

ASC BECKER'S Review

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Seven Tricks of the Trade in Establishing an ASC

By Dana Kulvin

Developing an ASC can be an exciting, yet complicated, venture. But how you go about it can have long-term effects on your bottom line. For this reason, it is important to proceed cautiously and intelligently through the process. It is also important to learn from others' successes and mistakes. To help you do this, here are seven tips or "tricks of the trade" that ASC experts suggest you consider.

1. Perform a Comprehensive Feasibility Study

The first step to take prior to establishing an ASC is to prepare a pro forma analysis as part of performing a feasibility study. "While building and designing is fun, jumping into that phase of a project without first performing adequate due diligence could be disastrous if the project ends up being financially impossible," warns John Daly, Vice President of Healthcare Services at McShane Construction. Rick DeHart, CEO of Pinnacle III agrees that is much more difficult to back into a project than to work from the ground up. "If a financial assessment does not result in a twenty percent or higher return for the ASC, there is not a great chance of success," says William Southwick, President and CEO of Health Mark Partners, Inc.

Because preparing a pro forma and feasibility study can be a tricky undertaking, you might want to hire a professional to assist in the process. "A pro forma is generally developed through complicated industry-specific formulas and market assumptions. As such, hiring a consultant experienced in developing ASCs will ensure you obtain the most accurate financial assessment," advises Daly.

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Developing an Ambulatory Surgery Center: Understanding the Key Legal Issues and the Essential Elements of an ASC Operating Agreement

By Scott Becker, Ron Lundeen and Alison Mikula

There has been tremendous growth in the number of ambulatory surgery centers ("ASCs") over the last several years. Currently, there exist approximately 5,000 to 5,500 ASCs in the country. Of these, many ASCs are physician owned or owned by physicians and management companies. In addition, a growing percentage of ASCs include a hospital partner. At present, approximately 25% of the country's ASCs include a hospital partner.

First, this article describes the key legal issues a lawyer, a physician or developer must recognize to effectively develop a surgery center. A certain number of these issues specifically relate to the development of an ASC with a hospital partner or to developing an ASC that grows out of the acquisition of a hospital outpatient department. This article discusses both the principal federal law issues and also touches on a handful of the key state law issues relating to the development of ASCs. Second, this article provides a discussion of the key elements of an ASC operating agreement.

I. Key Legal Issues

1. Medicare/Medicaid Fraud and Abuse Anti-Kickback Statute.

The Medicare/Medicaid Fraud and Abuse Anti-Kickback Statute (the "Anti-Kickback Statute") prohibits paying money or providing remuneration of any sort in exchange for federally-funded referrals. In the ASC context, the Anti-Kickback Statute applies to any center that provides Medicare or Medicaid services. Compliance with the Anti-Kickback Statute calls for a number of rules related to investment in an ASC. These rules include the following: (i) a party can-

not offer more or less shares to a physician based on the physician's referrals to the ASC; (ii) returns on investment in an ASC must be related to the ownership of shares and may not be related to the number of referrals made by an investor to the ASC, (iii) each investor must pay fair market value for shares in an ASC, (iv) subject to safe harbor compliance, the ASC must not provide the ability to redeem an investor based on an investor's failure to bring cases or generate business for the ASC, (v) no party should pay any amount to physicians for services unless such payments are fair market value and such services are unrelated to the volume or value of referrals generated for the ASC. Compliance with an Anti-Kickback Statute safe harbor may require several other actions as well.

The Anti-Kickback Statute may initially appear particularly restrictive in the ASC setting. The government made it less restrictive in 1999 by adopting an ASC-specific safe harbor to the Anti-Kickback Statute. This safe harbor sets forth the manner in which an ASC can structure equity ownership for its participants and gain immunity from prosecution based on that ownership. Thus, implementation of the elements of the safe harbor provides for protections to ASC ownership. The actual policing of the safe harbor raises a number of issues that are beyond the scope of this article.

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**SEE PAGE 23 FOR
INFORMATION ON THE
2006 FALL CONFERENCE.**

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Fall ASC Communications-FASA
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Letter from the Editor

1. Reasons Why Ambulatory Surgical Centers and Other Businesses Fail.

The U.S. Small Business Administration recently listed the ten main reasons why small businesses fail. Many of these are also applicable to ambulatory surgical centers. The ten that they set forth include:

1. Lack of Experience
2. Insufficient Capital
3. Poor Business Location
4. Bad Inventory Management
5. Over Investing in Fixed Assets
6. Making Bad Credit Arrangements
7. Mixing Personal and Business Funds
8. Mismanagement of Growth
9. Failing to Respond to Competition
10. Lack of Sales

Five or six of these reasons are often applicable to ambulatory surgical centers. For example, many ambulatory surgical centers fail due to a lack of experience in managing and developing surgery centers. These centers often suffer from many of the other reasons that cause businesses to fail. For example, they may have started with insufficient cash to withstand challenging the early (or ongoing) ramp up in collections and cases.

Further, many ambulatory surgical centers fail because they developed too large a physical plant and have too much cost tied up in equipment and other fixed assets such as the building. This is a problem which is extremely hard to ever overcome. We have seen several centers that have suffered greatly because they have building sizes that are 20,000 square feet or higher and they probably could have handled their patient load with building sizes that were 8,000 to 15,000 square feet. Further, where a center's physicians and management believe that they need the best of everything in terms of equipment, this is a luxury that is often paid for over a long period of time.

Bad inventory management often does not mean the death of a center. However, the combination of poor inventory management coupled with over staffing can seriously harm the bottom line and over the long run cause a gradual death to the center as lead physicians start to look for other opportunities. Finally, the flip side to overbuilding and poor management of the expenses is the failure to respond to competition and the lack of sales. Many ambulatory surgical centers suffer because they do not continue to recruit physicians or because they do not respond to efforts by others to develop surgery centers and recruit physicians. Many do not respond well to changes in reimbursement and to changes in hospital tactics and competition.

Another reason which is stated in the report is poor business location. Poor business location has a macro and micro context. For example, geographic areas differ dramatically in the reimbursement that will be provided for services. For a specific physician or center in a specific community, there is not a great deal that can be done about this location issue. However, a center in an area that does not receive great reimbursement, can at least develop its business plans so it is extremely careful as to not over invest in fixed assets and to make sure that they build in a manner that is suited for a

reasonable or lower reimbursement pay scale.

2. Department of Health and Human Services Issues Final Report Regarding Specialty Hospitals.

DHHS on August 8, 2006 as part of an 80 page report made several core recommendations in its report. These include the following:

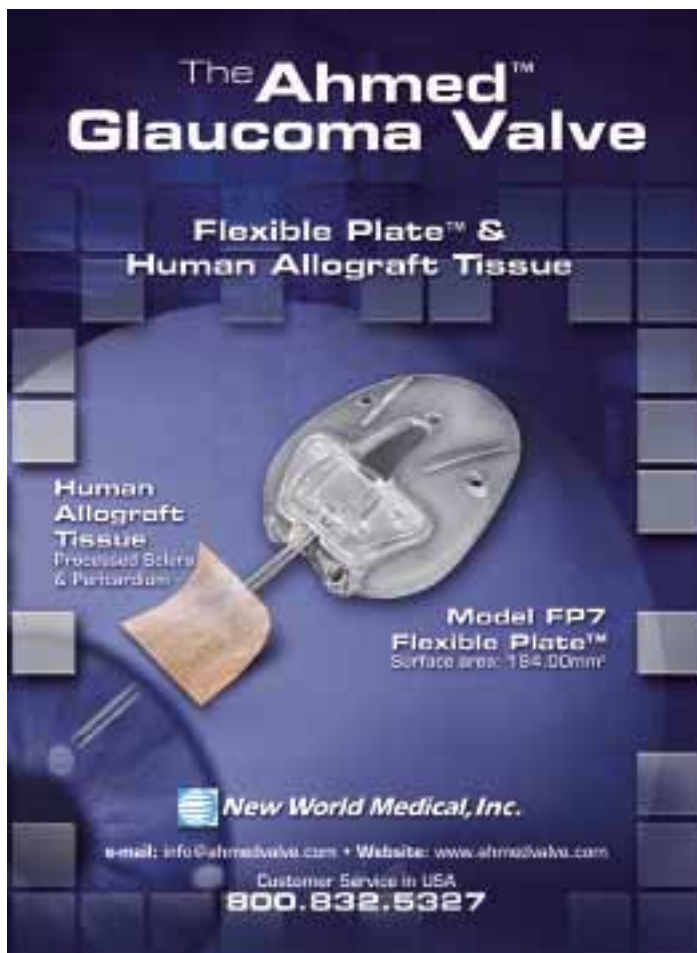
1. No legislation or expansion of the Stark Act "at this time."
2. Expiration of the moratorium on issuing provider numbers to specialty hospitals.
3. Improve the payment system to improve payments for more severe cases and possibly lower payments for less severe cases.
4. Align Physician and Hospital Incentives – Gain Sharing and Group Purchasing.
5. Assure hospitals meet EMTALA requirements
6. Create reporting requirements to CMS on physician's ownership – names, nature and extent of ownership, compensation reporting, and penalties for not reporting.
7. Disclosure of ownership to patients.
8. Continued and enhanced enforcement of the Stark Act and the Anti-Kickback Statute.

For a full copy of the report please contact either Scott Becker at sbecker@mcguirewoods.com or 312-750-6016 or Molly Gutierrez at mollyg@surgicalhospital.com or 605-275-5349. To join ASHA, please call Molly Gutierrez.

3. Internal Revenue Service Begins New Compliance Initiative for Community Hospitals.

The Internal Revenue Service has developed a lengthy questionnaire related to community hospitals. Here, the questionnaire is not an audit of community hospitals. However, it is a survey. This survey can result in further audits and also may result in further legislation relating to how hospitals must meet their community and charitable standards.

The issues raised in the checklist include items such as (1) uncompensated care (to what extent does the hospital provide uncompensated care) (2) community benefit programs (does the hospital sponsor and engage in community health programs), (3) executive compensation (how does the hospital pay its officers and executives), (4) medical research and professional medical training (to what extent does the hospital participate in the same) (5) medical staff privileges (does the hospital maintain an open



medical staff), (6) board of directors (how independent is the Board of Directors), (7) emergency room care (does the hospital maintain an emergency room) and (8) patient mix (what kind of patient mix does the hospital serve, does it include indigent, Medicare and Medicaid patients). This survey reflects increased scrutiny of tax exempt organizations. It will be interesting to see how this ultimately translates down into the handling of such issues by joint ventures that tax exempt hospitals are a partner in.

4. California Develops a Temporary Moratorium on the Development of Specialty Hospitals.

The State of California legislature has recently passed a temporary moratorium on the development of new surgical hospitals. The ambulatory surgical center industry and the American Surgical Hospital Association will watch the development of this very closely. It shows the great harm that a few parties can do as they attempt to stifle competition.

5. Ambulatory Surgical Center 13th Annual Conference.

We have posted the October 26th – 28th Ambulatory Surgical Centers Conference brochure on the www.BeckersASC.com website. We are very pleased with the commitments we have received for speakers. We will be covering such core subjects as improving profitability and developing surgery centers. In addition, there will be sessions on developing physician owned hospitals, customer service, financial modeling, managed care contracts, and staffing for surgery centers. We also have great speakers related to bench marking and developing a business plan for physician hospital joint ventures. All in all, we think it is a terrific agenda. FASA again joins us in helping to co-sponsor this conference. To join FASA, please contact 703-836-8808. For conference information, please email or call Michelle Freeland at michelle@pcmisandiego.com and at 858-565-9921.

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7. American Surgical Hospital Association Conference.

The American Surgical Hospital Association Conference will be held on November 2 – 4, 2006 in Newport Beach, California. Given the recent success in Washington, D.C. and the challenges that still face physician owned hospitals, we are expecting a lively and interesting event. If you have questions about the conference, please contact Molly Gutierrez at (605) 275-5349.

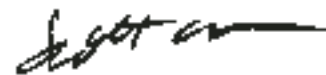
8. October 4, 2006 – Healthcare Private Equity Event – Four Seasons Hotel, Chicago, Illinois.

McGuireWoods LLP will host its 3rd Annual Healthcare Private Equity Event from 3:00 p.m., to 8:00 p.m. at the Four Seasons Hotel on October 4, 2006. The event will now have three different tracks and 16 speakers. It will focus on the trends and opportunities in healthcare investing for 2006-2007. We have representative speakers from three great private equity funds, Grotech Capital, Waud Capital and Senica Partners. We also have the CEO's of ten different health care companies presenting.

Should you have any questions, please contact myself at (312) 750-6016.

We hope you enjoy this issue!

Very truly yours,



Scott Becker

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Developing An Ambulatory Surgery Center: Understanding The Key Legal Issues And The Essential Elements Of An ASC Operating Agreement continued from page 1

The ASC safe harbor includes specific safe harbors for single-specialty surgery centers, multi-specialty surgery centers and surgery centers with a hospital partner. The general elements found in each of the safe harbors are as follows:

- (a) The ASC must be Medicare certified.
- (b) No investor may receive loans for the purpose of investing in the ASC from the ASC or other investors.
- (c) The same terms must be offered to each investor without regard to the potential volume or value of referrals.
- (d) All ancillary services must not be separately billed or reimbursable and provided only through the ASC rate.
- (e) The ASC and the investors must not discriminate against Medicare or Medicaid program beneficiaries.
- (f) Physician owners must disclose to patients his or her ownership interest in the facility.

Furthermore, each specific ASC safe harbor has unique elements. For example, the single-specialty surgery center safe harbor requires that at least one-third of each physician investor's medical practice income for the previous year derive from the physician's performance of certain ASC

procedures. The multi-specialty surgery center safe harbor requires, in addition to the one-third income element, that a physician investor perform at least one-third of those procedures at the ASC in which the physician has invested.

As a general rule, efforts should be made to attempt to structure an ASC venture to substantially comply with the safe harbor.


2. Stark Act.

The Ethics in Patient Referrals Act, also known as the Stark Act, prohibits physician investment in, and referrals to, facilities that provide certain types of services called "designated health services." These designated health services include inpatient and outpatient hospital services. Generally, the Stark Act does not apply to ambulatory surgical services and other services billed pursuant to a bundled ASC payment rate. Thus, for the most part, ASCs operating as freestanding outpatient surgical centers do not have a Stark Act concern.

Although ambulatory surgical services are not designated health services, some procedures performed in an ASC include prosthetic, DME and orthotic implantation

procedures, which are on the list of designated health services. However, when performed in an ASC setting, implants provided as part of a surgical procedure are specifically excepted from the Stark Act prohibition. In 2001, CMS stated in their responses to the Stark Phase II final rule:

We agree with the commenters that all prosthetic devices implanted in a Medicare-certified ASC by the referring physician or a member of the referring physician's group practice should be excluded. We have chosen this position because, if surgeons refer to an ASC in which they have an ownership interest, there will, in many cases, be no exception that would apply to their financial relationship with the ASC. Implanted prosthetic devices, implanted prosthetics, and implanted DME are not included in the bundled ASC payment rate and thus would retain their character as DHS even when implanted in an ASC. As a practical matter, the absence of an exception for all of these items implanted in ASCs is likely to result in these procedures moving to more costly hospital outpatient settings. We believe that the exclusion of these implants from [the Stark Act prohibition] will not increase the risk of overutilization beyond what is already presented by the surgeon's Part B



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physician fee and is consistent with the Congress's decision not to include ambulatory surgical services as a specific designated health service. We are specifically providing that the exception does not protect items implanted in other settings. Nor does it protect arrangements between physicians and manufacturers or distributors of implants where the manufacturers or distributors furnish DHS, for example, through subsidiaries or affiliates. We are providing that the arrangement for the provision of the implant in the ASC may not violate the anti-kickback statute and all billing and claims submission must be proper.

The Stark Act does come into play where a physician group or related group buys into a hospital outpatient department which will then be converted to a freestanding surgery center, as designated health services are provided by the hospital outpatient department. The Stark Act also comes into play where physicians are managing a surgery department of a hospital or operating pursuant to an "under arrangements" agreement with a hospital. In those situations, it is critical that all payments must be at fair market value, must meet a Stark Act exception and must not be intended to induce or require referrals.

3. Tax-Exempt Hospital Involvement in a Joint Venture.

Hospitals, as noted above, are increasingly included as partners in ASCs with physicians. Tax-exempt hospitals have two principal concerns with respect to the development and the operation of an ASC joint venture with physician owners. First, the hospital usually desires for income that it derives from the ASC to be treated as exempt income. Second, the hospital does not want involvement in the joint venture itself to cause the hospital to lose or jeopardize its tax exempt status as a whole.

For a tax-exempt hospital to be able to treat the income as exempt income, the hospital must have sufficient control of the venture to assure that the hospital is serving its charitable purposes. The necessary level of control can often come through control of the ASC board, reserve powers with certain unilateral rights, and other types of arbitration provisions. It is not necessary for a hospital to own more than 50% of the joint venture to maintain its tax exempt status and the exempt status of the joint venture income. However, it is critical that the hospital have sufficient control, whether or not it is a majority owner in the ASC joint ven-

ture, to assure that the joint venture serves charitable purposes.

In certain situations, the hospital must treat the joint venture income as taxable income. Here, this taxable income is unlikely to impact the hospital's tax exempt status as a whole. Generally, a hospital must have 10% to 15% of its assets, income or revenues coming from ventures that generate taxable income to jeopardize its tax-exempt status. Joint venture income from an ASC, when combined with the hospital's other taxable income, must remain below this 10% to 15% limit. Even with taxable income below this limit, a hospital involved in a kickback scheme or some other sort of problematic

legal relationship could find its status as a tax-exempt entity in jeopardy.

4. State Self-Referral Issues.

Many statutes have physician self-referral or anti-kickback statutes that are very similar to the Stark Act or the federal Anti-Kickback Statute. When establishing an ASC, it is important for counsel to the venture to assure that the venture and all investors are also complying with state self-referral laws. Many of these state laws can be more general than the Anti-Kickback Statute or Stark Act, applying to all services and not just Medicare or Medicaid services. Certain state laws may be more restrictive



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than the federal statutes. For example, federal law provides an exception that allows physicians to own interest in a hospital. In Nevada, however, physician ownership in a hospital is generally prohibited.

In developing an ASC, it is critical to assure that the venture complies with state laws as well as federal laws relating to physician self-referrals and kickbacks.

5. Certificate of Need Laws.

In more than 25 states, a state-granted Certificate of Need ("CON") is required to develop an ASC. In most states, a party developing an ASC must either obtain a CON or develop the surgery center pursuant to an exemption from the state CON requirement. In many states, it is very difficult to obtain a CON. In other states, it is significantly easier to develop an ASC and obtain a CON as long as the ASC has a hospital partner. In several of the CON states, it is possible to develop a surgery center pursuant to a practice-based exception or pursuant to a minimum size exception. For example, under Massachusetts law, a physician practice can develop an ASC under an exception to the Determination of Need requirements. In Illinois, a practice can develop a practice-based ASC without a CON by meeting certain restrictions. There

are certain types of CON exemptions developing in many states. However, operating pursuant to a CON exemption may significantly decrease the ability to ultimately sell the ASC to a third party or to obtain the services and capital of a management company.

6. Antitrust Laws.

All parties should be aware of and make efforts to comply with antitrust laws, particularly where a physician-owned surgery center partners with a hospital. Antitrust laws generally restrict competitors from having price-fixing arrangements or allocating markets between the competitors. Antitrust laws also impact certain other types of activities. Activities that pose antitrust risks include a situation where a hospital operates an outpatient surgical department and also invests in an ASC. In such a case, the hospital and the ASC may be deemed competitors for purposes of antitrust laws. Thus, the hospital and the ASC must set their prices separately and may not jointly attempt to price services with third-party payors. Also, there are risks when the hospital and ASC collaborate to decide which facility will serve which sections of the local outpatient surgery market. Antitrust issues may also arise when a hospital and an ASC combine in an attempt to

have greater market power in the local area.

A different set of antitrust issues, beyond the scope of this article, arises when a hospital with substantial market power restricts privileges of physicians who invest in alternative facilities, such as an independent ASC. This type of situation raises issues as to whether or not the hospital's actions can be challenged from an antitrust perspective.

7. Miscellaneous Legal Issues.

Several other legal issues must be considered in developing an ASC. These issues include compliance with securities laws, affiliated service group issues, licensure issues and certification requirements. For example, investment interests in an ASC must be sold in compliance with certain securities regulations requiring disclosure to investors meeting certain qualifications. In certain situations, these requirements can be met by providing a private placement memorandum to physician investors. In other circumstances, the venture may require selling to no more than a maximum number of investors under certain state and federal guidelines. ASC development also requires analysis of pension plan and affiliated service group issues. An ASC might be viewed as an affiliate of a practice that is related to the ASC. This may require the

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ASC and practice to combine pension and profit-sharing plans for purposes of ERISA laws and rules. Finally, ASC developers must be aware of and comply with licensure, accreditation, and Medicare certification rules. These certification rules require specific policies, procedures and operational guidelines in connection with the start-up of an ASC.

8. Operational Issues.

This article principally discusses issues related to the initial development of an ASC. In addition to these development concerns, all parties must become familiar with certain issues related to the operation of an ASC. These operational issues include rules and regulations related to the waiver of co-payment and deductibles, permitted methods of bringing in new physicians, compliance with billing and coding regulations, and several other rules and regulations. Furthermore, there are rules related to the creation and administration of the medical staff bylaws of the ASC.

II. Essential Elements of an ASC Operating Agreement

A limited liability company operating agreement for an ambulatory surgery center (ASC) is usually a long and detailed document. The most important elements of such an agreement, however, are typically found in only a handful of the key provisions. This article provides a brief overview of the issues those provisions should address. An operating agreement or a partnership agreement which addresses these issues well should provide an effective framework for the ASC's structure and governance.

1. Eligibility for Membership; Types of Members. The operating agreement should specify the investors or types of investors that will



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be permitted to invest in the company, whether the company will issue a single class of units or multiple classes, and who will be permitted to acquire each of the various classes of units. For example, operating agreements often establish separate membership categories for physician investors and non-physician investors. It is typical to require physician members to satisfy certain conditions not applicable to hospitals and other non-physician investors. The operating agreement may also set forth requirements for physician investors' continued ownership, including compliance with the ASC safe harbor to the Anti-Kickback Statute, maintenance of medical staff privileges, and other requirements related to the practice of medicine and compliance with health care fraud and abuse laws. A sample provision setting forth these requirements follows.

Membership. No Person shall be eligible to become a Member (or remain a Class A Member, as applicable) unless the following eligibility requirements are satisfied: (1) such Member shall be a physician, licensed and registered, in good standing, to practice medicine in the State where the Center is located; (2) such Member abides by the Safe Harbor Requirements of this Section; (3)

such Member shall maintain an active practice of medicine in the greater [city of Center] metropolitan area and, if permitted by the Stark Act and the Safe Harbor Requirements to refer patients to the Center for services, shall be able to perform surgical services at the Center (such physician shall maintain active privileges at the Center and privileges at least one hospital within thirty (30) miles of the Center); and (4) under applicable law, such Member's ownership shall not disqualify (and, without further action, would not disqualify) the Company or the Center from engaging in operations as a Medicare certified ambulatory surgical center for any reason or from having such physician perform cases at the Center. A physician who meets such requirements may be referred to herein as an "Eligible Physician."

Safe Harbor Requirements. The Members understand that the Company's and the Center's operations are subject to various state and federal laws regulating permissible relationships between the Members and entities such as the Company, including 42 U.S.C. § 1320a-7b(b) (the "Anti-Kickback Statute" or "Fraud and Abuse Statute"), and 42 U.S.C. § 1395nn (the "Stark Act"). It is the intent of the parties that the Company and the Center operate in a manner

consistent with the foregoing statutes. Accordingly, each Member represents and warrants that he or she (i) has not received loans for the purpose of investing in the Center from the Company or from any investor in the Company; (ii) has not been barred or suspended from participation in the Medicare and/or Medicaid programs; (iii) shall derive at least one-third (1/3) of his or her medical practice income from all sources for the previous fiscal year or previous 12-month period from his or her own performance of procedures that are ambulatory surgery procedures; (iv) shall perform at least one-third (1/3) of such physician's procedures that require or can be performed at an ambulatory surgery center at the Center; (v) shall fully inform each patient, prior to referring such patient to

the Center, of such physician's investment interest in the Center; and (vi) shall treat patients receiving medical benefits or assistance under any federal health care program in a nondiscriminatory manner. These requirements shall be referred to herein as the "Safe Harbor Requirements."

2. Board of Managers. The operating agreement should provide for a governing body, typically a Board of Managers. It should also specify the composition of the Board of Managers, state whether managers will be appointed or elected and by whom, and determine the approval threshold (e.g. majority approval or supermajority approval) required for the Board of Managers to act on behalf of the company. Where the operating agreement provides for multiple classes of members, it should also determine how many Board members each class will appoint or elect.

3. Board Powers and Member Powers. A well-drafted operating agreement will distinguish between actions requiring Board approval and those which require approval of the members. For example, many of the day-to-day business issues and operational matters, including staff-related decisions and clinical issues are often handled by the Board of Managers or an operating committee of the Board without consulting the members. In contrast, more substantial matters typically require a vote of the members. Examples include amending the operating agreement, selling a facility, spending in excess of a predetermined threshold amount, and requiring members to make additional capital contributions or guarantee debt, among others.

4. Special Member Powers. Where one or more investors is a tax-exempt entity, such as a hospital investor in an ASC, the operating agreement will often grant that member unique rights to veto certain actions that could jeopardize the investor's tax-exempt status and to generally cause the venture to serve the member's charitable purposes and provide community benefit. These charitable purposes should be clearly articulated, either in the body of the agreement or in an exhibit thereto that is referenced throughout the agreement. Particularly when a for-profit, public company collaborates with a tax-exempt organization, this approach can help to assure the tax-exempt member that the venture will support its mission and values by serving charitable purposes regardless of the for-profit member's preferences. For example, such a provision might read:

Class B Special Powers. Notwithstanding any other provision of this Agreement, the



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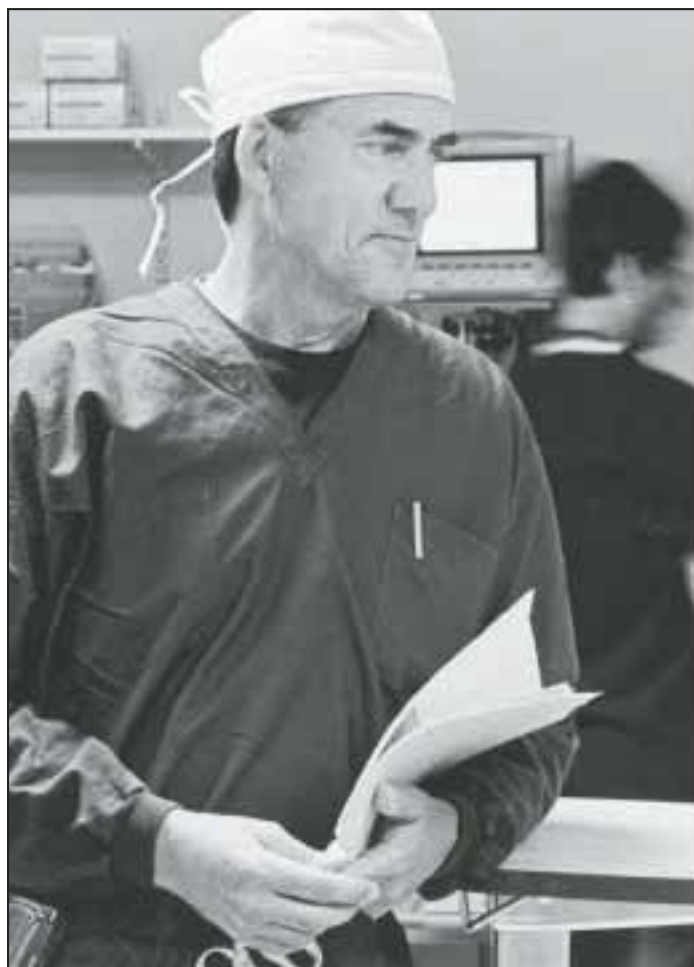
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Class B Member shall have the power to unilaterally take any and all actions required that are reasonably needed to (i) ensure that the Company as its primary objective serves community and charitable purposes; (ii) protect and promote the community benefits served by the Class B Member and to ensure that the assets and income of the Class B Member and the Company are used to serve community objectives; or (iii) maintain the tax-exempt status of the Class B Member or any of its Affiliates, including the right to unilaterally transfer the Class B Member's interests in the Company to an Affiliate. Consistent with this Section, the Class A Member(s) shall cooperate fully with the Class B Member regarding any action taken under this Section. Notwithstanding the foregoing, this Section shall not be used in any manner that would (i) cause the Center to provide a greater percentage of charitable and Medicaid care for outpatient surgical services than the Class B Member provides; (ii) amend this Agreement; (iii) provide payment of any sort to the Class B Member or an Affiliate or provide competitive advantage to the Class B Member; (iv) change the proportion of ownership; (v) require additional Capital Contributions; (vi) require personal guarantees; or (vii) take any other action that would specifically change the split of the profits and losses hereunder.

5. Non-Competition Covenant. Many operating agreements, including those used by ASCs, include limited non-competition covenants that preclude the members from owning, operating or receiving compensation from a competing venture (in the case of an ASC, a competing surgical center or, in some cases, an office-based practice that provides surgical procedures or a hospital). The covenant should specify the geographic area in which competition is prohibited and the time period during which the restrictions will apply (e.g. during membership and for one to three years thereafter).

Non-competition covenants are often limited by carve-outs and exceptions permitting the members to compete in certain specified circumstances. For example, a physician may be permitted to perform procedures at a competing surgical center as long as he or she is not an owner of the competing center and does not have any financial relationship with the center. Further, the non-competition covenant may permit a physician member to perform procedures in his or her own office (though the physician may be precluded from collecting a facility fee or site of service differential in connection with such procedures). Similarly, exceptions to the non-competition covenant may provide flexibility for

a hospital member to compete with the venture through the hospital's existing facility and any expansion thereof so long as the hospital does not participate in any venture to develop or operate a competing facility located off the hospital's main campus or in joint venture with other physicians.

6. Forced Redemption and Withdrawal.

The operating agreement should specify the events that will give rise to the venture's right to buy back a member's units. For example, breach of the agreement, failure to meet eligibility requirements, death, disability and retirement are among the events which could trigger redemption. Redemption is generally not tied to the value or volume of a member's referrals to the venture. The operating agreement should further distinguish between events that will trigger mandatory redemption of units and those that merely create an opportunity for the venture to buy back units at its option.

7. Valuation. A partnership agreement should set forth the means of valuing a member's share(s) for purposes of redemption. Using a formula amount for valuation is one common approach. The formula may be based on a multiple of EBITDA (net income before deduction of income, taxes, depreciation and amortization) multiplied by the partner's percentage ownership of the venture. Other options include using book value or obtaining an appraisal to determine the value of units upon redemption. A sample provision establishing a formula approach to valuation is as follows.

Purchase Price. If any Member's Units are purchased by the Company because of the occurrence of an Adverse Terminating Event, the amount the Company shall pay for the Units owned by such Member shall be the Formula Amount determined as of the date of the Terminating Event multiplied by the Member's Unit Proportion, discounted by forty percent (40%) (the "Adverse Purchase Price"). If any Member's Units are purchased by the Company because of the occurrence of a Non-Adverse Terminating Event, the amount the Company shall pay for the Units owned by such Member shall be the Formula Amount multiplied by the Member's Unit Proportion (the "Non-Adverse Purchase Price"). The "Formula Amount" shall mean the deemed value of the Company for purposes of redemption of a Member's ownership interest in the Company, and shall be equal to the product of a multiple (which initially shall be three (3) or four (4)) (the "Multiple") times the Company's net operating income (in accordance with generally accepted accounting principles), excluding extraordinary gains and losses, calculated


before deduction of interest, taxes, depreciation and amortization ("EBITDA"), then minus all of the Center's outstanding long term debt and long term liabilities (including equipment lease financing obligations) as of the date of the Terminating Event determined in accordance with generally accepted accounting principles.

8. Admission of New Members. An operating agreement should establish parameters governing the admission of new members. At a minimum, the agreement should specify the threshold level of member or board approval required to admit a new member. In addition, if any class of members will have the right to acquire new units to prevent dilution of its percentage of ownership as a result of the admission of one or more new members, these rights should be set forth in the operating agreement. For example, in many ventures involving physicians and a hospital or a national management company, the non-physician member agrees to dilute its ownership up to a specified maximum amount in connection with the admission of new physician members, but reserves the right to acquire additional units to prevent dilution below that specified level.

9. Dispute Resolution. Many operating agreements designate either litigation or arbitration as the method for resolving disputes among the members. Each approach has unique advantages and drawbacks. Arbitration is often quicker and more cost-effective than litigation. However, arbitration tends to lack the formality, and sometimes the professionalism, of litigation. Further, it can often be more expensive than the parties anticipate. Thus, preferences are mixed with respect to the use of arbitration or litigation to solve member disputes.

This article is intended as an overview of a few of the key legal issues facing ASCs and the essential elements of an ASC operating agreement. It does not contain an exhaustive list of the provisions that should be incorporated into an ASC operating agreement, nor does it fully address the regulatory compliance concerns that arise in connection with the development of an ASC. For further information about how your ASC can effectively resolve compliance and governance issues such as those discussed in this article, please contact Scott Becker at 312/750-6016, Ron Lundeen at 312/849-8106, or Alison Vratil Mikula at 312/750-8911. ■

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Seven Tricks of the Trade in Establishing an ASC continued from page 1

A pro forma analysis and feasibility study should also rely on sound physician data regarding projected case volumes, case mix, scheduling preferences and their expected reimbursement and for this reason it is imperative to involve the physicians in the process, says Robert Carrera, President of Pinnacle III. Physician involvement will not only ensure sound data but accomplishes two other important tasks. One, it provides a chance to inform potential partners exactly about the expectations, risks and profits, which is critical to them fully recognizing those factors, says DeHart. Second, it gives you a real opportunity to assess the physician's commitment level to the project. "The physicians' commitment to the ASC is the backbone of the operation and can enhance or detract from the ASC's success. By working with specific physicians at a preliminary stage, you will gain pertinent information about their investment history, practice, loyalty and hopefully, ultimately determine whether they truly intend to bring cases to your center," Carrera explains. A feasibility study will also account for other surrounding ASCs and the competitive risks related to them, says Southwick.

Note: Factor into your timeline a six to

eight week period to complete a comprehensive pro forma analysis and feasibility study, advises DeHart. "It can take even longer depending on the timeliness and adequacy of the physician responses," adds Southwick.

2. Assess Managed Care Contracts

As part of the feasibility study, it is important to assess all potential managed care contracts to fully characterize that revenue stream. The analysis should include looking at case mix, reimbursement rates and carve outs. Your physicians will be your main source of referrals and so you will target payors they work with and those to which their patients belong. Once potential payors have been identified, it is advised that you contact them during construction. "Securing commitments early in the process can result in having signed contracts upon the ASC's opening, a vital source of early revenue," Carrera explains. Working with a management group that has existing relationships within the managed care industry can help you secure contracts, he adds.

In addition, pay special attention to any potential barriers to payor reimbursement.

For example, plans may have exclusive arrangement with area hospitals or other ASCs or the largest managed care plan may be owned by a competing hospital. "In either case, payor contracts may be hard to obtain," says Southwick. For this reason, evaluating out-of-network reimbursement options is also essential, he adds.

3. Obtain Commitments from Active Physicians

Make sure you have an adequate number of physicians dedicated to the ASC, says Ajay Mangal, CEO of Prexus Health Partners. As mentioned above, the physicians' commitment can have a huge impact on the ASC's success. Certainly working with physicians in the preliminary phases will provide an opportunity to assess the legitimacy of their interest. "Physicians who meaningfully participate in meetings and want a full understanding of the project will generally result in active, committed partners," says Southwick. However, you may desire something more tangible. Southwick suggests having interested physicians sign a Letter of Intent (LOI) that confirms in writing their financial and service commitment to the ASC.

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While generally not legally binding, a LOI will outline the terms of the business arrangement permitting the physicians to clearly understand the terms.

Note: Work with an experienced, reputable ASC attorney when drafting LOIs to ensure their legitimacy. Also work with an experienced, reputable ASC attorney when drafting your operating agreements to ensure that they are compliant with state and federal requirements and fair to all parties, advises Mangal.

4. Do Not Overspend on Real Estate

"Don't pay too much for your dirt," advises Daly. Excited about their new venture and desiring to create a buzz, physicians may advocate for a piece of pricey commercial property on a main thoroughfare. But a visible, expensive parcel is an unnecessary cost, says Daly. "Because patients will be referred by their physicians to the ASC, it is not important that the ASC be visible in order to attract drive-by or foot traffic," he explains. This is significant because premier commercial lots can cost considerably more than otherwise equally appropriate, yet less visible, lots.

Southwick agrees and advises physicians to purchase property that is cost appropriate. "Normally a second or third tier commercial property that is level, safe, accessible to your physicians and patients and has easy parking will be sufficient," he explains. However, make sure that the less expensive land will not ultimately cost you more due to unknowns. "If the property is limited by a lack of utilities, set backs or zoning restrictions, you may end spending unbudgeted money or time to circumvent those hurdles," warns Jack Amormino, President of AMB Development Group. For this reason, Amormino suggests having the site evaluated by an experienced ASC architect to ensure that it meets the ASC's requirements. This includes performing a thorough analysis of state and municipal codes and regulations in regards health and zoning prior to purchasing the land.

Note: Have more than one real estate option available. It is not unusual for a real estate deal to fall through, so it is best to be prepared. "If the deal falls through and you have another available option, you can move forward without significant delay, saving you time and money," says Daly.

5. Do Not Overbuild

Avoid overbuilding the ASC. "The 'build it

and they will come' philosophy does not necessarily apply to ASCs. In fact, it can result in an ASC with two or more unused operating rooms or worse, either would be a costly error," says DeHart. To prevent this from happening, stick to your feasibility study as a guide. "To be fiscally responsible, the building should meet the physician's volume and specialty needs, as well as the financial parameters," explains Mangal. For example, a single specialty ophthalmology ASC where a physician sees eight patients an hour would require a larger number of operating rooms than a gastroenterology ASC

where three patients an hour would be seen. In addition, the space plan should be integrated with your staffing and equipment plans, adds Amormino. "Knowing how many technicians, nurses, schedulers, business office and administrative staff and other staff you will need, as well as your equipment requirements will dictate your space needs," he explains. For example, ophthalmologists have smaller equipment than orthopedics and thus would need less storage space, adds Daly.

On the other hand, be sure that you build to accommodate physician offices and for future growth. "Building adjoining physician offices is a smart basic business principal to satisfy physicians' needs. It may also keep them active in the ASC," says Daly. In addition, incorporating short-term growth plans established in the feasibility study may account for expansion, which can save your time and money, agrees DeHart, Mangal and Daly.

If necessary, enlist an expert's services. "Using an architectural, design and construction firm experienced with ASCs will help you align the building needs with the feasibility study," says Daly. An experienced firm will also be able to navigate

the complicated building codes and regulations, he adds. Amormino suggests specifically hiring builders with experience with multiple ASCs.

Note: Notify your state health department as soon as you know your opening date to schedule a mandated survey. "Each state has different ASC licensing requirements, however in all cases you will not want to be blind-sided by a delay, which can result in delays in operation and/or reimbursement," says Carrera. Payors may have requirements as well, so be sure to notify them and set up a survey appointment as well.

6. Hire Strong Leadership

As early as six months in advance of opening the ASC, hire a competent and experienced clinical nurse manager. By hiring someone early, you will get her or him involved early in developing policies and procedures that she or he will ultimately administer, explains DeHart. Also you will have someone prepared to immediately credential physicians, he adds.

It is important to hire an individual with a strong OR background, who is a good

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leader and has a personality that fits with your physician owners. "As the day to day manager of the ASC, the nurse manager will be guiding staff and physicians and you need to ensure from day one that there are no personality conflicts and that he or she has the ability to effectively lead and manage your staff and physicians," says DeHart.

To prevent turnover, empower and appreciate your staff leaders and staff, says Mangal. "Pay them well and profit share," he recommends.

Note: A market assessment is a critical part of the feasibility study and may affect your hiring decisions. For example, if the ASC is located in area with a nursing shortage, the ASC may need to provide a large sign-on bonus, says Southwick.

7. Establish MIS and Operational Systems Early

Early on, establish your Management Information System (MIS) and other operational systems, such as billing, materials management and marketing. As early as three months prior to your ASC's opening, set up your MIS. The MIS is the ASC's organizational backbone and when used to its full potential, can from day one support

the effective management of the ASC. If established early and populated with appropriate information, upon opening, your clinicians, front-office and management will have immediate efficiencies scheduling surgeries, billing, performing collections, case costing, taking inventory, amongst many other tasks, says Carrera.

You will also want to set up your billing office early so that you can start billing (and collecting) reimbursements from day one. "Cash collection is the ASC's lifeblood and as such you do not want any delays in billing," says Carrera. Because ASC billing can be complicated, you will want to hire billers and coders with specific ASC billing experience. You may also want to consider using an ASC-experienced centralized billing service. "A centralized billing service, like Pinnacle CBO, can provide an efficient and experienced coding and billing service. You will not have to worry about a back-up of claims and the resulting lull in payments if your billers or coders are out sick or on vacation," DeHart explains.

Additionally, managing materials and supplies from the onset will minimize operating costs. "A materials management

program developed from the beginning, and monitored afterwards, is far more likely to be successful than one that is implemented after the ASC is in operation," says Southwick. This includes standardizing by specialty such items as supplies, implants, surgical packs and equipment. It also means maximizing the use of consignment products which can save the ASC up to thirty days in cash flow, advises Carrera. A MIS can also improve material management dramatically. "Using a MIS that ensures you are adequately stocked will prevent you from overbuying and overspending," says Carrera. Once you have your inventory information populated in your MIS, you can use the system, prior to the ASC's opening to help negotiate contracts with group purchasing organizations and supply vendors, he adds.

Lastly, start marketing your ASC early on with a strong, targeted program. "While you have your core group of physician investors you should always try to attract additional business opportunities. For example, you may want other physicians for overflow business and/or for future investors," says Carrera. Part of this marketing program includes keeping apprised of new technologies in order to attract future physician investors, he adds. ■

Sources:

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An ASC Development – The Chief Financial Officer's Perspective

By John Harris

At a surgery center developer, the development team's objective is to find a transaction that will have a positive impact on the company. The CFO's job? To make sure the development team is correct.

Although the industry is maturing, CFOs see opportunities created by an aging population with a longer life expectancy. The demand and need for surgeries will grow and as technology becomes increasingly sophisticated, more and more procedures can be done at outpatient centers.

According to experts nearly one-third of ambulatory surgery centers in the U.S. break even or lose money. These underperforming centers provide additional opportunities for developers. "A lot of the low hanging fruit has been done," says Rob Westergard, CFO of Ambulatory Surgical Centers of America. "We expect in the next two or three years there will be more turnarounds."

CFOs Are Part of the Development Process

A CFO's role involves analyzing a deal and stressing the assumptions that are provided. Greg Cuniff, CFO of National Surgical Care, particularly challenges his de novo team because a new center is an unknown entity with more risk. "If a surgeon says he does 200 cases, you count 100," says Cuniff.

Each developer works a bit differently. While NSC's development takes a transaction to Cuniff for his own analysis, Regent Surgical Health's CFO, Mike Karnes, is part of the development process.

"It's collaborative," says Karnes. "Our senior executives talk through each center and each development deal. Once we think there is potential, doctor interest and a good contract environment, then I work directly with a development officer to put together financial pro forma."

Westergard explains the process as making sure development and finance have all of the facts. For example, does a big doctor say he has big number of cases but they are from his branch office 40 miles away?

Attracting a Developer

If you are searching for a developer, keep in mind the CFO's importance and expect to be asked difficult questions. A CFO's role is to be tough – and to discount your project considerably.

Cuniff's unwritten rule of thumb is to cut by half and see if the project is still viable. "You're more apt to have a project not meet expectations than an outright failure -15 to 20 percent under perform," he says. Karnes uses a similar philosophy. "We look at actual cases and then discount a third to half for our projections," says Karnes. After reviewing financial projections, the size of the community and the competition, Regent scales the center to the number of physicians involved.

Size is an important part of the formula for ASCOA as well. Westergard believes that if you can avoid being too big, having too

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much equipment and employing too many people a center has a good chance of succeeding. "Some docs are frugal," says Westergard, "and some are looking to build the Taj Mahal." The key is finding the right size for the circumstances.

The type of specialties also factor into a CFO's analysis. ASCOA, for example, avoids plastics but pursues eye, ENT, podiatry and general surgery. While pain is currently a good fit for this developer's model, Westergard thinks it is fading. Cuniff and Karnes favor multi-specialty over single-specialty centers because they bring diversification and improve new partner recruitment. "Single specialty risk profile is a lot higher. If they move reimbursement levels, you've got no leverage and no place to go," says Karnes.

Receiving a CFO's Stamp of Approval

While CFOs analyze a large amount of data using their firms' investment criteria, concentrating on a few key principles can help your search for a corporate partner.

■ Existing sources for cases

You need sufficient cases to be viable. Don't hope that the center will fill once it has been built.

■ Solid physician partners

The core physicians must be committed to the center and have a strong track record. CFOs will want to know if the doctors have commitments to a hospital or to another center and historical information about their cases.

■ Favorable payor climate

Understand your source of referrals, where cases are coming from and the external forces affecting them. Developers want enough payors to develop an in- and out-of-network strategy. One or two payors dominating and setting very low rates can raise a red flag. Both volume and reimbursement rates can be critical.

■ Location

Is something available you can lease and fix up? Do you have to take shell and core and construct a facility or start from the group up?

When a potential corporate partner does due diligence, be prepared and see your center through the critical and selective eyes of a CFO. According to Karnes, the key to a successful new development is understanding and managing realistic numbers. "If centers underestimate capital requirements and the time needed to break even, that's when they become turnarounds."

With opportunities still available in the industry, developers can be selective and minimize their risk. Cuniff says, "We need to do smart projects. It's better to pass on one good project than to do a couple of bad projects." ■



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Ask the Expert Question and Answer

Question 1: Our center desires to perform various benchmarking studies that will compare clinical quality indicators between our physicians. How do we best perform and report these studies without making our physicians potentially more vulnerable in litigation events?

Answer: The Center should examine the law of its state with respect to statutory or other protections for quality improvement efforts, peer review, and the like. The Center should also seek guidance under the Health Care Quality Improvement Act. To encourage candid introspection, and to improve the quality of care, most states do provide some form of privilege protection for documents generated by, and sometimes even supplied to, committees or other groups whose focus is upon these objectives. Privilege, however, is an exception to the general principle that a litigant is entitled to the testimony, compelled if necessary, of anyone with relevant knowledge. Courts tend to construe privileges narrowly. It is therefore important to comply with whatever procedure the law in your state provides to create and protect a privilege. Departures even in modest ways from what-

ever procedure is available in your state could damage the effort to maintain confidential the information that you want to keep to yourself. All those involved must be made aware that a privilege is often a fragile thing. Everyone participating should be enjoined to maintain confidential all that which is discussed at meetings, and all information provided to the members. Failure to maintain confidentiality in this way can often be fatal to a claim of privilege. Among other things, this means that if a report is generated, for example, it must be circulated only among those who need to know its contents. Those outside the protection of the privilege should not be permitted to see it.

Question 2: Our center has comprehensive credentialing requirements that include proctoring. If the board chooses not to credential a physician applicant because we feel they don't measure up to our standards, are we vulnerable to litigation by the applicant?

Answer: If a center does not credential an applicant but follows the requirements under the Health Care Quality Improvement Act and its own bylaws and it is not an arbitrary and capricious in its application of its requirements, the center should have a good deal of immunity to lawsuits from a physician who brings action based on the fact that he or she was not offered privileges at the

center. However, to enjoy the immunities provided by the Health Care Quality Improvement Act and the similar laws in many states, the center must meticulously follow the requirements of its bylaws and meticulously follow the requirements of the Health Care Quality Improvement Act. Here, for example, if a physician is not allowed privileges for reasons that are not based on quality, the Health Care Quality Improvement Act generally does not provide protection? ■

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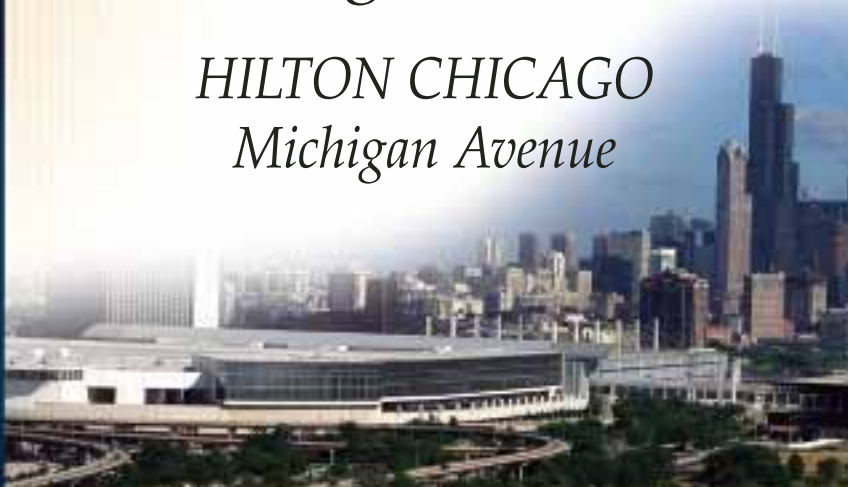
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