ESTABLISHING AN AMBULATORY SURGERY CENTER -
A FIFTEEN (15) ISSUE OVERVIEW PRIMER

By: Scott Becker

There are several issues that need to be considered in establishing an ambulatory surgery center (“ASC”). A brief summary of several of the important issues is provided herein.

1. Financial Feasibility. Initially, a group of physicians must examine their outpatient case numbers to determine whether an ambulatory surgery center will be financially feasible. ASC Revenue is a function of the number of procedures the group can perform at its own ASC multiplied by the expected reimbursement for the expected procedures to be performed at the ASC. As a general rule, in a reasonable reimbursement market, a center focusing on higher reimbursement procedures can be profitable with as little as 1,500 procedures per year. With lower reimbursement cases, this number can jump to 2,500 to 3,000 procedures. Financial prudence, notwithstanding break even numbers, dictates that one should only commence a project with a case level that is substantially higher than the threshold or break even amount.

2. Reimbursement by Market Differs Significantly. Throughout the country, independent centers have had difficulty contracting with certain insurance companies. Thus, in assessing case volumes, one should discount the number of cases to a certain extent to reflect the fact that in certain insurance plans may not be possible to contract with. Moreover, certain insurance plans (and geographic regions) provide for low reimbursement as compared to national standards. Hence, the center may not be able to provide services to these patients covered by such plans or in such regions.

3. Expense Management. The three biggest costs for an ASC typically include facility costs, staffing costs and supply costs. While staffing and supply costs can be modified over time, facility costs, once a lease has been signed or construction has commenced, are much more difficult to change. It is very important to obtain expert advice relative to these three cost items early and often.

4. Management and Equity Ownership. A group must determine whether or not it will have a management company as an equity partner. On the plus side, an experienced manager can help with myriad aspects of the project, such as financing, Medicare certification, equipment planning, construction planning, and physician recruitment. A good management company can significantly reduce the risks of ownership and operation of an ASC. It can also substantially reduce the likelihood of problems in completing the project, operating the center, financing the project and ultimately prospering from the project.
The key downside to having a management company as a long term equity partner relates to the disparate quality of companies that provide services to ambulatory surgery centers, and the profits that are shared in bringing in a management company. As a general rule, physician ownership alone, under the right circumstances, can be very attractive. However, having an experienced management team substantially lowers the risks, and, in the overwhelming majority of situations can provide substantial benefits and actually improve profitability by a substantial degree. Further, an equity owner/advisor often will have a much greater level of concern regarding the project’s success, even when it owns significantly less than a 50% interest in the center.

A solid management company partner can also substantially improve the financing prospects of a center.

5. Certificate of Need and Other Threshold Issues. Currently, certificate of need (“CON”) laws exist in 25 to 30 states. These laws prohibit a party from building a center without state approval. In each state, one must understand whether or not a CON is needed or not and, if so, (a) whether there are exceptions to the CON process (e.g., an in office ASC), or (b) whether a CON can be obtained.

6. Capital Requirements. The typical development of a stand alone ASC, with build out, requires a cost of approximately $200 per square foot to become operational. Additionally, money is also needed for equipment. Of the total budget amount, a substantial portion of the money can be provided through debt financing without guarantees. However, a certain portion of the debt may require personal guarantees (e.g., equipment financing). Moreover, a cash capital contribution of at least approximately 25% of the total amount, or at least three to six months of working capital, must be contributed in cash to an ambulatory surgery center venture.

7. Lease or Build from the Ground Up. A center need not have more than one operating room per 1,000 cases. A typical two-room ASC can be built in 7,000 to 8,000 square feet. Centers can be leased from a third party or built from the ground up. Often, it is quicker and less expensive to lease space and operate as a tenant. The disadvantage to this approach is that one does not ultimately own the real property nor completely control the project.

8. Governance. The split of the “Board of Managers,” which is the governing body of a venture, is typically proportionate to ownership in the venture. Thus, if physicians own 70% of the venture, they would have Board control via 70% of the Board votes. There are often a number of reserve rights provided to the minority partner or to the group as a whole to assure that certain bigger ticket actions cannot be taken without their input or vote. These may be issues such as (1) increasing the amount of capital required, (2) incurring personal guarantees, (3) merging the entity, (4) entering into “self dealing” arrangements, or (5) amending the core
governing documents. A hospital partner, whether or not tax exempt, will likely desire several reserve powers.

9. **Accreditation**. Many surgery centers are each state licensed, Medicare certified, and accredited. Over time, the ASC should attempt to become AAAHC accredited. Depending on the state in which the ASC is located, the ASC likely will also be required to be state licensed.

10. **Anti-Kickback Statute; State Self Referral**. All surgery centers should be structured to comply with the federal and state laws relative to health care regulatory and other issues. This includes laws that relate to the appropriate filing of claims for reimbursement, state and federal laws relating to physician financial relationships with surgical centers, laws that relate to privileges and credentialing, and all laws that relate to billing, coding, and claims filing. In addition, ASCs must also operate in compliance with the HIPAA Act and its privacy requirements.

The federal “Stark Act” does not generally apply to surgery centers. However, the anti-kickback statute does. Thus, many of the concepts set forth in the ASC safe harbor to the federal Anti-Kickback Statute should be implemented for a surgery center. For example, all distributions should be based on the amount of capital contributed, discrimination against Medicare or Medicaid patients should be prohibited, patients should be informed of their physician’s ownership interest in the center, returns to physicians should not be differentiated based on the value or volume of referrals they make to the center, and physicians should generate income from performing outpatient surgery and should use the center as an extension of their practice (“1/3 - 1/3” rule). These concepts should generally be made a part of the venture documents.

11. **Form of Legal Entity**. Typically, a surgery center is established as a limited liability company. This allows for the entity to have a single level of taxation, rather than the double level of taxation provided in a “C” corporation. It also provides for “limited liability” to the owners. Thus, in an LLC, unless otherwise agreed to, the physicians and the owners do not have liability for the debts of the entity. As noted above, the ambulatory surgery center must also determine whether it will lease or buy real estate for the ASC. If it chooses to buy real estate and build from the ground up, a further assessment must be made as to whether a separate LLC should be established for the real estate holdings. In some states, due to licensing or tax concerns, a dual limited partnership - LLC structure may be used.

12. **Tax Exempt Entities**. Where a venture is established as a joint venture with a tax exempt entity, the venture documents will need to reflect the need to serve indigent patients, provide for charity care, and provide for the serving of community needs. Moreover, when joint venturing with a tax exempt entity, the venture documents should provide that the company will
broadcast its intention to serve charitable patients to the community, and will make efforts to periodically measure and assure that it is serving such community benefits. Also, the tax exempt entity will need certain “controls” to help assure that its involvement does not harm its tax exempt status.

13. **Problems for Surgery Centers.** Surgery centers face various problems. The inability to obtain reimbursement from certain insurance companies, the inability to obtain the appropriate commitment from physician partners, the overbuilding of the surgery center, and several other problems can jeopardize the success of the venture. Increasingly, many centers are focused specifically around a core group of physicians. This lessens certain of the risks related to the center and increases the level of physician commitment. However, many centers still face significant risks related to reimbursement, managed care exclusion, and overbuilding. In essence, because the reimbursement for procedures is becoming less predictable, there is an extensive need to assure that the project is well managed and well thought out. A failure to do so can lead to significant financial problems for the entity.

14. **Single or Multi-specialty Center.** Single specialty centers can be more efficiently staffed and built than multi-specialty centers. Moreover, a single specialty center avoids the turf wars and the level of concern regarding sharing profits and revenues with other specialties that are often present with multi-specialty centers.

A multi-specialty center in contrast, can provide for greater staff and physical plant economics of scale, may be needed if single specialty volumes are insufficient, and, further, a multi-specialty center also can provide for risk reduction by diversifying the reimbursement mix and physician mix.

15. **Advisors, Management, Architects, Builders and Lawyers.** Given that more than three thousand ASCs now exist, we strongly advise that ASCs utilize experienced advisors. Should you need recommendations, please contact Scott Becker.

* * * *

Should you desire additional information or desire a copy, please contact Scott Becker at (312) 750-6016 or Email at scott.becker@rosshardies.com. Also, more extensive articles relative to several of these subjects have been authored by Mr. Becker.