

# ASC BECKER'S Review

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

## I Heard I Was In Town – Measuring ASC Staffing Costs

By Joseph S. Zasa, Principal – Woodrum/Ambulatory Systems Development

We received numerous responses regarding a quote in a recent edition of this newsletter. The statement generated interesting questions and responses. A paraphrase of the quote is:

**Staffing costs should be 20% of net revenue or lower. If not, it is an indicator of mismanagement.**

As the author of this statement, the responses were surprising since there is at best a vague recollection of the quote and the interview. In fact, I had to research back issues of this periodical to find the quote. The whole scenario reminded me of the Jimmy Buffet song, "I Heard I was in Town." Interestingly, at the risk of sounding like Charles Barkley who said he was misquoted in his autobiography, I do not necessarily agree with "my own" statement since it is accurate in some instances, but potentially misleading in others. In this instance, the problem may be that the statement was not expanded on in its proper context. Nevertheless, the responses are appreciated since it provides a good basis for this article and allows us to examine the very important issue of measuring staffing costs in ambulatory surgery centers.

### The Inherent Dilemma

Staffing costs are the first or second highest expenditure in a surgery center and effective management of this cost is a key function of effective administration. The challenge is that staffing is not a variable cost in the traditional sense whereby the more patients at the center, the more staff are hired. Rather, the ASC industry consists of generally small businesses that we estimate, on average, perform 200 cases per month. In fact, 64% of all

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## 33 Things You Should Know About Ambulatory Surgery Centers

By Scott Becker

There are many misconceptions about ambulatory surgery centers and the best ways to run them. To help you better understand ambulatory surgery centers, here is a list of thirty-three things that you should know about surgery centers. Should you have comments or disagree with an item, please email [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com).

### 1. CMS' Proposed New Rates Decrease ASC Reimbursement.

The new proposed Medicare rates for surgery centers are generally very negative. They essentially set reimbursement at an amount equal to 62% of the price paid for the same surgical procedures at hospital outpatient departments. These rates, if made final, will take full effect in 2008. Under the proposed rates, of the top 20 procedures performed in surgery centers, 17 will suffer a decrease in reimbursement. For many procedures, the decreases will be significant. For example, reimbursement for many gastroenterology and pain management procedures will decrease nearly 20 to 30%. Many ophthalmology procedures will experience a 10 to 15% reduction in reimbursement. Ultimately, many high volume procedures will cease to be profitable to perform. **The lower reimbursement rates can result in unintended impacts.** For example, the proposed lower rates will increase the number of parties that attempt to "game the system" through joint ventures that operate "under arrangements." In addition, lower reimbursements at surgery centers and higher reimbursements at hospitals may incentivize physicians to develop (and convert to) small hospitals instead of surgery centers.

**2. Many ASCs Still Fail.** Despite their growth throughout the country (nearly 6,000 ASCs), a number of ambulatory surgical centers still fail. The failures occur mostly due to bad management, low volume, poor reimbursement, or overbuilding. Knowing the risks involved in developing an ASC can

help to ensure that your ASC will prosper and not fail. Working with experienced managers in developing a center can also help prevent failures

### 3. RNs Often Make Superior Administrators. Experienced registered nurses often make great ASC administrators.

The RN must study and be interested in the business side of ASCs. Generally, RNs are trained to be disciplined and dedicated workers; a work ethic that carries over to the administrator position. As such, RNs are often vibrant and willing to contribute in a myriad of ways to improve the surgery center.

### 4. Leasing Equipment From Physician-Investors is Often a Bad Idea.

While it can look attractive, leasing equipment from entities owned by ASC physicians is often a legally risky business. Often these arrangements can be viewed as thinly veiled disguises to incentivize physicians to use the centers; arrangements generally viewed by the government as illegal. As such, as a rule these arrangements should be supported by a fair market value analysis, make business sense regardless of referrals, and preferably be set as a fixed annual fee and not as "per click."

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## Letter from the Editor

This is a tremendously uncertain time for ambulatory surgical centers and for providers who believe in a competitive healthcare environment in general. There are a number of different issues percolating that have the ability to deeply strengthen or deeply harm competitive healthcare. This issue provides a discussion of a broad array of healthcare topics. It also focuses to a certain extent on “turning around” surgery centers.

### Certain of the issues that are impacting healthcare include:

**1. Political Balance.** Before the election, there existed a political balance on health care issues between the House of Representatives and the Senate. At that time, a Republican controlled house provided a balance to a Senate (also Republican majority) that was more hostile on some issues towards competition in healthcare. The change in makeup of the House of Representatives and Senate, and a move towards a more Democratic constituted House and Senate will likely have a long term negative impact on competition

in healthcare. This is largely due to the fact that the Democrats as opposed to the Republicans have been more supportive of single payor initiatives, and expansions of laws such as the Stark Act that would restrict physician ownership of healthcare facilities with which they work. While changes may not occur fast, there is certainly a possibility that a change in the makeup of the House of Representatives would particularly have a negative impact on competition in healthcare.

### 2. Reimbursement Rates for Surgery Centers.

As most people are aware, CMS has proposed substantial reductions in payment rates for ambulatory surgery centers. These can have significant impacts on the profitability of surgery centers and the motivation to continue to grow and develop ambulatory surgical centers. In the face of such changes, different research analysts and investment banks have taken different positions on the potential impact on surgery centers. For example, one investment bank, Bank of America, lowered its ratings on the entire industry based in part on changes on out of network business and in part based on changes in Medicare reimbursement. Here, it downgraded the stock

of each of Amsurg, United Surgical Partners, and Symbion. In contrast, another investment bank actually raised its outlook on Symbion based on its view that the changes in Medicare reimbursement would have an overall mildly positive impact on Symbion due to its mix of orthopedic cases versus other types of cases.

### 3. Texas Sized Credentialing Case.

In what has been called a Texas-sized verdict, a hospital and certain physicians were hit with a \$366 million verdict in a lawsuit based on the improper or malicious revocation of privileges of a physician. The case discussed the concept of summarily suspending the physician without proper due process and a whole number of other items that lead to this verdict. In a fascinating situation, the hospital and its physicians were caught in a real “Catch 22.” If they did not suspend the physician, they potentially ran the risk of malpractice cases due to allowing the physicians to practice. They might also face Texas-sized verdicts. They acted quickly to suspend the privileges and in their view to protect patients and ended up with a horrible verdict.

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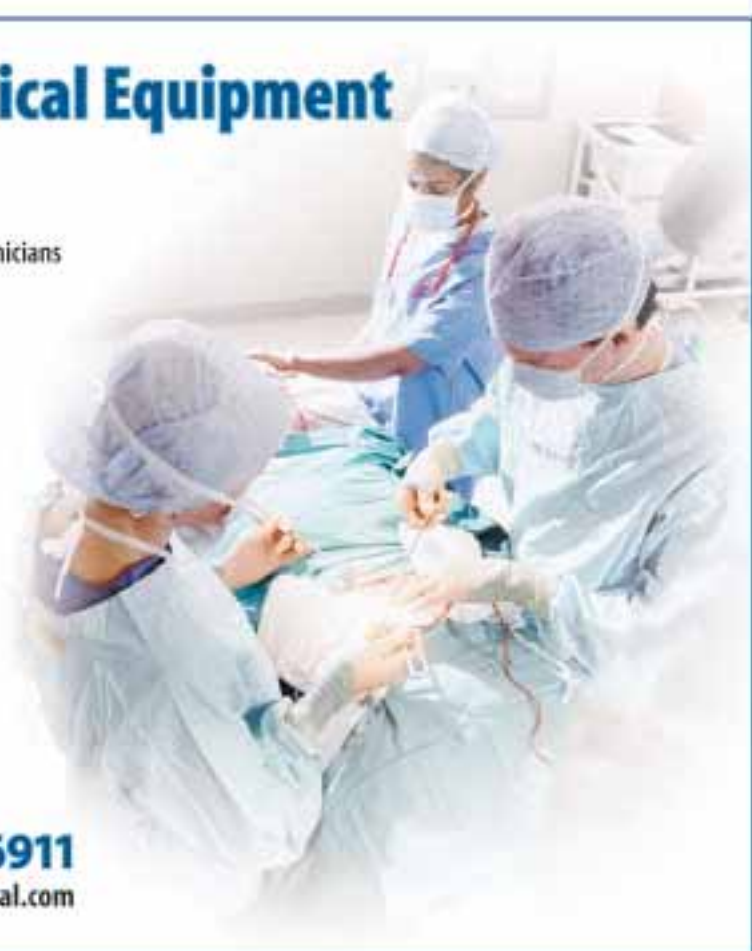
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This lawsuit, which we expect will be appealed, points to the continued need to be extremely careful with respect to credentialing decisions whether in the ambulatory surgical center setting or the hospital setting.

**4. Deals and Transactions.** We have had the great privilege, at the end of the third quarter, of helping to complete three different and interesting transactions. First, we had the chance to help a mid-sized hospital in California sell their hospital to a newly formed company called Tru Medical. This transaction involved the sale of 50 percent of the ownership of the hospital as well as the related real estate of the company. It was truly an exciting transaction to be a part of. Second, we had the opportunity to help Ambulatory Surgical Centers of America and its physician partners to help sell a surgical center in Texas to United Surgical Partners. Finally, we recently completed the sale of a surgery center in Colorado to National Surgical Care. For information regarding Tru Medical, please contact Tim Lavendar at 972-870-5142. For information regarding National Surgical Care, please contact Rick Pence at 972-447-8285. For information regarding Ambulatory Surgical Centers of America, please contact Brent Lambert at 781-258-1533. For information regarding United Surgical Partners, please contact Brett Brodnax at 972-713-3500.

We also had the opportunity to work to complete investments by each HealthMark Partners in a surgery center in Tennessee and to help Regent Surgical Health join with physicians and a hospital in Indiana to joint venture a center. Finally, we worked closely on a project led by physicians to develop a large hospital in California. There, Cirrus Healthcare is helping to drive the project forward. For information regarding HealthMark Partners, please contact Bill Southwick at 615-329-9000. For information regarding Regent Surgical Health, please contact Tom Mallon at 708-492-0531. For information regarding Cirrus Health, please contact John Thomas at 817-837-1187.

**5. Turning Around Ambulatory Surgical Centers.** The formula for turning around ambulatory surgical centers is misleadingly simple. In short, it amounts to increase cases, increase reimbursement, and/or reduce costs. Notwithstanding the simplicity of the formula, these steps are often extremely difficult to implement.

First, the recruitment of physicians in many markets is extremely difficult. Further, many physicians do not wish to join a facility that is not already succeeding. Where a facility is already succeeding greatly, physicians do not want to pay fair market value for the shares they need to buy to become owners in the center.

Second, increasing reimbursement takes a mix of finesse and strong resolve. First, parties can attempt to renegotiate with their payor. There are, of course, experts in handling such types of renegotiations. Naya Kehayes of Eveia Consulting and Management comes to mind. They can do this by themselves or with the help of Naya or a third party management company. Second, as part of the negotiations, they can work toward carve outs, they can work toward attempting to fix reimbursement for their top 10 to 20 procedures or they can handle it as an across the board negotiation. The negotiation is a mix of relationship building over the long run plus playing hardball from time to time. Increasingly, hospitals and payor periodically play hardball and have well publicized disputes over their differences over contracts. For surgery centers, many do not have the market power of hospitals. Thus, they often need to play hardball in a different manner. Specifically, they will look at methods by which to treat patients out of network rather than taking standard reimbursement.

The third core method for improving profitability is to cut costs. This often comes from reducing staffing, which is the largest single expense of most surgery centers. This often does not mean laying people off but it does often mean not hiring another person when somebody quits, closing the center a few days a week and trying to cluster as many cases over two or three days as possible, and attempting to reduce hours that the surgery center is open. We believe in paying the highest rates per hour but attempting to run a tighter ship. With regard to the cutting of costs, it takes tremendous discipline and willpower. Nine out of ten centers will tell you it cannot possibly reduce cost. However, in my experience, a willing leadership board can find ways to cut costs if they are willing to take some of the negative feedback that comes with it. Centers can cut costs through the better purchasing of equipment and supplies. It is often the situation where leadership of a center is "persuaded" to buy the newest or

most exciting supplies, implants, or technology. Often, the older technology and supplies and equipment can be cheaper but effective. One of the best examples of this I have witnessed related to a urology center. There, the urology center had to decide between buying a used stationary lithotripter, this was about ten years ago, or buying a brand new lithotripter. They ended up buying the used lithotripter for about \$200,000. The lithotripter paid for itself within about six months. Finally, recently, they actually had to step up to the plate and buy a newer model. The experience though, was convincing in terms of how effective it can be to purchase inexpensively.

**6. Electronic Medical Records.** With stops and starts, larger physician practices and some smaller practices as well as ambulatory surgical centers are starting to look regularly at the implementation of electronic medical records. Two of the leading sources which serve the ASC marketplace include ZChart and AMKAI, Inc. For information on either company, please contact Tom Felstead at ZChart at 866-924-2787 or contact Craig Veach at AMKAI, Inc. at 866-265-2434.

Should you have any questions on any of the items listed in this letter or any of the articles in this newsletter, please contact myself at 312-750-6016 or by email at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com).

Very truly yours,



Scott Becker

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### 33 Things You Should Know About Ambulatory Surgery Centers **continued from page 1**

**5. High-Quality Management is Key to Success.** High-quality management is critical to an ambulatory surgical center's success. Many management companies offer superior services. However, many are of little value. All management companies are not equal. For this reason, it is important to work with an experienced management company that has a proven track record of successes. Working with a low-quality, inexperienced company will do more harm than good.

**6. Paying Fees Plus Equity to a Management Company is Often the Norm.** In addition to a management fee, increasingly, the leading management companies are requiring fees, as well as a small portion of equity in the surgery center. Before writing off such an arrangement, evaluate how that management company compares to other management companies.

**7. Buying Out Non-Productive Partners Is an Option.** There is no silver bullet for buying out the equity in a center held by a physician who does not produce as expected. There are heavily weighted legal issues that relate to such issues. Whether or not you can buy out a partner is a critical legal question that must be examined in light of the ASC safe harbor regulations and their "1/3<sup>rd</sup>

– 1/3 rules, amongst other factors. Newly touted strategies like "squeeze out" mergers often carry substantial risk.

**8. Distributing Income Based on Referrals is Illegal.** A surgery center cannot distribute ASC income, whether the ASC is owned indirectly or directly by physicians, based on the referrals or the value or volume of referrals by physicians. The federal (and many state) government deems these types of distributions illegal. There is no "clean" way to avoid this rule.

**9. Growth Strategy is Key.** An ASC will not succeed long-term without an ongoing comprehensive growth strategy. A growth strategy should include goals for increasing case volume and types of procedures, and potentially increasing the ASC's size and number of physician investors. A stagnant ASC will not be able to effectively compete with other centers and hospitals that are actively vying for business.

**10. An ASC Can Have Too Many Physician Investors.** Perhaps you cannot be too thin or too rich, but you *can* have too many physician partners. With too many physician investors, there is often a dilution of individual physician responsibility and ownership interests. With less "skin in the

game," physician investors often lose their commitment to the ASC and often look for other alternatives.

**11. Think Twice Before Opening a Second Site.** Business may be booming and you may be considering opening a second site. Before embarking on this project, STOP! The surgery center business is based on economies of scale and therefore the more cases that can be performed at any one site with one staff results in higher profits. Opening another site, with double overheads, often results in diluting the profits at both sites. For this reason, opening a second site is generally bad, not good, for business.

**12. Third Party Reimbursement.** High reimbursement of procedures by third party payors at ambulatory surgery centers is becoming more difficult to obtain. Further, reimbursement differs dramatically throughout the country. For this reason, a mediocre ASC located in an area with strong third party reimbursement may do better than a great ASC in a bad reimbursement market. There is almost no way to fix a center that is built in a market with poor reimbursement from third party payors.

**13. Ophthalmology Procedures are Still Profitable.** While many parties scoff at

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ophthalmology procedures, do not make a blanket decision to not seek ophthalmology as a specialty. Even with the changes in Medicare reimbursement, ASCs can still profit from ophthalmology procedures if the ASC has significant volumes and has effective internal cost control (i.e., it is run very efficiently).

#### 14. Pain Can be a Four Letter Word.

Pain management services are often provided in an office setting. Centers are increasingly concerned that physician investors will perform their pain management procedures in their own offices rather than in the ASC. Medicare's site of service differentials, which often pay more for in-office procedures, along with other incentives, may very well encourage physician investors to perform these procedures in their own offices. Because of this, ASCs should plan accordingly and diversify services to accommodate a potential loss of pain management revenue. CMS has also proposed large reductions in pain management reimbursement for ASCs.

**15. Endoscopy.** Gastroenterologists will increasingly have to minor in anesthesiology. Increasingly, payors will not pay physicians separately for anesthesia procedures provided in connection with gastroenterology procedures. Thus, increasingly gastroenterologists must be competent at offering all types of anesthesia procedures.

**16. Plastics.** Plastics, at least cosmetics driven plastics, are procedures that are best left to discussion in the movie "The Graduate." In "The Graduate," Dustin Hoffman's character is advised that plastics will be the future. In surgery centers, plastics, particularly cosmetic procedures, do not provide the type of future that we would like to see. In many situations where the physician bills globally, the ASC and physician can be adverse to each other and the ASC must negotiate its own rates with the surgeon.

**17. Do Not Count on Bariatrics as a Long-Term Profit Center.** Bariatric procedures are growing rapidly and increasingly being performed in ASCs. Initially, ASCs will earn outsized profits from these procedures. However, as the number of bariatric providers increases and price competition evolves, the prices on these procedures will eventually normalize and become less profitable. For this reason, and because there remains substantial concerns regarding the safety and risks related to bariatric programs, ASCs should use caution and be conservative when developing bariatric programs. For more information on the risks involved in bariatric surgery see *Modern Healthcare* September 11, 2006.

**18. Lasik.** Lasik is best left to practices rather than surgery centers.

**19. Do Not Overbuild.** Overbuilding an ASC can result in its demise. A center that has substantial fixed building and equipment costs, will likely face long term cost problems. To prevent this from happening, the ASC should be built to meet the expected volume and specialty needs. There are not many things that can predict the long term death of a center more than over expenditure on fixed building costs and fixed equipment costs. These are costs that almost never go away. Where appropriate and fiscally viable, an ASC may consider building to accommodate future growth but this should be done with caution.

**20. A Great Staff Makes for a Successful ASC.** A great staff is crucial to an efficient and profitable ASC. You need not necessarily employ your staff full time. However, you are best off paying your staff extremely well and attempting to obtain the highest quality staff – even if paid high on an hourly basis. It is also critical that you treat the staff extremely well so that you are able to recruit and retain the best possible staff. Finding and retaining an experienced and competent staff can be difficult.

**21. Partnering with Single Physicians is Risky.** An ASC developed with only one or two physician investors is a risky proposition in most cases. It can create both political and financial problems. Often, one or two



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physicians generally cannot generate enough business to make the operation profitable. However, there are some situations where an ASC can be profitable with only one or two physician investors. For example, an ear, nose and throat physician specializing in sinus procedures may succeed himself or with a single partner if the ASC is run efficiently and the procedure volume is high.

**22. Small Hospitals Can Be a Good Alternative.** Increasingly, ASCs are successfully converting into small surgical hospitals. Investors benefit because reimbursements tend to be higher and small hospitals have more flexibility to add a variety of procedures, which increases profits. However, there are substantial increased costs and risks related to operating a small hospital. For example, the federal (and some state) government may enact legislative barriers to developing specialty hospitals. In addition, many states have a multitude of costly regulations for hospitals.

**23. Small Hospitals Should Remain Small.** Small hospitals can withstand problems and be successful because they can rely on a few core specialties or groups to be profitable. However, once a hospital is greater than about 50,000 square feet its fixed costs increase exponentially and the

services it provides must also increase in order to sustain itself. A small surgical hospital has greater financial flexibility, a flexibility that is lost when the hospital becomes too big.

**24. Work with Experienced Lenders.** Working with experienced lenders will facilitate the financing of an ASC. It can be tempting to work with a friend or a local bank, but this could be a mistake. Often with ASCs, time is of the essence and problems occur which are normally much better handled by an experienced lender than with a friend. For the best result, look for a lender with specific ASC financing experience.

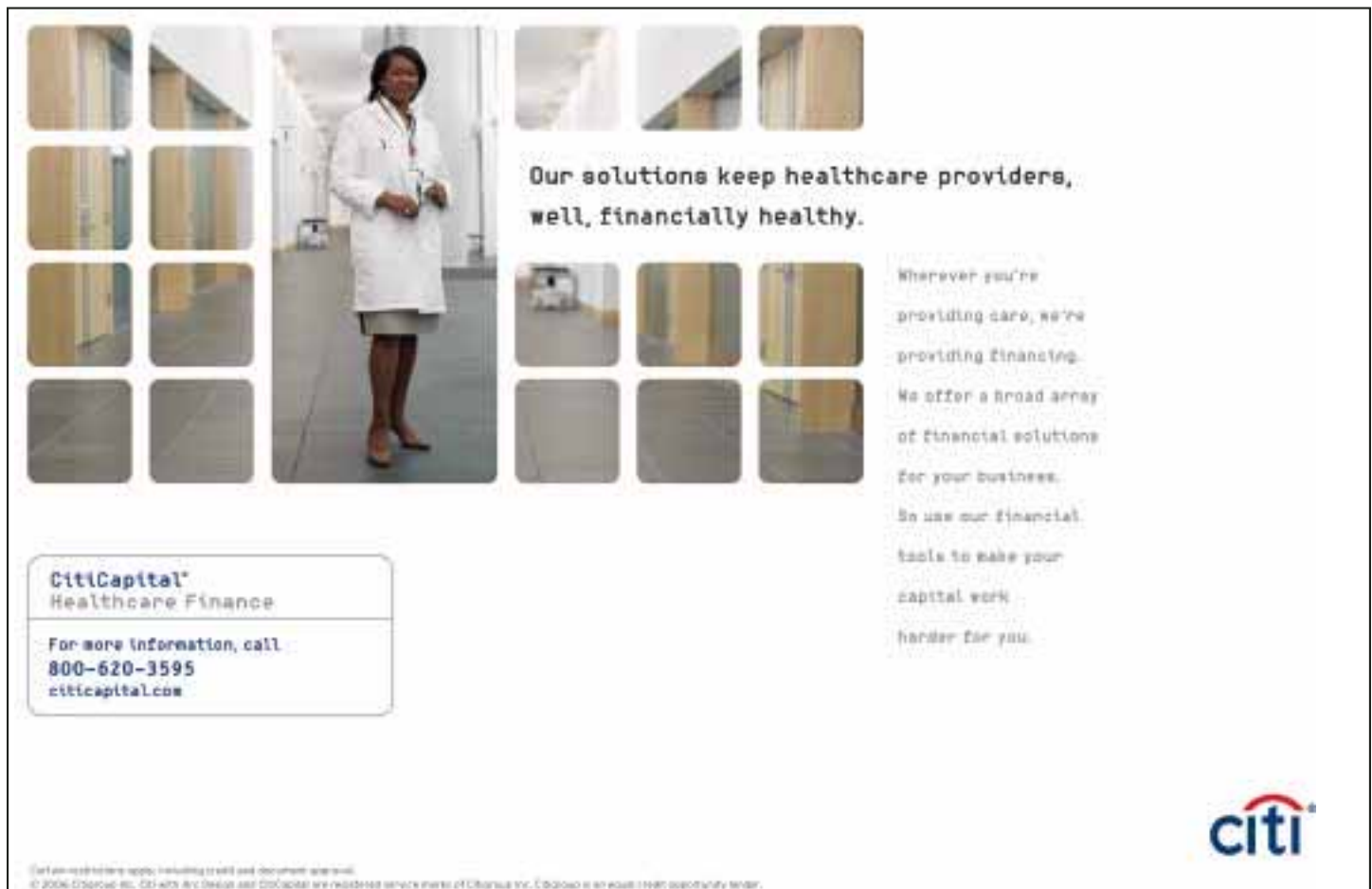
**25. Continually Recruit New Good Partners.** Generally an ASC should regularly recruit new surgeons. New surgeons can add capital and provide a transition from older or retiring surgeons, to keep the ASC viable. While it is important that new recruits be productive physicians and meet the Safe Harbor tests, it is equally important that they be high-quality people and team players. Often in ASCs, one difficult physician (or staff member) can ruin a great center.

**26. Neurosurgery and Orthopedics Remain Strong Specialties.** Orthopedic

procedures remain great procedures for ASCs, neurosurgery spine procedures increasingly so. They remain popular and growing specialties for ambulatory surgery centers. Orthopedics profit from the new CMS surgery center rates. Spine procedures can be increasingly performed in ASCs. These are likely to remain good specialties for ambulatory surgery centers for a long time to come.

**27. Take Care When Waiving Copayments.** The waiver of copayments and deductibles creates a number of issues for surgery centers. There are often legal constraints to such waivers. Waiving copayments and deductibles can be especially attractive to level the playing field for ASCs that do not have specific managed care contracts. However, a number of issues must be considered before waiving copayments. For example, several states have adopted some form of prohibition on waiving copayments.

**28. Good A/R, Billing and Collections is Key to a Successful ASC.** Well managed accounts receivables and billing and collections departments is critical to help ensure the success of an ASC. Cash collection is critical to an ASC and any delays or defaults in billing or payment can damage a bottom line. Consider hiring billers



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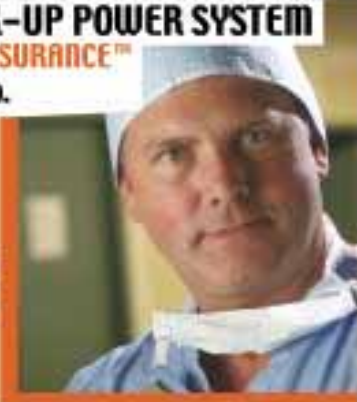
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and coders or a billing company with specific ASC billing experience.

**29. Do Not Discriminate Against Public Payors and Their Patients.** With the new Medicare fee schedule decreasing many reimbursements, ASCs may want to stop providing care to Medicare patients. This is often bad business and bad politics. However, we do have concern that with the new Medicare fee schedule, there will be increasing incentives to not provide services to Medicare patients.

**30. Charity Care.** Providing a fair share of charitable care is a positive and good thing.

**31. Do Not Provide Physicians with Free Office Space.** Providing any free benefits, such as office space or other types of services or value to physicians, is generally unlawful under federal anti kickback laws.

**32. Gastroenterology Can Still Be Profitable.** Medicare recently proposed decreased reimbursement for gastroenterology procedures performed in an ASC. This can hurt an ASC because gastroenterology-endoscopy centers typically rely on Medicare for about twenty to forty percent of their cases. Fortunately because these centers still generate from sixty to eighty percent of their gastroenterology business from outside Medicare, the specialty can still be profitable if that "outside" business continues to grow.

**33. ENT Continues to Be Strong.** Ear, nose and throat continues to be a strong specialty for surgery centers. It continues to be reimbursed reasonably well in many markets. ■



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**I Heard I Was In Town – Measuring ASC Staffing Costs continued from page 1**

ASC's have 20 or fewer employees. Source: *Federated Ambulatory Surgery Association*. This means that surgery centers do not initially generate significant economies of scale that lend themselves to formula driven sliding scale measures. The reason is that a center must employ a core group of staff in order to operate. As an example, a surgery center will have relatively the same number of staff to perform 100 cases per month that it will to perform 175 cases per month. This creates a measurement dilemma because staffing costs are fixed for a base level of cases, and become somewhat variable once the center performs additional cases. Thus, there is no sliding scale or easy measure that states for each additional case, staffing should be "x." The fact remains that staffing is a "quasi-variable" cost. A core staff is required to operate a center regardless of the number of cases, but a variable element is introduced once the center meets a base level of volume each month. Using the previous example, a surgery center may have 11.0 FTEs to perform 125 cases, 12.0 FTEs for 150 cases, and 13.0 FTEs for 200 cases per month. Therefore, in this example, economies of scale begin to be derived after the initial 150 cases per month and do not play a significant part in staffing

options until the center reaches 200 or more cases a month.

**Slicing the Data**

With this dichotomy between fixed and variable costs, how does a manager effectively measure and control this cost? We suggest that:

**Staffing costs are measured based on the relative size of the ambulatory surgery center as determined by its average number of cases performed relative to its case mix, market conditions and reimbursement.**

This means that surgery centers should be "sliced" based on:

1. The number of cases performed per year.
2. The type of cases performed by specialty, or the case mix.
3. The market conditions in terms of wages paid to employees; and
4. The amount of reimbursement on the cases performed by each specialty.

As discussed previously, there are few economies of scale until a center generates at least 200 cases per month, or 2,400 cases per year. These centers (less than 2,400 annual cases) should be grouped together and compared against one another since

their data is significantly different than the larger centers. For example, a multi-specialty surgery center that performs 150 cases per month must have higher staffing cost per case than a center with the same mix performing 500 cases per month since there are few economies of scale generated. See above.

Second, and perhaps more importantly, centers should be grouped based on the type of cases performed. A plastic surgery center will have radically different ratios than an endoscopy center. Thus, the data must be sorted based on case mix.

Third, the common measurement tools shown below will be skewed if the market conditions are abnormal. For example, the wage paid to a

registered nurse in San Francisco will be significantly different than the wage to the same nurse paid in Thibodaux, Louisiana. The annual FASA Salary Survey is a good tool to assess the relative impact of this since it is sorted by region.

Finally, payer reimbursement also radically impacts the ratio analysis. This is best illustrated by comparing a center that performs the majority of its cases at contracted rates with a center that performs a majority of its cases out of network. While being out of network impacts the number of cases, the reimbursement per case is typically higher. This will skew the ratios and must be factored into the analysis.

**Dicing – Key Measurement Tools**

Once the surgery center is categorized with its peers, it should be further "diced" using key measurement tools to assess staffing.

Prior to using the measuring tools, an agreed upon definition of staffing costs must be determined in order to best analyze the data. We suggest hours worked at the surgery center for the period (exclusive of bonuses, paid time off and vacations) is best for operational measures such as staffing hours per patient and staffing cost per patient. The benefits and bonuses should be separated on the income statement and measured separately using easily found benchmarks that are beyond the scope of this article.<sup>1</sup> Additionally, business office staff must be included in the measure along with administrative staff. The following are key measures along with some general guidelines:

1. Staffing as Percentage of Net Revenue - the total staffing cost (defined above) divided by the net revenue. Again, this should be interpreted based on the type of cases performed, the number of cases (small or large center), and the payer mix. For a large multi-specialty center, a range of between 23-25% is normal. For a high volume, high turnover center (i.e., endoscopy) this number is typically lower.
2. Staffing Cost Per Patient - the total staffing cost divided by the number of patients. This is a good measure, but must be interpreted properly. Again, the type of cases performed will be the major factor in determining an appropriate benchmark. Market salary conditions are also important. For a multi-specialty center performing 3,000 cases per year in a normal market, we like to see this below \$325.00 per case.



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<sup>1</sup> For the benefit of the reader, we see benefits running between 23-25% of payroll exclusive of bonuses.



3. Staffing Hours Per Patient – this is one of the best tools. It is the total hours worked divided by the number of cases. This filters salary anomalies and revenue anomalies and measures productivity. Again, it is a per-patient measure and this necessitates that the data be interpreted based on the type of cases performed (i.e. a pediatric center may have a slightly higher number than a center with an adult base with the same volume). Again for a multi-specialty center, 10.0 to 11.5 hours worked per patient is reasonable.

**Summary**

It is important to measure staffing costs to determine if a center is being operated efficiently. Since staffing is not a static measure and is a mix of fixed and variable costs, benchmarking is the best way to assess a center. However, in order to obtain meaningful benchmark data, the surgery center must be measured against similar centers with the same or similar number of cases, payer mix, type of cases, and surgical specialties within its region. Once complete, there are several ratio measures that can be used to assess the staffing performance.

Data measurement and benchmarking provides an objective assessment of operations, but it is only one of many devices that an effective manager uses. On site assessment and in depth understanding of operations cannot be replaced. Effective managers use the data as a tool to “know where to look.” The best managers are aware that each center is unique and should not be operated off a spreadsheet. Notwithstanding, the most effective managers use the staffing data as a valuable tool to augment on-site assessment of operations and drive efficiencies at their surgery centers. ■

*Joe Zasa is a co-founder and Principal of Woodrum/Ambulatory Systems Development, a national ambulatory surgery center management and development firm founded in 1996. He is a member of the Virginia State Bar and speaks frequently on the topic of ambulatory surgery center development and management. He has published numerous articles related to ambulatory care and can be reached in the Dallas, Texas office at (214) 369-2996.*

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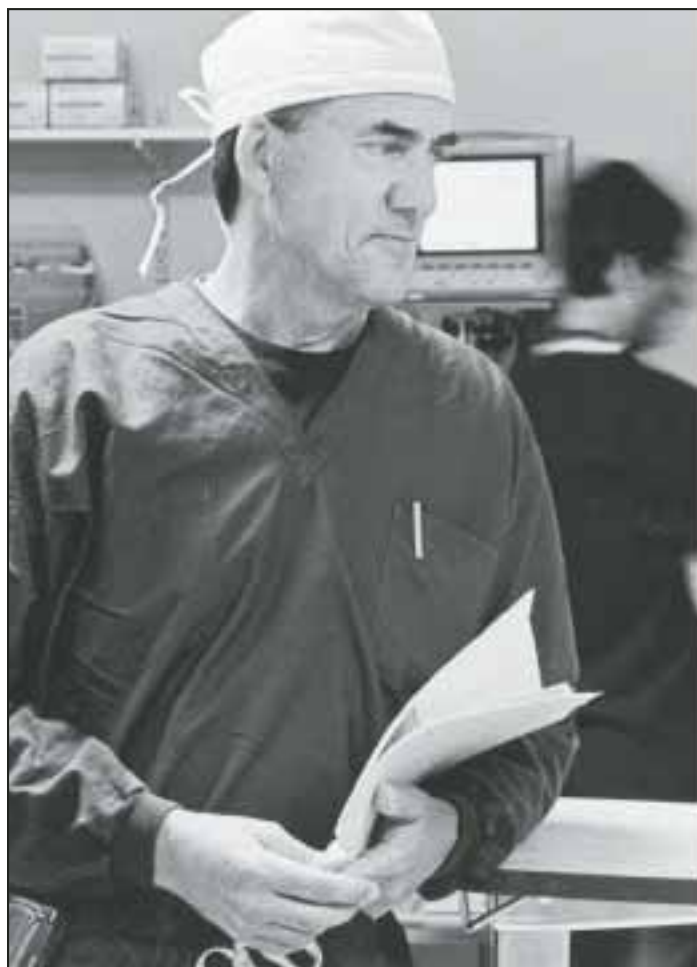
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# Five Signs You're In Need Of Outside Intervention: ASCOA's Perspective

By John Harris and Luke Lambert\*

If a surgery center is supposed to be a for-profit venture, why are so many in the red? Over the past twenty-plus years Luke Lambert, who is president of Ambulatory Surgery Centers of America, or ASCOA, has started and/or turned around dozens of ASCs. Lambert sees five distinct areas in which centers can improve to put the center in the black. Yet one aspect – commitment – is the most important.

"Turning a center around requires the commitment of the owners and staff to make the changes that need to happen," he says. "If you don't have that commitment you will trip. Change is critical if you're engineering the turnaround, so people have to be willing to change." Beyond commitment, here are the five top problems Lambert has identified:

## ■ Lack of cases equals low revenue

Struggling centers usually don't have enough cases or the proper mix of cases.

Physician owners need to have a commitment to work with the center as an extension of their practice. Often new owners need to be recruited to a center to provide improved stability. "Sometimes people want to ride the coattails and no one is wearing the coat," Lambert says. "Everyone needs to wear the coat."

## ■ Costs are too high, or worse, unknown

Most centers in need of a turnaround have costs that are too high. Lambert likes to see successful centers with 19 percent of the annual budget in staff costs. "We have seen centers where the percentage is 50 percent," he says.

Often, centers don't adjust hours based on volume and scheduling. "If you don't have full-time volume, you should adjust staff accordingly," says Lambert. Instead of full-time staff, a center can rely on part-time staff, which provides flexibility and reduces cost.

in trouble have too much debt and keep borrowing to stay afloat. Even a healthy center is usually highly leveraged, so it is critical to keep costs in line and stop borrowing, says Lambert. "Most lenders want to see a debt coverage ratio of 1.3 or better."

Lambert also notes that financially healthy centers can negotiate better interest rates, which could save hundreds of thousands of dollars.

## ■ Bad contracts lead to unprofitability

Many centers accept contracts without understanding the cost and reimbursement implications. "You have to know that the contract will cover all your costs, not just the procedure itself," says Lambert. "It usually goes like this: the administrator receives a contract from a major insurance carrier and says, 'Oh, we need that one, so go ahead and sign it. It's a lousy contract, but we can't live without it.' But you can lose your shirt." Lambert recommends that each contract be negotiated individually.

## ■ Collections are weak

At ASCOA centers, Lambert expects to collect within 28 days. Many centers that are in trouble collect in about 90 days, which impacts cash flow and ultimately profitability.

He emphasizes the need for a strong process, a "collection culture" and hiring the right personality to handle billing and collections. "You need someone who gets bills out right away and follows up so everyone can get a paycheck," he says. At one ASCOA center, the billing person began calling before the payment due date, and payers started paying early to avoid the call of the center's billing person.

When it comes to turning around a center, Lambert also believes it's important to have an outside perspective and experience at turning centers around. A developer with ownership brings expertise, experience and commitment – the first and most important quality in turning an ailing center around. ■


Habits need to change too. Often times, physicians don't know what it costs to perform each procedure, and many physicians operate out of habit. "We had one situation in which one physician was doing knee arthroscopy for \$380 while it was costing the center \$1,400 for another physician," says Lambert. "When we compared preference cards, the physician who was doing the procedure for \$1,400 said 'I don't need all this stuff.' He cut \$900 out right away."

## ■ Too much debt leads to poor financial health

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# An ASC In Need of Drastic Improvement – 26 Questions You Should Ask

By Scott Becker

1. Can you expand the types of procedures the ASC is performing?
2. Can you recruit additional partners?
3. Is there a local hospital that might buy into the venture?
4. Should you replace the administrator or director of nursing?
5. Can you close the center one to two or more days per week to reduce staff costs?
6. Do certain physicians want to add more capital?
7. Can you pay down center debt to reduce monthly debt cost?
8. Can you start to make small distributions?
9. Can you standardize purchasing to reduce supply costs?
10. Can you buy bigger cost items cheaper?
11. Can you bring in a management company with expertise in turning around ASCs?
12. Can physicians who are owners utilize the center more?
13. Can you renegotiate managed care contracts?
14. Can you use a benchmarking tool to better understand your costs per case?
15. Can you do better on reimbursement out of network vs. in network?
16. Can you buy used equipment and not new equipment?
17. Can you buyout non-safe harbor compliant doctors?
18. Are there specific procedures that are causing you great financial problems – are you losing money on each case?
19. Can you add spine and lower disk procedure surgeries?
20. Can you add green light laser or lithotripsy procedures?
21. Can you renegotiate loan terms with your lender?
22. Can an expert help you better assess your largest costs and methods to reduce them?
23. Can you improve your billing and collections?
24. Is there a specific nurse or physician that keeps physicians away?
25. Is the anesthesia group helping or hurting the center?
26. Can the center negotiate its rent? Is it paying too much?

For information on turning around ASCs, please contact Scott Becker at 312-750-6016 or at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com).



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# How to Keep Results Up and Sustainable

By Robert Welti, M.D. – Santa Barbara Surgical Center

Here are nine tips from an outstanding ASC\* leader on improving profits:

1. Nothing, NOTHING falls through the cracks. Our business manager looks to bill tons of stuff that was unbilled, not properly billed, etc.
2. We analyze every case with implants, etc., so that we don't end up owing thousands of dollars for things like spinal cord stimulators that we will never be reimbursed for.
3. We relentlessly collect tons of deductibles and copays at the front desk on the day of service.
4. We are cutting down our expenses on everything from internet, phone bills, unnecessary generator maintenance, etc.
5. Our case load is up thanks to pain guys, ENT guys and working closely with surgeons.
6. Great collection efforts from the team.
7. We have ridden ourselves of some less productive employees.
8. We relentlessly track down money owed to us by surgeons and others.
9. We have decreased the monthly debt load.

## In summary:

Increase case load + improved collections + renegotiating contracts + 1000% increase in efficiency of our business office + relentless efforts on the courting of surgeons + decreased monthly debt load after new loan = hopefully sustainable improvements. ■

\* These are the editor's comments and not the author's comments.

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# Five Signs You're In Need Of Outside Intervention: Regent Surgical Health's Perspective

By John Harris and Tom Mallon\*

**B**y some estimates, one-third to one-half of all surgery centers lose money. One reason: as the ASC market matures, increased competition has led to increased pressures on existing ASCs. Yet that's not the only reason. Listen to Tom Mallon, CEO of Regent Surgical Health, which develops and turns around ASCs: "In one center we took over, the physicians were doing penile implants, which cost \$6,000 per procedure," he says. "Yet reimbursement was only \$400 per procedure. So you might have happy patients, but your partners shouldn't be happy."

Beyond increased competition and out-of-control costs, Mallon has identified ten "fatal flaws" that routinely occur at unprofitable centers. The top five are:

- **Gross charges set at less than two times Medicare leads to unprofitability**

Medicare reimburses surgery centers at 50 percent to 60 percent of costs, so if a center charges two times Medicare and gets paid full charges, nothing is left for debt repayment and distributions, according to Mallon. The solution is to use a higher multiple to set the center's charge master. Mallon recommends centers charge five to six times Medicare and to continually review to ensure that costs are set at the right level. "With Medicare reimbursing you for 55 percent of costs, a low charge master is a certain way to lose money," says Mallon.

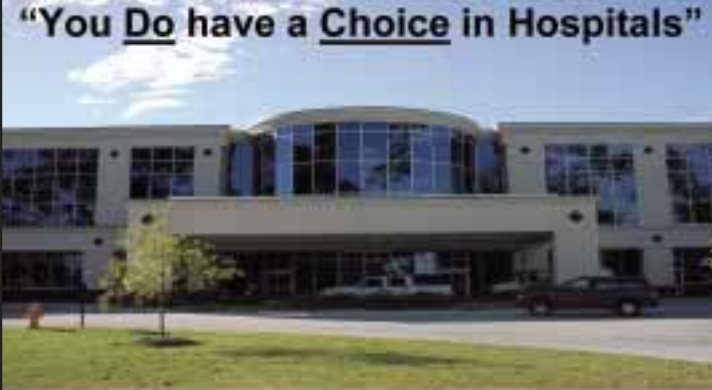
- **Signing every contract doesn't ensure a healthy center**

In healthcare, administrators often sign insurance contracts that aren't profitable for the center. Mallon reminds centers that an opening offer is usually not the best offer, and that contracts need to be negotiated and monitored over time. He recommends that centers only contract with payers that represent more than 10 percent of a center's patients, and that high cost cases should be carved out.

- **Allowing one physician to run the business can lead to disenfranchisement**

Most centers have a star physician that has been a catalyst for the center's development and is, on the flip side, a reason why the center has not fulfilled its potential. Mallon and Regent work with high profile physicians to give them the respect

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they deserve while coaching them on how to help grow the business. "Your greatest strength can be your greatest weakness," he says. "The trick is to work with your biggest asset and work to build something that is bigger and more sustainable."

#### ■ Encouraging productive physicians to leave and start a new center

In centers that have been open for several years, Mallon says it is not uncommon for a group of physicians to leave and start a new center. To prevent this, he recommends that centers and physicians agree to long term agreements with large financial commitments. "You need to have that commitment and buy-in from everyone at the center to start and continue to be successful," he says.

#### ■ Controlling costs begins with knowing them

Many centers, Mallon says, don't have a firm handle on costs of staff, supplies and equipment. He routinely sees centers that are open for 40 hours per week yet don't have enough cases, leaving employees idle between procedures, which drains the center financially.

Purchasing can be a problem; Mallon encourages centers to join a GPO and/or to shop around. He also says used equipment not only comes with a warranty but costs 40 to 60 percent less than new equipment.

Mallon stresses that while centers are strong clinically, they often are not run like businesses. And if they aren't, they're probably not making money, like the center that was doing \$6,000 penile implants and getting \$400 for the procedure. It takes commitment on the part of the physician owners, the developer involved and staff to turn a center around and keep it profitable. And if it is profitable, not only will patients be healthier, but the center will live longer too. ■

\* John Harris is the Founder of a5 Group, Inc. a consulting, marketing and public relations firm. He can be reached at 312-706-2529. Tom Mallon is the CEO of Regent Surgical Health. He can be reached at 708-492-0531.

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# Staffing a Turnaround Center

By Ann Geier, RN, MS, CNOR, CASC  
 Vice President of Operations, Ambulatory Surgical Centers of America, 843-216-2432

**S**urgery Centers change ownership frequently these days. Besides the financial, legal and regulatory concerns, significant staffing concerns can impede a smooth transition between ownership groups.

## How did the employees hear about the sale of the center?

This can have a tremendous impact on the employees. Do they feel that they were treated fairly? With respect? With honesty? Although the responsibility of informing the staff lies with the original owner, this delicate situation is not always handled properly.

I recently took control of a center where rumors of an impending sale filled the halls while the employees and most of the physicians remained in the dark about the center's future.

By the time the anxious and frustrated employees met me, they posed many questions I could not answer. Instead, I promised a search for honest answers.

During most sales, the center's original owners will fire all current employees, leaving them to reapply for their old positions. Questions they may have include: Will my salary stay the same? Will I keep my accrued benefits, including vacation and sick time? Will my hours change? How will my insurance coverage be affected? This is just the beginning.

The center's new owners often view all employees as new hires. That means accrued vacation time, sick days and level on the salary scale could be wiped clean, regardless of an employee's tenure.

In most instances, new owners strive to be fair when dealing with salary history. Vacation equity may be more difficult for new owner's to match, and some companies don't even differentiate between vacation time and sick days. These are significant issues for employees who expect to have their earned time off honored.

## Health Insurance.

Problems arise when the center had been

covered by a large group policy and the new owners secure individual coverage based on the small number of employees. The costs incurred by employees will be much higher, and probably for fewer services, including the elimination of dental or vision coverage. Dependent coverage may cost hundreds of dollars. If COBRA was not secured, pre-existing conditions may apply. Be aware that employees may leave if insurance expenses increase while coverage drops.

## The next hurdle involved "guaranteed hours."

Financial success of an ASC depends on controlling staffing costs, meaning employees cannot be guaranteed hours. Optimal staffing is composed of a small group of core staff who work full-time. This includes the Business Office staff, Administrator, Clinical Coordinator, a few RNs and surgical techs. All other employees should be hired on a part-time or per diem basis.

Problems arise when the new owners come in with a new staffing philosophy that

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eliminates full-time positions. This will not sit well with most of the employees.

So how do you get staff buy-in?

#### Meet with the employees.

Explain your staffing policies and be prepared to discuss the impact of those policies on the staff. Have alternate employment suggestions available for their consideration, as their hours will likely be reduced during the transition and during the center's start up.

Consider whether an employee needs to work a certain number of hours to be eligible for health benefits. What are the minimum hours required by your insurer? Is the employee cross-trained? If so, to what areas? If not, are they agreeable to work in other areas?

Can you assign two employees to one position in a job-sharing scenario? Are per diem positions available in other local facilities? Suggest that employees work in more than one facility until your volume builds up.

#### Is your work environment a positive one?

Do people like being there? Are they treated well? Remember, you bring a fresh perspective to the facility and have an opportunity to create a place where people want to work.

#### Attempt to keep the good employees.

Seek input from the previous managers and physicians about the skills and qualifications of the employees. I believe in keeping the entire staff for a 90-day evaluation period. Some workers may not be a good fit and will leave, whether on their own or because of your coaxing. Talk with those who stay, and ask for their help, as things may be a bit tight in the short term.

#### Ask your doctors for referrals.

Interview with a purpose. Look for employees with a priority on customer service, strong work ethic, and the ASC mindset, as not all clinical staff can adapt easily to the ambulatory setting.

During the ownership transition you may have closed the center for one or two days a week to reduce operating costs and fill the schedule. Staff will be swamped when the center is open, and, as always, ASC nurses

need to make pre-op and post-op calls. If they are working long hours on Tuesday, the center is closed on Wednesday, and you have a long day on Thursday, who will make the calls? Develop a schedule to spread the responsibility throughout the entire staff.

Managing a center with new owners is much like overseeing a start-up center. Verify all information appearing on the employee's application and allow time for orientation and training in all required areas, like OSHA and fire safety. Each employee also needs to be familiar with the new policies and procedures.

It may take a few months to build up the volume of cases, especially if you are awaiting insurance contracts. You will need loyal and dedicated employees, as the work will be hard and the hours may be long. Staff will stick with you if they see that you are truly working with their best interests in mind. When a nurse you wanted to keep leaves to work elsewhere, returns as a per diem, then turns down a full-time offer from a competitor because she likes working in your center, then you know you've succeeded. ■

Have you had problems negotiating carve outs or higher rates in your managed care contracts? A little outside intervention could go a long way.

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