the operation. "These requirements impact efficiency without adding value," she says. While some IT functions need to stay in place, the HOPD may be able to remove quite a few of them, she says.

4. Give physicians a say in staff selection. If staff members are brought over from the hospital, Ms. Dentler advises making sure they understand the importance of physician satisfaction and are dedicated to ensuring a quick turnaround time for the ORs. "Can they work in a fast-paced environment or are they volunteering for the HOPD just to escape night and evening shifts?" she asks.

The same applies to anesthesia services. Sometimes the hospital has an exclusive agreement with an anesthesiology practice, but in many cases "the hospital has an opportunity to refine what is delivered and handpick which anesthesiologists will work there," Ms. Dentler says.

5. Measure performance using benchmarks for freestanding ASCs. Measuring the HOPD's performance using metrics from freestanding ASCs will ensure the facility keeps the "efficient mindset" of a freestanding ASC, Ms. Dentler says. The benchmark for turnaround times may vary from 30 minutes for HOPDs to 15 minutes for freestanding facilities, she says.

To apply these metrics, Ms. Dentler advises hiring a consultant from the world of freestanding surgery centers rather than a hospital-based consultant. "An outside consultant will challenge the usual hospital status quo and keep it from being run like another department of the hospital," he says.

Mr. Smalley says when HVP comes in as a consultant, "we will typically do formal and informal education with key players at the beginning of the process. This allows us to proactively raise most of the issues that may subsequently arise and answer most questions before they're asked."

Legal commentary and concerns — 5 key thoughts

Scott Becker, partner at McGuireWoods and publisher of *Becker's ASC Review*, provides the following legal commentary and concerns on co-management of HOPDs.

1. Medicare pays HOPDs about 60-70 percent more than ASCs for the same procedures and the gap is often greater with commercial payors.
2. Hospitals have been seeking ways to align with physicians and not give up this higher payment level for procedures. This can mean not having true equity joint ventures in the ASC itself.
3. Until recently, some hospitals and physicians used "under arrangements" models to align interests while still billing as an HOPD. This model has been deemed no longer permitted under the Stark Act.
4. Some parties have now moved to co-management ventures, in which a physician group or a group of surgeons with a hospital partner manages the HOPD.
5. Several key legal questions that need to be addressed in each venture include:

- Are the management services provided by the physicians truly needed? Or are they just a way to lock up referrals?
- Do the physicians have clear and well-defined responsibilities?
- Are the physicians qualified to serve as managers? What qualifications do they have?
- Will payment be based on fair market value? Is it fixed and thus in a kickback-safe harbor? Or is it variable? Does it meet the legal tests as not being related to the value or volume of referral needs? Does it align the doctors and hospital on volume, which can cause concerns? Is there a third party valuation for the services and for all financial relationships?
- Will the hospital still have sufficient control to bill for the services as "provider based" under the Medicare rules? ■

Contact Leigh Page at leigh@beckersasc.com.

4 Ways to Ensure Profitability When Adding Procedures

By Barbara Kirchheimer

In a tenuous economy with declining reimbursements, many ASCs are simply hunkering down to see how the healthcare reform landscape will shape up before making any bold moves. Still, says Joyce Deno, chief operations officer for the Eastern Region of Regent Surgical Health, there are ways ASCs can begin testing out some newer procedures that hold promise for their clinical and financial futures. She shares some of her thoughts here on procedures some of Regent's 16 ASCs have recently added that have been panning out well during the past year or two.

1. Best additions may not require big investments. Ms. Deno says many clinically or technologically advanced procedures are not worthwhile for ASCs simply because reimbursement rates won't support the investment necessary to add them. Take robotic surgery, for example. "It is wonderful, but we just don't get

those kinds of margins to allow us to invest in that kind of technology," she says.

Therefore, some of the procedures Deno highlights as potential winners for ASCs may not appear all that glamorous. Here are a few:

- Fracture fixation
- Pacemaker generator and leads replacement
- Unicompartmental knee replacement (partial knee replacement)
- Microdiscectomy
- Anterior cervical discectomy and fusion
- Vertebroplasty
- Prostate cryoablation for treatment of prostate cancer
- Bladder stimulator implant
- Stress incontinence procedures

Ms. Deno says some of these procedures, while not necessarily representing brand new

technologies or advances, have been successful contributors to Regent ASCs' margins thanks to favorable reimbursement rates. For some of them, Medicare began reimbursing in the ASC environment only within the past couple of years.

2. Know the market. While ASCs should always be on the hunt for new advances and developments in the procedures they offer, Ms. Deno cautions that administrators need to have a good handle on their current offerings and costs of doing business first.

"It's going to be really hard to reach out for new procedures now because margins are shrinking," she says. Take another example: gastric sleeve resection surgery, a bariatric surgery procedure. While this relatively new procedure can be a winner for ASCs, the fact that it is often an out-of-pocket expense for patients who might

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now be losing their jobs or insurance coverage makes it a more financially uncertain procedure to launch than might have been the case when the economy was stronger.

3. Determine ROI. Given these constraints, ASC managers need to thoroughly examine the potential return on investment of a new procedure before they leap. Their analysis should involve calls to insurance representatives to determine ahead of time what they would reimburse for the procedure (or if they would reimburse for it at all).

"If you're going to lose money, don't even buy the equipment," says Ms. Deno. "Don't go any further." Administrators also need to talk to their physician partners to find out their perspective on any new procedures. For example, in the case of vertebroplasties, in which bone cement is inserted into cracks in the vertebra to reduce the pain of spinal fractures, the procedure may be profitable if a surgeon uses a less expensive cement but unprofitable if the surgeon prefers a more expensive product.

4. Conduct due diligence before acting. The bottom line, according to Ms. Deno, is that ASCs need to use their information systems to thoroughly examine their fixed and variable costs before heading into unknown territory. Their homework should also include estimating how much it might cost to ramp up a new procedure.

"As a good administrator," she says, "before you look outside the box, you'd better know what's inside your box." ■

Contact Joyce Deno at jdeno@regentsurgicalhealth.com.

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The “Co-Managed” Hospital-Owned ASC: An Alternative Partnership Model

By John A. Smalley, Principal, Healthcare Venture Professionals

Over the past few years, there has been a growing trends of ASCs being operated as HOPDs. As we move through 2010, this trend toward HOPD ASCs continues.

For new ASC projects, the recent economic downturn has added deal structure complexity and an increased risk aversion on the part of many physicians when it comes to traditional equity-based ASC models. For existing equity-based ASCs, there appears to be a growing desire by physician-investors to recoup their initial investments. At the same time, more hospitals are aggressively “joining the fray” as potential ASC purchasers. As a result, we at Healthcare Venture Professionals have become involved with a number of projects dealing with new hospital-owned ASCs or “conversion” of existing freestanding ASCs into HOPD ASCs.

For the past several years, HVP has had the good fortune to work with the West Hartford (Conn.)

Surgery Center, a hospital-owned ASC. We see WHSC as an prime example of a facility demonstrating the opportunities that exist to take the HOPD model and make it an exciting, creative and effective alternative partnership model between hospital and physician through the concept of “co-management” for the ASC.

WHSC history

Due to a longstanding positive relationship and strong desire to collaborate, WHSC was initially planned as a 50-50 equity-based joint venture (a for-profit LLC) between Hartford Hospital, a prominent tertiary care/teaching facility and the Connecticut Surgical Group, a prestigious 40-plus surgeon multispecialty organization. WHSC would be located in the “Blue Back Square” section of West Hartford, a rapidly growing commercial development about 10 miles from the hospital and main CSG offices. HVP was engaged in 2005 to provide develop-

ment and long-term management services for the joint-venture ASC.

While the ASC was still under development, HH and CSG decided (for a variety of business reasons) to look at alternative approaches to the ownership and operation of WHSC. After much discussion and research, the decision was made to convert WHSC to an HOPD ASC. At the same time, both HH and CSG clearly wanted to retain a collaborative approach to WHSC operations.

To support this goal of collaboration under an HOPD approach, a simple set of “partnership guiding principles” were developed for WHSC. These included:

- WHSC would be operated like a free-standing ASC vs. a hospital department.
- Emphasis would be placed on providing patients and physicians with a high quality “five-star” experience.



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- HH and CSG leadership would work to minimize the bureaucracy and “red tape” inherent to a large, tertiary care facility such as HH.
- Recruitment activities would be expanded to include surgical specialties and physicians not represented within CSG.
- Key ASC functions (e.g., scheduling, pre-certification, registration and billing, medical supply and instrumentation standards, etc.) would be controlled by WHSC rather than HH.
- HH resources and relationships (e.g., group purchasing, biomedical engineering, anesthesia, laboratory, etc.) would be used to the extent possible but WHSC would also be free to pursue outside sources if justified to obtain required clinical or support services in an improved, more efficient or cost-effective fashion.

These guiding principles, together with the shared vision and ongoing commitment by HH and CSG to a collaborative relationship, resulted in the creation of a unique “co-management” approach to the future operations of WHSC.

Co-management model

The co-management model combines two approaches typically (but usually separately) seen in transactions where a hospital acquires a physician-owned clinical service and converts it to an HOPD: 1) The hospital enters into a management or professional services agreement with the previous physician-owners in order to maintain their involvement and interest in the service; or 2) The hospital engages a professional management company to provide day-to-day management in order to ensure the service in question is operated in an efficient or “freestanding” fashion.

This co-management model was implemented in the following manner:

- HH purchased the CSG equity interest in WHSC at a formally determined fair market value.
- HH entered into a management services agreement with CSG at a negotiated and externally validated FMV rate.
- CSG entered into a “management services subcontract agreement” with HVP for defined operational and support services.

The end result of this process is a scenario wherein WHSC is effectively co-managed by CSG and HVP.

At several points in this process, the services of an external valuation company were employed to validate that all financial arrangements were consistent with a documentable FMV approach. Experienced legal counsel was also an integral part of all transactions and agreements. Finally, incentives contained in the management agreement between HH and CSG were based on defined quality, patient satisfaction and operational benchmarks vs. volume or revenue-related criteria.

The conversion of WHSC from an equity-based joint venture to an HOPD ASC also entailed the successful accomplishment of several other tasks dealing with:

- Certificate of need
- Medicare HOPD requirements
- State licensure requirements
- Other state and federal requirements

Co-management roles and responsibilities

Under the management services agreement with HH, CSG assumed a number of responsibilities to include:

- Provision of the ASC medical director
- Provision of key leadership to the WHSC operations committee (see additional discussion to follow)
- Oversight of the management services subcontractor (HVP)
- Designation of a formal contact person to work with HH
- Establishment and maintenance of quality assurance standards
- Recommendations as to approved surgical procedures, capital equipment needs and ASC staffing and personnel
- Implementation of clinical education and training programs
- Recommendations and implementation of all quality improvement and utilization review programs
- Development of community education and outreach programs
- Other clinical and administrative responsibilities as defined in the management services agreement

Under the “management services subcontract agreement” with CSG, the major responsibilities of HVP include:

- Provision of the on-site ASC administrator
- Management of day-to-day ASC operations
- Provision of defined consultative and support resources
- Routine involvement of HVP principal and regional director of operations as an advisory and support resource to the administrator and to CSG
- Coordination of and attendance at monthly operations committee meetings
- Monitoring and benchmarking of operational performance
- Support for WHSC strategic planning efforts
- Provision of information and education related to industry trends, regulatory and safety issues
- Annual budgeting
- Monthly financial reporting
- Business analysis of proposed equipment purchases, new surgical procedures and other matters affecting future WHSC performance

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- Development of operating policies and procedures
- Administrative coordination with HH on behalf of CSG (a "buffer" role)
- Other administrative responsibilities as defined in the management services subcontract agreement

Operations committee

One of the important ingredients to the success of the co-management model is the role and function of the WHSC operations committee. From the outset of the decision to convert from the equity-based joint venture model to the HOPD ASC co-management model, this committee was envisioned as a de facto "board" for WHSC. In essence, the operations committee assumes many of the same responsibilities that would have been fulfilled by the LLC board had the joint-venture model remained in place. Key among these is serving as ongoing formal vehicle for direct physician input and involvement with all aspects of WHSC operations.

The operations committee meets monthly and is comprised of three senior leaders from both HH and CSG. The WHSC medical director, administrator and an HVP corporate representative are ex-officio members of the committee. The primary responsibilities of the committee include:

- Advisor to HH on all WHSC clinical, management and operational issues
- Review of all quality, financial and operational results
- Dealing with all licensure, accreditation, health and safety matters for WHSC

- Review of patient, physician and employee satisfaction results
- Oversight of performance of the medical director, administrator, HVP and all other professional or support subcontractors and agreements
- Establishment of performance objectives for WHSC
- Strategic planning, marketing and physician recruitment efforts
- Other key clinical and administrative matters

Hospital/surgery center integration issues

As noted earlier, one of the guiding principles for HH and CSG under the HOPD ASC approach was that WHSC would be operated like a freestanding ASC rather than a hospital department to the extent possible. The following operational areas merited special attention related to the integration of WHSC into the HH organization:

- Information systems
- Patient scheduling, registration, PAT, insurance pre-certifications, billing and collections
- Hospital support services
- Policies and procedures
- Forms/medical records
- Drug control procedures
- HR/staffing/recruitment

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For each of these above areas (and others to a lesser extent), the challenge was to achieve an appropriate balance which supported the goal of having WHSC function in a “freestanding” fashion while at the same time recognizing that it must be an integral part of the HH organization in order to meet a variety of intra-organizational and external requirements (e.g., “provider-based” regulations, Joint Commission standards, etc.).

Admittedly, HH-WHSC integration is (and, to some extent, will always be) a work in progress as new questions, challenges or “turf issues” inevitably arise. Ongoing sensitivity to this potential, together with effective communication between all involved parties as issues occur has helped to minimize or prevent any long-term problems from an integration perspective. The operations committee and its members have certainly played a key role in this regard.

Benefits to physicians

There are numerous benefits to involved CSG (and other) physicians under the co-management model. Primary among these benefits are:

- Direct involvement and control of the ambulatory surgery process (especially through the operations committee)
- Ability to perform surgery and to offer a high quality ambulatory surgery experience in a non-hospital environment
- Participation in an innovative alternative form of hospital-physician collaboration
- Physician recruitment tool
- Growth of outpatient surgery market share and related revenue base
- Recouping of original investment in freestanding ASC joint venture (with conversion to HOPD)
- An additional ongoing source of revenue without the risk of a capital investment
- Professional ASC management (with HVP as co-manager)

Benefits to hospital

There are a number of similar benefits to HH due to the conversion of WHSC to an HOPD using the co-management model. These benefits include:

- 100 percent ownership of a dedicated ambulatory surgery setting
- Participation in an innovative alternative form of hospital-physician collaboration
- Ability to offer a high quality ambulatory surgery experience in a non-hospital environment
- Freeing up of the hospital's OR space
- Physician recruitment tool
- Growth of outpatient surgery market share
- Enhanced profitability from ambulatory surgery (vs. shared profits under ASC joint-venture model)
- Professional management (with HVP as co-manager)

WHSC today

Since its formal opening in Sept. 2007, operating results for WHSC are supportive of the benefits to physicians and hospital as discussed above and are consistent with the original partnership guiding principles developed by HH and the CSG with HVP's assistance. A few examples would be:

- New surgical specialties have been added to include orthopedics, GYN and pain management.
- 34 new physicians (beyond the original CSG contingent) are now performing surgery at WHSC
- Surgical volume at WHSC increased by 36 percent in 2009 over 2008
- Discussions are underway about future WHSC expansion
- WHSC recently received national recognition for excellence in patient satisfaction

Summary

The ultimate success of the HOPD ASC approach in general and the co-management model specifically hinges on a number of factors discussed in this column. To reiterate just a few, we would stress the following key ingredients to success:

- Hospital and physician commitment to a collaborative approach
- Appropriate “balance” between hospital integration vs. operational freedom for the ASC
- Meaningful physician participation
- Involvement of experienced legal counsel and professional ASC management expertise

A properly designed and professionally implemented HOPD ASC approach, together with use of the co-management model, presents a unique opportunity for hospitals and physicians to collaborate in the provision of state-of-the-art ambulatory surgery. This has certainly been the case at WHSC.

Hartford Hospital and the Connecticut Surgical Group (as well as non-CSG physicians) are integrally involved in providing an enhanced outpatient surgery delivery model hand-in-hand with an innovative form of hospital-physician collaboration. Physicians and the hospital are working together to their mutual benefit and, more importantly, to the benefit of the patients and communities served by West Hartford Surgery Center. ■

John A. Smalley (jsmalley@bipros.com) is a principal and co-founder of Healthcare Venture Professionals, a full-service ASC management, development and consulting company with special emphasis on physician-hospital collaborative ventures.

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5 Tips to Increasing ASC Value Before A Sale

By Lindsey Dunn

Here are five tips for physician owners to increase the value of a surgery center before a sale, according to Jon Vick, president, ASCs Inc.

1. Know your goals. Physician owners should first meet to determine each individual physician's goals for the sale and document these goals in a "Statement of Goals," says Mr. Vick. Doing this will allow the physicians to approach prospective buyers with a clear understanding of their goals and who wants to sell how much, he says.

"Older doctors may want to sell 100 percent, and the younger [physicians] may want to sell none. These are not conflicting goals; they are individual goals," he says. "Based on the aggregate of the goals, the doctors may want to sell a minority or majority interest. Knowing this up front allows them to solicit purchase proposals from the right companies as some companies only buy majority interests and some just buy minority interests."

2. Know the buyers. "There are 40-plus ASC management companies interested in investing in ASCs, but each company is looking for something unique to their own model and expertise," says Mr. Vick.

Mr. Vick recommends that centers narrow down the list of potential buyers before soliciting proposals. "Narrow the field down to five or six of the best buyers for your center so you or your representative can solicit competitive purchase proposals," he says. "Consider which companies are looking for your type of center, in your location, with your specialties, revenues, profits and growth opportunities, etc."

3. Quantify your growth opportunities. While ASC values are usually determined by trailing 12-month (TTM) EBITDA, buyers are also interested in an ASC's growth opportunities, says Mr. Vick.

"[Buyers] want to buy into a growth situation, not into a center that is already fully utilized," he says. "Be specific: What strategies will enable your revenues and profits to increase? What doctors are available to be recruited? What hospital is available for a three-way deal? What contracts need renegotiating? How will you replace your out-of-network cases with in-network cases?"

4. Identify physicians who can be recruited. New physician recruitment is the number one growth opportunity for most centers. Therefore,

physician owners should identify colleagues available to invest in or utilize the center and pass that information on to prospective buyers.

"You don't have to recruit new doctors, but you should identify good-quality physicians in attractive specialties for ASCs who can be recruited," says Mr. Vick.

5. Sell the ASC real estate as a second transaction. Finally, physician owners may want to consider selling the ASC real estate in a second transaction after they are affiliated with an ASC management company.

"The market for ASC real estate has improved markedly, and there are several excellent real estate companies competing to buy ASC real estate. ASC tenants are considered very attractive because they are stable, long-duration tenants," says Mr. Vick. "As soon as you have a corporate partner, the real estate becomes even more attractive, so the time to sell is after you have affiliated with an ASC management company." ■

Mr. Vick has assisted physician owners at over 200 ASCs to form strategic relationships with leading ASC management companies, since 1984. To learn more about ASCs Inc., visit www.ascs-inc.com.



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6 Key Practices for Growing Volume and Profits

By Barbara Kirchheimer

Bayou Region Surgical Center, in Thibodaux, La., is a multi-specialty ASC that operates as a 50-50 partnership between physician investors and a subsidiary of the local community hospital, Thibodaux Regional Medical Center, and is managed by ASD Management. Here's how it increased patient revenue by 8 percent and net income by 20 percent last year, according to Tona Savoie, the ASC's administrative director.

1. Increase cases, procedures and staff. Bayou Region opened in mid-2007. In its first year, it performed 1,153 cases. In 2008, it performed 3,356, and in 2009, it performed 3,834. This growth was measured and deliberate, Ms. Savoie says. The center's biggest service lines are orthopedics and ENT.

"Last year we bought more equipment for orthopedics so we could do some of these bigger cases," Ms. Savoie says. "We've just been keeping a close eye on our costs and reimbursements."

To be able to perform more cases, Bayou Region brought on more physicians. In 2008, it added four, and in 2009, it added six more. Bringing in more physician-investors necessitated adding a whole new OR crew, including a nurse, an OR technician and a person to handle decontamination. This enabled the center to staff three ORs per day for three days a week, up from two ORs staffed two days a week the previous year, which helped manage the growth in volume. "You can't do cases when the doctors want to if you don't have the staff," Ms. Savoie says. "It's all about making everybody happy."

2. Create a positive environment that prioritizes education and communication. With the center relatively new, physicians were coming from very different backgrounds and viewpoints. "We sent out surveys to our physicians and our staff members and reviewed everything," says Ms. Savoie. On the surveys, physicians and staff were given an opportunity to rate and comment on atmosphere, communication and teamwork within the center. Educating staff and physicians about regulatory requirements and reimbursement challenges also went a long way toward clearing up disagreements about how to run the center, she adds.

3. Educate physicians on expenses and revenue generated. Physicians are given a quarterly report on costs and reimbursement. The center's physicians appreciate this educational tool, which includes both a summary and a case-by-case breakdown, because it allows them to track

the cost of supplies for a given case, the reimbursement for that case and their performance compared to other physicians. "It makes them more aware, and they really like that a lot," Ms. Savoie says.

4. Continually evaluate managed care contracts. Bayou Region did not add any new managed care contracts last year, and it is currently renegotiating three that were initially signed in 2007 and 2008. Giving careful consideration to each contract is essential for the success of a center, Ms. Savoie says. "There are a few we still have not signed yet because we're just not going to sign bad contracts."

Keeping track of reimbursement and cost data helps a center stay on top of potentially detrimental contracts, Ms. Savoie explains. "I think you have to be choosy, I think you have to know your market, you have to know your physicians' markets and you pick your big players."

5. Pay special attention to the purchasing manager and other business office functions. Hiring a skilled purchasing manager will help keep costs under control, Ms. Savoie says. Bayou Region purchases through a GPO and now has an in-house purchasing agent who is devoted to placing orders, staying on top of new vendors entering the market, meeting with physicians to discuss their needs and keeping track of how often certain procedures are performed. "One of the biggest problems with revenue when a center doesn't do well is because they purchase lots of supplies that their physicians don't use," Ms. Savoie says. Other key staff positions include a collector to keep on top of billing issues and a business office manager. Diligent collection efforts by the business office staff have helped Bayou Region keep its accounts receivable below the industry standard of 90 days, Ms. Savoie says.

6. Stay on top of regulatory changes. ASD Management helps keep the center abreast of changes in regulatory policy from CMS and the state on a monthly, and sometimes weekly, basis, Ms. Savoie says. "Keeping constantly updated with CMS and federal regulations is a must," she says. Otherwise, one audit could bring operations to a halt while a center remedies compliance issues it should have been on top of in the first place. "That will definitely affect your bottom line, as well as the happiness of your surgeons," she says. ■

Thank you to ASD Management (www.asdmanagement.com) for arranging this story.

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3 Common ASC Physician Recruitment Mistakes

Sarah Martin, regional vice president of operations of Meridian Surgical Partners, shares three mistakes ASCs often make when trying to recruit physicians to their ASC.

1. Not including center management staff in the recruiting efforts. With coaching on what to say or not say, these people can be the best marketers you have.
2. Seeking physicians with low volume. Unless you are looking to add incremental volume only, try to recruit the higher volume physicians first.

3. Recruiting for specialties that are not a good source of revenue. If a center is a well-rounded multi-specialty center, this is still important to consider, but to a lesser degree. It is best to continue to try and recruit physicians in a specialty that is already represented at the center, and therefore the equipment is purchased, staff is knowledgeable and the revenue is a known factor. ■

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