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EXPLAINING THE GROWTH IN ORTHOPEDIC DRIVEN AMBULATORY SURGERY CENTERS

There are several reasons as to why the surgery center industry has focused on orthopedic development of surgery centers. These include:

1. *Complexity.* The complexity of orthopedic cases makes it likely that such cases will remain in surgery centers for several years to come. In contrast, many of the leading procedures in surgery centers are being prodded towards office based settings and office based reimbursement. For example, Medicare continues to increase site of service differentials for certain pain procedures and for gastrointestinal procedures. This leaves owners and operators of surgery centers concerned about relying on such cases for the long run.

2. *Reimbursement.* While reimbursement is decreasing for ambulatory surgery center procedures in certain specialties, the reimbursement rates from a governmental perspective have tended to move in a positive direction for orthopedic driven surgical procedures.

3. *Improvement in Technology.* Improvements in technology have taken away the question as to whether certain orthopedic procedures should be done in ambulatory surgery centers or not. Currently, this debate has been substantially resolved with the conclusion that many procedures can be performed safely in surgery centers. In fact, increasingly, more complex spinal procedures are likely to move to ASCs.

4. *Convenience and Accessability.* Despite the fact that the procedures of orthopedic physicians often drive whether a hospital is profitable or not profitable, scheduling difficulties continue to cause many orthopedic procedures to be bumped and moved. An ambulatory surgery center greatly enhances orthopedic physician conveniences and accessibility.

5. *Problems and Risks.* The greatest risk to an orthopedic surgery center remains the exclusion from managed care contracts. More than a handful of orthopedic driven surgery centers are built and end up being very problematic because of the inability to serve certain segments of the patient population due to such exclusion.

Perhaps, the second greatest risk to an orthopedic driven surgery center is being built around just one or two physicians. In many situations, if those physicians do not remain fully loyal to the surgery center, the surgery center cannot be viable or profitable.

MOVING CASES -- THE NEXT GREAT OPPORTUNITY AND THREAT

The single greatest addition to many surgical centers is likely to be the addition of lower spine cases performed by neurosurgeons and orthopedic spine trained physicians. These cases are high enough in complexity to remain in surgery centers for many years to come. At the same time, many believe that such cases can now be safely performed in surgical center settings. These cases should be a tremendous financial addition to many surgery centers over the next several years.

Another substantial addition to surgery centers should be lithotripsy. As CMS finally begins to reimburse lithotripsy in surgical center settings, the profitability and pricing of lithotripsy procedures is likely to make lithotripsy irresistible to surgery centers. As an interesting side note, this may again make urologists important to surgery centers. As many are aware, over the last few years the decrease in reimbursement for urology procedures and the movement of such procedure to the office setting has tended to make urologists less important to ambulatory surgery centers.

Certain general surgery cases, in addition to neurosurgical and lithotripsy cases, are also likely to be a positive addition for surgery centers over the next several years.

On the minus side, surgery centers could expect the continued migration of gastrointestinal cases and pain cases out of multi-specialty surgery centers. To an extent, this movement may be restrained by each the lack of efficiency of performing many of these procedures in the office setting, and substantial concerns regarding medical safety when performing many procedures in the office setting, as opposed to a fully licensed and accredited ambulatory surgery center setting.

Two conferences will be held this year that are sponsored by ASC Communications. These include:

HEALTH CARE MERGERS, ACQUISITIONS AND FINANCING -- AMBULATORY SURGERY CENTERS, HOSPITALS AND PHARMACEUTICAL COMPANIES

JUNE 20, 2002
HILTON,
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AMBULATORY SURGERY CENTERS: IMPROVING PROFITABILITY - BUSINESS AND LEGAL ISSUES; PRESENTED BY ASC COMMUNICATIONS, INC. AND FASA

OCTOBER 4-5, 2002
O'HARE HILTON
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Mergers & Acquisitions - June 20, 2002
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Registration fee per attendee is $450. The second attendee fee is $350 and each attendee thereafter from the same organization is $200. Please fax your registration form to ASC Communications, Inc., Attn: Scott Becker at (312) 920-6135 or mail to ASC Communications, Inc. at 150 North Michigan Avenue, Suite 2500, Chicago, Illinois 60601. A $50 discount is provided to any person who is a subscriber to Becker's ASC Review.

SURGICAL HOSPITALS - A PASSING FANCY OR A REAL ADDITION TO THE HEALTH CARE COMMUNITY

Over time, we believe that it is increasingly likely that surgical hospitals will become a very important part of the health care community. This is because surgical hospitals allow surgery centers to add inpatient procedures and imaging services to their service lines. As surgical centers increasingly lose lower complexity cases to the office setting and to single specialty centers, surgical centers will need the revenues from these services to remain profitable in years to come.

Imaging in many situations can substantially contribute to the bottom line. Further, each inpatient case typically provides reimbursement equal to two to ten times an average outpatient case. Thus, the financial revenues from inpatient services will become a needed component to maintain viable surgery centers.

The core risk that may cause surgical hospitals not to develop fully relates to legislative action. If governmental action restricts the development of surgical hospitals, they will likely be doing a disservice to the ambulatory surgery center community and to the health care community as a whole. Particularly, as funding for health care development expansion dries up, it has become increasingly clear that physician capital placed into the health care community, including through hospitals, serves real benefits.

SURGICAL HOSPITALS -- PROS AND CONS

I. *Advantages*.

Surgical hospitals can provide the following advantages.

1. They enable the surgical center to perform a great number of additional cases that require 24 to 72 hour stay.

2. They allow for provisions of imaging and radiology services. This is due to a hospital exception under the Stark Act.

3. They provide for increased physician control over the delivery of health care services.

4. For many physician groups, it can provide for enhanced recruiting.

5. They can provide an ability to improve the quality and delivery of care in the community. They also add a significant health care resource to the community.

II. *Disadvantages*.

There are also a number of potential disadvantages with the development of a surgical and specialty hospital. These include:

1. A surgical hospital requires a great deal more capital investment than a surgery center.

2. The staffing cost of a surgical hospital are much more extensive than that of a surgical center. They are also much harder to control.

3. A surgical hospital has greater risk that it will be excluded from managed care plans and from insurance plans.

4. A surgical hospital, particularly where the local hospital is not in partnership with the surgical hospital, can generate greater community political problems and challenges.

5. A surgical hospital has attached to it a greater level of legal and regulatory concern and risk due to less comfort being provided to physician ownership of hospitals generally than of surgery centers. It also provides concerns in that there is not a specific applicable safe harbor and that there is not an extension of practice requirement for the use of a surgical hospital.

6. Surgical hospitals often face greater working capital and cash ramp-up needs in their early operation. There are often delays with certification, and in cash flow and collections. The handling of billing, coding and collections for a surgical hospital is also much more difficult than for a surgery center.

7. A surgical hospital also requires greater debt than the surgery center. Again, once debt is taken on, it is a cost that cannot be decreased easily.

8. A surgical hospital typically takes a great deal more time to complete than a surgery center. This leads to a greater chance for political disruption or other problems with the relationships amongst the members prior to the opening of the hospital. It also can lead to projections to be less true in that the membership group and other factors can change between such period of time.

This is intended as solely a brief summary of the issues related to the potential surgical hospital. It is not intended to be a complete discussion of all risks and issues related thereto.

BUILDING AROUND A CORE GROUP

As the surgery center business grows and the building boom continues, it is becoming more difficult to round up a very desperate group of physicians and keep them focused. This difficulty impedes development, makes ramp-up more difficult, and generally makes operating a surgery center more challenging. Thus, it is no surprise that successful developments are more often focused around close relationships with a single group or single specialty. The more congruence that exists in the group, the easier it tends to be to bring the surgery center project from conception to completion, and to assure loyalty to the center as it becomes operational.

Certain companies have adapted this "core group" strategy as a single means of doing business. This does not mean that other physicians and other groups cannot be added to this core group, it simply means that as a starting point in development, a core group makes development much easier.

REFINANCING OF NON-RECOURSE DEBT

As interest rates have declined significantly, parties attempting to refinance a non-recourse debt are finding substantial difficulty in two areas. First, the amortization of their original debt may not turn out as expected, (e.g., more interest may have been front loaded. Thus, a smaller amount of principal may be paid off.) Second, parties may find the pre-payment penalties to be prohibitive. Certain of the national companies have recently begun developing refinancing programs which may enable investors to take advantage of the current lower rates.

BUYING AND SELLING SURGERY CENTERS

The market for buying and selling surgery centers remains extremely hot. History shows that the market window for this level of interest is fleeting. The last such window was open approximately four to six years ago, when HealthSouth, Surgical Care Affiliates, National Surgical Centers and a still developing AmSurg and Symbion ARC were buying surgery centers. That market window closed when HealthSouth essentially bought its two largest competitors. We now see the market window opening again for an unknown period of time, with several buyers out there competing to purchase centers.

ANTI-KICKBACK STATUTE SAFE HARBORS

Now that the ASC safe harbors have existed for nearly two and a half years, a number of observations can be made. The safe harbors have arguably raised far more issues and questions for surgery centers than they have answered. A number of such issues include the following:

A) Non-Compliance with the Safe Harbor. Many surgery centers do not comply with the safe harbors due to the types of physicians that are owners, due to managed care exclusions from insurance contracts, or due to practice location issues. The ASC safe harbor requires physician investors to perform one-third of their procedures at the surgery center. However, it is very difficult for a physician to meet this test if he or she is excluded from certain managed care contracts, or the ASC is at a remote location, or if the ASC is at a satellite that is not the physician's typical practice location.

B) Measuring Medical Practice Income. The Office of Inspector General ("OIG") has provided very little guidance regarding how to measure practice income. For example, it is still unclear whether practice income should be measured based upon procedure-specific revenues to determine if one-third of a physician's income derives from performing outpatient surgical procedures, or whether it should be measured by practice income among all of the different sources of revenue. If measured by medical procedure income, it is unclear whether the practice can apply different or higher overhead percentages to the in-office practice income, which would render procedural income to be a larger portion of total income. For example, a physician's overhead rate at his or her own office practice location is likely to be much higher than it is at the location at which the physician performs outpatient surgical procedures.

C) Testing Compliance. There are a number of ways to test compliance, either through an annual certification from physicians that they comply with the safe harbors, or through an audit of their practice. Of course, many issues are raised as to the proposed benefits, and means of testing compliance.

D) Redeeming Non-Compliant Physicians. Many surgery centers desire to use the ASC safe harbor as a compliance tool, and condition physician investors' continued involvement in the surgery center upon compliance with the safe harbors. This issue provides challenging problems from a governmental and legal perspective, as it can be viewed on one hand as in line with the intent of the safe harbors to ensure that all physicians utilize the center as an extension of their practice and not as indirect referral sources, but can also be viewed as cutting against the grain of traditional Anti-Kickback statute analysis. We expect this issue to raise substantial civil and, potentially, criminal litigation over time. A further issue of *ASC Review* will discuss this in greater detail.

E) Employee and Management Company Ownership. The safe harbor still does not provide for a clear ability for employees or management companies to have ownership interests in surgery centers. Although there ultimately appears to be little legal risk with such ownership, the lack of clarity does cast a cloud over this type of ownership.

F) Hospital Ownership. In the case of hospital-owned surgery centers, the safe harbor requires that the hospital not be in a position to refer cases to the surgery center. History has shown that the ownership by a hospital that is not local and that does not have the ability to impact local health care is almost useless to a surgery center. However, groups desire to have hospitals as owners for various reasons, including avoiding managed care exclusion problems, avoiding physician steerage problems, and helping with Certificate of Need issues. Typically, it is only the local hospital that can help with these issues.

G) Ownership by Multi-Specialty Groups. The safe harbor does not permit ownership by multi-specialty groups, including groups that have non-surgeons as owners. However, many surgery centers have been developed by multi-specialty groups, and these groups view their centers as a core practice asset.

H) Non-ASC List Procedures. Recently, surgical centers have begun performing more complex procedures which have not yet made it on to the CMS ASC procedures list. Because compliance with the one-third practice income test revolves around the ASC procedures list, this creates uncertainty for a great number of these surgical centers that are focusing a more complex procedures.

I) Single Group Ownership that includes Non-Compliant Physicians. Many surgical center owners include groups that consiste of physicians practicing partially in the inpatient sector and partially in the outpatient sector. Again, for a group to allow certain physicians to invest and not others often causes tremendous political conflict within the group. Moreover, the lack of safe harbor protection for such groups currently creates a level of legal concern for such groups.

Congratulations!

♦ Aspen Healthcare on the hiring of Senior Vice President Susan Hollander.

♦ Ambulatory Surgical Centers of America on the opening of surgical centers in Reading, Pennsylvania and Torrance, California.

♦ Physicians Endoscopy on the opening of an endoscopy center in Reading, Pennsylvania.

♦ Regent Surgical Health on the completion of their initial financing.

♦ Woodrum/ASD on the opening of surgical centers in Houston, Texas and Wilkes-Barre, Pennsylvania.