Ambulatory Surgical Centers – An Analysis for the Next Five Years

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The last several years have been an outstanding time for surgery centers. There has been explosive growth in the overall industry and in the number of surgery centers.[1] There have also been a great number of developments that have been extremely positive for the surgery center business. Now, for the first time in several years, the surgery center industry faces several different challenges, including changes in reimbursement, reductions in the number of independent physicians available to engage in surgery center ventures, and changes in rules relating to how to work with managed care payors.

This article discusses six different items. First it reviews which areas are providing cash flow to surgery centers today, essentially reviewing today's bread winners and cash cows. Second, it looks at the types of surgery centers that are likely to be bread winners tomorrow, where surgery centers may excel in the next few years. Third, it examines problematic situations for surgery centers, essentially which areas are difficult and challenging for surgery centers. Fourth, it looks at areas that are potentially positive for the next few years. Fifth, it discusses situations where we expect there to be growth in the surgery center business. Finally, sixth, this article examines certain weaknesses and challenges that the surgery center industry is facing. Here, it also touches on problem centers and issues that are symptomatic of such centers.

I. **Today's Bread Winners and Cash Cows**. The current areas that can be categorized as cash cows and today's bread winners are detailed below. Here, each individual venture is unique. Thus, even though an area may generally be a cash cow, it still needs to be well planned with the right physicians to be successful. Also, it often has to be in right market to be successful.

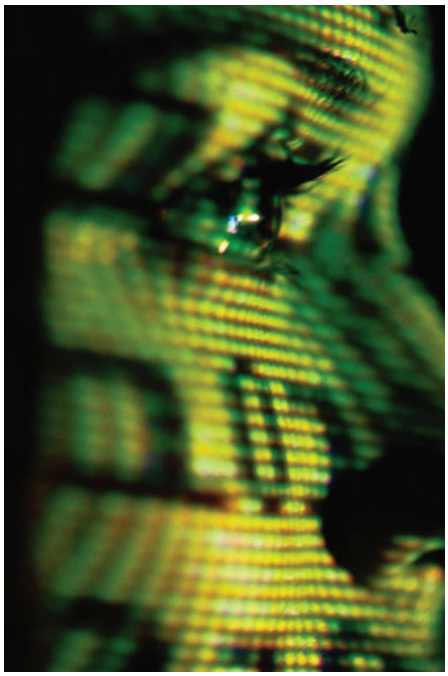
There has been explosive growth in the overall industry and in the number of surgery centers.

1. **Orthopedic Driven Centers**. These centers continue to enjoy very solid reimbursement. Further, the fact that they serve higher acuity patients generally means that orthopedic services will remain in surgery centers for a long time to come. In essence, generally, procedures are not at risk of moving to offices. Further, the frequency of need for orthopedic procedures – demand is forecasted to rise 25%, relative to 2001, by 2020 – coupled with solid reimbursement makes them a sweet spot for surgery centers.[2]

2. **Well Planned and Managed Physician-Hospital Joint Ventures**. There has been a significant increase in physician-hospital joint ventures over the last several years. According to the most recent data, these joint ventures account for approximately 27% of all ASCs, up 4% from 2004.[3] A well planned physician-hospital joint venture often includes better opportunities for reimbursement, less conflict with the hospital over issues such as privileges, and a halo effect for recruiting other physicians.

3. **Gastroenterology Centers**. Gastroenterology centers have been very successful over the last few years. More gastroenterology procedures are performed in surgery centers than any other procedures. This is due in part to the fact that Medicare reimburses for screening colonoscopies. Thus, while reimbursement is not overly high for

[1]There are now around 5,000 Medicare-certified surgery centers in the United States alone, and the industry has grown an average of 7.43% per year over the last decade. American Association of Ambulatory Surgical Centers (AAASC), Growth Chart Table 1/11/07.
[2]ASC Trend Report 1/2/07, AASC.
[3]AAASC Ownership Survey 1/18/07



gastroenterology centers[4], the volumes for many gastroenterology centers have been outstanding. Currently, GI centers face some risk in both reimbursement and in the movement of procedures to in office environments. "With the proposed CMS reductions to ASC payments for GI cases, the 'worst-case' scenario paints a 22% to 30% full phase-in reduction by January 2009 for the most frequently performed GI procedures at Endoscopic Ambulatory Surgery Centers."[5] In fact, payors are increasingly providing higher site-of-service differentials to encourage gastroenterologists to move procedures to offices.

4. **Ophthalmology**. Ophthalmology-driven ASCs continue to be an important part of the ASC landscape. Generally, they are one of the top three procedures performed in surgery centers in aggregate.[6] The risks that are present for ophthalmology driven centers are similar to the risks present for gastroenterology centers. Ophthalmology centers are usually more dependent upon Medicare revenues compared to gastroenterology centers. They have risk of reduced reimbursement. They also require sufficient volume to make them successful. When operating well, single specialty centers can often perform better on an operating margin basis than other types of surgery centers.

5. **Pain Management Driven Centers**. Pain management driven centers have been an extra base hit for many parties over the last several years. Many pain management physicians do a high volume of procedures[7] and the reimbursement for procedures has generally been good. This is particularly when compared to the cost of providing pain management services. That stated, pain management centers, whether in a single specialty center or part of a multi specialty center, are at serious risk. They have two great risks. First, they face serious reimbursement risk from Medicare and other payors. Second, they face significant risk of movement from centers to office environments.[8]

6. **Ear Nose and Throat**. ENT centers have been quite successful where they are focused on "tubes" or sinus procedures. The sinus procedures are often high value procedures. The tube procedures are often high volume procedures. ENT procedures are often provided as part of other surgery centers and not as single specialty centers.[9]

7. **Out-of-Network Centers**. For the last several years, many parties have done very well serving out-of-network patients.[10] Here,

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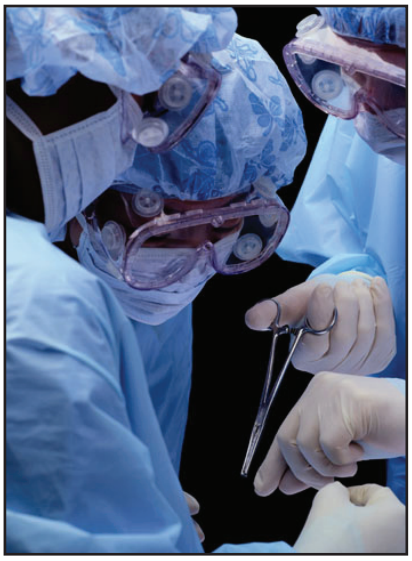
[4]Average reimbursement for GI procedures on a referral basis in 2006 was 749. See Intellimarker.
[5]Tammy Hamm, "Protecting Your Endoscopy Center's Profitability," AAASC Monitor 2007, pg. 3.
[6]Furthermore, the anticipated relative growth in demand for opthmalogical procedures significantly outpaces most others: demand is forecasted to have increased by 50% percent over the years spanning 2001-2020. ASC Trend Report
[7]Most pain management procedures at ASCs fall into Medicare Payment Group 1, yielding an average national allowance of $333.00. Many pain procedures involve multiple injections and/or multiple levels, so each procedure can result in two or three facility fees. Medicare currently pays 100 percent of the highest payment for multiple procedures in a single session and 50 percent for each additional procedure. Furthermore, "as only a short recovery time is needed for most pain procedures, it is possible to perform three to four procedures an hour, thus maximizing the productivity of both the facility and staff." A. Mowles, "Pain Management in ASC Facilities," p. 1
[8]The cost of running a pain management ASC is "typically between 10 and 35 percent higher than in an office," thus the incentive to move to an office environment. Mowle, p. 2. The higher operating costs arise from the greater requirements pain management centers face with respect to square footage, fire protection, air quality standards, and costs of meeting various states' Life Safety Codes.
[9]Average net revenues per case were 1536 in 2006 for ENT procedures nationally. See Intellimarker.
[10]In a 2006 Deutsche Bank ASC Sector Survey, facilities with 10%+ net revenue per case growth had, on

reimbursement is often much better than "in network" reimbursement. However, currently, payors are becoming increasingly aggressive about reducing the ability for providers to thrive through out-of-network models.

8. **Centers in Certificate of Need States**. The Certificate of Need, in 27 states, still provides a helpful moat and protective barrier for surgery centers.[11] The center still has to be very well planned to be successful in a CON state. However, the CON can provide a useful barrier.

9. **Management Company**. The quality of management companies differs substantially across the board. However, a center planned and executed by an intelligent and strong management company still has a much greater chance at success than a physician only center or a center planned without a management company or with a poor management company.



10. **Bariatrics**. Increasingly, bariatrics provide an opportunity for surgery centers. These are often private pay procedures and do face some of the problems that relate to globally billed procedures. Also, after the first wave of development of bariatric-driven centers, they are likely to face some reimbursement risk just like LASIK-driven centers did at one time.

II. **Tomorrow's Breadwinners**. The following centers tend to be the types of surgery centers that are likely to be successful in the next several years. This is not an exclusive list but provides some thoughts on where success is likely to lie.

1. **Well Planned and Managed Physician Hospital Driven ASCs**. Today, more than 25% of all ASCs are physician hospital joint ventures. These joint ventures enjoy significant advantages.

2. **Orthopedic Driven Joint Ventures**. Orthopedic driven centers, for a number of reasons, are likely to continue to thrive. They do face significant risk related to issues with commercial payors. However, overall, the prognosis for orthopedic driven centers is very good.

3. **Spine Driven Centers**. Increasingly, lower spine procedures are being preformed in surgery centers. These are not reimbursed by Medicare but can be very profitable for commercial payor patients. The big risk related to these procedures remains the inability to enter into contracts with commercial payors. The secondary risk relates to the handling of recovery care and how to handle longer recovery time types of cases.

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average, 16% of their revenue coming from out-of-network business, vs. 9% for the average. DB ASC Sector Survey, p. 12. The out-of-network strategy is favored primarily by smaller, locally owned or independent ASCs (p. 17). "We emphasize that none of the major publicly traded chains utilizes an overt out-of-network strategy."

[11]A Certificate of Need (CON) requires an ASC developer to "withstand regulatory scrutiny of proving the 'local health care need' for a new project" before going ahead with it. DB ASC Sector Report, p. 89.

4. **General Surgery**. Increasingly, more complex general surgery cases are moving towards surgery centers. These are particularly well positioned where there is a hospital partner. General surgeons often rely heavily on hospital partners and affiliated physicians for their referrals and for their business. Thus, they tend to do much better and face fewer threats of cases being cut off where they have a hospital partner in the transaction.[12]

III. **Problematic Surgery Centers**. The following types of centers and situations are often problematic.

1. **Cosmetic Plastics in Multi-Specialty ASCs**. In these situations, the surgery center relies on the plastic surgeon to pay the fees for the operating room. This conflict between the surgeon and the surgery center leads to lower reimbursement than the surgery center can bear.

2. **Pain Management**. Typically, with non complex cases, there is increased risk of these cases moving to office sites. Often the pain management physician will be paid well pursuant to site-of-service differential in his office and is able to retain 100% of that differential. Further, it is not that difficult to develop an in office setting for many pain management procedures.

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3. **Pediatric Dental in Certain States**. In many situations, pediatric dental cases pay so poorly that surgery centers cannot handle such cases profitably.

4. **General Surgery with No Hospital Partner**. In situations where a general surgeon is part of a surgery center, they often struggle because there is not the ability to retain the amount of referrals. This is particularly true in a general surgery practice where the physician relies on a broad range of primary care physicians for referrals or an emergency department for referrals.

IV. **Questionable Areas**.

Certain of the questionable areas for surgery centers going forward include the following.

1. **Well Planned Small Hospitals**. It is unclear whether either the regulatory risk of physician prohibitions on ownership of hospitals or reimbursement risks will make it difficult for physicians to own and operate small hospitals. Well planned small hospitals, if they have sufficient volume and a sufficient group to build around, can be very successful. However, they face increasing risks and increasing costs to develop and operate the same.

2. **Under Arrangement Models**. Over the past few years, many parties have profited extensively from joint ventures planned around full under arrangement models. Here, there are many questions as to whether this model will withstand legal scrutiny over the next few years. [13]

[12]Net revenues per case for general surgery cases were $1,239 on a national basis in 2006. See Intellimarker.

[13]For example, a hospital's payments to an ASC likely fall outside of the safe harbor of the federal Anti-Kickback Statute, and therefore "the government could allege that one purpose of the hospital's payments to the ASC venture is to induce or pay for referrals in violation of the federal Anti-Kickback Statute, even if the economic incentive to refer would not be any greater than the incentive arising

V. **Growth of Surgery Centers**.

1. **5,000 to 6,000 ASCs**. There are currently approximately 5,000 Medicare certified surgery centers. There are probably another 1,000 surgery centers that are not "certified" but are accredited in some manner.

2. **Organic Growth**. There is still an amount of organic growth to be had in the surgery center business. It will not be at the pace it has been over the last several years. However, we do expect 150 to 200 surgery centers to be opened each year nationally. Certain of these surgery centers will have evolved from previous surgery center where physicians have become disenchanted or new physicians together with old physicians are developing a new center.

3. **Turn Around Surgery Centers**. An increasing amount of management company time and efforts is spent on turning around surgery centers. There are tremendous amount of centers that were either built too big or without a strong enough base of physicians that face the need for a turn arounds.

4. **Joint Ventures**. We expect that at least half of the growth of surgery centers in the next few years will come from hospital-physician joint ventures. Hospitals are softening on the bullishness of joint ventures but it remains a strategy that will be in vogue for many years to come.

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VI. **Key Weakness and Challenge**. Certain of the key weaknesses that surgery centers generally face and surgery centers in certain markets face are the following.

1. **Many Surgery Centers Lack Reimbursement Clout**. The national surgery center industry still lacks reimbursement clout to an extent, particularly in contrast to hospitals. "Hospital political clout eclipses that of surgery centers and they are using it to our industry's detriment," says Luke Lambert of Ambulatory Surgery Centers of America, LLC (ASCOA). However, the surgery center industry has greatly improved its efforts at developing national clout over the last few years.

2. **A Lack of Reimbursement Clout in Certain Markets**. In certain markets, surgery centers get paid very poorly. This is also true for all providers in some markets. This continues to plague surgery centers in many markets. It is almost impossible to develop a very successful surgery center in markets where reimbursement is very poor.

3. **A Lack of Free Physicians**. In many situations, particularly in non-CON states, many of the existing mature physician practices are already involved in some way or another in a surgery center. In states where this is the case, it is very difficult to develop a new surgery center around a core base of solid physicians. This provides challenges to growth particularly of de novo centers.

4. **Out-of-Network**. Increasingly, payors are becoming aggressive about entering into "exclusives" that do not allow out-of-network patients, or penalizing physicians for sending patients to out-of-network facilities

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from investment in a safe harbored ASC." D. Melvin & E. Zimmerman, "A New Hospital-Physician Partnership Model: "Under Arrangements," p. 2.

by delisting them or paying them less. This will be a bigger and bigger challenge for surgery centers going forward. "Smaller facilities using [an out-of-network] strategy could come under pressure in the next few years as managed care payers exert pressure to go in-network. Over time, we believe this issue will come to a head among the small minority of players in the market that utilize the out-of-network strategy – likely creating distressed asset sales and fueling an acceleration of consolidation."[14]

VII. **Problem Centers**. Many surgery centers face similar problems. Certain of the problems that surgery centers face include the following.

1. **Overbuilt Centers**. If the average center is 13,000 square feet, many surgery centers are built at 18,000 to 22,000 square feet and end up paying for this through reduced profits.

2. **Overstaffing**. There are a great number of surgery centers that are not staffed efficiently.

3. **Many Unaffiliated Physicians**. Many surgery centers are built around many "one off" single physicians. This is a very hard model to manage and a very hard model to assure that there is a core volume in place to make the center viable.

4. **Reliant on Too Few Physicians**. Many surgery centers are heavily reliant on a few physicians. This becomes very problematic as those physicians change their practice over time.

5. **Difficulty with Managed Care**. Increasingly, managed care has become more difficult rather than easier to deal with in many markets. Many of the managed care plans have become part of national managed care payors. Further, the managed care payors continue to be more closely tied to their relationships hospital than their physician ambulatory surgical center relationships. Many of the payors also have increased clout and can negotiate hard or leave physician driven surgery centers out of their plans.

6. **Too Reliant on Out of Network or Substantial Reimbursement Risk**. Many centers are overly dependent on out of network payments or face reimbursement that is at significant risk.

7. **Non Compete Problems**. Centers which have many physicians that may move procedures to their offices or where many of the doctors also own interests in other centers are also viewed as at substantial longer term risk.

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This provides an overview summary of many of the issues facing surgery centers today's. While it is not exhaustive, we hope it provides some useful framework for understanding the current status of the surgery center industry.

[14]DB ASC Sector Survey 10/6/06, p. 18. However, out-of-network exposure "may not be as pervasive as the investment community believes." Only 15% of respondents to the survey indicated that out-of-network revenues comprised more than 20% of their total revenues. DB Survey, p. 7