

ASC BECKER'S Review

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Hospital Tactics – “Friendly” and “Not-So-Friendly” Competition

By Scott Becker and Alison Vratil Mikula

Physician-owned surgery centers and small hospitals are increasingly providing an attractive alternative for care to patients in many communities. Not surprisingly, many hospitals are attempting to fight back and compete with these alternative facilities. Generally, hospitals take one of two courses of action. This article describes both the alliance-based, or “friendly” strategies that hospitals use to compete with physician-owned facilities as well as certain of the more aggressive tactics adopted by hospitals in an effort to undermine their physician competitors. Each of these strategies carries different legal concerns, some of which are presented below.

This article aims to identify and analyze some of the strategies we have observed. It is not intended as an endorsement of or legal opinion regarding any particular approach.

I. Alliance Strategies

1. Provider Joint Venture. Hospitals, in many situations, are attempting to develop true joint ventures with physicians. This approach involves joint ownership of a provider of services by a hospital and physicians. There, the actual joint venture entity holds the license and Medicare provider number. The joint venture strategy is most common with respect to ambulatory surgery centers (“ASCs”) and whole hospital joint ventures. There are approximately 1,200 – 1,400 physician-hospital joint venture ASCs in the U.S. There are also approximately 20 to 30 whole hospital joint ventures owned by both hospitals and physicians.

2. Shared Services or Infrastructure Joint Venture. Physicians and hospitals are also examining the development of and implementing “shared services” joint ventures.

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Fifty People to Know in the Ambulatory Surgical Center Industry

1. Joseph Banno, M.D. – Dr. Banno is the founder of a very successful surgery center as well as the Vice President of the AAASC. He is driven and smart and a tireless worker on behalf of his community and the ASC industry.

2. Tom Bombardier, M.D. – Tom Bombardier is an ophthalmologist and a founding member of Ambulatory Surgical Centers of America, where he serves as the Chief Operating Officer. His past experience includes establishing ambulatory surgery centers as well as being a successful real estate developer. He is a bright and gifted leader in the industry.

3. Brett Brodnax – Brett Brodnax has distinguished himself as one of the ambulatory surgical center industry’s leading development executives. He is Executive Vice President and Chief Development Officer at United Surgical Partners. Due to his leadership, efforts and integrity, Brett has made United Surgical Partners one of the fastest growing ambulatory surgical chains, with a portfolio of nearly 100 surgical centers and several surgical hospitals. He accomplished this through a mix of acquisitions of small surgical center chains, individual surgical centers and through the development of joint ventures with hospital systems.

4. Kathy J. Bryant – As the Executive Director (now Executive Vice President) of Federated Ambulatory Surgery Association (“FASA”) for approximately the past seven years, Kathy Bryant has developed FASA into the leading ambulatory surgery center trade association. Representing more than 1,500 surgical centers, FASA, with Kathy at its helm, has done a tremendous job of advocating for surgery centers in Washington, D.C. and effecting important changes in federal reimbursement and coverage policy.

5. Robert J. Carrera – Rob Carrera is the President of PINNACLE III, an ASC design, development and management company. He has over twenty years of healthcare experience and has spent the last fifteen years developing and managing free standing ASCs, as well as physician/hospital ASC joint ventures, physical/occupational rehabilitation centers, and diagnostic imaging facilities. Rob has been very active in state legislation regarding ASC issues in Colorado, Minnesota and Utah.

6. Pat Churchwell – Pat is a Senior Vice President with Surgery Consultants of America and Surgery Center Billing. She is extremely smart, works tirelessly, and is a great advisor to surgery centers on a national basis. She works extensively with both physician hospital joint ventures and with physician only surgery centers. She has a great understanding of the financial issues relative to surgery center management and is a tremendous asset to Surgery Consultants of America.

7. Ryan Daniels – Ryan Daniels is the country’s premier ambulatory surgical center industry research analyst. As a research analyst at William Blair and Company and a regular speaker at ambulatory surgical center events and conferences, he has proven to have a terrific understanding of the ASC market and its relationship to Wall Street. In

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SEE PAGE 10 FOR
INFORMATION ON THE
2006 FALL CONFERENCE.

Letter from the Editor

RE: Recent Healthcare Investment Trends and ASC Events and Highlights

This letter highlights recent investment activity in the Health Care sector as well as certain rules relative to investment in health care. This letter also notes certain ASC events and publications.

A. HealthCare Market Investment Activity

We are continuing to see substantial investment in healthcare businesses and healthcare facilities. As the second half of the year develops, we are witnessing the following:

1. Continued interest in investing in ambulatory surgical centers and ambulatory surgical center chains. There continues to be substantial growth in ambulatory surgical centers. Here, this is evidenced in part by the investment of nearly \$75 million in Meridian Surgical Partners. On the flipside, Surgis (funded by New Mountain Capital) exits its investment by selling to United Surgical Partners.

2. We are seeing renewed interest in development of specialty hospitals. Here, we are seeing a rapid development of some smaller chains such as Cirrus Health. We are also seeing the development of a certain number of hospitals poised to move forward as the moratorium on the development of specialty hospitals ends.

3. There seems to be continued tremendous interest in healthcare real estate. I.e., companies such as REITs which are buying medical office building ASC and hospital real estate. Multiples remain high and capitalization rates seem low. We are expecting some softening in this sector.

4. The massive amount of infusion of investment in hospital companies over the last few years seems to be now being digested as the results of the acute care hospital companies soften. This is particularly true as the market tries to determine where the long term future of the hospital industry lies.

5. We are seeing continued strong investment in dialysis chains. Dialysis continues to be a great cash flow investment. We recently saw the investment of nearly a half a billion dollars in a private equity funded purchase of over 100 dialysis facilities. The acquiring company there was a company called DSI. The acquisition was led by private equity fund Centre Partners.

6. There is a great deal of interest in healthcare ancillary and healthcare lite businesses. These are often businesses that are not directly involved in the provision of healthcare but provide services to healthcare providers and other parties. Five of the types of investments that we are witnessing include the investment in a revenue cycle management company, the development of a healthcare financing-leasing company, the investment and development of a prescription benefit management company and the renewed growth of companies that are in the business of managing physician practices and physician related companies. These range the gamut from companies that manage hospital based practices to dental management practices to other types of practices.

In addition to witnessing the development of different types of investment in healthcare, we are seeing several different investment rules that seem to apply to healthcare. Certain of these are as follows:

1. Reimbursement is critical to profits. Like in many businesses, there is only so much cost containment that can be done. Cost containment is critical. However, at the end of the day, once cost containment is achieved, profitability is largely dependent upon reimbursement as well as numbers of procedures. Reimbursement tends to be the great uncontrollable variable in many situations.

2. When investing, entities often don't overpay for great reimbursement. In essence, with great reimbursement seems to come significant risks that reimbursement will not continue to be stable. Hence, we often do not see substantial overpayment (i.e., excess multiples) for great reimbursement.

3. There tend to be certain reimbursement moats. These are often found in smaller to mid sized communities where there is not a concentrated portfolio of payors and there is not a substantial employer that is pushing hard to control costs.

4. The regulatory rules and the targets of the government are often changing. Here, two concepts evolve. First, once in a while, a macro economic healthcare change kills an industry. This has happened before periodically e.g. to the home health industry, the SNF business and the home infusion industry. It continues to threaten the specialty hospital industry. Second, more often, there are regulatory changes and reimbursement changes that can be managed. Here, rather than having a crystal ball as to what industry may or may not get hit by a macro change, it is often as valuable to have great management to help you manage through and adopt to changes that do come up.

5. The physician management business is again becoming a real business. There are several factors that are driving this. Today many of these entities' efforts provide a real service and are more than a financing game. We are seeing increased physician management businesses which thrive in specific niches.

B. 13th Annual Ambulatory Surgical Center Conference on Improving Profits and Developing Surgery Centers.

This will be held in conjunction with FASA at the Hilton Hotel in Chicago on Michigan Avenue from October 26th to 28th. To join FASA, please call 703-836-8808. At the June Orthopedic, Neurosurgery and Pain Management Driven Ambulatory Surgical Center Conference, there were nearly 360 attendees. The fall conference is generally a little larger. Should you have an interest in the fall conference, we will shortly send out information and post information at the website at www.BeckersASC.com regarding the same. Also, please feel free to call me or Michelle Freeland at 858-565-9921 or michelle@pcmisandiego.com regarding the same.

C. Healthcare Private Equity Event.

McGuireWoods LLP will be hosting its Annual Fall Private Equity Event at the Four Seasons Hotel in Chicago on October 4th. Should you have an interest in this event or a suggestion for a company or fund speaker for the event, please contact me at 312-750-6016 or Amy Nolan at 312-849-3687. We have a very good mix on speakers for this event. We are specifically seeking two more fund speakers, one to discuss the anatomy of an investment in a health care company, and one to discuss, as a case study, the successful investment and sale of a health care company.

D. ASC Review Updates. We have posted a digital edition of the ASC Review at www.BeckersASC.com. We also welcome two new advertisers to the ASC Review. First, we welcome Matt Sweitzer and Alpine Surgical. Alpine Surgical is a leading provider of equipment and supplies to ASCs. Second, we welcome Marilyn Lyons at (203) 348-2886 from MediProducts. Finally, we thank CIT Healthcare, our first full page annual advertiser in the ASC Review. Please contact Anthony Mai at Anthony.Mai@cit.com or 201-750-5155.

E. Ambulatory Surgery Centers Legal and Regulatory Issues 3rd Edition.

We recently, with Amber Walsh, Melissa Szabad, Ron Lundeen and Elissa Koch, completed the third edition of this book for the American Health Lawyers Association. This is a non royalty publication (i.e., we do not get paid for it). Nevertheless, you can

buy the same through the AHLA by calling 202-833-1100.

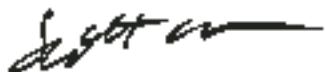
F. Allegiance Leasing Company, LLC.

We congratulate Dave Young on the founding of Allegiance Leasing. Dave can be reached at 708-246-7228. His company will focus on lending to ASCs, MRIs and practices.

Should you have suggestions for speakers or ideas for the ASC conference or the private equity event, or if we can assist you in any way, please contact me at 312-750-6016 or at sbecker@mcguirewoods.com.

We hope you enjoy this issue!

Very truly yours,



Scott Becker

The ASC Review is published 6 times per year. It is distributed to approximately 12,000 persons per issue with distribution of 20,000 issues for each the May-June issue and the September-October issue. For information regarding advertising or subscribing, please contact Ken or Michelle Freeland at 858-565-9921 or by email at ken@pcmisandiego.com and michelle@pcmisandiego.com.

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These are alliances in which the parties jointly own the underlying assets needed to furnish services, such as the facility and/or equipment. However, typically each party provides the services itself utilizing the assets of the joint venture. This approach is most commonly used with imaging joint ventures. There are several legal risks associated with “shared services” ventures, whether they are operated on a per-click or block lease basis. In these shared services ventures, the hospital often operates the services as provider based during certain hours and days of the week. Then, different group practices may operate services during other blocks of time. Each practice often must operate per the Stark Act In-Office exception.

3. Under Arrangements. Another strategy, which resembles the true joint venture model in some respects, but strives to capitalize on the higher reimbursement rates available to hospitals, is the “under arrangements” model. Here, a hospital forms a joint venture with physicians to own the underlying assets necessary to furnish services. Then, rather than having the joint venture itself obtain a provider number, the hospital buys services “under arrangements” from the venture, which is to say that it purchases, on a per-

service basis, the facility component of services provided by the joint venture using the equipment, staff, and other assets of the joint venture. The hospital then bills payors under its own provider and tax identification numbers. While hospital outpatient services are generally covered by Medicare when provided “under arrangements” in the hospital, this approach involves several risks related to billing, Stark Law and Anti-Kickback Statute compliance, and tax-exempt status.

4. Service Agreements. As an alternative to entering into any sort of joint venture, hospitals frequently attempt to persuade physicians not to compete by offering them management agreements and medical director positions. Often, these arrangements involve high compensation and are very lucrative to physicians. In all situations, the parties must take care to ensure that such arrangements are legitimate, and not disguised efforts to induce or reward referrals. These types of arrangements tend to raise substantial concerns from a kickback standpoint. In a well-known case involving a Kansas City hospital that engaged two local physicians to serve as medical directors, key hospital executives as well as the physicians themselves were charged with, and ultimately convicted of,

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violating the federal anti-kickback statute based on the excessive nature of the compensation relative to the medical director services rendered. *U.S. v. McClatchey*, 217 F.3d 823 (10th Cir. 2000).

Here the parties must be able to defend the amount of money paid to the physicians and often the rationale for choosing the physicians, rather than an experienced management company, as the service provider.

5. Medical Office Buildings. Another increasingly common type of joint venture strategy relates to the joint ownership of medical office buildings and equipment. This provides physicians rental income but does not allow them to actually own interests in the provider itself. By way of example, in the Denver, Colorado metropolitan-area both Longmont United Hospital and HCA have teamed with local physicians to own and develop medical office buildings to house various physician practices and other health care facilities.

6. Gain Sharing. Finally, in the wake of several favorable OIG Advisory Opinions, “gain sharing agreements” between hospitals and physicians on their medical staffs has become more prevalent. Gain sharing refers to efforts by hospitals to involve physicians directly and substantially in certain cost-containment endeavors, and to share with those physicians the resultant savings. These programs must be carefully structured to avoid any inference that a purpose of such gain sharing efforts is to induce participating physicians to refer patients to the hospital, or to reward such referrals. One recent gainsharing program, implemented by St. Francis Cabrini Hospital of Alexandria, Louisiana, aimed to reduce health care supply costs through information sharing and alignment of hospital and physician financial incentives. The reported cost savings from the program, which was put into place in early 2006, total \$900,000.

The key legal issues related to the alliance-based efforts discussed above vary by the type of project. Generally, though, compliance concerns relate primarily to the federal and state anti-kickback statute, the Stark Law relating to self-referral by physicians, issues related to a hospital’s tax-exempt status, and antitrust laws.

II. Combative Efforts

Hospitals, in addition to attempting to co-opt physician competition, through hospital-physician alliances, are also engaging in aggressive efforts to fight physician competitors. Strategies that are

more aggressive in nature include the following:

1. Exclusive Privileges. Hospitals are increasingly offering exclusive privileges to certain physicians that are deemed loyal to the hospital, and cutting off the privileges of other physicians. Over the past few years, hospitals have begun extending exclusive privileges to surgical specialties and not just within traditional hospital based specialties. Courts have more often than not recognized such contracts and actions as valid and enforceable. However, there are situations in which physicians have prevailed in their legal actions.

2. Conflicts Policies. Hospitals are also adopting conflict of interest policies, which preclude physicians from maintaining privileges, or any other position, at the hospital if they have a financial interest in any competing facility (i.e., a “conflict of interest”). These policies have generated a great deal of litigation in recent years.

A recent lawsuit illustrates the potentially destructive effect that conflicts policies can have on physician-hospital relations and hospital results. In 2003, Community Memorial Hospital in Ventura, California unilaterally imposed conflict-of-interest policy on its medical staff, prohibiting any physician with a competing financial interest from serving as a medical staff officer or committee member or voting on a medical staff matter. The policy spurred litigation between the medical staff and the hospital, and case volumes at the hospital suffered as the dispute played out.

In another reported controversy, West Allis Memorial Hospital and the medical staff at West Allis Memorial Hospital in Milwaukee, Wisconsin area overturned its medical staff’s election of a local cardiologist to serve as chief of the medical staff based on that physician’s investment in a competing for-profit specialty hospital, which West Allis Memorial characterized as a pervasive conflict of interest. Many physicians involved viewed the hospital’s action as a means of punishing and deterring investment in competing facilities.

The “Conflicts” provisions are almost always upheld when limited to preventing doctors with competing interests from having a hospital leadership position.

3. Exclusive Contracts. Hospitals have attempted to use exclusive provider contracts with commercial payors to exclude physicians from having the ability to use their facilities. This strategy is intended to

cut off the supply of patients to competitor facilities.

4. Political Efforts. Hospitals are attempting to drive change at the government level, primarily by petitioning their legislatures to enact laws that preclude physician ownership of hospitals and tighten licensure restrictions, making it more difficult for physicians to develop and operate facilities. For example, many hospitals have contacted federal legislators, both directly and through trade associations such as the American Hospital Association and the Federation of American Hospitals, in an effort to pass of legislation aimed at restricting the development of physician-owned specialty hospitals and banning physician self-referrals to limited-service hospitals. For example, the State of California may pass a bill, AB 2212, that would place a moratorium on development of physician owned specialty hospitals. Specifically, one current advocacy agenda item identified by the American Hospital Association 2006 is to make permanent a ban on physician self-referrals to new limited-service providers.

5. Recruitment of Competitors. Hospitals often recruit staff physicians’ competitors to key leaders of physician efforts in an effort to put pressure upon the physicians. The idea is to recruit competitors and make it more difficult for the medical staff physicians to retain economic strength in the community and their project. Here, for business and regulatory compliance reasons hospitals must be careful to not overpay such new competitors.

6. Economic Credentialing. Hospitals are increasingly adopting economic credentialing policies, which generally prohibit a physician from maintaining staff privileges at the hospital unless he or she performs some minimum number of procedures at the hospital. The objective underlying such policies is to prevent a physician from economically benefiting from having privileges at a facility unless that physician will also provide economic benefit to the facility. This strategy is legal in some states, but not in others. Courts have generally upheld the ability of private hospitals to take economic factors into consideration when making credentialing decisions; however, some states have expressly prohibited such economic credentialing policies.

7. Litigation. Hospitals increasingly look at litigation options as a means to financially harm a competing facility. Much of this litigation may be groundless, but because

physician-owned facilities are often developed with minimal financial resources it is a tactic that often can cause great harm.

8. Public Relations Campaign. Some hospitals have attacked physician competitors through extensive public relations campaigns aiming to portray the physicians as greedy or self-interested and discourage patients from using physician-owned facilities. To the extent these campaigns successfully deter physicians from joining such facilities or discouraging patients from using the physician-owned facilities, they harm such facilities.

9. Employing of Physicians. Much like in the 1990's, hospitals are again pursuing efforts to own primary care physician practices as a way to lock up referrals that could otherwise go to competing specialists.

10. Certificate of Need. In states with certificate of need (CON) laws applicable to hospitals and surgery centers, hospitals often challenge the efforts of physicians to obtain a CON. They also oppose the loosening of CON requirements. Further, some states such as Indiana and Pennsylvania have looked to bring back CON laws. Certain state hospital trade associations have prioritized the issue on their lobbying agendas. For example, the Kentucky Hospital Association's published 2006 legislative priorities identifies legislation to "level the playing field" between hospitals and their freestanding surgery center and diagnostic center competitors through CON standards relating to charity care and hours of service. The trade group also actively opposes legislation exempting freestanding facilities from the CON standards.

11. Fragmentation. Hospitals often attempt to "divide and conquer" a physician-driven competitive effort. This can include making efforts to alienate valuable physician participants, "buy" the loyalty of key physicians, and various other tactics.

Many of the legal issues surrounding these types of strategies are similar to those implicated by alliance-based, or joint venture, strategies. Certain issues relating to antitrust law and medical staff bylaws often are also very significant where hospitals employ such aggressive tactics.

Should you like to discuss any of these strategies, or their legal ramifications, please feel free to contact Scott Becker at 312-750-6016 or Alison Vratil Mikula at 312-750-8911. ■

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particular, Ryan gained his fine reputation monitoring ambulatory surgery companies, such as Amsurg, and accurately reporting on their financial health.

8. Richard E. Francis, Jr. – As President, Chairman of the Board, CEO and a Director of Symbion, Inc., Richard Francis has helped transform Symbion into one of the country's leading surgical center management and development firms. Under his leadership, Symbion has become a publicly held company and an ambulatory surgical center chain with nearly 90 successful surgical centers.

9. E. Timothy Geary – Timothy Geary is a co-founder, Chairman and CEO of National Surgical Care. Prior to founding National Surgical Care, Timothy was the Chairman and CEO of National Surgery Centers, a publicly traded ASC company, until its sale in 1998 to HealthSouth for nearly six hundred million dollars. His experience, skill and knowledge of the ambulatory surgery industry are vast.

10. Brett Gosney – Brett Gosney is a founder and the CEO of Animas Surgical Hospital. He is a leading advocate on behalf of physician ownership of surgical hospitals both nationally and in his home state of Colorado. He also serves on the Board of the American Surgical Hospital Association as the Secretary and Treasurer.

11. James T. Grant – Jim Grant is the COO of National Surgical Hospitals and the President of the American Surgical Hospital Association ("ASHA"). In his role as ASHA's President, he has overseen a nearly five year battle to prevent limits and prohibitions on physician ownership of specialty and surgical hospitals. Prior to his position at National Surgical Hospitals, Jim was an executive at Quorum Health Group and Talus Health Systems. His leadership, devotion, experience, intelligence and energy in the ambulatory surgical hospital industry are unparalleled.

12. Donna Green – Donna Green is the Vice President of Corporate Development at National Surgical Care. She is a leader at the company and has been a tremendous asset in helping to strengthen the company's development and acquisitions. She has extensive experience in the healthcare industry, where she has served in a executive capacity at several healthcare providers and has overseen the development of hundreds of healthcare centers nationwide.

13. Molly Gutierrez – Molly Gutierrez is the Executive Director of the American Surgical Hospital Association ("ASHA"). Her professional efforts at the helm of ASHA have dramatically improved the organization's importance and presence in the industry. She tirelessly works and advocates on behalf of surgical and physician owned hospitals.

14. David Hall – David Hall has a long and successful career as a health care innovator and businessman. Currently he is Chairman at Titan Health Corporation, an ASC management company; Director of Radiant Research, a clinical trials company; and Director of Cogent Healthcare, a hospitalist staffing company. In the past, he has served as: President and CEO of ASC Network, an ambulatory surgery center company; Executive Vice President at Medical Care America, then the country's largest operator of outpatient surgery centers; and the President and CEO of two acute care hospital companies.

15. Thomas Hall – Thomas Hall is the CEO

and President of Novamed. Novamed is probably the fastest growing publicly traded ASC company. Previously, Mr. Hall was the CEO of Matria Healthcare. He is a dynamic leader.

16. Kenneth N. Hancock – Kenny Hancock is the President and Chief Development Officer of Meridian Surgical Partners, a venture capital-funded firm that is actively acquiring ambulatory surgical centers and small hospitals. He has over twenty years experience in the healthcare industry and is a co-founder of both Surgical Alliance Corporation and OrthoLink Physicians Corporation. OrthoLink was sold in 2001 to United Surgical Partners International in a stock transaction valued at ninety-two million dollars. With a wealth of experience and as one of the country's first specialty hospital developers, Kenny has a unique knowledge of the industry.


17. Richard Hanley – Richard Hanley is the CEO and founder of Health Inventures. Richard has held leadership positions at Health Inventures for the past twenty years. He also is a FASA Board Member and leading national advocate for ASCs.

18. Allen Hecht – Allen Hecht is the CEO and President of Health Resources International. He is also the President elect of FASA. He is one of the pioneers in the ASC industry and an extremely astute and likable leader. He adds great value to FASA and to the organizations he works with.

19. Marc Jang – Marc Jang is President and CEO of Titan Health Corporation. Marc has held executive positions in healthcare for 16 years, including serving as Vice President of Finance for Sutter Surgery Centers, Inc. and Regional Vice President for ASC Network, Inc. He has vast experience in finance, mergers and acquisitions, and development and operations as they relate to the ambulatory services industry.

20. Craig Jeffries – Craig Jeffries is the Executive Director of the American Association of Ambulatory Surgery Centers ("AAASC"). Under his direction, AAASC has become an important voice for the industry at the national and state level and a leader in the ASC industry. He has done a tremendous job of developing the organization, and advocating for and educating AAASC's members.

21. I. Naya Kehayes – I. Naya Kehayes is the founder and CEO of Eveia Health Consulting & Management (formerly Millennium Health Consulting). She is a nationally recognized expert in the area of reimbursement and managed care and insurance contract negotiations for ASCs






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and surgical practices. She is equally proficient in ASC operations and financial management and serves as a financial advisor to several national ASC corporations. She is intelligent, has a wealth of experience and has made (and continues to make) her mark in the healthcare sector by helping her clients dramatically improve their managed care contracts and reimbursements.

22. Mike Karnes – Mike is the Chief Operating Officer of Regent Surgical Health. He is a gifted executive. He has a hands on nature and is extremely effective at working through problems related to financing and other issues relative to surgical centers and surgical hospitals.

23. Michael Kulczycki – Michael is the Executive Director of Ambulatory Care Accreditation for the Joint Commission. In his role, he has greatly expanded the import of the JCAHO with respect to ambulatory surgical centers.

24. Brent Lambert, M.D. – Brent Lambert is an ophthalmologist and founder of Ambulatory Surgical Centers of America, a company owning nearly 30 ambulatory surgery centers nationwide. He is responsible for business development at the company. With his Harvard and Columbia University medical education and vast experience developing his own ambulatory surgery centers, Brent is well known as one of the country's leading experts on a variety of issues related to ambulatory surgery center development. He is also a FASA Board Member.

25. Luke Lambert – Luke Lambert is the CEO of Ambulatory Surgical Centers of America. He has a background in equity research and management consulting. With his experience and his MBA from Columbia University, he is a regular speaker at ambulatory surgical conferences and brings a wealth of experience and knowledge to the industry.

26. Jeff Leland – Jeff Leland recently founded Blue Chip Surgical Center Partners, a company that manages and develops spine driven ambulatory surgical centers. He serves as managing partner and brings a broad range of experience to his business. His prior experience includes working in development at Ambulatory Surgical Centers of America, serving as Executive Director of Lutheran General Medical Group in Chicago, and acting as a senior level executive at Advocate Health Care in Chicago, HealthSpring Medical Group and Western Ohio Healthcare. In addition, he holds an MBA from Harvard.

27. Tom Mallon – Tom Mallon is the founder and CEO of Regent Surgical Health, a company specializing in helping to turn

around ASCs and with regard to surgery center development and management. Tom is one of the most gifted manager leaders in the ASC business. Prior to founding Regent in 2001, Tom was a founding member of a venture-capital fund. Notably, in 1994 he co-founded Same Day Surgery, and in four years grew the two million dollar ASC and physician management company into a twenty million dollar enterprise. As an experienced executive leader with an MBA from the Harvard Business School, Tom is widely respected throughout the entire ASC industry.

28. Ajay Mangal, M.D. – Ajay Mangal is the founder, CEO and a Board Member of Prexus Health Partners. He is also an ear, nose and throat physician. As a hands on executive at Prexus, Ajay has been instrumental in developing surgery centers and assisting existing centers and hospitals to prosper. He is becoming a major force in the ASC industry.

29. Mark Mayo – Mark is the Executive Director of the Illinois Association of Ambulatory Surgery Centers and the Secretary of AAASC. He is an extremely effective advocate for the ASC industry. He is also a very skilled administrator.

30. Thomas A. Michaud – Tom Michaud is the founder, Board Chairman and CEO of Foundation Surgery Affiliates. A larger than life individual and an intelligent businessman, Tom has developed a great number of surgery centers and surgical hospitals. He is also heavily involved in a project to develop bariatric hospitals.

31. Amy Mowles – Amy is the owner of Mowles Medical Management. Amy is the nation's premier expert with respect to pain management services provided in practices and provided in surgery centers. She is thoughtful and also has strong opinions for what works and what does not work. She is very smart and a talented advisor to pain management physicians.

32. Tom Mulhern – Tom Mulhern is the executive director of Limestone Medical Center, a large medical office building complex and ambulatory surgical center in Delaware. He has been a leader in the development of ambulatory surgical services and an advocate for the industry. As a member of Delaware's health planning commission, he has been instrumental in the development of Delaware's health planning, as well as health planning on a national level.

33. Allen Pierrot, M.D. – Allen Pierrot has been one of the great leaders in the surgical hospital industry. He is also an orthopedic surgeon. After being one of the first developers of an ASC which became a surgical hospital, he founded the American Surgical

Hospital Association ("ASHA"). While he is now partially retired from his work with ASHA, Allen was instrumental in ensuring the survival of the organization and the industry as a whole. His efforts are to be applauded.

34. Thomas J. Pliura, M.D. – Tom Pliura is a doctor, lawyer and the founder and manager of several ambulatory surgical centers. Additionally, he is the founder of zChart EMR, an electronic medical records related company. In addition to these accomplishments, he is an incredibly inventive and interesting individual.

35. John Poisson – John Poisson is the Executive Vice President and Strategic Partnerships Officer of Physicians Endoscopy, the leading ASC industry company specializing in the development and management of freestanding endoscopic ASCs. He has over fourteen years experience in the healthcare field, most of which is specifically focused on medical service outsourcing. He also has extensive experience in information technologies, practice management, and contract management. Remaining actively involved post-development, John regularly assists providers meet or exceed their targets.

36. Karen Sablyak – Karen Sablyak is the CFO and Executive Vice President of Management Services at Physicians Endoscopy. With ten years experience in healthcare finance and operations, Karen's leadership skills and financial acumen have resulted in tremendous results in reporting and management at Physicians Endoscopy. She has particular expertise in billing processes, the development of policies and procedures, and the analysis and interpretation of healthcare financial data.

37. Caryl Serbin – Caryl Serbin is the President and founder of Surgery Consultants of America, Inc. and Surgery Center Billing, LLC. She has developed a tremendous team and provides credible and hard working leadership for her company. She provides consulting services for a variety of ASCs including orthopedic, ophthalmology, gastroenterology, pain management, urology, and multi-specialty. She is one of the best executives in the ASC industry and a leading woman executive in the business. Recently, one client commented on Caryl's efforts as follows, "Her team has been very hard working and has dramatically helped us turn around our center."

38. Jeff Simmons – Jeff Simmons is on the Board of Directors of Regent Surgical Health. He is a leading developer of surgery centers in the country and extremely gifted at trying to keep centers focused on its core goals. He

has long term experience in the surgical center industry and hospital industry and is a terrific advocate of physician interests.

39. Barry Tanner – Barry Tanner is the President and CEO of Physicians Endoscopy. Prior to joining Physicians Endoscopy, Barry was the co-founder, CFO and COO of Navix Radiology Systems, Inc. of Miami, Florida, where he helped build the company into a seventy-five million dollar enterprise. Additionally, Barry has worked for and successfully turned around several other healthcare companies. His knowledge, success and experience are held in high esteem.

40. Daniel R. Tasset – Dan Tasset is the Chairman and CEO of Nueterra, Healthcare, a company that manages, develops and owns interest in many ambulatory surgical centers. He founded Nueterra with a goal of empowering physicians to gain more control of their practices. Under his leadership, Nueterra expanded its services to include medical real estate, physical therapy, imaging, financial services and joint venture surgical centers. His long and esteemed career in the ambulatory surgical center business makes him a leader in the industry.

41. Larry Teuber, M.D. – Larry Teuber, a neurosurgeon, is the founder and Physician Executive of Black Hills Surgery Center, LLP, one of the country's most successful small surgical hospitals. Due to his dynamic skills and knowledge, Larry transformed the ownership of that hospital so that now it is a publicly held company that is partially owned by the Medical Facilities Corporation, where he now is President. Larry is also the founder and current managing partner of The Spine Center in Rapid City, South Dakota.

42. John T. Thomas – John Thomas is the President, Chief Development Officer and Business Counsel of Cirrus Health. Cirrus, under John's leadership, has quickly become one of the country's leading companies in ASC and specialty hospital development.

43. John Vick – John Vick is a leading consultant in the ASC industry and is renowned for matching corporate partners with physicians and matching buyers and sellers of surgery centers. John's career in the industry started with his development of an endoscopy chain.

44. E. Michele Vickery – Michele Vickery is the Executive Vice President of Operations at NovaMed. Over the last seven years, NovaMed has become one of the leading publicly traded companies in the ambulatory surgical center business. Michele has earned the industry's respect for her tremendous work helping NovaMed strengthen its core operational efforts and value-added services to its existing surgery centers. Prior to joining NovaMed, Michele was an executive specializing in surgery center management at Surgical Care Affiliates.

45. David Woodrum – David Woodrum is one of the founders and a Partner of Woodrum ASD, an ASC management and development company. In this role, he provides clients with consultations in the areas of planning, management, finance, loss prevention, marketing, physician group practice management, executive recruitment, and JCAHO compliance. David brings a wealth of experience to his position as he previously served as executive vice president and COO of the American Hospital Association.

46. Thomas R. Yerden – Tom Yerden is the CEO and founder of TRY Health Care

Solutions, LLC. Previously, he founded and served as the CEO of Aspen Healthcare. In his roles, he has developed many ambulatory surgical centers and has become a leader in the industry. Tom is also a FASA Board Member.

47. Joe Zasa – Joe Zasa is a Partner of Woodrum ASD, where he is a smart, efficient and diligent leader who is extremely active in forming physician-hospital joint ventures. Joe also specializes in raising capital to finance his client's ambulatory surgery centers.

48. Robert Zasa – Robert Zasa is a founder and Partner at Woodrum/ASD. He is experienced in all phases of business development in multiservice ambulatory care facilities, group practices, ambulatory surgery centers and hospitals. That experience includes management, development, expansion, acquisition, ownership structuring and marketing. He is a founder and former executive of Premier Ambulatory Systems, Inc. and a long time advocate and leader in the ASC business.

49. Billy Webb – Billy Webb, as a Senior Vice President at Symbion, Inc. has headed up one of the most successful teams in the ASC industry. His company went public approximately two years ago. Largely due to his efforts and the leadership of his team, it has become one of the leading publicly traded companies in the ASC business.

50. Michael Weaver – Michael Weaver is one of the strongest development executives in the ASC industry. He is smart and driven and has helped Symbion to grow into one of the largest ASC chains. He currently serves as an Executive Vice President at Symbion. ■



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Unlocking Value in Your ASC

By Jon Vick

Jon Vick is founder and president of ASCs Inc. (www.asc-inc.com), a consulting firm that specializes in strategic partnering—helping physicians find the right partners and negotiate the best deals for their ASCs, performing valuations, and providing other merger and acquisition services as needed.

Most surgeons are either already partners in an ASC (center) or are seriously considering becoming a partner in a new or existing center. The one topic that is almost never fully explored when planning a center is the “exit” strategy, and how the senior partners will benefit from the financial and other risks they took in starting up the center. In other words, how will the partners extract value from the facility they have developed when they want to take some money off the table or retire. Fortunately, a competitive market for these facilities has developed that results in attractive valuations for ASCs.

Today, more than 40 corporate partners (management companies) are actively competing to partner with good quality, physician-owned ASCs with growth potential. The range of corporate partners currently available coupled with an ongoing trend

toward consolidation in the industry has created a “seller’s market” that makes this an ideal time to explore the advantages of corporate partnership for your center.

Why would ASC owners want a corporate partner?

The most common reasons for selling an interest in a physician-owned center to a corporate partner include:

- **Improving financial performance.** ASCs with corporate partners have higher utilization rates and average more revenue per case than independent ASCs. Additionally, many independent centers fail to fully utilize their ORs and procedure rooms (PRs), which results in less than optimal revenue. A corporate partner will find ways to increase utilization, often by bringing in new users and enhancing case scheduling. They also generate more revenue per case, often by charging more appropriate fees for the procedures performed at the center.
- **Professional management results in higher profits.** Management companies use sophisticated benchmarking techniques to measure the performance of one center against others. They can tell when a center is

performing below average and will take steps to correct that situation. Profits typically increase as a result.

- **A strategy to buy-out non-productive physician partners and add new physician partners.** A management company will pay a fair price to buy out the non-productive physicians and will recruit new users and new partners who will buy into the center. For physician-owners of a center, this process is usually very difficult, but for a management company, this process is considered a routine part of the job.

- **An exit strategy.** One of the most common reasons owners seek a corporate partner is to facilitate an exit strategy for the senior owners. Corporate partners typically buy shares at market-rate multiples while other physicians frequently expect to buy-in at a substantial (e.g., 50%) discount. A management company buying either a minority or majority interest will typically pay a fair market value without a discount thus returning the selling physicians a much higher price than if they sold to other physicians.

- **A safety net to guarantee a buy-out at a predetermined price in the event of adverse**

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ASC center legislation. The moratorium on surgical hospitals and discussions about the propriety of physician ownership of ASCs has created an atmosphere of greater risk for physician-owners of ASCs. Some management companies are willing to guarantee a buy-out price in the operating agreement in the event of adverse legislation that limits or prohibits physician ownership.

What is your center worth?

ASCs are usually valued as a multiple of earnings before interest, taxes, depreciation and amortization (EBITDA), minus long-term debt. The range of valuations is typically between four and six times EBITDA for single specialty centers, and five to seven times EBITDA for multi-specialty centers. For example, a multi-specialty center with trailing 12-month EBITDA of \$1,000,000 and with \$500,000 in long-term debt would have a valuation of \$6,000,000 less \$500,000 or \$5,500,000, if valued at 6 times EBITDA. If the physician-owners sold 40% of this center to a corporate partner, they would receive \$2,200,000 in cash and would retain ownership of 60% of the center. Higher valuations may be offered for ASCs with a solid record of sustainable profitability, good growth potential, a pool of available new physicians, certificate of need (CON) approval (where required), an attractive payor environment, etc. Higher prices have been realized where multiple companies are bidding for a center.

Before seeking purchase offers, owners can employ a number of strategies to increase the value of their center. These strategies include identifying new potential medical staff, adding new cases, contracting for additional cases at higher fees, and projecting the financial growth that will result from these efforts.

What are your choices for a corporate partner?

Center owners have three choices of corporate partnership models. Each model offers some distinct advantages depending on your goals.

For-Profit ASC Management Company Partnership. For-profit ASC management companies will purchase a 20% to 60% minority or majority interest in your center. The popularity of this partnership model has escalated in the last five years, and now more than 40 management companies are seeking to partner with independent centers.

Pros – Management companies offer their physician-partners reduced physician risk, syndication of new physicians, investment security, professional management and management systems, higher revenues and profits, contracting and recruiting expertise, increased case volume and facility fees, access to capital without personal guaran-

tees, and performance benchmarking. In addition, professionally managed centers generally enjoy expedited turnover times and higher facility fees than independent centers. Corporate-partnered centers tend to be the most profitable of all of the ownership models due to management expertise and the focus on utilization and profitability that the corporate partner brings to the center. Corporate-managed centers are managed for efficiency and productivity. Physicians can focus on surgery and their office practices and are not forced to be center managers. Corporate partners also facilitate exit strategies for senior partners.

Cons – As in most joint ventures, control will be shared. Generally the corporate partner manages the business and the physicians manage the medical decisions. In addition to shared control, profits are also shared. Management companies tend to be very businesslike and bring a business productivity and profit-oriented culture to the center.

Hospital Partnership. At long last, hospitals are climbing on the ASC bandwagon and more centers are being approached by hospitals that want to partner with them. Hospitals often require at least a 51% ownership interest and management control to preserve their 501(c)(3) tax-exempt status (or so they say). Some hospital-physician joint ventures contract with management companies for their management services.

Pros – Typically, hospital joint ventured centers are conveniently located near a hospital. This model facilitates supply and services contracting, access to the hospital's payor contracts, hospital capital, and access to a CON, if needed.

Cons – Some hospitals may resist paying fair market value for a center and, when they assume an ownership interest, may want to control and run the center as if it were a hospital. Additionally, if competing needs for capital arise, the physician-owners may have less control and leverage than the hospital in the final decision-making process.

Three-Way (Physician/ ASC Company/ Hospital) Partnership. These joint venture models are typically managed by the ASC management company. The most popular three-way model incorporates equal or near-equal ownership amongst all three parties. These partnerships work best if the physician partners engage initially with the management company to collaboratively determine the best strategic structure into which the hospital partner will be added. As a result, engaging the management company before approaching the selected hospital is the recommended first step in facilitating the development of an optimum three-way joint

venture partnership. This strategy leaves the control of the process in the hands of the physicians and their corporate partner and results in a stronger position from which to deal with the hospital. If the hospital is brought in first, the hospital often wants to control the organizational structure and the decisions that are made may not always be in the physicians' best interest.

Pros – This model provides a balance of interests between the physicians, the hospital, and the corporate partner and is thus less adversarial. In this partnership model, the management company typically provides professional management to the center so it is managed like an ASC and not like a hospital. Three parties provide capital, and risk is spread between them. Facility fees tend to be similar to the corporate partner model, significantly higher than independent centers.

Cons – In this partnership model, profits are split three ways and physicians have less ownership and less control than they would have in either of the other two models described above. This is a more delicate partnership structure that requires a more complicated decision-making process because each partner typically has different priorities. For this model to work well, the hospital must enhance the profitability of the business by providing access to attractive payor contracts, a CON, supply services, etc.

How do physician-owners go about adding a corporate partner?

To identify and negotiate a partnership that meets the goals of the physicians, the following steps are recommended:

- Clearly specify the goals and objectives of the physician-owners.
- Identify the type of partner that best suits the goals of the physician-owners. For example, owners of a very profitable center who want to sell a majority interest as an exit strategy would want to solicit offers from well-capitalized companies that are seeking this type (size, location, specialties, etc.) of center. Owners of a relatively new independent centers with plenty of growth potential may want to solicit offers from companies with outstanding track records in building new business. They may also be interested in partnering with a management company that is willing to buy a minority interest, or that would agree to buy more later or consider reselling their interest in the future.
- Identify the potential partners that will enable the owners to achieve their goals. While ASC owners have more than 40 companies from which to choose, about 20 of those companies are start-ups that don't have a long track record or are just at the point of

seeking capital to make acquisitions. To decide which company is the right partner, the owners must know who the potential buyers are and which ones would be best for them.

- Interview several potential partners. Center owners frequently interview and solicit partnership proposals from several management companies so they can compare business approaches, meet a variety of managers with a variety of management styles, and receive alternative proposals they can use to compare offers.

- Check references to confirm that the potential partner has a successful track record. Most importantly, speak to physician-partners at several centers to see if the corporate partner is accomplishing the agreed-upon objectives. The goal for an independent center is to do better with a corporate partner than it was doing or can do on its own. The owners need to make certain that the potential partner with which they are speaking has a track record of producing better results than the owners can achieve on their own.

- Once the owners of an independent center and their potential partner reach the Letter of Intent (LOI) or Term Sheet stage of their negotiations, the owners should engage a health care attorney who has expertise in ASC transactions to review the documents related to the potential partnership.

What questions should you ask?

To arrive at the best partnering alternatives, here are some questions that should be answered early in the search.

- Which partner(s) has/have the track record needed to meet the unique needs of our center?
- Which companies will value our center at the highest multiple?
- How much is our center worth?
- How do we get the best terms and value for our center?
- Should we sell a minority or a majority interest?
- What level of control will we retain?
- What will be the relationship between ownership and management at our center?
- Does the potential partner have other ASCs in the state or market?
- Can our potential partner document the financial performance of its other centers before and after forming its partnerships with them?
- Will our potential partner agree to non-compete terms in the same market that our center serves?
- Who will employ and manage the employees at our center?

There are corporate partnering opportunities for most surgery centers, and pros and cons of the various models. If your goal is to improve the financial performance of your center, or to have an exit strategy, a partnership with one of the corporate partners with a proven track record is a strategy worth considering. ■

Jonathan C. Vick, the founder and President of ASCs Inc., has assisted in development, merger, and acquisition transactions for over 150 physician-owned ambulatory surgery and endoscopy centers (ASCs) and surgical hospitals since 1984. He founded and was a principle shareholder of SurgiCenter Development Corporation (90 ASCs) in 1984 and Endoscopy Center Affiliates (20 Endoscopy Center Partnerships) in 1994. He participated as a general partner for a national network of Medicare certified surgery and endoscopy centers that he sold in 1995. He has extensive experience in ASC sales, development, business planning, operations, valuations, and mergers & acquisitions. ASCs Inc. can be reached at 760-751-0250; Fax 760-751-0263.

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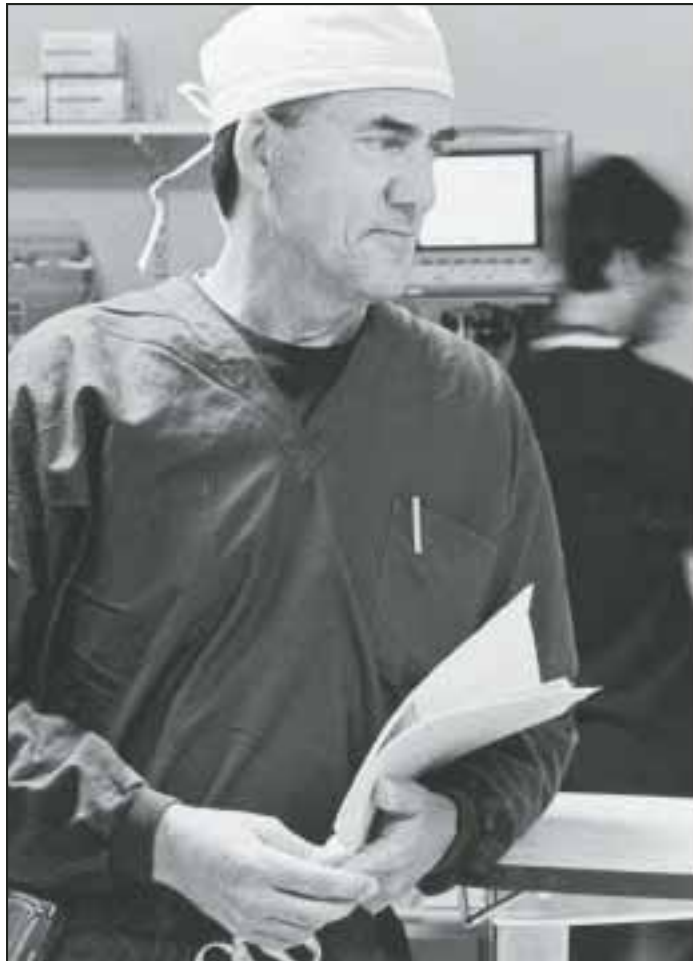
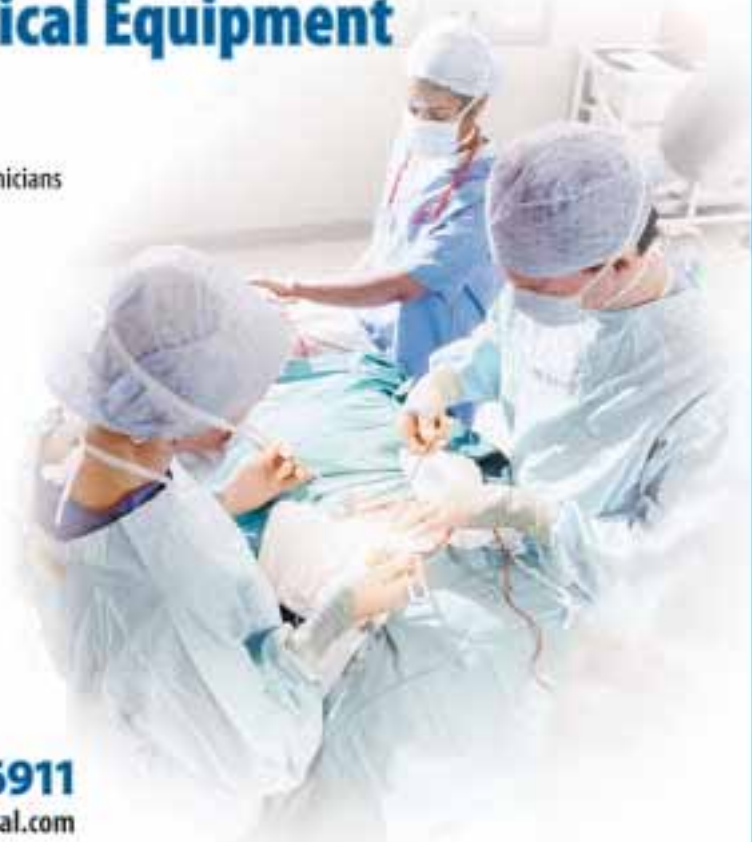
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Question and Answer

Question: We are considering joint venturing with our hospital to develop an ASC. The model being discussed is a management arrangement. We are aware this model has some significant potential liability. What are the important things we will need to address to insure we remain compliant?

Answer: The most important aspect of a management arrangement includes assuring that the fee paid for management services is fair market value, and that the services are actually fully needed and rendered. In many situations, hospitals have attempted to engage physicians in a management model such that the hospital will continue to own the entire enterprise. The physicians then receive a management fee. However, the management fee must be an appropriate fee for services rendered as the manager. It cannot reflect the type of value that the physicians would otherwise receive if they had owned a part of the

surgery center or endoscopy center. Further, the physicians would actually have to provide the management services, and the parties should attempt to be able to demonstrate why the physicians are an appropriate choice for management services. We are particularly concerned about situations where physicians are paid a management fee and then turn around and hire another management company to provide the actual services. There, the physicians may render very little services but be able to keep the difference between what they receive and what they pay to a third-party management company.

Question: We are thinking about developing an ASC on the hospital's campus. The lease price per square foot seems higher than other sites off the campus. Doesn't the hospital need to charge fair market value?

Answer: Yes, the lease rate should be fair

market value. It should not take into account the volume or value of any referrals that you may receive from the hospital or that you may receive by being part of the hospital campus. In essence, the lease rate should be a true fair market value amount.

Question: We are thinking about buying certain support services from our hospital such as payor contracting negotiations and billing and collection services. What is the fair price for these services?

Answer: For billing and collection services, we typically see a price of 6-10% of collections. For payor contracting services, we often see these types of services provided at a flat-fee annual basis or for an hourly rate. We would be concerned with situations where a party is simply paying a "license fee" for the opportunity to serve on the payor's contracts or receive the rates. This could raise antitrust and other issues. It could also raise antitrust issues where a potential competitor is actually performing managed care contracting services for your center.

Question: If a hospital has an equity position in our proposed ASC, will we be able to piggyback on their payor contracting rates?

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Answer: The answer to this question depends on two different sets of issues. First, the payor contracts the hospital currently has may or may not permit “affiliates” to access the same managed care contracting rates. In certain situations, the definition of “affiliate” often depends on the extent of equity that the hospital owns in the center. For example, it is more likely the case that the managed care contract will allow this type of piggybacking when the hospital owns 50% or more of the center.

The answer to this question also depends upon antitrust issues. As a general rule, there is more flexibility as to this type of behavior when the hospital owns a great percentage of the center and also has substantial control of the center. In certain situations, with the right level of ownership or control, the parties are considered “one” party for purposes of antitrust laws and thus not capable of violating certain antitrust laws related to price fixing. In contrast, where the hospital owns a small portion of the ASC, and has minimal control over management, they are generally considered two parties, and this type of piggybacking in some situations could be considered a violation of the antitrust laws.

Question: We have heard of economic credentialing. What is actually meant by economic credentialing?

Answer: Economic credentialing relates to the ability to not allow somebody to have privileges at a hospital or surgery center based on economic reasons and not based on quality reasons. In practice, it most often gets discussed today as it relates to “conflict-of-interest” policies. Usually, this is the policy by which a hospital says that a person cannot have privileges at their hospital if the person is an investor in a competitive facility. Case law and the statutory law on the ability to use economic credentialing vary from state to state.

The second manner in which economic credentialing is often used relates to the concept of not allowing somebody to have privileges at a center or hospital if their performance of cases at the hospital or surgery center is likely to lead to losses. This type of economic credentialing is often used to not allow somebody to have privileges who may use very expensive supplies or take a very long time for procedures. It also is often used to not allow somebody to maintain privileges that does only a small number of cases per year at an institution. Again, the law on such issues is evolving and is not settled in most places. ■



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