RESEARCH REPORT EXCERPT

The New Rules of Ambulatory Surgery Center Competition

Three steps to build a winning ASC strategy

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EXCERPT

Table of contents

Executive summary

While the outmigration of care from inpatient settings to the outpatient arena is not new to hospitals and health systems, the forces driving today's outpatient shift are fundamentally different than in the past. Technology is no longer the principal factor dictating the site of service delivery. Instead, key stakeholders—especially payers and physicians—are driving patients to receive care in low-cost settings. As a result, many traditionally profitable surgical procedures are shifting from hospital outpatient departments (HOPD) to ambulatory surgery centers (ASCs). Services that leave the hospital campus are reimbursed at a lower rate and are entering a highly competitive market. Incumbent hospitals and health systems are often poorly positioned to win in this growing market. In response, leaders must implement a dedicated ASC strategy to compete against both traditional and new competitors.

Winning share in the ambulatory surgery market requires hospitals and health systems to take three steps. First, leaders need to refine their ASC strategy by pinpointing specific goals and purposely integrating ASCs into their broader procedural care strategy. Second, they should identify the role of partners in establishing the facility footprint—both with management companies (potentially) and with physicians (certainly). Finally, they must create a specific and compelling value proposition to attract both proceduralists and the key constituents that drive referrals.

In our research, we identified three fundamental steps for hospitals and health systems to successfully compete in the lucrative but competitive ASC market. Read this excerpt to learn how you can realize the full benefit of your organization's investment in ASCs.

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Exploring the market for ambulatory surgery

Unpacking today's outpatient shift

Historical drivers of outpatient shift

The outpatient shift is not a wholly new concept in health care. In the past, the outmigration of care was largely driven by advances in technology and the clinical ability to safely complete procedures less invasively, which dramatically decreased the need for lengthy hospital stays. With new clinical capabilities in place, physicians were then motivated to own equity in ambulatory surgery centers (ASCs) to gain access to technical revenue.

This combination of technological advancement and financial motivation fueled outmigration and permanently changed how care is delivered. For example, when physicians started using a laparoscope for cholecystectomies, the length of stay dropped from one week to one day, and there was a steady shift toward laparoscopic cholecystectomies. Today, nearly 90% of routine gallbladder cases are completed in the outpatient setting.

Technology and technique

Advances in clinical innovation enabled less-invasive procedures with a shorter recovery time, avoiding an inpatient stay.

Financial motivation

Investment in ASCs allowed physicians to gain access to technical revenue to supplement professional fees.

Today's outpatient shift is fundamentally different

The outpatient shift today, however, is principally driven by purchasers' desire to push care to lower-cost settings. For example, there was no specific new technology that swayed CMS to remove total knee arthroplasty (TKA) from the inpatient-only list in 2018. Although there have continuously been small advances in technology, CMS now believes that many TKAs can (and should) safely be completed in a lower-acuity setting. CMS will likely follow suit with additional procedures, accelerating the outmigration of care for Medicare beneficiaries.

CMS is hardly the only stakeholder influencing site-of-care selection. Commercial payers, consumers, and physicians are all motivated to redirect care away from high-cost settings. As a result, there has been a massive growth of ambulatory surgeries, which are projected to increase dramatically in the next decade.

January 2018: CMS removes total knee arthroplasty from inpatient only list

CY 2019: CMS adds 12 cardiac catheterization procedures to ASC-covered procedures list

2018: CMS suggests that total and partial hip replacements will be removed from inpatient-only list and added to ASC-covered procedure list

22.9%
Increase in ASC surgical procedural volumes in 2017

27.6%
Projected increase in ASC volumes by 2027

Stakeholders driving surgical procedures from HOPD[1] to ASC setting

1. Payers 2. Consumers 3. Physicians

Source: Franklin Trust Ratings, "Ambulatory Surgical Care Growth," February 2, 2018; Advisory Board Market Scenario Planner; Health Care Advisory Board interviews and analysis.

1) Hospital outpatient department.

Several constituencies drive surgical shift from HOPD to ASC

Payers, consumers, and physicians all play roles in today's outmigration of care

Payers are actively relocating patients

Payers are currently the leading influencer on the ambulatory surgery outmigration and are aggressively steering patients from HOPDs to ASCs. In addition to providing more attractive payment rate increases in the ASC setting, CMS passed new policies to discourage HOPD billing rates. Commercial payers are altering payer-provider contracts to encourage ASC utilization, and both public and private payers are making ASCs more attractive and affordable for consumers.

Examples of payer steerage tactics

Medicare policy

- CMS implements site-neutral payments to discourage future HOPD billing rates
- CMS modifies payment rate increases to be more attractive in ASCs than HOPDs
- CMS requires minimal quality reporting requirements in ASC
- CMS expands the definition of "surgery" to include "surgery-like" services and expands the range of procedures that could be added to ASC list in the future

Payer-provider contracts

- Some payers adjust contracts with lower HOPD reimbursement over time while keeping ASC reimbursement constant to encourage ASC utilization
- Some payers require hospitals to perform a certain percentage of outpatient cases in ASCs in order to receive reimbursement increases over time
- UnitedHealthcare[1] and Molina Healthcare let PCPs refer directly for most services in ASCs, but require preauthorization for procedures in HOPDs

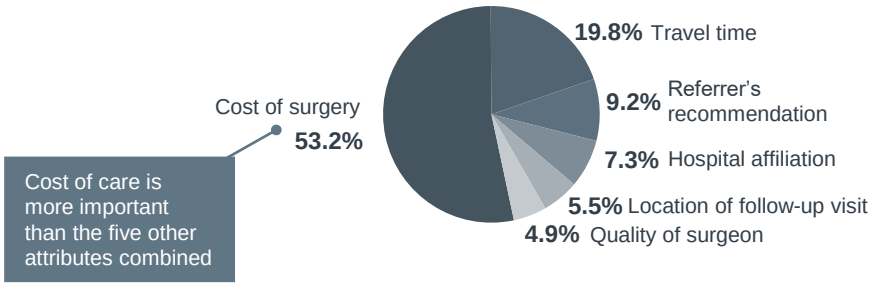
Patient benefit design

- CalPERs[2] uses reference-based pricing to steer patients to ASCs; patients are required to pay any costs exceeding an established reference price
- UnitedHealthcare, Aetna, and Medicare offer patients lower copays for ASCs than HOPDs

Consumers are exerting influence on site selection

When payers alter consumers' out-of-pocket costs, it has a large impact. Advisory Board's Market Innovation Center surveyed consumers to determine the most important factors when choosing a provider for surgical care. The results reveal that consumers consider cost of surgery to be most important. In fact, consumers rated cost more important than all other factors in the survey combined. Given the pricing differentials, the ASC setting is enticing to patients. Most ASCs also offer consumer-friendly features that appeal to consumers, such as convenience and short wait times.

Average relative importance of six surgical care attributes



Comparison of copays for Medicare beneficiaries by setting

	HOPD	ASC
Cataract removal	$490	$193
Upper GI endoscopy	$139	$68
Colonoscopy	$185	$76

1) Advisory Board is a subsidiary of UnitedHealth Group, the parent company of UnitedHealthcare. All Advisory Board research, expert perspectives, and recommendations remain independent.
2) California Public Employees Retirement System.

Source: Ambulatory Surgery Center Association; 2015 Surgical Care Consumer Choice Survey, Market Innovation Center, Advisory Board; Health Care Advisory Board interviews and analysis.

Confronting two forms of outmigration

Physicians are continuing to shift cases to ASCs

Physicians are the third stakeholder driving today's outmigration of care from HOPDs to ASCs. Completing surgical cases in ASCs is an increasingly lucrative opportunity for physicians. Physicians continue to benefit from investing in equity ownership in ASCs, allowing them to share in lucrative technical revenue, but they also have additional avenues for increasing their financial opportunity from practicing in ASCs.

For example, some payers are now rewarding physicians with bonus payments and attractive payment rates for completing cases in ASCs. More importantly, the combination of growing volumes of high-revenue procedures eligible for reimbursement in ASCs and higher productivity in the ASC setting creates a massive financial opportunity for physicians.

Appealing ownership

- Long-term equity options
- Capture revenue from ancillary services

Payer influence

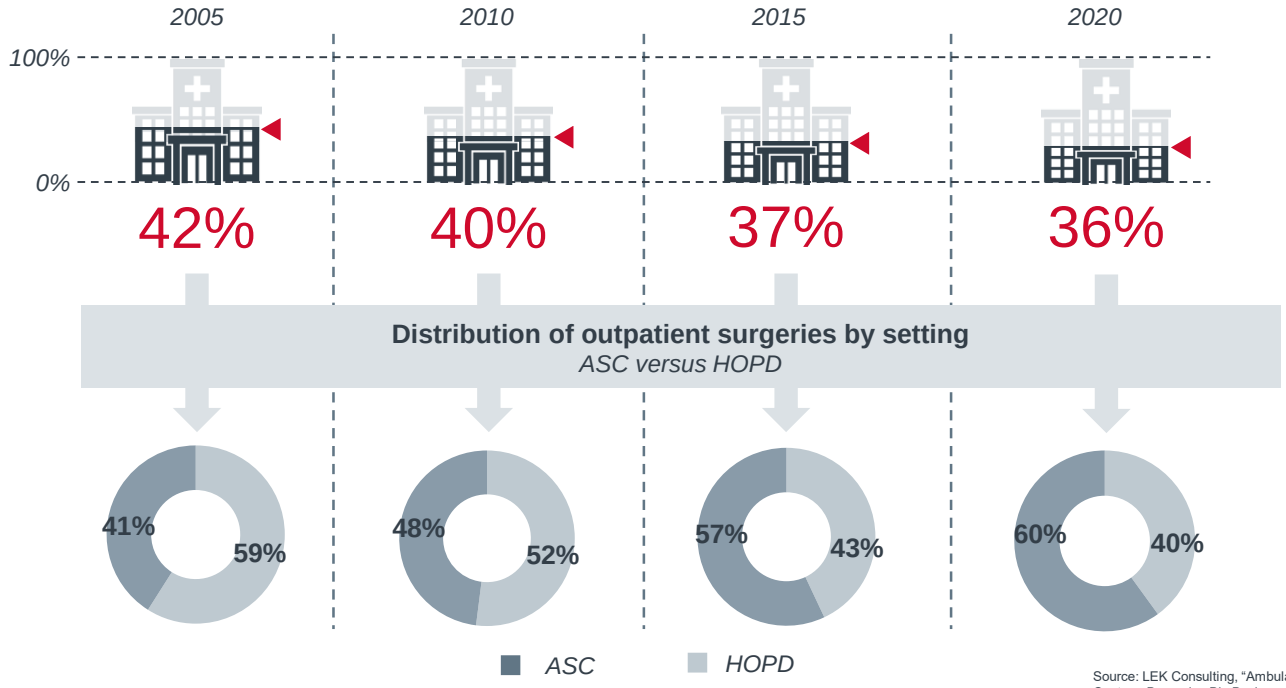
- Offering bonus per case for each patient who receives care in ASC instead of HOPD
- Commercial payers offer physicians higher rates in ASCs rather than HOPDs

Higher volumes

- Increase in high-revenue cases as more procedures are approved for ASC setting
- Growing demand from patients seeking low-cost care
- High throughput and efficiency boost productivity rates

The relocation of patients from the HOPD to ASC setting introduces a second form of outmigration for health systems. Previously, health systems retained the majority of cases that shifted to the outpatient setting since they were completed at hospitals' own outpatient departments. As the shift from HOPDs to ASCs accelerates over time, cases are leaving the hospital campus altogether. This new form of outmigration has two main implications for health system business.

Percentage of surgeries completed in the inpatient setting by year



Source: LEK Consulting, "Ambulatory Surgery Centers: Becoming Big Business," 2017; Health Care Advisory Board interviews and analysis.

Hospitals are confronting price cuts and new competition

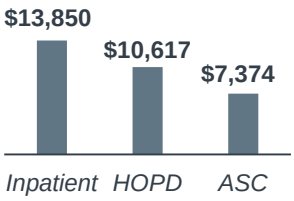
Implications of outmigration on hospital economics

First, health systems are facing significant price cuts when services shift to the ASC setting—and many of these cases are among health systems' traditionally most profitable procedures. To backfill for the lower revenue of outpatient services, health systems would need to capture a significant increase in volumes in the ASC setting.

For example, to account for the shift of partial knee arthroplasty (PKA) from the HOPD to ASC setting for 2018 alone, health systems would need to increase ASC volumes by about 28%.[1] Since CMS added PKA to the ASC-eligible list about 10 years ago, a large portion of eligible cases have already shifted to the ASC setting.

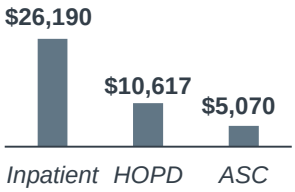
Procedures such as lumbar spine fusion or pacemaker implant that have a larger differential in HOPD versus ASC reimbursement rates require even greater volume growth to backfill shifted cases. Both lumbar spine fusion and pacemaker implant were only recently approved for ASC reimbursement, so fewer cases are completed in the ASC setting at this time. As outmigration continues, however, they could have a large impact on provider revenue.

Partial knee arthroplasty



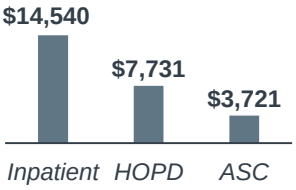
$3,243
Decline in reimbursement from HOPD to ASC setting

Lumbar spine fusion



$5,547
Decline in reimbursement from HOPD to ASC setting

Pacemaker implant

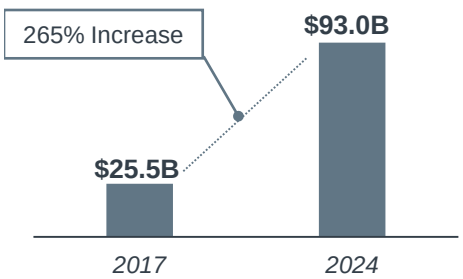


$4,010
Decline in reimbursement from HOPD to ASC setting

The second implication of today's outmigration is that the cases leaving the hospital campus are entering a crowded market. The ambulatory surgery market in the United States is expected to skyrocket across the next decade, attracting well-capitalized competitors looking to benefit from the growing opportunity.

The competitive marketplace is already having a noticeable impact on health systems' business. In 2017, the growth rate of health systems' outpatient surgeries declined to just 0.8%, which was largely attributed to the increase in competition.

Predicted growth of US ambulatory surgery market



> The reduced median rate of growth in outpatient visits to 2.2%—down for the first time in five years—and the decline in the median growth rate of outpatient surgeries to 0.8% speak to the increasing supply of competing sites providing these more lucrative services."
>
> *Moody's Investors Service*

1) Considering the health system completes 200 PKAs per year, at a ratio of 46% inpatient, 37% HOPD, and 17% ASC, which is consistent with the national average of procedures across each setting.

Source: Centers for Medicare and Medicaid Services; Global Market Insights, "Ambulatory Surgical Centers Market Worth Over USD 93 Billion by 2024"; Kacik A, "Not-For-Profit Hospitals' Cost-Cutting Isn't Keeping Up With Revenue Decline," *Modern Healthcare*, August 29,2018; Health Care Advisory Board interviews and analysis.

Unleashing latent demand

Ambulatory surgery represents a rare nugget of organic growth

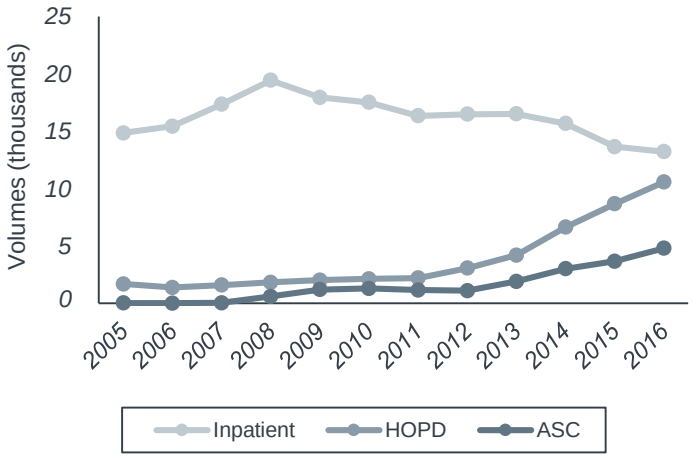
Three potential strategic responses

Hospital and health system leaders have three strategic options for how to proceed in the growing but competitive ASC market. First, they can attempt to reverse the outpatient shift by engaging in protectionist tactics intended to keep cases in the inpatient setting and convert ASCs to hospital-based reimbursement rates. In the long term, however, this approach is unlikely to be effective with consumers and payers.

Second, health systems could overlook the outpatient setting altogether by prioritizing the inpatient business and not actively undermining outmigration or investing in ASCs. Given the relatively lower growth of inpatient care and higher growth of outpatient procedures, organizations will struggle to meet revenue goals without capturing outpatient growth.

Third, leaders can implement a proactive strategy to compete for outmigrating cases. Fortunately, the shift to outpatient surgery is unleashing latent demand. For every one inpatient partial knee surgery that was lost across the past decade, there was an increase in eight outpatient surgeries. Even after accounting for lost hospital revenue, the outmigration of partial knees alone generated more than $100 billion in new revenue for the provider industry since 2005. By competing more effectively, hospitals and health systems can capture a portion of this growing and lucrative market. As a result, this is the most appealing for hospital and health system leaders, at least in the long term.

Volumes of PKA[1] covered by Medicare, 2005-2016[2]



Outmigration of PKA a 1:8 shift

Decline in inpatient Medicare PKA cases, 2005-2016

-1,625

Increase in outpatient Medicare PKA cases, 2005-2016

+13,666

$107B

Total net revenue growth opportunity for PKAs from outpatient shift

Opportunities for ASC volume growth

- Attract consumers who would not otherwise undergo procedure
- Align with physicians not currently engaged with health system
- Gain in-network payer status from offering low-cost sites of care

1) Defined by CPT/HCPCS code 27446.
2) Volumes are total allowable Medicare physician claims from inpatient, hospital outpatient, and ASC settings, CY 2005–2016.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

Unprecedented health system interest in ASCs

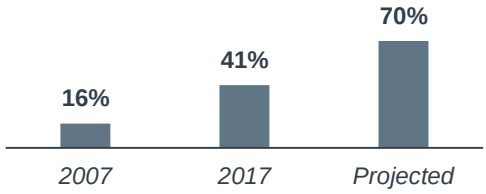
However, competing for ambulatory surgery is not a guaranteed win

Given this growth opportunity, it's not surprising that the number of hospitals and health systems owning or affiliating with an ASC has more than doubled in the past decade—and that number is expected to continue growing.

But the ASC market is not a guaranteed win for health systems. Services delivered in ASCs have lower reimbursement rates, requiring high volumes to remain profitable. As a result, ASC closures are not uncommon, and organizations need a clear and effective strategy for competing in the ASC market.

Advisory Board research identified five common pitfalls that health systems encounter while competing for ambulatory procedural volumes. These pitfalls are the barriers to success in the ASC market. Navigating these obstacles requires leaders to address a range of strategic and practical questions. For example, how should ASCs fit into a health system's broader strategic goals and procedural care offerings? Should health systems partner with management companies to operate their ASCs? How can health systems offer a value proposition that engages physician partners and generates referrals?

Percentage of health systems owning or affiliating with a freestanding ASC…



…but ASC market is not without risks

Lower profit margin for surgical services requires high efficiency for profitability and means there is a thin margin for error

2:1 Since 2009, for approximately every two Medicare-certified ASCs that have opened, one has closed

Five common pitfalls of health systems competing for ambulatory procedural care

Reactive ambulatory surgery strategy

ASC investments are defensive in nature and do not advance system's strategic goals

Assets do not match the market's service demands

Unclear service distribution plan

Lack of a service line strategy that offers top-of-site care

Fragmented service offerings do not maximize supply offerings

Ineffective alignment with key partners

Do not deploy the operational expertise to operate ASC in a different economic model

Commensal relationship with stakeholders in favor of the health system

Inefficient operations and poor throughput

Fails to attract proceduralists due to limited financial opportunity

Equity physicians complete procedures at different facilities

Lack of value for key referral drivers

Inability to meet the needs of referring providers

Consumer experience does not generate self-referring and repeat business

Market-specific considerations

Precise facility locations | Capital prioritization | Local market pro forma

Source: "Ambulatory Surgery Center Special Report: 2017 Benchmarks," Avanza Healthcare Strategies; MedPAC, *A Data Book: Health Care Spending and the Medicare Program*, June 2017; Tenet Health Q1 Earnings Call 2018; Health Care Advisory Board interviews and analysis.

The new rules of ambulatory surgery competition

Three steps to build a winning ASC strategy

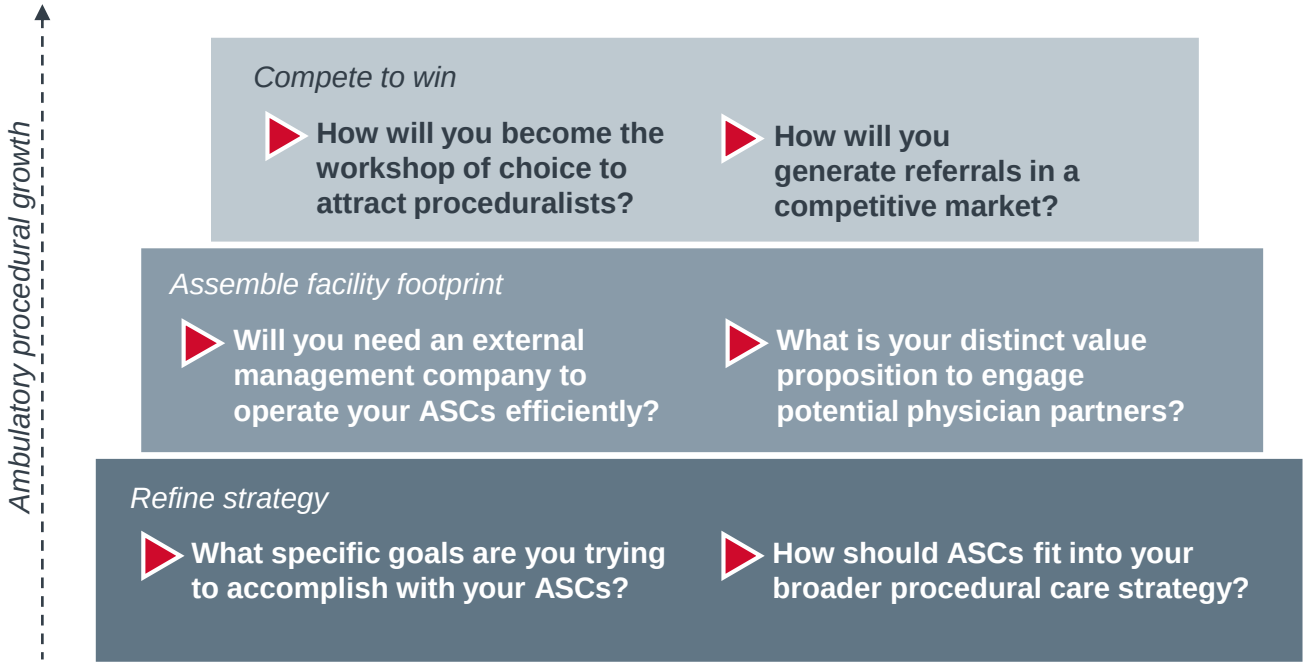
Advisory Board research identified three critical steps for hospitals and health systems to effectively compete in the ASC marketplace.

First, leaders need to refine the ASC strategy. This requires leaders to determine the specific goals the health system is trying to accomplish with the ASC and integrate the ASC into the health system's broader procedural care strategy.

Second, after leaders establish the goals of the ASC, they must determine their organization's go-to market strategy and assemble the facility footprint. Leaders will need to evaluate operational models and partners to run ASCs efficiently and how to work with physician partners.

Finally, hospitals and health systems need to drive revenue by both attracting physicians to complete surgical cases at the ASC and then win referrals from key decision makers to keep those surgeons busy.

Read on to explore the fundamental questions that leaders must address in order to complete these three steps—and discover case examples of organizations succeeding in the ASC market.



Source: Health Care Advisory Board interviews and analysis.

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Three steps to build a winning ASC strategy

A principled approach to ASC network development

Ambulatory surgery strategy aligns with health system initiatives

As surgical cases shift out of the hospital, health systems face increasing pressure to invest in ASCs to protect market share, retain physician talent, and appeal to purchaser demands. Local market dynamics also drive this growing demand for ASC partnerships. For example, health systems often view ASCs as strategic investments that will enable them to counter (or even block) competitors or to more closely align with physicians. However, to achieve sustainable growth in the ASC market, organizations must also consider how ASC investments will align with broader system-wide objectives. Otherwise, health systems are likely to pursue opportunistic investments, leading to haphazardly configured ambulatory networks and subpar results.

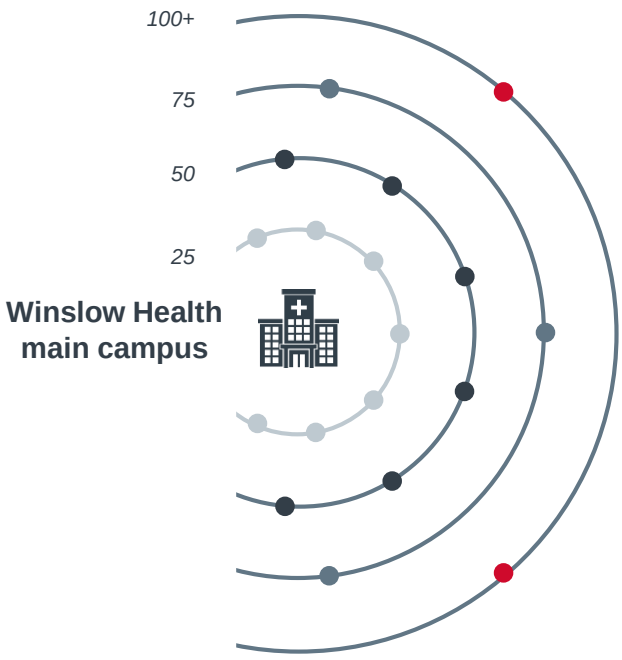
ASCs enable Winslow Health (pseudonym) to expand into new geographies

A frequent motivation driving health system investments in ASCs is the ability to reach new markets by expanding into outlying areas. In addition to accessing new patients, this strategy can be an effective way for organizations to enter the ASC market without risk of cannibalizing their existing inpatient surgery volumes. Expanding to new markets with ASCs also provides systems the opportunity to forge relationships with new physician partners and generate referrals.

Winslow Health, a multi-hospital not-for-profit health system in the Northeast, has been investing in ASC joint ventures (JVs) with physicians since the 1980s and recently started expanding into outlying markets. Winslow's ASC network includes 18 facilities that range in distance from within five miles of the system's main hospital campus to as far as 100 miles away. As the system continues to grow its ASC footprint, distant markets provide an opportunity to expand Winslow's geographic reach and generate new revenue streams for the organization.

Winslow Health's ASC distribution map

Miles from main hospital campus



$210M	Total revenue generated from ASC business
300+	Number of physician partners across 18 ASCs
110,000	Surgical cases performed in ASCs annually
13	ASCs within 50 miles of main hospital campus
5	ASCs over 50 miles from main hospital campus

Source: Health Care Advisory Board interviews and analysis.

Nuanced goals guide ASC strategy

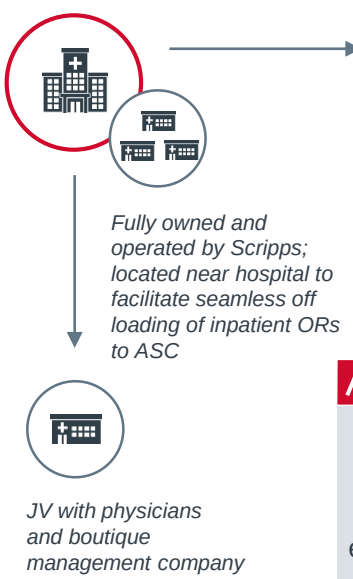
Principled ASC investments align with critical organization-wide initiatives

Scripps Health's ASC strategy advances specific health system objectives

Organizations with more than one ASC can deploy facility-specific strategies to advance a range of system goals. Scripps Health, a four-hospital non-for-profit health system in San Diego, California, operates five ASCs that have targeted objectives, which are reflected both in the ownership structure and operating model of each facility.

Three of the Scripps ASCs are fully owned and operated by the health system. These facilities are located near Scripps' hospital campuses and play an active role in decompressing the hospitals' over-capacity operating rooms by redirecting appropriate cases to the outpatient sites. Since Scripps owns and operates these facilities, the system has greater flexibility to work with physicians in determining which cases will be shifted to the ASCs.

Scripps has also entered into JVs with physicians and a boutique management company for two other ASCs. These facilities expand access to lower-cost sites of care, which enables Scripps to effectively manage risk in a highly capitated market.



40%

Of inpatient surgical volumes at Scripps are expected to shift outpatient across coming years

ASCs can support a range of health system initiatives

The ASC market—while growing and profitable—is not without risks. To mitigate these risks, health systems should begin by clearly defining at the outset what goals the organization aims to accomplish by investing in ASCs. Starting with the end in mind is a principled way to ensure ASC investments align with broader health system objectives and are not solely in reaction to external market pressures.

Potential applications of ASCs to fuel growth

- **Off load inpatient ORs:** Shift low-acuity cases to ASC to protect hospital capacity and increase case mix index (CMI)
- **Enter new markets:** Expand into new areas by investing in ASCs outside traditional market area
- **Capture new revenue streams:** Generate new sources of growth by expanding services for procedural care
- **Align with physicians:** Retain physician talent by appealing to physicians' unique practice preferences
- **Provide lower-cost option:** Appeal to payers and consumers by offering lower-cost surgical sites of care
- **Improve access:** Offer more convenient locations for patients to receive surgical care without needing inpatient admission

Source: Health Care Advisory Board interviews and analysis.

Confronting the question of what lives where

Site-of-service redistribution is easier said than done

As health systems expand their ambulatory surgery footprint, leaders need to redistribute services across the network to enable top-of-site care. Determining which services to offer in the outpatient setting—especially for systems considering multi specialty surgery centers—can be challenging. As more procedures are approved for the ASC setting, leaders will need to be strategic not only about which services they actively redistribute, but also about when they redistribute them. Since this process requires systems to self-disrupt existing business lines, leaders must evaluate the strategic implications of redistribution and proactively address potential barriers that could stand in the way of successful implementation.

Strategic considerations

- With more services approved for ASCs, system leaders must prioritize shifting services with strong growth potential
- Local market dynamics influence the timing and staging for when services shift to ASCs
- Prioritize shifting low-revenue cases to the ASC to avoid cannibalizing inpatient volumes

Barriers to redistribution

- Physician practice preferences have financial and practical motivations that will inform where they want to perform procedures
- Hospital leaders are principally concerned with performance for their discrete business unit, not enterprise-wide performance
- Performance-based incentives remain heavily skewed toward unit level metrics, not system-wide goals

Some service lines—especially orthopedics, gastroenterology, and general surgery—are well suited to the ASC setting. In addition to looking at future growth potential, leaders should also evaluate market demands and weigh the risks and benefits associated with specific ASC services. A holistic assessment—both at the service and sub-service line levels—can help system leaders narrow their scope when determining the most strategic approach to site-of-care redistribution.

- **High-volume, high-throughput services**
  - *Gastroenterology:* endoscopy, colonoscopy
  - *Pain management:* cervical, lumbar epidural
- **Core ASC volume drivers with strong growth**
  - *Orthopedics:* arthroscopy, shoulder scope
  - *Ophthalmology:* cataract surgery
- **ASC-suitable cases dependent on competitive dynamics**
  - *Urology:* bladder scope, prostate biopsy
  - *General surgery:* laparoscopic cholecystectomy, breast
- **Progressive services offering niche differentiation**
  - *Spine:* decompression, fusion
  - *Total joint replacements:* knees, hips

29%
of all ASC cases are for gastroenterology

99%
of patients are comfortable undergoing cataract surgery at an ASC[1]

$2,368
average net revenue per ASC urology case

215+
ASCs perform total joint replacements

1) According to one 2017 multi-site ASC survey.

Source: 2017 ASC Service Outlook Primer, Service Line Strategy Advisor, Advisory Board; Health Care Advisory Board interviews and analysis.

Applying a system approach to service redistribution

Proactively engage internal stakeholders to support organization-wide success

UK HealthCare strategically redistributes services

University of Kentucky HealthCare, a four-hospital academic health center based in Lexington, implemented a principled service redistribution strategy as part of its first ASC JV. The system targeted four service lines where high volumes of low-acuity cases caused capacity constraints at the system's inpatient and HOPD operating rooms, resulting in long waits for procedures, including some that were strong candidates for the ASC. The redistribution plan is intended to protect hospital capacity for high-acuity cases and reduces wait times across the board.

To drive adherence to this deliberate redistribution strategy, the system created a committee to oversee the physician credentialing process for the ASC. This committee is responsible for ensuring the appropriate number and specialty of physicians are approved to shift their cases to the ASC.

Service lines targeted for redistribution to ASC

- Gastroenterology
- Pediatric ENT[1]
- Ophthalmology
- Plastic surgery

ASC Credentialing Committee

Surgical chairs and select group of medical staff leaders determine which physicians to credential to practice in ASC

Aligning leadership incentives to promote service redistribution

Hospital leaders who are evaluated based on the performance of discrete business units, as opposed to system-wide performance, may view service redistributions as a threat to their specific divisions. Organizations must align performance incentives of key stakeholders to successfully redistribute services.

At Intermountain Healthcare, a 22-hospital, not-for-profit health system in Salt Lake City, Utah, facilities are classified based on the intensity of the services they offer. This system provides an effective mechanism for assigning roles and responsibilities across sites of care. The assignments help inform goals and incentives, rewarding leaders across the organization for advancing system-wide success rather than the performance of their individual facilities alone. Hospital administrators' performance is composed of a mix of hospital, regional, and system performance measures.

Intermountain's facility classification

	Facility classification	Average drive time for 80% of population to reach service offerings
Level 1	Family practice clinic	6 minutes
Level 2	Pediatrics, internal medicine, urgent care	10 minutes
Level 3	Outpatient surgery, advanced imaging	15 minutes
Level 4	General community hospital	15 minutes
Level 5	Broader community hospital	20 minutes
Level 6	Tertiary hospital, full service portfolio, NICU	30 minutes
Level 7	Teaching, transplant, level 1 trauma	One per region

Hospital administrators
Composition of incentive plan

- 50% Hospital performance
- 25% Regional performance
- 25% System performance

1) Otolaryngology.

Source: Health Care Advisory Board interviews and analysis.

Determining the go-to-market strategy

A range of options for ASC partners

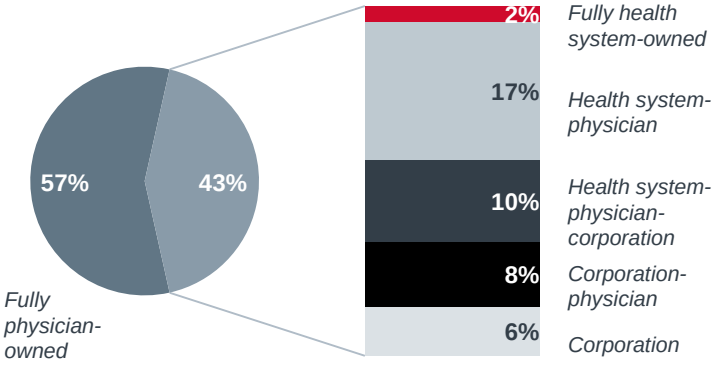
After formalizing strategic goals for ASCs, the second major step is to assemble the network. Historically, hospitals and health systems have not played a key role in the ASC market. While physicians fully own more than half of all ASCs, health systems fully own only 2%. And with regulatory hurdles such as Certificate of Need (CON) laws making it more difficult to open new facilities, systems may need to partner with physicians and/or management companies to gain a foothold into the ASC market. As health systems evaluate partnership options, it is important to keep in mind two imperatives that drive ASC success.

The first is that health systems must understand that ASCs are not mini-hospitals—they are distinct businesses and require specific expertise to achieve lean, highly efficient workflows. ASCs will not be successful if they operate as an extension of a health system's hospital or HOPD operating rooms.

The second imperative is that health systems must demonstrate value to physicians, especially when recruiting potential equity partners. Quality aside, physicians' principal concern is that ASCs are managed as efficiently as possible to enable a successful venture.

Ownership breakdown of ASCs

2015



Three stakeholders in the ASC market

Hospitals and health systems

Physicians

Management companies

Successful ASCs demonstrate lean and efficient operations

The economics of ASCs differ from hospital operating rooms in fundamental ways. Compared to hospitals, ASCs have higher supply costs and lower labor costs, higher profits to enable revenue distributions to equity investors, and faster turnaround times that promote high throughput and handle larger case volumes. ASCs are fine-tuned, focused factories.

High supply costs, low labor costs

Salaries, wages, benefits as a % of net revenue

◀ 57% Hospitals

◀ 24% ASCs

High profits enable distribution to partners

Total operating expenses as a % of net revenue

◀ 97% Hospitals

◀ 67% ASCs

High throughput, quick turnaround

Average room turnover time (minutes)

◀ 29 Hospitals

◀ 8 ASCs

Source: LEK Consulting, "Ambulatory Surgery Centers: Becoming Big Business," 2017; "Ambulatory Surgery Center Special Report: 2017 Benchmarks," Avanza Healthcare Strategies; Advisory Board Hospital Benchmark Generator; Health Care Advisory Board interviews and analysis.

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Learn the drivers of the emerging margin management challenge and get a road map of strategic solutions for hospital and health system leaders.

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Tool: The Hospital Benchmark Generator

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