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ASC Review

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Establishing an ASC – The Building Blocks for Success

By Kenneth Hancock and Catherine Kowalski

The number of ASCs continues to grow as a result of the demand by the key participants in the industry – physicians, patients and payers. The high levels of patient satisfaction, physician efficiency and lower costs are all associated with this innovative model. More and more physicians are choosing to develop their own ASCs. Because development is so complex, physicians should be well-informed of all of the moving parts involved, and should learn what type of professionals they should enlist to assist them throughout the project. With the right information and the right support team in place, physicians can successfully build and own their own ASCs.

Establishing the Partnership

Number of physicians. The number of physicians (at least eight to 10 who are committed and ready to proceed) and proper planning are crucial determinants in initiating a project. A physician leader must emerge as the catalyst to drive the organization forward.

Case volume. It's vital to accurately analyze the surgical case volume. Determine the universe of surgical cases by physician and always calculate the net case transfer to the ASC, factoring in issues that discount volume including insurance contracts, regulatory, politics, convenience, scheduling and surgeon behavior. For a conservative analysis, consider 50 percent of the surgical case universe.

Specialty mix. A new ASC project must have the right mix of surgeons whether the project is single or multi-specialty. A dominant sub-specialty thread such as orthopedics, pain, ENT, ophthalmology, GI or general surgery will give the project its best opportunity for success.

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CMS Issues a Revised Proposed Payment System for Services Provided in Ambulatory Surgery Centers

By Scott Becker JD, CPA, Ron Lundeen, JD, and Gretchen Heinze, JD

The Centers for Medicare and Medicaid Services drastically changed on July 16 how ASCs will be reimbursed. Here, CMS issued a proposed rule establishing the policies for the revised payment system for ASCs, several elements of which were addressed in a final rule released the same day and published in the *Federal Register* Aug. 2.

CMS began providing reimbursement for services provided in ASCs in 1982; as of 2007, approximately 4,600 ASCs are enrolled in the Medicare program and being reimbursed for about 2,500 types of surgical procedures at the nine, prospectively determined ASC payment rate. The simple fee schedule long in place reimburses the ASC for the facility cost only; anesthesiologists, surgeons and other treating professionals are paid separately under Medicare's physician fee schedule (MPFS).

The new issuances will change how ASC facility fees will be paid to a variation of the HOPD payment system.

Summary of the Proposed Rule

The proposed rule includes several core concepts. These are summarized briefly here.

• **The revised payment rates.** The proposed and final rules set the ASC payment rates using the hospital outpatient prospective payment system (OPPS) as a guide. The core concept is to link the two payment systems so that, rather than billing pursuant to nine different ASC payment codes, ASCs will now bill pursuant to various different ambulatory payment classifications (APCs) the way hospitals do.

The revised payment rates for ASCs are expected to be set at approximately 65 percent of the comparable payment rates for hospital outpatient services. Because of the annual inflation adjustment to hospital outpatient department rates, the payment rate for ASCs for 2008 will approximate 67 percent of the corresponding payment rates for HOPD services. Going forward, the inflationary adjustment for ASC rates is slightly different than the inflationary adjustment for HOPD rates.

• **Timing and implementation of the proposed rule.** The revisions set forth in the proposed and final rules will be implemented in January. The ASC payment rates will be implemented over a four-year period. Throughout 2007, 100 percent of all payments to ASCs will be based on the existing ASC payment rates; in 2008, 25 percent of total payments will be based on the new payment system and 75 percent on the old payment rate; in 2009, it will be a blended 50-50 rate; in 2010, 75 percent of payments will be based on the new payment system and 25 percent on the old; and, finally, in 2011, the conversion will be complete and all payments will be based on the new APC structure.

• **New procedures eligible for payment in ASCs.** The new payment system will also add approximately 700 new procedures eligible for payment when performed in an ASC. However, many of the newly eligible ASC procedures are simple procedures currently performed in physician offices. To ensure physicians and ASCs do not have an incentive to move these simple procedures to ASCs for higher reimbursements, physicians won't receive a site-of-service differential when performing these procedures in the ASC setting. Instead, an ASC will be paid at the lesser of the ASC rate or what is called

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INSIDE

See Improving ASC Profits conference brochure on page 19.

Letter from the Editor

RE: CMS Proposed Final Payment Rule; Physician Ownership of Hospitals; Stock Market Challenges

The past 30 to 60 days have been extremely challenging for entrepreneurial healthcare and for ASCs. First, there was the release of the proposed final rule and payment plan for ASCs. Second, the House of Representatives, as part of the SCHIP bill, included language that would eliminate physician ownership of hospitals and grandfather in only existing hospitals as of the legislation's introductory date. In other words, there would be no grandfathering for hospitals under construction. Third, the stock market has finally started to falter a bit. This has resulted from an excess use of leverage in different parts of the economy. Each of these things ultimately has a negative impact on entrepreneurial healthcare.

Typically, after a relatively negative cycle, the tide starts to turn. This usually ends up creating an abundance of opportunities in the healthcare business marketplace. We would expect for those who are paying close attention that those challenges may lead, in the next 12 to 18 months, to provide that kind of opportunity.

This issue of *Becker's ASC Review* covers a variety of interesting issues, including an article on building a surgery center, an article related to amending an operating agreement, discussion of the Stark Act and a discussion of the CMS proposed and final rules for surgery centers.

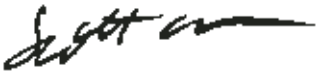
We are expecting an exceptional event on improving profitability for ASCs at our 14th Annual Fall Conference, held Oct. 18 to 20 in Chicago. The conference will be held in connection with FASA. We expect outstanding attendance, and it is at the terrific Westin Hotel. Visit www.Beckersasc.com for a brochure. Call (703) 836-5904 to register. Attendance is limited; exhibit space is fully sold out.

The *Becker's ASC Review* has taken another step toward significant improvement over the last few issues. We are delighted with the way in which both readers and advertisers have taken to the *Becker's ASC Review*. We are seeing an increase in advertising in large part due to the increase in the professionalism of the efforts. We are extremely thankful to our advertisers, which includes a broad mix of companies that supply different products and equipment to surgery centers, and financial services as well as finance and development firms. It is truly an exceptional group. Should you have an interest in ever advertising in the *ASC Review*, please contact me at (800) 417-2035 and we would be delighted to put you in touch with the right representative; or feel free to directly contact Grace Boyles at Blue House at (202) 337-5739 or grace@bluehouse.us, or Jessica Cole at (312) 505-9387 or jessica@beckerasc.com.

ASC Communications is in the process of examining and adding special issues as well as looking at additional market niches, including items relative to a publication for ortho-spine medical devices and a publication for hospitals. Should you have an interest or feedback on the concepts behind either of these publications please feel free to contact me at (312) 750-6016.

We look forward to speaking with you shortly.

Very truly yours,



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The *ASC Review* is published six times per year. It is distributed to approximately 20,000 persons per issue.

Letter from the Editor

RE: Issues Small and Large With the ASC Payment System

So CMS finally issued the final ASC payment system ruling July 19 (along with a companion proposed rule, just to keep the industry on its toes). Based on some of the fallout, it's easy to think the end is nigh.

The American College of Gastroenterology, for example, immediately hit back, pronouncing the final rule a "death blow" for GI ASCs. "These unfair and arbitrary cuts to reimbursement for endoscopic procedures performed in the ambulatory setting…creates a profound and disproportionate negative impact on GI ASCs," the ACG says.

Now it's true that the national average payment for diagnostic colonoscopy in a GI ASC will gradually drop from $446 in 2007 to $373.04 in 2011, when the payment system is fully implemented. And more power to the ACG for promising to "explore all possible avenues, both regulatory and legislative," to further improve the rule. Quite a few aspects of the rule could use remedying, after all.

But the situation need not be – and, indeed, it is not – dire. To take a phrase on loan from the terrific (and, regrettably, late) Douglas Adams, don't panic.

"You really need to look at all your payers and not just Medicare in determining what will be the real impact on your center," says John Poisson, the executive vice president at Physicians Endoscopy, which works with the same GI facilities seemingly doomed by the ACG. "When we do that calculation, not taking into account payment increases from non-governmental payers over the next couple years, we're seeing an impact of only about 1 percent per year average reimbursement per procedure."

Mr. Poisson says, that, for a center that does 11,000 procedures (34 percent of them being Medicare and commercial Medicare patients), the bottom-line impact is only $60,000.

"That's only three endoscopes in the grand scheme of things," he notes. "Reimbursement is clearly going down. But you can't look at it in a vacuum; if you integrate Medicare payments with the rest of your payer mix, the situation is not nearly as Draconian as has been broadcasted."

On the micro-level, then, things might not be so terrible. So what about the big picture?

"If you had asked people, 'If you get 3 percent beyond what CMS proposed, would you be happy?' most would have said yes," says Kathy Bryant, JD, the executive director of FASA. "We shouldn't underestimate what an achievement it was for the industry to go from 62 to 65 percent of HOPD rates. In most cases, where CMS made a change [between last fall's proposed rule and the final rule], it made a change in the right direction, which says to me that the ASC industry was doing a great job of getting its message out there.

"In no case did it go backward from what was initially proposed."

Further, CMS expanded the list of procedures that may be performed in the ASC setting, and mandated a four-year phase-in for the new system, giving everyone enough time to adjust.

"Other good things that are coming out of this final rule are the stability and predictability of payment that should improve over the relative uncertainty of inflation updates and coverage changes over the past decade," says Craig Jeffries, Esq., the executive director of AAASC. "In that respect, [this is] very positive."

Again, that's not to say some aspects of the rule weren't disappointing or aren't in need of improvement.

"The absolute biggest disappointment is the percentage," says Ms. Bryant. "We showed them how they could be budget-neutral at 73. I've spent nine years of my life on this; driving home [the night after the rule was announced], that was my reaction: For this huge portion of my life, I've accomplished 3 percentage points.

"And in terms of the savings and providing access, 65 just doesn't cut it."

Further, ASCs' inflation updates will be based on a different price index than HOPDs', a move that Ms. Bryant succinctly and accurately says "makes no sense." Essentially, in the first year, ASCs will get 65 percent of hospital rates for procedures performed on Medicare patients — but a different percentage in ensuing years because different data was used to calculate the inflation updates. AAASC and FASA intend to address this in their comments on the proposed rule.

"Nothing's set in stone yet," says Nancy McCann, the director of government relations for the American Society of Cataract and Refractive Surgery. "It's going to be an interesting couple of months."

Regardless of how it all turns out, there's no time to panic; you've got to start preparing for best- and worst-case scenarios.

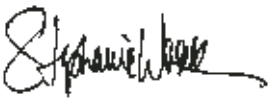
"You have to ask, 'What's the potential business opportunity?'" says Bill Southwick, the president and CEO of HealthMark Partners. "You'll be able to do more orthopedic Medicare patients; the new procedure list no longer hamstrings the ability to work with general surgeons; urology is expanding a little bit; and we're pleased to see the expansion and increase in GYN procedures. You can make an interesting discussion now for vascular and retina work as well.

"Basically, it's going to double your work, but life in the surgery center business gets more complicated every year."

You're in it for the long haul – where "some changes are inevitably going to be right, and some are going to be wrong," says Mr. Southwick – and that necessitates looking at the big picture, as cliché as it is, as much as possible.

"They always say, and this is perhaps hard for ASCs right now: Politics is the art of the possible, not the perfect," says Ms. Bryant. "And rarely does anyone get what they think is the appropriate result."

For an in-depth take, see the analysis by Scott Becker, Ron Lundeen and Gretchen Heinze, "CMS Issues a Revised Proposed Payment System for Services in Ambulatory Surgery Centers," on p. 1. Get even more – payment calculations, final and proposed rule analysis, conference information, ways to make your voice heard – at www.AAASC.org and www.FASA.org.



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Reimbursement. It is imperative that you have a plan for reimbursement and insurance contracting before starting construction of the facility. The business may have a strong number of surgical cases but if you cannot get paid for the work performed, it is a potentially devastating blow to cash collections.

Partnership Formation

Syndication. Seek appropriate legal counsel to best determine the process for syndication, the binding of the partnership. A private placement memorandum will describe the project in detail covering all aspects of the business including the strategic plan, financial projections, project scope, operating agreement, management agreement, development agreement, and investment opportunity and risks associated with the investment. Depending on the size of the partnership, legal counsel may advise hiring a securities group to properly syndicate the transaction.

Partnership options. Seek legal counsel to guide the partnership in selecting the appropriate legal structure such as a limited liability company or limited partnership.

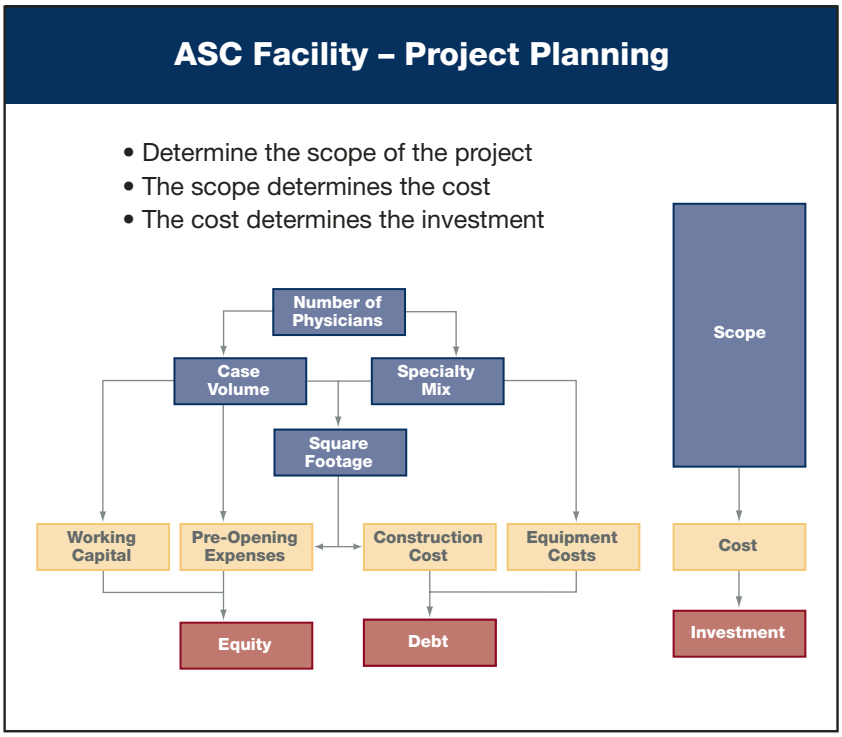
Types of ownership. Physicians may own ASCs entirely or may partner with a hospital or corporation in some combination. There are positives and negatives to consider with all approaches:

- **All-physician.** Physicians are busy being physicians and their administrators are busy running practices, so who develops and operates the ASC? Physicians will often hire consultants to navigate development and initial setup. A drawback of consultants is that, once the ASC is operational, they move on, leaving the physicians to find dedicated management or run the facility themselves.

- **Hospital and physician.** The overarching benefit of this model is that you have a partner with whom to share the risk: The community hospital usually has capital and is able to secure insurance contracts at attractive rates. The challenge is that many physicians simply don't trust hospital management, so the trust factor must be weighed when diluting ownership, because most hospitals want a structure that allows the hospital majority ownership in the ASC. According to 2004 data, hospitals have ownership interest in 21 percent of all ASCs.[1]

- **Corporation and physician.** There are approximately 30 companies in the business of partnering with physicians to develop, own and manage surgery centers. Of the 4,500 Medicare-certified ASCs operating in the United States, only 837, or less than 20 percent, are owned and managed by multi-facility chains.[2] In this model, physicians benefit from having a strong capital partner to ensure their return on investment is based on the success of an excellent plan and well-run business. Corporate partners have experience recruiting, budgeting, financial analysis, human resources, technology, clinical benchmarking and marketing, which can let physicians focus on surgery instead of on the business. The aligned incentives of ownership work well in many partnerships.

- **Three-way partnership.** Popularized by USPI and Baylor, this model combines the interests of physicians, hospital and a corporate partner. The advantage of this model is that the two parties that typically don't trust each other have an independent partner to operate the business in everyone's best interests. This model can eliminate tension between the physicians and hospital, adds a strong capital partner and provides the ASC with insurance contracts. Meanwhile, the day-to-day operations are driven by an independent corporate partner and access to hospital volumes is strong. The caveat is the hospital must have evolved its strategy to the point that allows such a joint-venture.



Defining Project Scope

Here are some of the critical points related to the cost of a project and the investments required.

- **Project scope.** Be careful to not overbuild a facility beyond its capacity – it's perhaps the No. 1 reason for failure. It's easy to overbuild, which creates undue stress on the financial performance of the ASC. It's better to under-build initially and plan future expansion.

- **Surgical case volume.** What is the net projected case count of all procedure types? This information defines the scope of the facility and determines the net revenue.

- **Equity.** Ensure that enough cash is committed to the project; a lack of cash in the crucial start-up phase is a common problem. It's easy to miscalculate cash needs and be forced to initiate capital calls from the partnership to meet cash needs in the first 12 months to keep the project running.

- **Debt.** Obtain a commitment for financing before starting the project. Rates may vary between sources, so shop around. Non-recourse financing is always contingent on the strength of the financial projections for the business, the number of committed physician partners, the equity raised by the partners, the business plan, and the experience level of the partners, management and likelihood of successful execution. Expect guarantees on tenant improvements and equipment, and try to negotiate a structure that eliminates guarantees after cash flow objectives are met in the first 24 months.

- **Cost to build.** Usually running about $1 million per OR, a small, single-specialty center with two surgical suites ranges from $2 million to $3 million, with larger-multispecialty ASCs costing $4 million to $8 million. Typically, the majority of the costs associated with development, including the tenant improvements and surgical equipment may be leveraged with debt. The need for equity is isolated to working capital – typically four to eight months'

operating expenses totaling $1 million to $1.5 million. The investment ranges from $10,000 to $15,000 for a 1 percent interest in the partnership plus assumption of pro-rata debt dependent on debt structure.

Real Estate

Consider a real estate partnership separate from the operating entity, as this affords the partnership another investment opportunity and eliminates costs that would be capitalized by the operating entity. The real estate partnership becomes the landlord – capturing land improvements, shell building and a tenant improvement allowance of $40 per square foot – and structures an operating lease with the operating entity. The real estate investors may be the same or different partners from the operating entity; they will receive a fair market value return and may someday take advantage of appreciation in the real estate asset by selling the entity.

Financing

It's vital that you detail the amount of capital required to successfully deliver the facility and run operations for five years, including costs associated with real estate, construction, equipment and working capital.

• **Real estate.** The real estate entity is responsible for the land purchase and improvements such as site grading, water, sewer, fees and permits. In addition, this entity is responsible for the shell building, which typically costs $60 to $80 per square foot and provides some allowance for tenant improvements, usually $20 to $40 per square foot. The real estate partnership will execute a fair market value lease with the operating entity, typically with a 10-year term that covers the investment plus a reasonable return on investment.

• **Equipment costs.** It's well worth the fees to seek an equipment planning professional or firm with significant ASC experience to properly plan, select, warehouse and install the equipment. Plan to spend between $450,000 and $600,000 per OR for all equipment needs.

• **Working capital.** Don't go into a project without enough cash. It's important to have four to eight months of operating expenses covered. This need is established in the budget but typically ranges from $1 to $1.5 million dollars in cash available to cover the initial start-up and ramp-up of the business.

A proper plan lets the partnership leverage the tenant improvements and equipment with debt, but must invest cash to cover the working capital needed pre- and post-opening. There are plenty of banks and specialty ASC financers; be sure to use one familiar with the needs of the physician ownership model.

Construction

Work with an architect who has significant experience in designing ASCs. Check references and one or two centers in the architect's portfolio. An experienced architect will be know mechanical, electrical and plumbing design engineers necessary to properly designing a facility. The real estate partnership chooses the contractor to construct the shell building. The construction firm should also have significant ASC experience. Check references and the experience level of the project manager; this is not a time for rookies.

Operations

Develop a detailed pre-opening checklist that includes all milestones, specific tasks, completion dates and accountability assignments to team members.

• **Human resources/staffing.** Build a ramp-up strategy around volume to help manage labor costs during start-up. Bring on the administrator or top tier employees early to assist with the growing task list, adding other employees as opening approaches. Design initial staffing around a condensed schedule, opening only

enough days to accommodate early volume, then expand to run a full schedule as volume dictates. The best way to manage early and ongoing labor costs is to establish a plan to staff the appropriately-sized facility to accommodate anticipated volume.

• **Licensing.** Early planning is your best friend. Gather appropriate information from all investors during the initial stage and submitting all your licensing applications promptly will help eliminate any last minute delays. When applicable, many ASCs choose to obtain deemed status through the Joint Commission or AAAHC while waiting for the state to complete their survey.

• **Managed care.** Knowing which contracts to establish and successfully negotiating these contracts are key to ensuring your ASC receives the best reimbursements possible. Vital strategies include establishing a relationship with your main contact, anticipating your costs and consistently negotiating. Plan carefully, be persistent, understand your leverage and don't be afraid to tout the ASC's benefits (such as lower costs and high quality/reputations of physicians).

• **Supply costs and management.** A strong GPO/supplier relationship will ensure your ASC opens and operates with the necessary inventory. Define your process around procedure standardization and utilization of a preference card system to make supply cost management easier and more effective.

• **IT systems.** Determine ahead of time the data points you want to retrieve from an IT system so you can ensure appropriate utilization. Carefully review the support history of products you're considering and talk candidly with other clients using the different systems. The system you choose must be user-friendly and provide data lets you track performance.

• **Measurement of performance.** To know if your ASC is running efficiently, you need to collect solid data, then analyze it based on your targets. Develop benchmarks based on your budget, industry averages or historical data from your management company. Consistently track your progress in labor costs per case, staffing hours per case, supply cost per case and days in A/R.

As the certificate of occupancy date approaches, the number of items to be completed frequently becomes cumbersome, so having a plan helps eliminate unnecessary and costly last-minute delays. There are six key operations to focus on after opening.

Successful Development

Developing and owning an ASC requires commitment, capital and a comprehensive plan. By understanding all the building blocks to success, physicians can better set and meet their expectations and achieve their ultimate goal of ASC ownership. ■

Mr. Hancock is the president and chief development officer of Meridian Surgical Partners and Ms. Kowalski is the executive vice president and chief operating officer of Meridian.

Sources:
1. *2004 ASC Salary and Benefits Survey*, Federated Ambulatory Surgery Association, 2004.
2. Informed Healthcare Media, LLC, 2006.

See conference brochure on page 19.

CMS Issues a Revised Proposed Payment System For Services Provided In Ambulatory Surgery Centers **(continued from page 1)**

the MPFS non-facility practice expense (PE) amount. In essence, Medicare will pay the lesser of the true ASC payment rate or the site-of-service differential or facility payment that a physician would have received.

• **ASC payment for device-intensive procedures.** The proposed rule provides a change in payment for certain high-cost devices. A device is deemed high-cost if its cost is more than half of the median cost of the procedure. Under the proposed rule, an ASC will be paid the full amount for the device, just as hospitals are paid pursuant the HOPD rate. Therefore, the ASC will receive 100 percent of the corresponding HOPD rate for the device cost. CMS has also proposed a lower payment to the ASC when the cost of the device is less than half the cost of the procedure. Here, the ASC will receive some reimbursement for some, but not all, of the cost of the device.

• **Ancillary services.** Many services currently provided in an ASC are considered Stark services and are not separately payable. Under the final rule, some ancillary procedures provided before, during or immediately after a surgical procedure will now be eligible for separate payment when furnished in an ASC. They include radiology services, drugs and biological services separately payable under the OPPS, devices eligible for pass-through payment under the OPPS, brachytherapy services and corneal tissue acquisition. Under the final rule, only an ASC may seek payment for these services; physicians may not bill for the non-facility component under the MPFS. Additionally, Medicare will pay separately for all drugs and biologicals currently separately paid under the OPPS when they're provided as part of covered surgical procedures.

• **Physician billing.** Currently, if a procedure is not on the ASC list, a physician may perform the procedure in an ASC and receive both the normal physician service component as well as the higher, non-facility PE amount. Pursuant to the proposed rule, a physician will receive a payment as though he or she performed the services in the facility that receives payment. The intent here is to ensure that a physician does not receive an extra payment for providing a service when the surgery center itself is receiving a facility payment for that service.

• **Overview of CMS view of rates.** CMS has commented that its intent in changing the ASC payment system is to encourage ASC operators to adjust the mix of procedures performed in ASCs. By a redistribution of ASC payments, CMS plans to more aggressively shift certain procedures to ASCs. Here's what CMS has to say:

> We believe the revised ASC payment system represents a major stride towards encouraging greater efficiency in ASCs and promoting a significant increase in the breadth of surgical procedures performed in ASCs, because it more appropriately distributes payments across the entire spectrum of covered surgical procedures, based on a coherent system of relative payment weights that are related to the clinical and facility resource characteristics of those procedures.
>
> […] As a result of the redistribution of payments across the expanded breadth of surgical procedures for which Medicare will provide an ASC payment, we believe that ASCs may change the mix of services they provide over the next several years. The revised ASC payment system should encourage ASCs to expand their service mix beyond the handful of the highest paying procedures which comprise the majority of ASC utilization under the existing ASC payment system. […] [W]e believe that under the revised ASC payment system, each ASC has the opportunity to adapt to the payment decrease for its most frequently performed procedures by offering an increased breadth of procedures, still within the clinical specialty area, and receive payments that are adequate to support continued operations.
>
> […] For those procedures that will be paid a significantly lower amount under the revised payment system than they are currently paid, we believe that their current payment rates, which are closer to the OPPS payment rates than other ASC procedures, are likely to be generous relative to ASC costs, so ASCs would, in all likelihood, continue performing those procedures under the revised payment system.

[…] We estimate that payments for most of the highest volume colonoscopy and upper gastrointestinal endoscopy procedures will decrease under the revised payment system. In fact, payment decreases also are expected for the gastrointestinal surgical specialty group overall. We believe that decreased payments for so many of the gastrointestinal procedures are because current ASC payment rates are close to the OPPS rates. Procedures with current payment rates that are nearly as high as their OPPS rates are affected more negatively under the revised payment system than procedures for which ASC rates have historically been much lower than the comparable OPPS rates. The payment decreases expected in the first year under the revised ASC payment system for some of the high volume gastrointestinal procedures are not large (all less than 7 percent). We believe that ASCs can generally continue to cover their costs for these procedures, and that ASCs specializing in providing those services will be able to adapt their business practices and case mix to manage declines for individual procedures.

In CY 2008, we also are adding hundreds of surgical procedures to the already extensive list of procedures for which Medicare allows payment to ASCs, creating new opportunities for ASCs to expand their range of covered surgical procedures. For the first time, ASCs will be paid separately for covered ancillary services that are integral to covered surgical procedures, including certain radiology procedures, costly drugs and biologicals, devices with pass-through status under the OPPS, and brachytherapy sources.[1]

Detailed Discussion of Proposed Rule

Here is a more extensive discussion of some of the key concepts summarized above.

• **Surgical procedures covered under the revised ASC payment system.** The new rules for ASC payments more broadly define what is included on the list of procedures that may be reimbursed when performed in an ASC and, thus, which will be performed there. Generally, any procedure on the OPPS Outpatient Surgical Procedures List is eligible for payment if performed in an ASC. The ASC procedure list excludes procedures on the OPPS inpatient list as well as procedures expected to require active medical monitoring and care at night after the procedure – that is, procedures requiring an overnight stay. In addition, the ASC procedure list excludes any procedures that pose a significant risk to a Medicare patient. The final rule defines "covered surgical procedures" as follows:

(a) *Covered surgical procedures.* Effective for services furnished on or after January 1, 2008, covered surgical procedures are those procedures that meet the general standards described in paragraph (b) of this section (whether commonly furnished in an ASC or a physician's office) and are not excluded under paragraph (c) of this section.

(b) *General standards.* Subject to the exclusions in paragraph (c) of this section, covered surgical procedures are surgical procedures specified by the Secretary and published in the *Federal Register* that are separately paid under the OPPS, that would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

(c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical procedures that –

(1) Generally result in extensive blood loss;

(2) Require major or prolonged invasion of body cavities;

(3) Directly involve major blood vessels;

(4) Are generally emergent or lifethreatening in nature;

(5) Commonly require systemic thrombolytic therapy;

(6) Are designated as requiring inpatient care under § 419.22(n) of this subchapter;

(7) Can only be reported using a CPT unlisted surgical procedure code; or

(8) Are otherwise excluded under §411.15 of this subchapter.[2]

• Inflationary updates. The ASC conversion factor for the revised payment system will include an inflationary update based on the percentage increase in the Consumer Price Index for all Urban Consumers (U.S. city average) as estimated beginning in the calendar year 2010. However, this inflationary update may be smaller than the hospital inflationary update, and CMS reserves the right to review this update if it leads to more inflation than expended.

• Office-based procedures. The new payment rate system adds a significant number of office-based procedures to the ASC procedure list. However, the payment rate for these procedures is not generous; it is capped for office-based surgical procedures at the lesser of the MPFS non-facility PE amount or the ASC rate developed according to the standards of the revised ASC payment system. Further, if an ASC bills a facility fee, the practice physician is not entitled to also bill for a non-facility PE amount. ASCs will be eligible for payment for such services beginning in 2008.

• Device-intensive procedures. The new payment rate includes a specific payment rate and rule for device-intensive procedures, long viewed as a challenging issue for ASCs. CMS has stated the following in the proposed rule:

> Under the final policy of the revised ASC payment system, we use a modified payment methodology to establish the ASC payment rates for device-intensive procedures. We identify device-intensive procedures as covered surgical procedures that, under the OPPS, are assigned to those device-dependent APCs for which the "device offset percentage" is greater than 50 percent of the APC's median cost. The device offset percentage is our best estimate of the percentage of device cost that is included in an APC payment under the OPPS. The CY 2008 proposed device-dependent APCs and device offset percentages are discussed in section IV.A. of this proposed rule.
>
> According to the final ASC policy, payment for implantable devices is packaged into payment for the covered surgical procedures, but we utilize a modified ASC methodology based on OPPS data to establish payment rates for the device-intensive procedures under the revised ASC payment system.
>
> […] We also reduce the amount of payment made to ASCs for device-intensive procedures assigned to certain OPPS APCs in those cases in which the necessary device is furnished without cost to the ASC or the beneficiary, or with a full credit for the cost of the device being replaced. A full discussion of that policy may be found in section XVI.F. of this proposed rule.[3]

An example of this calculation is provided in the final rule for insertion of a cochlear implant, CPT code 69930 (Cochlear device implantation, with or without mastoidectomy), as follows:

OPPS CY 2007 national unadjusted payment rate	$25,499.72
OPPS CY 2007 device offset percent	84.61%
OPPS/ASC device portion	$21,575.31 ($25,499.72 x 0.8461)
OPPS service portion	$3,924.41
OPPS relative payment weight attributable to service (OPPS service portion divided by estimated CY 2008 OPPS conversion factor)	61.8047 ($3,924.41/63.497)
ASC service portion (OPPS relative payment weight for service portion multiplied by estimated CY 2008 ASC conversion factor)	$2,629.36 (61.8047 x $42.543)
CY 2007 ASC payment (without device payment) ASC service payment	$995 $1,403.59 (0.25 x $2,629.36) + (0.75 x $995)
Estimated CY 2008 ASC total payment (sum of service payment and device payment)	$22,978.90 ($1,403.59 + $21,575.31)[4]

• Multiple and interrupted procedures. Under the final rule, payments may be discounted if multiple procedures are performed in an ASC as part of a single case. However, certain procedures will not be subject to this discount, as CMS explains:

> Specifically, when more than one covered surgical procedure is provided by an ASC in a single operative session to a Medicare beneficiary, the procedure with the highest ASC payment rate would be paid 100 percent of the ASC payment amount, and ASC payments for any other surgical procedures not expressly exempt from the discounting policy would be reduced by half. Certain ASC covered surgical procedures with relatively high fixed costs would be specifically exempt from the ASC multiple procedure discounting policy, consistent with the current OPPS multiple procedure discounting policy for those surgical procedures assigned to a status indicator other than "T" under the OPPS. We […] further believe that adopting an ASC policy that parallels the OPPS discounting policy would assist in timely and coordinated updates to the multiple procedure discounting status of services payable under both payment systems.[5]

Furthermore, the final rule proposes an additional limitation on payments made for interrupted procedures, clarified by CMS as follows:

> [W]e are clarifying here the payment policies for interrupted procedures in ASCs. First, procedures requiring anesthesia that are terminated after the patient has been prepared for surgery and taken to the operating room but before the administration of anesthesia will be reported with modifier 73, and the ASC payment for the covered surgical procedure will be reduced by 50 percent. Second, procedures and services not requiring anesthesia that are partially reduced or discontinued at the physician's discretion will be reported with modifier 52, and the ASC payment for the covered surgical procedure or covered ancillary service will be reduced by 50 percent. Third, procedures requiring anesthesia that are terminated after the administration of anesthesia or the initiation of the procedure will be reported with modifier 74, and the full ASC payment for the covered surgical procedure will be provided.[6]

• Transition to revised payment rates. The revised payment rates will take effect over four years. ASCs will benefit from this longer phase-in with respect to procedures reimbursed at a rate that is higher than the OPPS and will be disadvantaged by this phase-in with respect to procedures that are currently reimbursed at a rate which is lower than 65 percent of the current OPPS.

> We believe a transition period of 4 years, comparable to transition periods provided under other payment systems (for example, the recent practice expense changes to the MPFS) and as suggested in comments concerning this issue, will provide a reasonable and balanced approach to implementation that addresses two important objectives, in particular offering sufficient notice and time for ASCs to adapt to the revised payment system and providing more accurate and appropriate ASC payments for covered surgical procedures. The contribution of CY 2007 ASC payment rates to the blended transitional rates will decrease by 25 percentage point increments each year of transitional payment, until CY 2011, when we will fully implement the ASC payment rates calculated under the final methodology of the revised payment system.[7]

Procedures new to ASC payment for 2008 or later calendar years, including device-intensive procedures added to the ASC procedure list in 2008 or later, receive payments determined according to the final methodology of the revised ASC payment system, without a transition.

The transitioned payments provide for a smaller impact on payments for ASC services in 2008, as illustrated by this table showing ASC payments broken down by surgical specialty group. This is an at-a-glance look at the impact of the revised payment system on estimated aggregate calendar year 2008 Medicare program payments under the 75/25 transition blend and without a transition.

Estimated Impact of the New ASC Payment System[8]

Surgical Specialty Group	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change with transition (75/25 blend)	Estimated CY 2008 percent change without transition (fully implemented)
Eye and ocular adnexa	$1,365	1	5
Digestive system	721	-4	-15
Nervous system	274	2	-5
Musculoskeletal system	167	24	97
Integumentary system	85	4	15
Genitourinary system	76	10	38
Respiratory system	23	16	65
Cardiovascular system	8	25	95
Auditory system	4	30	85
Hemic and lymphatic systems	2	28	110
Other systems	0.1	19	75

• **Ancillary services.** Under the new rules, certain ancillary services will be billable when performed in the ASC. This will require an adjustment to the Stark Act and will let ASCs bill for certain procedures that they were previously prohibited from billing for.

> [U]nder the final policy of the revised ASC payment system, covered ancillary services that are integral to a covered ASC surgical procedure will be allowed separate payment. These covered ancillary services, which are outside of the scope of ASC facility services defined at § 416.2 and described at new § 416.164(a) for which payment is packaged into the ASC payment for covered surgical procedures, are defined at § 416.2 and described at new § 416.164(b) as follows: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced (payment rate is determined by the Medicare contractor) including, but not limited to, the procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS. […]
>
> We will consider to be outside the scope of ASC services, as set forth in § 416.164(c), the following items and services, including, but not limited to: physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician); anesthetists' services; radiology services (other than those integral to performance of a covered surgical procedure); diagnostic procedures (other than those directly related to performance of a covered surgical procedure); ambulance services; leg, arm, back, and neck braces other than those that serve the function of a cast or splint; artificial limbs; and nonimplantable prosthetic devices and DME.[9]

The new ancillary services rule includes certain separate payments for radiology services, certain types of brachytherapy services related to implant of the needle during brachytherapy, and certain other services. Regarding radiology services, CMS commented that its incentive was to properly reimburse ASCs for these ancillary procedures without shifting these services from physician offices or independent diagnostic testing facilities (IDTFs) to ASCs:

> We will, therefore, provide separate payment to ASCs for certain ancillary radiology services

when they are integral to the performance of a covered surgical procedure billed by the ASC on the same day, provided that separate payment for the radiology service would be made under the OPPS.

We specify that a radiology service is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is performed in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Based on our analysis of the OPPS data, we believe that, in most cases, a radiology service that is separately payable under the OPPS that is performed in the ASC on the same day as a covered surgical procedure will be provided integral to a covered surgical procedure, and the ASC will be able to receive separate payment for the service as a covered ancillary service. The separate ASC payments for these radiology services will be made at the lower of: (1) The amount calculated according to the standard methodology of the revised ASC payment system; or (2) the MPFS nonfacility practice expense amount for the service (specifically, for the technical component (TC) if the service's HCPCS code is assigned a TC under the MPFS). This is similar to our final payment policy for covered office-based surgical procedures added to the ASC list in CY 2008 or later years. Payment for the costs of the facility resources associated with the radiology service would have been made to IDTFs under the existing ASC payment system at the MPFS nonfacility practice expense amount. Therefore, we believe the revised payment system beginning January 1, 2008, will both ensure appropriate and equitable payment for covered ancillary radiology services integral to covered surgical procedures and not provide a payment incentive for migration of services from physicians' offices or IDTFs to ASCs.[10]

CMS also commented on separate payments to ASCs for brachytherapy services:

> Based on the comments received and our review of the issue, we have concluded that the most appropriate policy under the revised ASC payment system is to provide separate payment to ASCs for the brachytherapy sources as covered ancillary services implanted in conjunction with covered surgical procedures billed by ASCs. Further, as evidenced by our decisions regarding payment for other covered ancillary services under the CY 2008 revised ASC payment system, our intention is to maintain consistent payment and packaging policies across HOPD and ASC settings for covered ancillary services that are integral to covered surgical procedures performed in ASCs. Therefore, consistent with our policy to pay separately for some drugs, biologicals, and radiology services as covered ancillary services, we also believe that adopting a payment policy consistent with the OPPS for payment of brachytherapy sources is reasonable and appropriate to ensure that the comprehensive brachytherapy service can be provided by ASCs. The application of the brachytherapy sources is integrally related to the surgical procedures for insertion of brachytherapy needles and catheters, which are appropriate for performance in ASCs. There is a statutory requirement that the OPPS establish separate payment groups for brachytherapy sources related to their number, radioisotope, and radioactive intensity, as well as for stranded and non-stranded sources as of July 1, 2007, OPPS procedure payments do not include payment for brachytherapy sources. We agree with both MedPAC and the PPAC that consistent payment bundles between the two payment systems are desirable. Therefore, under the revised ASC payment system, we will pay ASCs separately for brachytherapy sources when they are provided in association with a surgical procedure not excluded from ASC payment and billed by the ASC on the same day. The ASC brachytherapy source payment rate for a given calendar year will be the same as the OPPS payment rate for that year or, if specific OPPS prospective payment rates are unavailable, ASC payments for brachytherapy sources will be contractor-priced. The ASC brachytherapy source payment rate will be established at its OPPS payment rate, without application of the ASC budget neutrality adjustment factor to the OPPS conversion factor. In addition, consistent with the payment of brachytherapy sources under the OPPS, the ASC payment rates for brachytherapy sources will not be adjusted for geographic wage differences. Because brachytherapy sources are implantable devices with relatively fixed costs for which we would not expect efficiencies that would permit ASCs to acquire them at lower costs than HOPDs, we believe it is most appropriate to pay for the brachytherapy sources at the same rates as the OPPS if possible.[11]

The new payment system also provides extensive reimbursement for certain drugs and biologicals and certain medical devices, as outlined by CMS:

> [W]e believe that the significant expansion of the procedures eligible for payment under the revised ASC payment system, in addition to evolving

surgical practice, may necessitate the use of different drugs and biologicals in ASCs in the future. To ensure appropriate access to all surgical procedures that are safe for performance in ASCs, we believe it is prudent under the revised ASC payment system to provide separate payment in the ASC setting for drugs and biologicals that are integral to covered surgical procedures for which the ASC is billing, when the costs of those drugs and biologicals were not included in developing the base procedure payment weights under the OPPS. We do not believe it would be appropriate to select only a subset of these drugs and biologicals that are separately payable under the OPPS because we do not see a clear rationale for doing so.

We specify that a drug or biological is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is provided in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Based on our analysis of OPPS data, we believe that, in most cases, a drug or biological that is separately payable under the OPPS that is provided in an ASC on the same day as a covered surgical procedure will be provided as integral to the covered surgical procedure, and the ASC will be able to receive separate payment for the drug or biological as a covered ancillary service.[12]

• Physician payment for procedures and services provided in ASCs. One of the more controversial aspects of the new payment rule prohibits physicians from receiving the PE increased payment for procedures performed at an ASC that were previously performed in office. Here's what CMS had to say in proposed rule:

> Under current policy, when physicians perform surgical procedures in ASCs that are included on the ASC list of covered surgical procedures, they are paid under the MPFS for the PE component using the facility PE RVUs. This is appropriate because the surgical procedures are those for which Medicare allows facility payment to ASCs. However, when physicians perform surgical procedures in ASCs that are not included on the ASC list of covered surgical procedures and for which Medicare does not allow facility payments to ASCs, physicians are paid for the PE component at the higher nonfacility PE RVUs (unless a nonfacility rate does not exist, in which case Medicare pays the physician at the facility rate). These policies are set forth in §414.22(b)(5)(i)(A) and (B), respectively. Furthermore, physician payment for nonsurgical services provided in ASCs, for which no facility payment is made to ASCs under the existing ASC payment system, varies based on local Medicare contractor policy.[13]

Here, CMS explains its concept as follows:

The revised ASC payment system is based on the APC groups and payment weights of the OPPS. We believe ASCs are facilities that are similar, insofar as the delivery of surgical and related nonsurgical services, to HOPDs. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services. Therefore, we believe it would be more appropriate for physicians to be paid for all services furnished in ASCs just as they would be paid for all services furnished in the hospital outpatient setting. In addition, because we have adopted a final policy for the revised ASC payment system that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we believe that it would be incongruous with the revised ASC payment system methodology to continue to pay the higher nonfacility rate to physicians who furnish excluded ASC procedures. Because these excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we do not believe it would be appropriate to provide payment based on the higher nonfacility PE RVUs to physicians who furnish them. In fact, we do not expect that

the excluded procedures will be performed in ASCs after the revised ASC payment system is implemented on January 1, 2008. Therefore, we are proposing to revise §414.22(b)(5)(i)(A) and (B) to reflect this proposed policy.

We believe that the proposed revised policy would provide appropriate payment to physicians for services provided in the ASC facility setting and would encourage the most appropriate utilization of ASCs. For procedures that are not excluded from coverage under the revised ASC payment system, the ASC would be paid for the covered surgical procedure and associated covered ancillary services, and the physician would be paid for the professional work and facility PE associated with performing the procedure. In the case of noncovered surgical procedures or other noncovered services provided in ASCs, Medicare would make no payment to the ASC under the revised ASC payment system and no payment to the physician under the MPFS for the facility resources associated with providing those services. Although the current MPFS payment policy provides payment to the physician for some facility costs as if the service were being furnished in a physician's office, according to the final policy of the revised payment system, these services would not be covered ASC services. These services have been excluded from ASC payment for safety reasons, because they are expected to require an overnight stay, or because they are not surgical procedures, and they would not be covered by Medicare either directly, under the ASC payment system, or indirectly, through PE payments to the physicians who perform them.[14]

CMS elected not to finalize the proposed revision of § 414.22(b)(5)(i)(B) in the final rule.

• **Payment-conversion factor.** The new payment structure will establish a rate of payment for procedures performed at an ASC that works out to about 65 percent of the payment for the same procedures performed in an HOPD. CMS has not yet released the exact conversion factor.

> As discussed in section XVI.C. of this proposed rule, we finalized our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights established under the OPPS in the July 2007 final rule for the ASC revised payment system. In that rule, we made final our proposal to set the ASC relative payment weight for certain office-based surgical procedures so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility PE RVU amount. Our final policy is to calculate ASC payment rates by multiplying the ASC relative payment weights by the ASC conversion factor. In the July 2007 final rule for the revised ASC payment system, our estimate of the CY 2008 budget neutral ASC conversion factor was $42.542. In this proposed rule, the proposed ASC conversion factor for CY 2008 is $41.400. This new estimate of the ASC conversion factor differs from the estimate in the July 2007 final rule for the revised ASC payment system for a number of reasons, including: (1) use of the proposed OPPS relative payment weights for CY 2008; (2) use of the proposed MPFS nonfacility practice expense payment amounts for CY 2008; and (3) use of updated utilization data from CY 2006. Specific details regarding our final methodology for estimating the CY 2008 ASC conversion factor may be found in the July 2007 final rule for the revised ASC payment system.[15]

The final rule established the ASC conversion factor at $42.543, based on the OPPS conversion factor. In the final rule, CMS provided significant detail about how this conversion factor was reached:

> After developing the estimated CY 2008 budget neutrality adjustment of 0.67 according to the policies established in this final rule, in order to determine the estimated CY 2008 ASC conversion factor we multiply the estimated CY 2008 OPPS conversion factor by the budget neutrality adjustment. At this time, our estimate of the CY 2008 OPPS conversion factor is $63.497. Multiplying the estimated CY 2008 OPPS

conversion factor by the 0.67 budget neutrality adjustment yields our estimated CY 2008 ASC conversion factor of $42.543 for this final rule.[16]

• **Impact on payments.** The final rule also includes estimates of the total costs and percentage changes for several top procedures performed in an ASC for the first year of inclusion. These estimated changes are set forth in accompanying table, which lists the estimated calendar year 2008 impact of the revised ASC payment system on aggregate payments for procedures with the highest estimated calendar year 2008 payments under the current system. If the ultimate payment changes little over the time, the impact on ASCs will likely be negative. However, if there is a positive change, the complete implementation of the new payment system will not have a great impact on the overall payments to ASCs.

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Sources:

1. 72 Fed. Reg. 42542-43 (August 2, 2007).
2. *Id.* at 42546.
3. CMS-1392-P 575-76 (July 16, 2007).
4. 72 Fed. Reg. at 42506.
5. *Id.* at 42514.
6. *Id.* at 42517.
7. *Id.* at 42520.
8. *Id.* at 42541.
9. *Id.* at 42495.
10. *Id.* at 42496-97.
11. *Id.* at 42498-99.
12. *Id.* at 42500.
13. CMS-1392-P at 616.
14. *Id.* at 618-19.
15. *Id.* at 638-639.
16. 72 Fed. Reg. at 42531.
17. 72 Fed. Reg. at 42541-42.

Impact on Highest-paid Procedures[17]

HCPCS Code	Short Descriptor	Estimated CY 2008 ASC Payments (in Millions)	Estimated CY 2008 First Transition Year Payment
66984	Cataract surg w/iol, 1 stage	$1,112	$981.09
45378	Diagnostic colonoscopy	$153	$427.76
43239	Upper GI endoscopy, biopsy	$148	$422.96
45380	Colonoscopy and biopsy	$114	$427.76
66821	After cataract laser surgery	$102	$288.45
45385	Lesion removal colonoscopy	$96	$427.76
62311	Inject spine l/s (cd)	$81	$317.40
45384	Lesion remove colonoscopy	$44	$427.76
64483	Inj foramen epidural l/s	$44	$317.40
G0121	Colon ca scrn not hi rsk ind	$37	$417.98
15823	Revision of upper eyelid	$35	$687.02
66982	Cataract surgery, complex	$33	$981.09
64476	Inj paravertebral l/s add-on	$29	$310.64
G0105	Colorectal scrn; hi risk ind	$27	$417.98
43235	Uppr gi endoscopy, diagnosis	$25	$338.21
52000	Cystoscopy	$24	$318.83
64475	Inj paravertebral l/s	$24	$317.40
67904	Repair eyelid defect	$22	$654.63
64721	Carpal tunnel surgery	$17	$524.35
29881	Knee arthroscopy/surgery	$16	$776.94
43248	Uppr gi endoscopy/guide wire	$15	$422.96
62310	Inject spine c/t	$14	$317.40
29880	Knee arthroscopy/surgery	$11	$776.94
64484	Inj foramen epidural add-on	$11	$317.40
28285	Repair of hammertoe	$10	$599.75
67038	Strip retinal membrane	$10	$935.84
29848	Wrist endoscopy/surgery	$9	$1,308.69
64623	Destr paravertebral n add-on	$9	$317.40
45383	Lesion removal colonoscopy	$9	$427.76
26055	Incise finger tendon sheath	$9	$506.31

ASC Development: Success in the "Red Zone"

By Fred W. Ortmann, III, MHA

Sports metaphors can be overused in business, but this one is on-target: In, football, a team's success in the win column directly correlates with its success in the red zone – the last 20 yards before the goal line. As such, coaches devise and employ special plays to ensure their success inside the red zone. While ASCs' successes are measured in terms of profitability and return on investment rather than touchdowns and extra points, ASCs also have an analogous red zone – the 60-day period immediately preceding the date when an ASC is scheduled to receive its certificate of occupancy (CO) from the local building authority.

The development of an ASC can take 18 to 20 months to complete, and not all are successful in the red zone, as evidenced by the reports that roughly one-third of new ASCs fail. Reasons given for this high failure rate are excessive equipment purchases, the absence of a pro-forma, excessive square footage, inadequate managed care contracts and various anti-competitive actions by hospitals. Here's what you need to know about executing in the red zone to ensure your new ASC is a success.

Crucial But Not a Crisis

The 60 days before an ASC gets its CO is a period of intense activity, a time when you might feel as if you're hemorrhaging capital with no transfusion of funds from patient care in sight: Final construction payments, the majority of equipment invoices, and many working capital bills will be presented for payment. You'll hire staff during this time and start adding employees to the payroll. If the individuals involved in planning and developing the ASC prepared a realistic pro-forma that included financial data and accurate project development times – before development began – then there should be no problems. However, anything that delays the CO presents a significant obstacle to financial success, as the entire project could be delayed by months.

And there are many such potential delays lurking, delays that can lead to failing in the red zone. For example, if you fail to have the boilers on your sterilizers inspected, don't timely apply for a pharmacy inspection, don't timely complete and submit the CMS 855, or fail to properly implement any one of perhaps a hundred other tasks, you could potentially fail a state inspection. In most states, failure to pass an inspection means you go to the back of the line for re-inspection. This type of glitch could delay your project by an unanticipated one to two months – which would mean you would need additional working capital from either the owner or additional loans. Regardless of the source of the extra monies, the added debt will delay the ASC's profitability.

Many of the crises encountered near the end of a project can be avoided, however, with the proper planning: by mapping the state regulatory process, by developing an integrated timeline for all project tasks and by identifying and completing critical tasks early in the development process.

Mapping the Regulatory Process

Each state has a process whereby the state licenses and then, under federal contract, certifies a facility for Medicare participation. Put that way, licensure and certification sound almost simple – but make a mistake in predicting the timeframe and requirements, and failure is almost certain. I can't give you an educated guess on these, either, as it's rare for any two states to have the same process; to find a publication or guidance describing the various state processes; and to deal with the same set of inspection agencies in each state. In my experience, various parts of state regulatory issues can be handled by any of these offices:

- sanitarian,
- fire marshal,
- department of construction,
- board of pharmacy,
- boiler inspection department,
- department of radiation protection,
- department of hazardous waste,
- department of water quality,
- department of health – licensure division,
- department of health – Medicare division and
- department of health – Medicaid facilitiation.

Each agency will have a pre-determined inspection sequence, and scheduling an inspection may take weeks. To avoid missing any deadlines and delaying your project, it's a good idea to map the regulatory process in your state at the very beginning of the project. Start by communicating with, or better yet, visiting your state department of health to ensure you identify all relevant inspection agencies and learn who schedules the inspections for each agency.

This will let you develop a timeline – the ASC version of a football playbook – that sequentially lists the actions you need to take along with the start and end times for each task. You should integrate all project tasks on the timeline, including those listed above dealing with regulatory aspects and inspection. This gives you a centralized visual representation of the project so that you're less likely to miss critical steps. In fact, many computer software programs are available to help simplify timeline creation and tracking task completion for you.

Linking Tasks on the Timeline

Some tasks simply can't be started and completed if the developer/consultant were to wait to implement them in the Red Zone. There are also tasks dependent upon or linked to other tasks that must be done sequentially, which makes it almost impossible to

start and complete such linked tasks during those critical final 60 days.

The critical tasks are primarily related to the acquisition of construction materials that require long lead times. Some examples:

- heating, ventilation, and air-conditioning units (extremely long delivery times);
- emergency generators and transfer switches;
- vacuum pumps;
- rated doors and door assemblies;
- ADA-compliant door hardware; and
- concrete (which is very limited in supply in some areas).

Other tasks are directly linked to another task which must be completed before the task can begin. Here are some examples, and how they might appear on your timeline:

Tasks	Linked tasks
- complete CMS 855	- undergo Medicare certification inspection
- obtain state pharmacy license	- obtain DEA license to buy drugs and medical gases
- acquire insurance for ASC	- negotiate managed care contracts
- obtain DEA license	- buy medical gases
- undergo boiler inspection	- obtain state approval of ASC

Planning in the Red Zone

If this were an ideal world, you could rely on a timeline to ensure orderly completion of your project. Since it's the real world, though, you have to view the timeline as a guide while being prepared to quickly adjust as needed. Just before you enter the red zone, you should assess how well you have achieved objectives and whether any changes must be made.

At this time, the principals on the development team should meet, assess their progress to date and develop a detailed plan to finalize the project. At a minimum the meeting should include the developer, the architect, the general contractor, the equipment planner, the interior designer and the ASC's director. The general contractor is the key player in this meeting; he should report when the CO will be received and he should be reminded that the ASC will be scheduling equipment deliveries, hiring staff and purchasing services based on this crucial date. The date must be accurate and, once given, he should do everything necessary, including hiring added staff, to meet it. Some would say this date is a function of the dates stipulated in the construction contract; however, we don't mention contract dates at this meeting, and prefer to ask the contractor to commit to an absolute date. We have generally found that a contractor will impose a more demanding date on himself than if we impose an artificial one on him. In certain circumstances, it may be advisable to offer economic incentives if the contractor can accelerate the schedule.

Managing the Red Zone

Once you have an absolute date for the CO, you can identify all remaining key tasks and their required completion times at the pre-red zone meeting. Type this list and distribute to all project participants – it's your red zone plan. Be sure to charge just one person with maintaining the plan and communicating changes to all participants. Each participant must understand that any deviation from the plan must be immediately reported to the person in charge of the red zone plan, who likewise has to communicate all changes to all participants, and devise a means of overcoming any obstacles that may cause the plan to fail. Once the plan is distributed to members of the team, weekly conference calls (or more frequently, if necessary) with all team members can reinforce the process, and keep the plan alive. ■

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9 Key Benefits of Red Zone Management

1. Early focus on completing the project leads to consensus building and on-time job completion.

2. We're able to eliminate the development of most crises near the end of the project.

3. We've been able to achieve better planning among all members of the development team.

4. Working capital budgets are met and pro-formas are generally not exceeded.

5. Medical partners have a higher degree of satisfaction in the process.

6. General contractors like the process and honor their commitments.

7. The ASC opens on time, sees patients shortly after opening and receives reimbursements from patient care early in the ramp-up process.

8. We dramatically reduce the time needed to fully develop a center, thereby saving substantial resources.

9. We cross the red line – in three years of using red zone management, we've finished more than 90 percent of projects on time.

– Fred Ortman, MHA

Spotlight On: Design-Build Construction

An interview with John Wodoslawsky

What are the drawbacks to the conventional approach to construction?

Historically, the bulk of medical construction has been through the conventional design-bid-build approach where an owner hires a fee-for-service architect to design a building, the architect develops the building program, and the project is ultimately put out to bid. Then a contractor is hired to build the project.

As a result, developing a building program has too often been a fragmented effort, with architects leading the way, engineers in charge of some activities, contractors in charge of others, and the balance left up to fate. With today's technological advances, designing and building ambulatory surgery centers has become very complex. This process is fraught with pressures and uncertainty, and in many instances characterized by cost and schedule overruns, which also makes it expensive: There are no cost guarantees with the design-bid-build approach.

Such shortcomings are becoming more and more unacceptable in all industries, but they seem to be more intolerable in healthcare. Economic pressures are forcing healthcare providers to reexamine every aspect of operations, staffing ratios and energy consumption. The push is definitely on to find the most patient-friendly, efficient and cost-effective way to do business and provide healthcare on a day-to-day basis and, as a result of the above mentioned pitfalls, many owners have recently turned to the design-build concept of building program development.

What is design-build?

The design-build format integrates the design, engineering and construction segments of a project into a team approach, with all team members being in the same boat and rowing in the same direction. With the sophistication of today's medical facilities, a team should minimally be composed of the following technical disciplines: architectural; mechanical; electrical; plumbing; civil; structural; and construction. Good communication between these team disciplines is paramount. The left hand must know what the right hand is doing at all times. All technical disciplines must be involved and have input into the development of design/build projects from the outset.

What are the advantages?

This integration has proven to reduce construction costs and save owners both time and money – a true single-source design/build firm will offer an owner a guaranteed cost to develop the owner's project as a result. The designer-builder will be the owner's single point of contact throughout all stages of the project's development process. The owner will have one firm to communicate with, depend upon and hold accountable for complete project development. There will be no finger-pointing during the construction process. If the design/build firm makes an error or an omission, the company will correct it with absolutely no additional cost to the owner.

The design/build concept of consolidating these design and construction segments in one format is nothing new, though: When a king or pharaoh wanted to build a new palace, stadium or temple, he would simply go to an individual called the master builder, who was the architect, engineer and contractor all rolled up into one. Many great architectural and engineering feats, like the pyramids, the Great Wall of China and the Taj Mahal were developed by the master-builder through a design-build system. This trend is, in some respects, actually going back to the future. ■

Mr. Wodoslawsky is an architect and the vice president of BBL Medical Facilities.

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- *To describe the current business and legal issues pertaining to ambulatory surgery centers (ASCs).*
- *To identify the disciplines involved in the development and operation of a successful ASC.*
- *To enable participants to incorporate innovative business and strategic strategies into their ASCs.*
- *To identify the key business, clinical and staffing issues involved in ASCs.*
- *To provide the opportunity for participants to interact with a variety of different ambulatory surgery center experts throughout the conference.*

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This 2 1/2 day conference is designed to provide orthopedic surgeons, ENTs, hospital and ASC administrators, ophthalmologists, neurosurgeons, gastroenterologists, pain management physicians, surgeons, and all physicians involved in single- or multi-specialty ASCs the latest information on business, legal and regulatory issues, establishing and improving the profitability of ASCs.

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This conference will focus on Improving the Profitability of and Establishing ambulatory surgery centers (ASCs). The topics will be addressed through panel discussions, case studies and lectures. These will be presented by distinguished faculty who are experts in the ambulatory surgery center industry.

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During the exhibit viewing, reception and luncheons you will be in contact with key industry partners who can make a tremendous impact on the success of your business.

Join other surgeons, ASC administrators, ASC owners, medical directors, hospital administrators, nursing directors and consultants for this dynamic 2 1/2 day conference.

CONFERENCE PROGRAM

THURSDAY, OCTOBER 18, 2007

12:00 – 2:00 pm
Registration

Pre-Conference Workshop – Concurrent Sessions A, B, C

2:00 – 3:15 pm

A. A Case Study Approach to Turning Around ASCs
Brent Lambert, MD, Founder, Ambulatory Surgical Centers of America

B. Understanding the Impact of the New CMS Rules and the CMS Reimbursement Rates
Kathy Bryant, President, FASA

C. Using Spine and Bariatrics as the Cornerstone of a Thriving ASC
Jim Lynch, MD, Kent Sasse, MD, Founders, Surgery Center of Reno
Tom Mallon, CEO, Regent Surgical Health, Jeff Simmons and Nap Gary, Western and Eastern Region, President, Regent Surgical Health

3:15 – 3:30 pm
Break

3:30 – 5:15 pm

A. Key Legal and Regulatory Issues for ASCs and a Brief Discussion on Selling ASCs
Scott Becker, Krist Werling, Alison Mikula, Elissa Moore, McGuireWoods, LLP

3:30 – 4:20 pm

B. How to Make Sure an ASC Succeeds After Selling a Part of the ASC to a National Partner
Rick Pence, President and COO, National Surgical Care

C. Developing a Successful Physician Hospital Joint Venture - A Step by Step Approach
Jo Vinson, CASC, V.P., and John Goehle, MBA, CASC, V.P., Surgery Consultants of America, LLC

4:20 – 5:15 pm

B. A Step-by-step Approach to Establishing an Ambulatory Surgical Center
Joe Zasa and Robert Zasa, Woodrum ASD

C. The Negotiation of Managed Care Contracts for the Start-Up Center
Naya Kehayes, CEO, Eveia Health Consulting and Management

EXHIBITS OPEN
Thursday Evening Cocktail Party

FRIDAY, OCTOBER 19, 2007

7:00 – 8:00 am
Registration & Continental Breakfast

8:00 – 8:45 am

His Perspective on the Future of ASCs
Mark McClellan, MD, Former Administrator, Centers for Medicare and Medicaid Services

8:50 – 9:30 am

Code Red, Reviving the American Healthcare System
David Dranove, Professor Northwestern University Kellogg School of Business

9:35 – 10:15 am

His Views on Building a First Class Company in the ASC Arena
Tom Hall, CEO NovaMed

10:15 – 11:15 am
Exhibits Open

11:15 – 11:50 am

7 Keys to Turning Around a Failing ASC
Brent Lambert, MD, Founder, Ambulatory Surgical Centers of America

FRIDAY, OCTOBER 19, 2007

11:55 – 12:30 pm

5 Key Steps to Establishing a Successful ASC
Tom Mallon, CEO, Regent Surgical Health

12:30 – 1:30 pm
Networking Lunch & Exhibits

1:30 – 2:05 pm
Concurrent Sessions A, B, C, D, E

A. Developing a Pediatric Driven ASC
Joe Zasa and Robert Zasa, Woodrum ASD

B. Revitalizing an ASC - A Case Study Based on a Texas Turnaround
Bill Southwick, CEO, HealthMark Partners

C. Joint Ventures Between Physicians and Hospitals - Core Tips for Success
Tom Yerden, CEO, TRY Ventures

D. Advanced Case Costing for ASCs
Susan Kizirian, Vice President, Ambulatory Surgical Centers of America

E. Bariatric Lap Band Surgery in the ASC and Other Minimally Invasive Bariatric Solutions, Pros and Cons
Tom Michaud, CEO, Foundation Surgery Affiliates

2:10 – 2:45 pm

A. The Power of a Three-party Model - A Hospital, Physician and a Best in Class Management Company
Evelyn Miller, Director of Acquisitions, and Monica Cintado, Senior Vice President, United Surgical Partners International

B. Business Strategies for Endoscopy Centers and GI Practices
Barry Tanner, CEO and Karen Sablyak, VP, Physicians Endoscopy

C. How to Maintain the Success of Your Center Throughout the Life Cycle of Your Business
Mary Beth Brust, CASC, VP of Operations Eastern Region, Health Inventures, and Dr. Chris Danis, MD, Hand and Reconstructive Surgeons, Dayton, Ohio

D. The ABCs of Benchmarking for ASCs
Sanda Jones, CASC, President, Woodrum ASD

E. How an Expert ASC Manager Can Prepare to Manage a Start Up Hospital
Alex Rintoul, CEO, Medical Center at St. Elizabeth Place

2:45 – 3:15 pm

A. Success Tips for Operating an ASC with a Management Partner
Steve Stern, MD, Northwestern University Orthopedics

B. Developing a Consistent Model for Success - Why What Works in One Market Often Works in Another Market
Ajay Mangal, MD, CEO, Prexus Health

C. The Inside Scoop on Preparing Your ASC For Acquisition
Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners

D. 7 Keys to Making Partnerships Successful Over the Long Run
James Jackson, Vice President, United Surgical Partners International

E. The Pros and Cons of Different Specialties for ASCs - From Orthopedics to Podiatry to Ophthalmology
Luke Lambert, CEO, CASC, Ambulatory Surgical Centers of America

3:15 – 4:10 pm
Exhibits Open

4:10 – 4:40 pm

A. Combining Specialties and Finding a Means to Work Together for Patient Quality and Financial Success
Scott Holley, MD, Surgery Center of Kalamazoo

CONFERENCE PROGRAM

FRIDAY, OCTOBER 19, 2007

B. What to Do When the 800-pound Hospital Wants to Put You Out of Business
Joe Banno, MD, and Bryan Zowin, Peoria Day Surgery Center

C. Billing and Coding with the New ASC Payment System
Caryl Serbin, President, Serbin Surgery Center Billing

D. Why Are Prices so High and What Is the Price at Which a National Company Should Buy Your ASC?
Mike Weaver, Senior Vice President, Symbion, Inc.

E. Doing a Cost Benefit Analysis on Implementing an EMR System for an ASC
Tom Pliura, MD, JD, CEO and Founder Z-Chart

4:40 – 5:15 pm

A. How Aggressive Hospital Competition Led to a Very Successful Tertiary Care Hospital
Jeff Mason, CEO, FACHE, BayCare Clinic, LLP

B. How to Recruit Doctors and Improve Financial Stability
Chris Bishop, VP, Ambulatory Surgical Centers of America, Krist Werling and Ron Lundeen, McGuireWoods, LLP

C. Single Specialty ASCs - How to Operate Single Specialty ASCs for High Quality and Outstanding Operating Margins
Rob Carrera, CEO, Pinnacle

D. Financing Start-up ASCs and the Recapitalization of ASCs
Anthony Mai, National Business Deveopment, CIT Healthcare, Brad Stern, Senior Vice President, MarCap Corp.

E. Current Legal Issues - Safe Harbor Issues and Credentialing and Staff Privileges Issues
Scott Becker, Alison Mikula and Tom Stallings, McGuireWoods LLP

5:15 – 7:30 pm

Networking Reception & Exhibits

SATURDAY, OCTOBER 20, 2007

8:00 – 9:00 am

Continental Breakfast

9:00 – 9:40 am

Building a Successful Physician Hospital Joint Venture
Richard Hanley, CEO, Health Inventures

9:40 – 10:25 am

The State of the Union for ASCs
Kathy Bryant, President, FASA

10:25 – 11:00 am

(Concurrent Sessions A, B, C & D)

A. The Societal and Business Case for Physician Owned Hospitals
Brett Gosney, CEO and Founder, Animas Surgical Hospital

B. The Anatomy of Three Deals - A Large Multi Specialty Deal, a Spine Driven Deal, and a Large Scale Single Specialty Deal
David Abraham, Reading Neck & Spine Center and Jon Vick, ASCs Inc.

C. Working with Letters of Protection as a Vital ASC Revenue Source
Robert Goetlling

D. Developing a Successful Lap-Band Program at Your ASC
Kenny Bozorgi, MD, Mark Mayo and Bret Petkus, Day One Health

11:00 – 11:40 am

(Concurrent Sessions A, B, C & D)

A. Progressive Surgical Solutions - Outcomes Monitoring for ASCs
Debra Saxton Stinchcomb, CASC, Progressive Surgical Systems

SATURDAY, OCTOBER 20, 2007

B. Buy Outs and Syndications - A Case Study Approach
Bill Southwick, CEO, HealthMark Partners, and Jim Corum

C. Developing Spine Driven Centers of Excellence and Other Customer Services Around Spine Services
Marcy Rogers, Spine Mark, CEO

D. Is the ASC Healthy? Assessing the Vital Signs of Your ASC
Kyle Goldammer, Senior Vice President and CFO, Surgical Management Professionals

11:45 – 12:30 pm

(Concurrent Sessions A, B, C & D)

A. How to Make an ASC or Specialty Hospital Hum - A Talk on Strategy
Mike Lipomi, Founder, CEO of Stanislaus Surgical Center, Administrator Pinehurst Surgical Center

B. Key Tips to Finding Great Leaders and Managers for ASCs
Greg Zoch, Partner, Kaye Bassman International

C. The Economics of Different Real Estate Decisions, Buy or Lease, Sell or Hold, and Single Use or Part of MOB
John Daly, Alex Hlavacek, McShane Construction

D. 2 Key Valuation Issues - (1) The Value of Shares for Physician Buyins and (2) Valuing Compensation Relationships in Under Arrangement Models
Greg Koonsman, VMG and Todd Mello, Health Care Appraisers

12:35 – 1:15 pm

(Concurrent Sessions A, B, C & D)

A. Managing in the Red Zone - Key Things to Do in the 60 Days Before Opening an ASC
Fred Ortmann, CEO, Ortmann Healthcare

B. Financing - The Lender's and Borrower's Perspectives
Ken Seip, Vice President, Citicapital, and Bart Walker, McGuireWoods

C. Certificate of Need in the 21st Century - Is It a Good Thing?
Tom Mulhern, Administrator, Limestone Surgical Center, Member Delaware Bureau of Health Planning

D. Understanding the Three C's (Compliance, Convenience and Cash Flow) Related to Medication at an ASC
Dan Connolly, MHS, ARM, Vice President of Operations, Pinnacle III, Medication Dispensing

1:20 – 2:00 pm

(Concurrent Sessions A, B, C & D)

A. What You Need to Know About Facility Regulation Before You Invest in an ASC, and Forever After
Bill Lindeman, CEO, WEL Designs PLC

B. How, When and Why to Separate the Real Estate from the Operating Company and the Keys to the Making Real Estate Deals Work, Including Lease Terms
David Thoene, VP, Titan Healthcare Care

C. Managing Your Portfolio - Indexing Strategies - The Most Effective Approach to Portfolio Management
David Rapport, Founder, Rapport Reiches

D. "The Best of Both Worlds": Hospital Management Contract with Surgeons vs. an Equity JV (An Alternative Collaborative Model - Case Study)
Chuck Owen & John Smalley, Principals & Co-Founders Healthcare Venture Professionals (HVP); Louise DeChesser, RN, CNOR, MS, Administrator West Hartford Surgery Center (WHSC); Jeffrey Morgenstern, MD, Medical Director WHSC, and Kevin J. Kinsella, Vice President Hartford Hospital

2:00 pm

Meeting Adjourn

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Becker's ASC Review	$199 (per year)	$ _____
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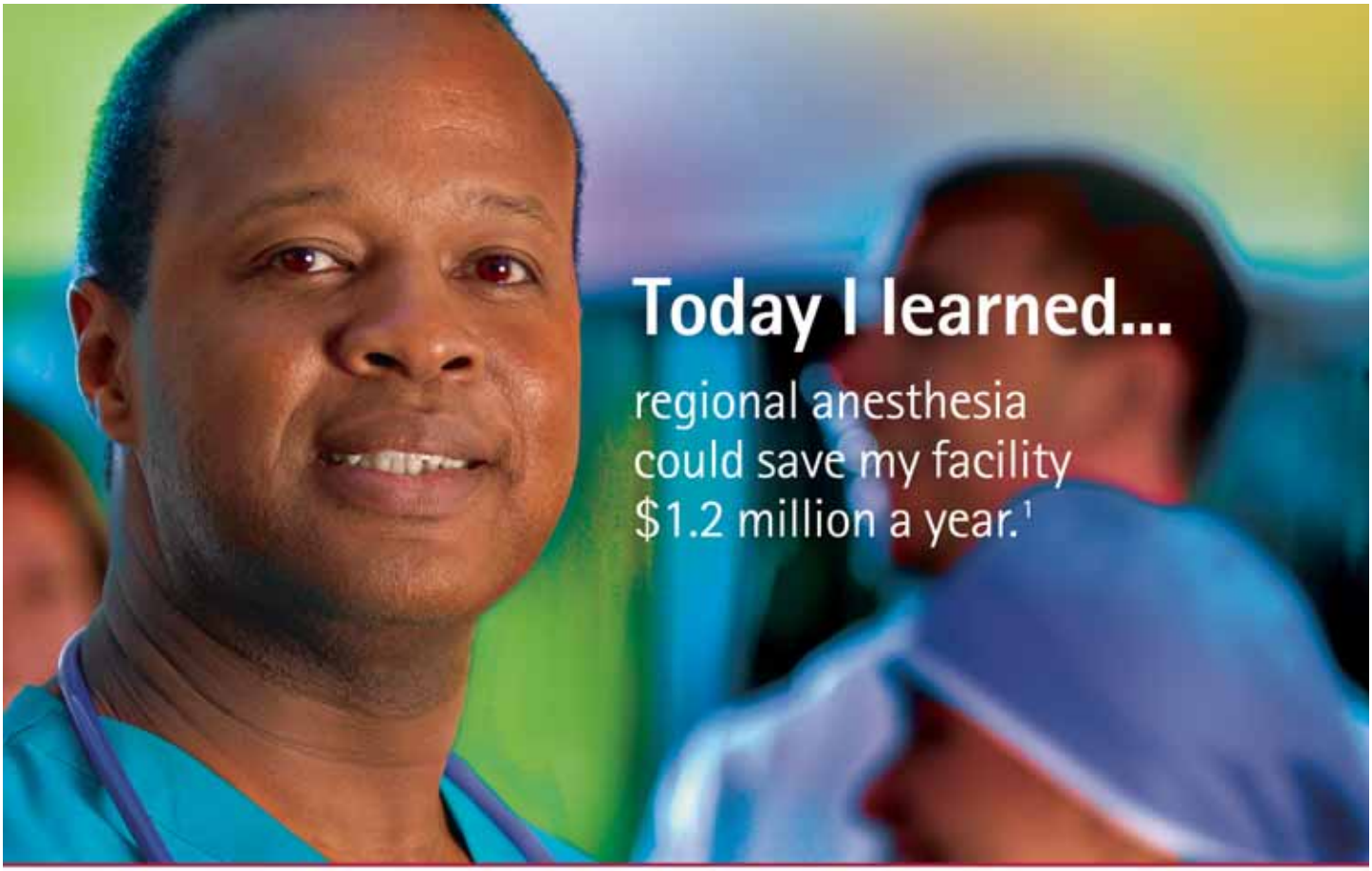

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[1] Williams BA, Mototenich P, Kentor ML. Hospital Facilities and Resource Management: Economic Impact of a High-Volume Regional Anesthesia Program for Outpatients. *Int Anesthesiol Clin.* 2005 Summer; 43(3):43-51

Under-Arrangements Model Joint-Ventures: The End May Be Near

By Scott Becker, JD, CPA

Under-arrangements joint-ventures received a direct blow that may spell their end. The structures may be abusive, and can be used to reward referrals and to game the reimbursement system, the Centers for Medicare and Medicaid Services asserted when the agency published its thoughts relating to the impending Stark III rules on July 2.

Here are the 12 core points in the document relating to under-arrangements JVs.

1. A physician can have an incentive to overutilize services if she or he has a financial relationship with the entity that directly furnishes Designated Health Services, even if the physician's entity is not the entity ultimately billing for the services.

2. The physician can potentially recognize a profit from each referral based on the fact that a DHS will, in essence, be sold to the entity that bills.

3. CMS writes, "we continue to have concerns with services provided under arrangements to hospitals and other providers. We believe that the risk of overutilization viewed that we identified in the 1998 proposed rule has continued, particularly with hospital outpatient services for which Medicare pays on a per-service basis."

4. In some under-arrangements transactions, "there appears to be no legitimate reason for these arrangements for services other than to allow referring physicians an opportunity to make money on referrals for separately payable services."

5. CMS recognizes and voices concern that many of the services provided by joint ventures were previously furnished directly by the hospital, and in most cases, could continue to be furnished by the hospitals.

6. Services furnished under arrangements are often furnished in a less medically intensive setting than a hospital but bill at outpatient hospital PPS rates, notes CMS. This costs the Medicare program and Medicare beneficiaries more.

7. Physician specialists often set up the underlying joint-ventures and include a hospital as an owner in the underlying joint-venture, says CMS.

8. CMS states that the joint-venture then owns an entity that furnishes medically less intensive services than a hospital, such as an ASC, an IDTF or a physician office.

9. It appears, writes CMS, that the use of these arrangements can be little more than a method to share hospital revenues with some referring physicians in spite of unnecessary costs to the program and to beneficiaries.

10. CMS notes that it believes that more and more procedures are being furnished as arranged for hospital services. It also speaks specially to ASCs, writing: "The provider community is well aware that, effective for services furnished on or after January 1, 2008, Medicare may pay more for hospital outpatient surgical procedures than for the same procedures billed by ASCs under the revised ASC payment system."

11. It also notes that arrangement structures in which the referring physicians own leasing, staffing, and other entities that furnish items and services to entities furnishing DHS – but do not submit claims – raise significant concerns under fraud and abuse laws.

12. CMS notes that we believe such arrangements to be contrary to the plain intent of the physician referral law.

In this overall condemnation of these arrangements, CMS states very clearly its concerns that these can be simply a method to provide profits to physicians and to utilize payment differentials for profits.

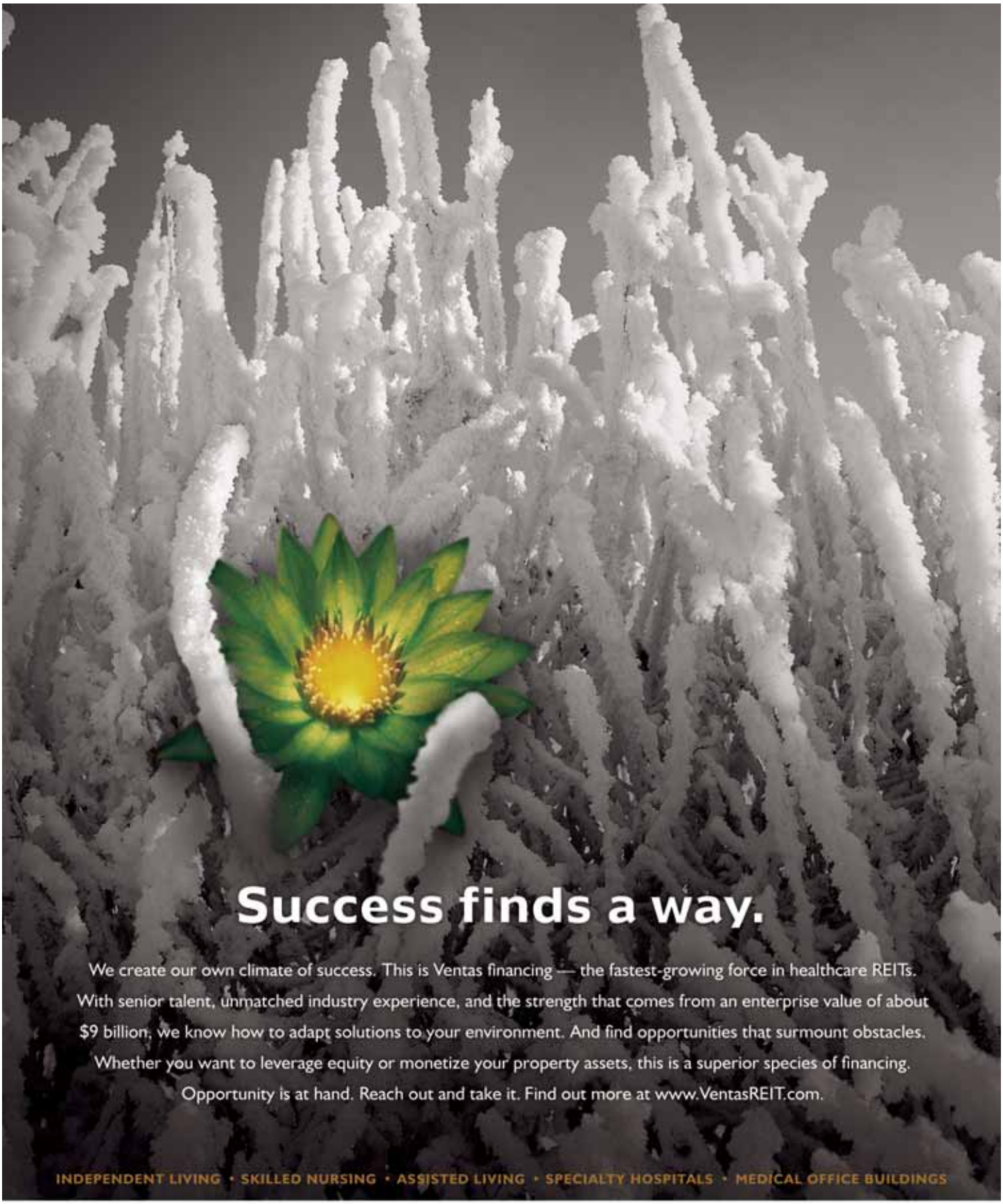
Two things will likely occur. First, in relatively short order, expect a vast restructuring of theses types of arrangements. Second, there will be a significant chilling on the further development of these types of relationships. Notwithstanding the fact that many people understood the risky nature of under-arrangements joint-ventures, they continued to develop or try and sell these types of arrangements. It is now likely time, with the government's clear direction, to stop developing such ventures.

The government also noted in the Stark III issuance that it has significant concerns with per-click leasing arrangements as well certain abuses of the in-office ancillary services exception under Stark.

Here, CMS stated that it intends to reverse its earlier position, which allowed a certain amount of per-click leasing, writing: "We are proposing that space and equipment leases may not include unit of service based payments to a physician lessor for services rendered by an entity lessee to patients who were referred by a physician lessor to the entity. We believe that such arrangements are inherently susceptible to abuse because the physician lessor has an incentive to profit from referring a high volume of patients to the lessee and we would disallow such per-click payments." ■

For more information on CMS's Stark III issuance, download the white paper available at **www.beckersasc.com/pdfs/Rules_of_Concern_White_Paper.pdf**.

Contact Mr. Becker at ***sbecker@mcguirewoods.com****.*



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Amending an Operating Agreement: Avoiding Controversy and Litigation

By Scott Becker, JD, CPA, and Sarah E. Abraham, JD

An operating agreement for a surgery center (or any type of facility) is rarely a static document. For example, as laws change over time or as the center's members experience different issues related to the center, it's fairly typical for the membership to periodically examine changes to the center's core rules set forth in the operating agreement.

Sometimes, these changes deal with some of the most sensitive issues. For example, when the federal government issued safe harbors for ASCs, it became very common for surgery centers to examine the possibility of amending their operating agreements to include requirements that each physician must meet the safe harbors. It also became common to require a buyout of a physician upon such physician's failure to meet such safe harbor requirements. This article briefly examines some of the legal background and considerations related to amending an operating agreement and potential opposition of such amendments.

There are several considerations and questions that need to be answered when attempting to amend an operating agreement. Some of these questions include the following:

1. Does the current operating agreement provide a means by which it can be amended? For more recent operating agreements, such agreements include provisions that allow the members to amend the operating agreement by a certain percentage vote. This is typically set at 51 percent, 66 percent or 75 percent of the membership vote. In some situations, the operating agreement either provides a requirement that any amendments to the agreement be by unanimous consent or by a lower threshold, such as by the board of managers. A first step in any analysis of potential amendments is to examine who has the right to make such amendments, (for example, the board, or a certain percentage of the members) and whether there are any restrictions on making such amendments. In addition, when the board or a general partner is given the power to make such amendments, as opposed to the members or limited partners of the membership as a whole, one must consider under applicable state law whether such amendment is likely to be enforceable.

Here, in one case, the party argued that, notwithstanding the apparent authority to amend the operating agreement, the right to amend was not unlimited:

> Appellants further argue that if this court should find that Sec. 338 gave the corporation the right to amend its Articles in any respect, the nevertheless such right is not unlimited and the courts when called upon to do so, should interpret and place a construction on this right of amendment which would protect the rights of minority stockholders against abuse of authority by the majority. They argue that since the corporation has always been in sound financial condition, that the preferred stock as a practical matter has a much higher value than par plus interest, and that by making the non-callable stock callable, this value which is a vested property interest is destroyed and becomes a much less desirable investment. That under the circumstances disclosed in this case, it is highly inequitable to allow such an amendment, because its only purpose was to benefit the holders of common stock at the expense of the holders of preferred stock and not to alleviate some emergency condition for the benefit of all the stockholders and the corporation, and this court in determining whether the corporation has acted within the limits of its reserved power to amend should apply the test of whether the amendment is fair, equitable and just to all concerned.

2. Does the amendment strike of fairness and/or at having a legitimate business purpose? Assuming that an amendment is permitted under the operating agreement, this would be the next question parties must examine. In certain situations, parties have examined making amendments to an operating agreement with a thinly veiled purpose of using the amendments to kick out or freeze out certain other shareholders/owners. In fact, in some situations, the amendment may be negotiated or worked through in such a way as to simply obtain the votes of enough parties pass the amendment, but the amendment may be so convoluted that it does not strike as fundamentally fair to those parties who will not vote in

favor of the amendment because of the negative effect on such parties. Here, where an amendment is passed and it appears to be for the purpose of freezing out certain shareholders/owners without a valid business purpose, courts, in some situations, will not enforce the amendment or will invalidate the amendment.

Here, a court examined whether in fact the amendments were, in reality, a squeeze-out plan.

> The plaintiffs' second claim involves the decision by the general partner to amend the partnership agreement and to take away key protections belonging to owners of Weeden's "Basic Units." Because the general partner and its affiliates controlled the vote on the amendments, the vote's outcome was preordained. Moreover, in connection with the vote, the general partner misinformed the Outside Investors by indicating that the amendments and, as important, the redemption plan they were designed to implement, had been crafted by a committee of outside, non-employee directors, when in fact the amendments and the plan had been crafted primarily by management and the unit committee had been chaired by Donald Weeden, Weeden's Chairman, controlling stockholder, and most powerful executive, and had taken its cue from management, who attended and led each of the brief meetings held by the unit committee.

The redemption plan that the amendments implemented involved the involuntary squeeze-out of unitholders on a schedule that took into account partners' employment and director status. The defendants' rationale for the plan was that it was necessary for Weeden to put in place a system for recycling units from one generation of employees to the next and to come to grips with its need to be an employee-owned firm. Because Weeden had never used written employment contracts and had not obtained the contractual right to redeem Basic Units from holders, except if the general partner owned 90% of the units and even then only if it paid fair market value, the general partner wanted to set up a more structured system going forward and designed the amendments with that in mind. The problem with the system that the defendants designed, from the plaintiffs' perspective, is that it exacted a steep penalty from the Outside Investors. For Outside Investors who owned fewer than 1000 Basic Units, the plan called for them to be deprived of their units for book value immediately. For Outside Investors who used to be employees, the plan redeemed their units on a schedule tied to years of service but applied retroactively to their date of departure, leading to very short redemption schedules, again at book value. For Outside Investors who never served as employees, they were to lose their units on a 10-year schedule in exchange for book value. For former employees who had exercised their freedom to work for a competitor – a freedom they had under the partnership agreement and because Weeden had no contractual protections against competition – the schedule took their units immediately at book value.

> Critical to this claim is the undisputed fact that a unit of Weeden is worth far more than book value. No defendant would willingly accept anything near book value for a unit of Weeden. Yet the defendants consciously decided to deprive Outside Investors of their units for less than fair market value in order to shift the ownership of Weeden exclusively to employees, directors, and the close family members of employees and directors.

3. Are shares priced at fair market value? Where an amendment will have the effect of freezing out certain shareholders/owners, courts tend to look more favorably upon situations where the center has offered some level of appraised fair market value as a buyout to those physicians who are forcibly redeemed. The combination of an appraised fair market value plus some validity to the business reason for the buyout tends to greatly enhance the position of the majority that is voting in favor of such an amendment. In contrast, where a party, pursuant to an amendment, will be bought out at below fair market value or book value, this tends to significantly undermine the potential enforceability of the amendment.

Here, one court requested a fair market value analysis.

> For all of the above reasons, the decision of the court of appeals is reversed and the case is remanded to the trial court for a determination of the fair value of appellant's shares to be awarded to him in accordance with Minn.Stat.ch.302A.471.

Here, a court sides with the company where the company procured a third party valuation.

> The $78,408 tendered to the partners for their partnership units was the "fair value" of those interests in an ongoing business without discounts for lack of marketability or the fact they were minority investors. The plaintiffs controverted this statement, arguing that

their subsequent appraisal demonstrated the fair value to be $117,533 per unit.

Pursuant to the merger agreement approved by both MR Imaging Center, LP, and MRI, LLC, MR Imaging Center, LP, tendered $78,408 per unit for all MR Imaging Center, LP, units, including those held by Via Christi, those held by the other nonplaintiff owners, and those owned by the plaintiffs. Everyone received the same price, which was the fair value price determined by the valuation company, Paragon. The plaintiffs rejected this tender and filed the present lawsuit against Via Christi and MR Imaging Center, LP.

4. What is the amendment's purpose? Where an amendment is being enforced, the parties may look at whether the amendment tends to have an illegal or improper purpose. In at least a couple of cases, courts have examined whether a buyout driven by enforcement of certain rules related to case volume or safe harbors is enforceable. In one case, a center had passed amendments related to safe harbor compliance. Then, the physician brought a declaratory judgment action to declare the amendments unenforceable. The court did not examine whether or not the amendments were legal under the partnership agreement or state law. Rather, the court decided that the physician had no private right of action under the Anti-Kickback Statute, which was the statute that the plaintiff was trying to use to stop the amendments' being enforceable. In another situation, a center moved to redeem a physician based on his failure to perform cases at the surgery center in which he was an investor. There, the

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court reasoned that the physician was kicked out for essentially what was based on an illegal purpose – due to not bringing cases to the center, and he or she was deemed entitled to punitive damages against the center.

Here, a court asserted that an individual does not have a private right of action under the Anti-Kickback Statute.

> The partnership amendment in dispute includes a section which requires that all limited partners certify annually that one-third of his or her medical practice income is derived from performing outpatient surgical procedures, and that these procedures are conducted at the ASC. Another section provides for the forced redemption of a limited partner's units in the event that the limited partner no longer uses the [center] as an extension of his or her medical practice. Debartolo received a letter requesting that he complete his certification in the spring of 2005. He did not return the certification, as he no longer had privileges to perform procedures at the [center]. In January of 2006, Debartolo received a check and a letter informing him that the JSCLP had purchased his units. Debartolo rejected the offer and returned the check. Shortly thereafter, he requested to be placed on the surgical schedule and was told to submit a credentialing application. After submitting the application, Debartolo requested nullification of the buyback of his units. Debartolo received a letter from HealthSouth stating that he had not met the requirements for limited partners and denying his request to nullify the buyback.

Summary

In summary, it is critical when adopting amendments to an operating agreement that will have the effect of causing or forcing the redemption of a person, to ensure that one has the appropriate votes to approve such amendments and that one can generally attempt to meet a fundamental fairness and business purposes test in most situations. While this standard may not be necessary in many states, it is the more conservative approach to take. In essence, it is important that the person who is being forced to be redeemed is being treated fairly and that the majority is not using the amendment process simply to enhance or improve their own financial position against the minority party. ■

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Utilize Cost-Saving Devices to Economize on Supply Expenses

By Dana Kulvin, JD, MPH

In the competitive ASC market, you must control supply costs in order to thrive financially. Most ASCs have implemented successful strategies to reduce costs. For example, ASCs typically standardize supplies and avoid overstocking them. However, in this evolving industry with so many skillful professionals, it is useful to share ideas and learn new strategies to employ or simply be reminded of old approaches that might need to be invigorated. Here are six tips experts suggest to control supply costs.

1. Perform cost analyses. ASCs can use the data from case costing to educate physicians and staff about the supply and equipment expenses associated with certain cases. "One of the best ways to manage supply costs is to create awareness amongst physicians and staff of the cost of certain supplies and the impact of those costs on the ASC's profits," says David Moody, RN, BA, administrator at Knightsbridge Surgery Center in Columbus, Ohio.

ASC consultant Sandra Jones, CASC, FHFMA, LHRM, agrees: "By comparing the costs of a procedure performed by different physicians and presenting the comparison in a clear graphic form, staff and physicians are reminded about the ways costs can be minimized."

Ms. Jones recounts an ASC physician, who after being presented with a case analysis, recognized that his case cost the most and later asked the administrator how he could perform the surgery more economically. Mr. Moody describes a similar success story at Knightsbridge. He performed a cost analysis of different hernia meshes used by his physicians, which revealed a wide disparity in the cost of the meshes. Mr. Moody then reported the study to physicians and staff. After hearing the results, physicians opted for a lower-cost, but equally clinically beneficial mesh, and the ASC saved over $15,000 annually.

2. Benchmark costs against other ASCs. Benchmarking costs by CPT code amongst a company's individual ASCs or against outside centers can help ASCs compare costs and staffing requirements to ascertain where expenses can be trimmed. "WoodrumASD has had great success using benchmarking amongst its twenty-seven centers to cut costs throughout its network," Ms. Jones reports. Single-entity ASCs that aren't part of a bigger network can join with non-competing centers to benchmark costs per case with each other. "Creating a network of eight to 10 ASCs in different market areas to compare data on a quarterly basis is a great way for independent centers to regularly evaluate any atypical costs," advises Ms. Jones.

Help for Benchmarking

The following have financial benchmarking surveys and outcome and performance studies available for ASCs to use for improving care, minimizing costs and maximizing outcomes.

- FASA
www.fasa.org/benchmark
- MGMA
www.mgma.com
- AAAHC
www.aaahc.org (see the AAAHC Institute for Quality Improvement)

Costs and conditions of using these studies differ, so contact the organizations for further information.

3. Update supply lists regularly. Update surgical packs and supply lists regularly in order to meet current needs. "Because physicians often change their surgical techniques and supplies, an ASC needs to ensure that it is not squandering money by ordering items that are no longer used," says Ms. Jones. "For this reason, an ASC should meet frequently with physicians and staff to ask them what supplies or drugs they do need, as well as those they do not need anymore."

This is particularly true with surgical packs. "Custom surgical packs are a huge drain on your bottom line if all of the items in the package are not being used," adds Mr. Moody.

Periodically, ASCs should also perform comprehensive inventory reviews to ensure that all stocked supplies and medications will be used. Mr. Moody usually performs a detailed inventory three times a year but notes that every ASC has different needs. In addition, inventory case-costing software (see tip No. 4) may allow for perpetual inventories.

4. Use inventory case-costing software. Inventory-management software can help an ASC manage supply costs on a case-by-case basis and succinctly report that information to the physicians and staff. "A system that captures every item used on every case with the ability to run in-depth case cost analyses is indispensable. By tracking inventory on each case, an ASC can easily identify outlying costs and streamline efficiencies," says Josiah Lamz, the director of marketing for OptOR Systems.

In addition, by automating purchase orders, receiving, and email notifications, an ASC can have more control over inventory and ordering. Lastly, an inventory management system that provides an itemized cost breakdown of supplies per-case can be a valuable tool for billing and collections.

"One of our clients, Pacific Heights Surgery Center in San Francisco, estimates a per-case increase in revenue of 10 to 15 percent, or about $50,000 per month, by utilizing cost reports for each case," says Mr. Lamz. A cost breakdown of each case is also extremely valuable in establishing or renegotiating managed care contracts.

5. Work with different vendors to control supply costs. While working with a group purchasing organization is critical to getting discounts on supplies, there are also other methods that can help decrease supply costs. First, developing good relationships with vendors can motivate them to agree to offer volume discounts and/or provide free shipping. Talk to colleagues as well.

"Networking with other ASCs on pricing can provide necessary information for an ASC to use in negotiating prices with vendors," says Gary Malinowski, ORT, the materials manager at Santa Barbara Surgery Center in California.

Second, purchase as much supplies and implants through consignment vendors as possible, especially higher priced items. "By purchasing lenses, slings and nuts, bolts and screws on consignment, our ASC has been able to stock expensive necessary supplies without disrupting our cash flow," says Mr. Moody.

Third, for high-ticket items like implantables, work with a device benefit management vendor that will assume the cost of the items and then work with the patient's payor itself to obtain reimbursement. "This allows an ASC to use an expensive item without having to float the $10,000 to $20,000 cost of it for 60 days or have the administrative reimbursement burden," Moody adds. Moody says he has had success working with Access Mediquip (www.accessmediquip.com).




6. Use two low-tech methods to effect change. Some cost-cutting solutions are quick and easy, but make a huge impact on supply costs. For one, ASCs have had success changing supply use behavior by placing sticky notes on particular high-expense, often-used supplies in order to bring awareness to the costs of those items.

"One ASC placed sticky notes on their high-priced sutures," recounts Ms. Jones. "Upon seeing the notes, nurses reminded the physicians of the sutures' high cost and many physicians decided to instead use the tail end of a previously opened pack of sutures."

In the aggregate, this saved the ASC tremendously on their supply expenses. Two, have the costs of each supply used in a procedure printed out on the pull ticket.

"With the costs set out on the pull ticket in black and white, we found our physicians and staff were often inclined to pick their supplies more economically," Moody explains. ■

Sources:
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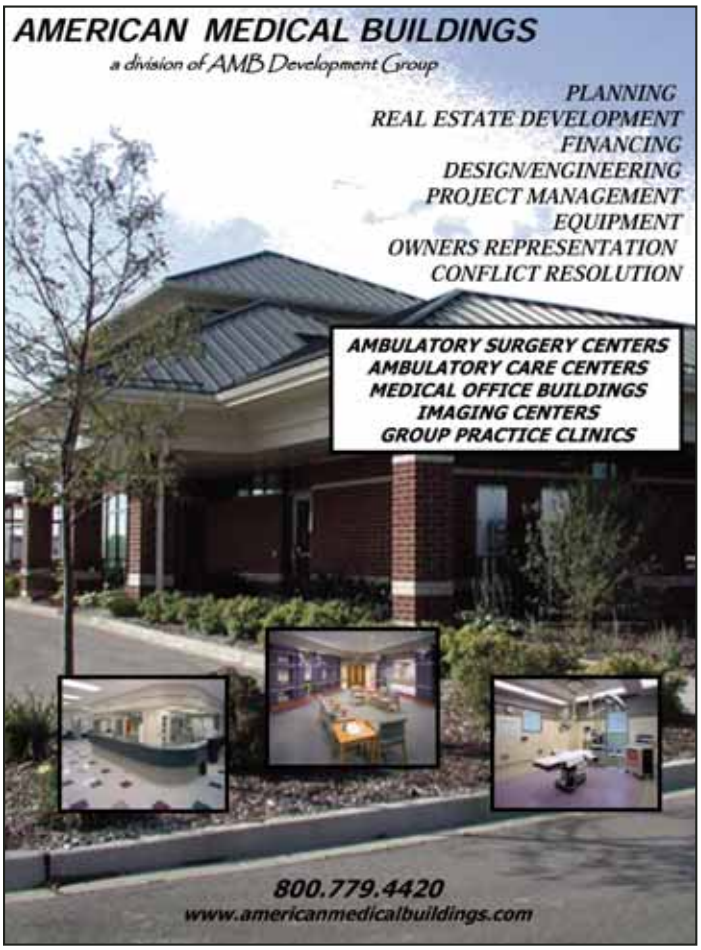

Latest Supply and Equipment Trends

Successful ASCs are known for their quality care and efficient operations. But often it's their cutting-edge surgical procedures and use of new supplies and equipment that puts them a step above the rest. To help your ASC make that step, experts share some of the new surgical supplies and equipment (in no particular order) being used in their facilities.

Supplies

1. Power port (*Bard*). This is an MRI-safe implantable port. "The port is advantageous to our chemotherapy patients because it can infuse more quickly and receive pressure better than previous ports," explains Gary Malinowski, ORT, the materials manager at Santa Barbara Surgery Center in California.

2. PPH stapling device. This device is used to eliminate hemorrhoids with staples as opposed to the traditional suturing. "Use of this device in our ASC has led to decreased recovery times and less postoperative pain," says Mr. Malinowski. His ASC uses a device manufactured by Ethicon Endo-Surgery.

3. Pubovaginal sling. This is a surgical device used to control female stress incontinence. "Our surgeons are using the ARIS pubovaginal sling (from Coloplast) to correct female incontinence and have decreased their operative times to ten minutes!" highlights Robert Welti, MD, the medical director of Santa Barbara Surgery Center.

Equipment

1. Booms. Booms are structures affixed to the OR ceiling that hold monitoring systems, electrical surgical units, medical gases and other equipment. Booms provide an effective way for ASCs to organize equipment, integrate systems and free up floor space in the OR. "While booms have been available for several years, we have seen an increasing interest in them, particularly in newly constructed ASCs," says Matt Sweitzer, the president of Alpine Surgical Equipment.

2. Communication integration. Communication integration involves importing various surgical images onto one flat screen monitor in the OR. With the press of a button, touch-screen control or other device, a surgical team member can immediately access different images from a patient monitor, endoscopic camera, C-arm, X-ray or other remote machine.

3. Electronic medical records system. Electronic medical records systems are being used more and more by ASCs in order to improve the quality of care, reduce paper and files, reduce risks, cut costs and increase revenues, says Mr. Sweitzer. "ASCs are particularly impressed with the ability to efficiently and effectively monitor and manage a patient's care," he adds.

A good way to save money on expensive equipment is to buy it refurbished, advises Mr. Sweitzer. "As long as you can ensure the quality of the equipment by using a reputable company with certified technicians, your savings can be anywhere between 30 and 50 percent of the original cost," he explains. Be sure get at least a year's full warranty on parts and labor, he adds.

– Dana Kulvin, JD, MPH

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