New study benchmarks performance of ASCs

The impact of health care reform on ambulatory surgery centers (ASC)—like that on health care in general—is still uncertain. But plenty of other factors are at work that are likely to play a role in shaping the industry’s future.

While the dramatic growth of the 1990s has largely abated, a new study indicates ASCs will continue to consolidate with hospitals or larger chains, that gastrointestinal and orthopedic procedures will continue to provide the largest portion of the industry’s revenue, and that cost savings will take on a higher priority.

A look at macro factors
The study, by VMG Health in Dallas, released in November 2011, is part of the firm’s annual Intellimarker series of ASC financial analyses. VMG collected data from 2,010 operations at 240 multi-specialty ASCs nationwide.

Although this is VMG’s first study following passage of health care reform, it is too early to find evidence of any effects on ASCs of the Patient Protection and Affordable Care Act in this study, according to VMG senior manager and lead researcher Aaron Murski. Instead, he says, changes in the past year resulted “from macro factors affecting the ASC industry.” These include a trend toward increased efficiency due to lack of investment capital or volume increases that would bring in more revenue.

“There are not enough qualified physician investors to go around,” Murski notes. “You can only do so much to improve revenue, so ASCs are saying, ‘If we’re not a growth industry, we have to be more cost conscious.’”

Another restraint on growth may be the limits of technology. While Medicare continues to add procedures to the list of those it will reimburse, there tend to be variants in currently approved categories rather than new categories moving from inpatient status. (One exception is spine surgery, once thought too complex for outpatient status, now increasingly common.)

“Every year more procedures are okayed,” Murski says, “and this will continue to some extent over time, but I don’t think there will be any windfall where a whole class of procedures will be allowed as outpatient.”

Even new surgical techniques take time to achieve acceptance among physicians, he adds.

Still, he adds, “ASCs should have a place at the table” whenever the legal challenges surrounding health care reform are ironed out because they are among the lowest cost providers.

Applying the data
The Intellimarker study provides aggregate and regional financial data as well as breakdowns by specialty and annual case volume. VMG recommends that an ASC look at the benchmarks for each category that applies but also to remember that “all centers are unique.”

The study’s national averages provide a picture of the state of the industry during
the 2009-2010 study period.

Researchers estimate the number of US ASCs at 5,900, with about 22% owned by multi-facility chains. The largest chains:

- AmSurg: 208 centers
- United Surgical Partners International: 191 centers
- Surgical Care Affiliates: 145 centers
- HCA: 98 centers
- Nuetera: 90 centers.

Murski does not anticipate much further consolidation because of the local nature of health care, which tends to counteract the pull of large organizations. But as the data show, larger centers tend to be more financially healthy and thus more attractive to buyers, yet better able to fend them off.

**Weighing specialties**

Even for the multi-specialty subgroup of ASCs, procedures are unequally distributed.

For the group as a whole, GI/endoscopy procedures account for 29% of total case volume. Next are ophthalmology and orthopedics, with 17% each. Pain management accounts for 14%, and the other specialties for less than 10% each.

Some specialties are more profitable than others, based on the revenue per case. The study measured both gross charges and net revenue per case and found orthopedics topped the list, with the highest gross charge of $9,398, as well as the highest net income of $2,585. The difference, $6,813, represents average contracted discounts or regulated reimbursement levels (chart).

As Murski notes, there is a wide variation among specialties, and the highest gross charges do not always translate into high net revenue. Much of the disparity is due to reimbursement, either from Medicare or contracted commercial insurance discounts.

Because reimbursement is difficult to change, ASCs must focus on efficiency through scheduling, productivity, and supply cost control, “or profits can disappear quickly.”

**The productive few**

The average case volume per ASC is 4,258 per year and 17 per day. At all facilities, the top 2 physicians perform nearly a third of all procedures. For smaller centers with 1 or 2 ORs, that jumps to 39%; it is less at larger centers.

Regardless of size, for all multi-specialty ASCs, the mean gross revenue in the study period was $29,979,000, and the mean net revenue, after adjustments, was $7,736,000. There was a wide variance, however, as shown in the chart on p 25.

**Accounts receivable**

As a national average, ASCs had accounts receivable outstanding for 36 days. The range was 28 days (25th percentile) to 51 days (90th percentile). While 25% of income on average came from Medicare, 58% was from commercial insurers.
ASC assets
ASCs with the highest case volume also had the greatest average assets, worth $1.6 million for those performing 6,000 or more cases annually. Those with the lowest volume, less than 3,000 cases, had assets averaging $833,000.

The lower-volume ASCs also had more long-term debt as a portion of their total liabilities—$212,000 out of $501,000. The highest volume group had long-term debt averaging $231,000 out of $573,000.

Highest expenses
The highest expense categories were for staffing, primarily nurses and administrators, and for medical-surgical supplies. The average staff, by profession, included 1 administrator, 5.4 technical staff, 8.5 administrative staff, and 13.3 nurses. (Average salaries are in the chart.)

Using the benchmarks
These and other benchmarks are national averages. Regional sections of the report provide more detailed local findings.

Though variances point to areas in which to seek improvement, they do not provide the reasons why a particular facility may look different from its peers.

“There may be perfectly valid reasons for variances from the benchmark, and it does not necessarily signal underperformance in that area,” the researchers note.

In addition to providing benchmarks, the study allows readers to step back and understand trends and conditions in the industry.

“It always helps to understand your position in your industry,” Murski advises. “Forward thinking administrators need to focus on the local market but also on the wider industry. It helps to pick your head up now and then.”

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—Paula DeJohn

The 2011 Intellimarker ASC Benchmarking Study is available from VMG Health at www.vmgh.com