

Ambulatory Surgery Center Turnaround: Building on the Basics

White Paper



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Abstract: Ambulatory Surgery Centers (ASCs) consist of many moving parts that must operate effectively for the ASC to flourish. If even one of these components malfunctions, the ASC will suffer. Left unchecked, the financial health of the center will deteriorate. To maximize operational and financial efficiency it is important to understand the basic components at work and discern how well each is functioning. Only then can changes occur that reverse the trends.

Using a case study, this paper will describe the decline of one ASC and the discovery of dysfunction throughout the center. Then, it will outline the positive turnaround in financial and operational actualization that resulted from addressing each component that was off track and on the verge of breaking apart. The study also reports on the creation and deployment of a broader strategic plan to help the ASC expand its procedural breadth.

Key Words: Ambulatory Surgery Center (ASC), Accounts Payable, Accounts Receivable, Revenue Cycle Management (RCM), Billing, Case Load, Administration, Physical Plant, Physician Relations, Technology, Turnaround, Operations, Strategy, Financial Improvement, Enhanced Ambulatory Patient Grouping (EAPG)

INTRODUCTION

Healthcare provider organizations are a complex amalgamation of components. These pieces are meshed together to aid organizations in the fluid and efficient delivery of care. Ambulatory Surgery Centers (ASCs) are no different. They comprise many moving parts that lead to optimal ASC functionality if they operate effectively. However, if one of these components “breaks,” the ASC will suffer.

The advent of the ASC occurred in 1970 as a path to improve the delivery of outpatient surgical services to the community. The smaller, more intimate setting allowed patients to feel more comfortable while receiving care in a timelier manner than a larger venue, such as in a hospital. Overall, ASCs made surgical services more convenient for patients. By 1982, Medicare had approved payments for procedures performed in ASCs.

The Affordable Care Act (ACA), signed in 2010, set many changes in motion. The fallout from this legislation is still being realized as providers continue to navigate the transformations needed to shift from volume to value. One matter is sure: the ACA is bringing more patients to ASCs—but will the revenue and profits follow? ASCs must make every effort to improve operations, maximize their revenue cycle, and address every aspect of their functionality to stay on point.

The following case study will demonstrate the turnaround of one ASC that was off track from the center’s mission and about to break apart.

BASELINE ASSESSMENT

In the first quarter of 2016, Coker was asked to assess and implement changes in a physician-owned, stand-alone, multi-specialty ASC. The ASC is a 16,000 square foot facility with four operating rooms and one procedure room, performing 4,500 outpatient surgical procedures (to date in 2016, an increase of 44.5% year-over-year), including orthopedics, podiatry, ophthalmology, pain management, and gastroenterology.

Coker was engaged to address not only operational issues in the ASC but to provide insight into strategy, including the addition of service lines. Inherent concerns encompassed, but were not limited to, poor case mix, low utilization, staffing inefficiencies, a sub-optimal physical plant, and a management disconnect from the mission of the center. We soon learned that those matters were the tip of the iceberg. Greater problems lay beneath the surface.

A team was dispatched to review the ASC including staffing, revenue cycle, payer contracts, management skill sets and management span of control, inventory, room utilization, scheduling, and case mix. The resulting report delineated financial ramifications based on the ASC's "current state" (both revenues and expenses), prioritized issues for management to address, and defined a course of action to remedy systemic dysfunction throughout the center. The report also contemplated creation and deployment of a broader strategic plan to help the ASC expand its procedural breadth.

PROCESS/IMPLEMENTATION METHODOLOGY

After a review of and discussion about the assessment report, an inventory of current human capital, and the timeline for the turnaround, the client asked Coker to provide an interim executive leader to get the ASC on the right track, both structurally (operationally) and financially.

Coker deployed a seasoned interim executive who was both Masters prepared and an RN with a rich history of surgicenter turnarounds. In fact, our interim was licensed in the client's state and scrubbed in on some cases, when needed.

Our interim immediately set about working with Coker's assessment document to examine priorities and to massage the ASC into a structurally sound entity.

Within four months, the ASC was well on its way to substantial improvement in financial and operational actualization.

In addition to the multitude of fractured items and processes, critical areas of focus that would deliver either the largest financial impact and/or the greatest structural return, included:

REDUCTION OF ACCOUNTS PAYABLE (AP):

Prior State – When Coker arrived, AP was in arrears approximately \$1.3M and multiple vendors had placed the center on “credit hold” status, predicated on payment of outstanding invoices. Past due payables languished for 270 days. There was no strategy deployed to manage, or even significantly reduce, the outstanding past due AP.

Current State – Coker developed and implemented a consistent strategy to reduce outstanding past due AP. As of this writing, \$650K of AP is aging less than 60 days past due. All credit holds were removed. By the end of 2016, the surgery center will be able to satisfy outstanding AP within established vendor account terms (30-45 days).

ACCOUNTS RECEIVABLE (AR) AND REVENUE CYCLE MANAGEMENT (RCM):

Prior State – When Coker arrived, collections were under 60% and totaled \$550K-600K/mo. The RCM was in disarray where front desk (registrars) whether intentionally or overtly, avoided collecting insurance copays or deductibles. In fact, patient responsibility collections were well in excess of 180 days.

Current State – Due to a more aggressive case mix and enhanced registration and collection processes (including eligibility, pre-certification, patient responsibility), the current revenue run-rate is trending over \$1MM month, a pickup of \$400--\$450K *per month*. Over the last three months, this is a pickup of nearly \$1.5MM. Coker’s interim executive worked with the team to establish protocols for collecting patient financial responsibility. Additionally, Coker worked with a third-party vendor to develop other options for patients (financing) to cover their contractual financial obligation. Patient responsibility collections greater than 90 days have been significantly reduced.

BILLING:

Prior State – Coker noticed that the client was losing a significant amount of money on Worker’s Compensation and No-Fault cases due to incorrect Enhanced Ambulatory Patient Grouping (EAPG) coding and submission. EAPG grouping is used to establish reimbursements for worker’s compensation and no-fault claims.

Inconsistent business office processes (point-of-service collections mentioned above) and an out-of-date fee schedule contributed to reduced collections.

Current State – With the client Coker helped implement a software solution to assist billers/coders in determining the correct EAPG coding. Past claims (January 2016 to May 2016) were resubmitted to recover missed charges. This effort has netted an additional \$600K in

revenue. As we move forward, claims are billed at the correct higher reimbursement rate, which should result in an *additional* \$800K unanticipated revenue through the remainder of 2016. Coker also examined and appropriately adjusted the fee schedule (allowables) for the center. Lastly, Coker helped streamline many operational processes to eliminate redundancy, increase efficiency, and improve financial stability.

CASE LOAD:

Prior State – When Coker became engaged, case load volumes averaged approximately 550 cases per month. The site administrator, at the time, consistently denied additional cases from physicians outside of block times. This action ran counter to the stated goal of increasing case volume and servicing the clients. No other service lines had been pursued.

Current State – Since April, the ASC has averaged 680 cases per month, with a high of 724 cases in June, a record for the surgery center. Additional case volume is now encouraged, and surgeons can add more cases, efficiently, expediently, and painlessly. Spine and total joint service lines are being established, and performance of those cases will begin in November 2016. Also, a plastic surgery service line is being pursued.

ADMINISTRATION/HR:

Prior State – An ineffective Administrator, a clinician with little to no business acumen, ran the ASC absent a strategic plan or a solid, fundamentally sound operational infrastructure. In that vacuum, physician and staff morale plummeted due to a lack of clear leadership. Misaligned staffing supply/demand led to disequilibrium and staff compensation plans that lacked objective rigor.

Current State – After review, careful consideration, and contemplation, the nonperforming Administrator was replaced with a well-versed professional administrator who was capable and able to focus, and assist, on the structural rebuild of the ASC's operations. Staffing was realigned to fulfill the needs of the surgery center, and pay scales were equalized to enable management to offer staff an average 3% raises. Some team members had endured up to four years without a salary increase. Some staff adjustments occurred via attrition, and newly added staff members were compensated within competitive and geographically adjusted pay rates.

PHYSICAL PLANT:

Prior State – Owing to the disarray of management, many legacy issues permeated the physical plant. These problems were either ignored or not addressed promptly. The environment was unclean and in disarray. The patient waiting area and business office were dated, and the flooring was tattered and worn. In some areas, Duct Tape was used to repair tears.

Current State – In the time since the engagement commenced, we worked with the owners to contract with an outside company to bring cleanliness up to par, including an ongoing maintenance plan. Part of the physical plant improvement includes a complete remodel of the waiting areas and business office, a \$400k capital improvement. As a component of the remodel, a consultation room is being built to provide privacy for discussions between patients, families, and physicians.

PHYSICIAN RELATIONS:

Prior State – As previously noted, physician morale was perpetually low. Physician-owners had not received a distribution since purchasing the surgery center three years ago, and they were not actively involved in the management of cost reduction or efficiency discussions. Additionally, they ordered many different supplies to satisfy their individual needs leading to added expense to the ASC.

Current State – In June, three (3) months after the Coker’s engagement began, the physician-owners received a \$300K distribution. In the last month, an additional \$400K was distributed, bringing the total distribution from the onset of Coker’s engagement to \$700K. While not an earth-shattering sum, this was, in many ways, a watershed moment as it purchased immediate goodwill, improved physician morale, and revealed that the ASC could indeed produce a profit if appropriately managed.

Physician interest and input immediately improved, and physicians became involved in cost management and containment, cost reduction, and product consolidation to reduce pricing and leverage buying power. As an outside force, this good-faith gesture displayed for the providers that their investment in Coker’s services was worth the risk. The owners have expressed their approval and pleasure with the direction the surgery center is going.

TECHNOLOGY:

Prior State – Information technology (IT) services were outsourced entirely with no onsite resources available. This factor built a certain “lag” into responses where IT supplier response was measured in days, not hours. Further, technology offerings were not optimized, and the tech infrastructure was inefficient with some systems’ multiple iterations out of current software versions.

Current State – Coker suggested bringing IT services in-house, which ultimately resulted in a 60% savings, greater control and management, and “real time” response to issues where turnaround times are measured in minutes, not days. Technology has/is being optimized for the surgery center. Additional critical applications have been added to increase efficiencies, data access, and response.

SUMMARY

Coker began its tenure with the client via an operational (and financial) assessment of the provider-owned ASC. The resulting report delineated changes required to rebuild the infrastructure. Coker was engaged to implement these changes via its seasoned interim executive leader.

Coker remains involved with the client to continue improvement activities, especially related to clinical care process design to ensure high-quality and cost-effective outcomes. Our work with the client remains in its infancy. But with honest brokers and associates who are invested in the success of the practice, we envision a stronger ASC and concurrent strength in revenues with future distributions to shareholders. In four months on site, Coker has, generally:

- Helped generate hundreds of thousands of dollars in additional revenue
- Reduced expenses
- Negotiated and navigated supplies to manage inventory and costs
- Paid shareholders their first distribution in more than 3 years
- Reduced accounts payable by 50% while renegotiating “credit holds”
- Increased caseload in the ASC
- Improved case mix for the center
- Managed staff into a cohesive, and team-led, unit
- Obtained raises for quality employees
- Revamped a tired and substandard management structure
- Revisited the fee schedules and revenue cycle driving higher revenues
- Redesigned and deployed efficient IT systems

FINANCIAL SUMMARY:

Through a recap of measured changes over a 4-month period, the following tables illustrate the financial picture, both past and present, of the ASC.

Table 1

| Measured changes (over 4 months) | | | | |
|----------------------------------|--------------|--------------|--------------|----------|
| | Then | Now | Difference | % change |
| Accounts Payable | \$ 1,300,000 | \$ 650,000 | \$ (650,000) | -50% |
| Monthly Revenue | \$ 500,000 | \$ 1,000,000 | \$ 500,000 | 100% |
| W/C & No Fault Gains | \$ - | \$ 600,000 | \$ 600,000 | 100% |
| Cases per Month | 550 | 680 | 130 | 24% |
| Case growth YoY (YTD) | 3115 | 4500 | 1385 | 45% |
| Salary Savings* | 0 | 0 | 0 | 0% |
| EAPG "Capture" | \$ - | \$ 600,000 | \$ 600,000 | 100% |
| Technology Solutions | 0 | \$ 12,000 | \$ 12,000 | - |
| Distribution to Shareholders | \$ - | \$ 700,000 | \$ 700,000 | 100% |

* attrition and realignment

26 to 1 ROI through 4 months

Many challenges face healthcare today, and ASCs are not exempt from the problems addressed in this paper. We offer our resources to evaluate the current operations and navigate the necessary changes to ensure success.

For information on ASC turnarounds and other practice management services, contact Coker Group at 1-800-345-5829 x2021 to speak with Jeff Gorke, Senior Vice President.