# ASCs: ONE SURGEON'S PERSPECTIVE ON OWNERSHIP

I can comprehend the value of running your own ASC and the benefits that come with ownership, but I also see the potential disadvantages of such a responsibility.

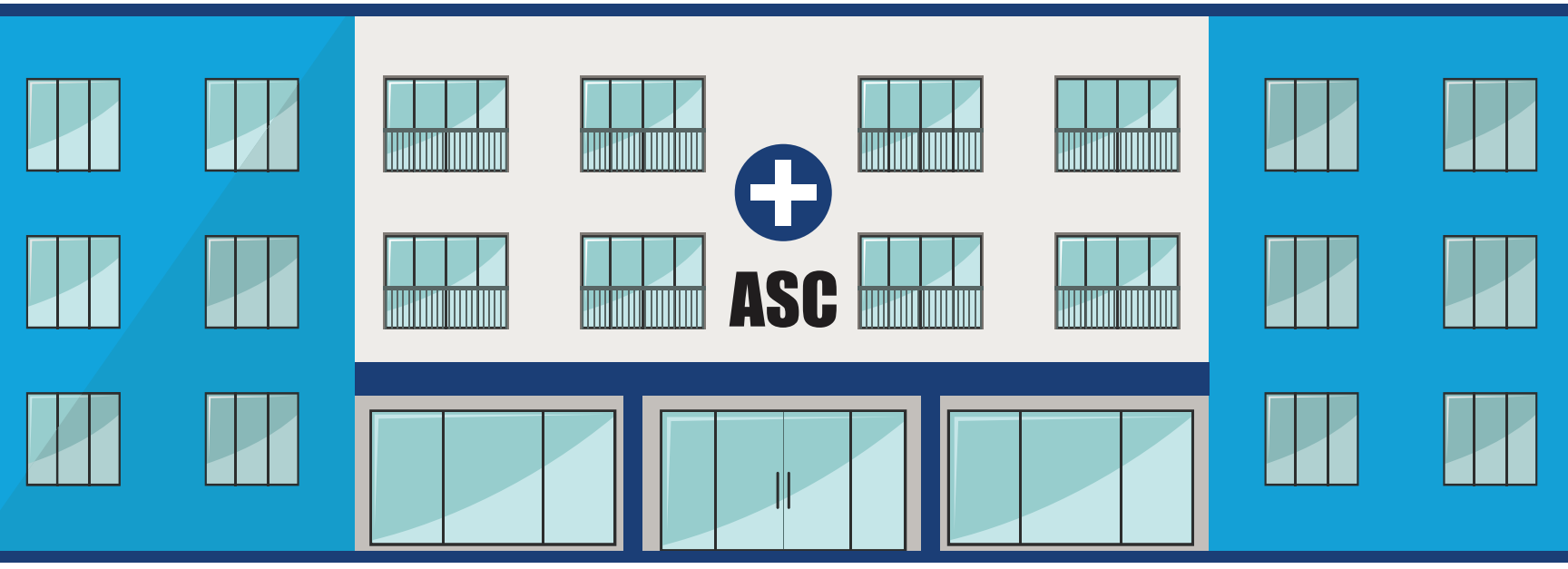
**BY JONATHAN D. SOLOMON, MD**

Over the past decade, like clockwork, I have been presented with opportunities to join as a shareholder in a surgeon-owned ambulatory surgery center (ASC) or a venture to open an ASC, in which I would be a principal investor. Each time, I am provided a prospectus that invariably outlines the significant growth I can expect to see over the next 5 years—assuming a few simple changes anticipated in my surgical volume. The small print always reads, "assuming current [Centers for Medicare & Medicaid Services] reimbursement," which accurately reflects that Medicare cuts are a possibility. This is also frequently accompanied by a statement from the executives who help build and manage ASCs that reads, "This revenue should help offset the expected changes to the Medicare Physician Fee Schedule." So, it raises the question: Am I making the biggest mistake of my professional life by not owning an ASC?

Let me share my own experience. I joined my father's practice, and one of his offices is in the same building as a health system-owned ASC. Although my mother is the director of anesthesia at the ASC, and I have to brave the awkwardness of working with my mom over my shoulder, I can walk down the hall to do cases and then return to the office in the afternoon for clinic. In addition, it is not uncommon for me to consult on an eye emergency between cases and then run back down to the ASC to return to my surgical cases. The convenience of this setup has always been an unbeatable factor.

Now, arguably, moving my office would allow me the opportunity to build an ASC and a clinic, but this brings me to my next concern. It is also presented as part of the annual prospectus that a certain number of cases must be performed to make the center profitable. In order for me to reduce the financial risk, I would want to approach other surgeons to join the center. In my community, there are a number of busy, efficient surgeons who happen to get along, but I always felt that asking them to come to a center attached to my office might be a deal breaker. A neutral site would be ideal, but then I lose the convenience. Plus, working with doctors can be like herding cats. This brings me to my next point.

I have had the opportunity to work at other centers around




the DC metro area that serve communities for a number of my satellite offices. Some have been surgeon-owned ASCs, while others were hospital-owned ASCs. None of them has been as difficult as the OR in the hospital, but I would also say that, despite the fact that the hospital-owned ASC actually has a profit-sharing structure for the surgeons, there is a clear distinction in quality of care when compared with the surgeon-owned ASC. Without question, the experience for both surgeon and patient alike is better across the board when the surgeon has a vested interest in the patient's journey. Recently, I applied for privileges at a surgeon-owned center that, by all accounts, is Nirvana for eye care. To put a finer point on things, the medical director has made every effort to offer every convenience and nearly every technology to facilitate superior outcomes and patient experience. This center did not appear out of thin air, and it required yeoman's work to accomplish.

As an owner, I would be expected to address different surgeons' issues, manage the administrative/human resource burdens, and review the contracts with the different vendors for everything from billing companies to phaco/vitrectomy equipment—no small feat. As is frequently the case, companies tend to provide you with pricing that is predicated on utilization, and bundling is the great sleight of hand. For those who do not know, a price is quoted per phaco pack, and it may change if you happen to use the company's IOL in the form of a rebate based on percent utilization. This often does not end with the IOL; the price could also be affected if you were to include a femtosecond laser and even intraoperative imaging systems. Often, the real price of a product is elusive, and a great deal of effort is required to truly compare apples to apples. Predicting future reimbursements is marginally easier with conditional probability and a dash of speculation as to the solvency of Medicare. How many ways can you split up 66984 or $980.29?[1]

The problem I have with this approach stems from the inherent desire to bundle. In effect, this frequently places the bottom line at odds with competing technology. In other words, I like the practice of optimizing surgical solutions for each patient. I want my sole motivation to be the best in class for each case and have been in the situation with other surgical centers where it was politely, yet firmly, suggested that I consider an alternative lens that would help with the bottom line. Needless to say, I did not feel very good about that conversation.

In turn, I made the decision a number of years ago to accept the medical directorship of the hospital-owned center down the hall in exchange for a stipend. We have, cooperatively, placed a femtosecond laser, intraoperative aberrometry, and 3-D surgical capability in the center for all to use in an effort to make the facility not only competitive but also a center of excellence. At the same time, I encourage the staff to consider the patient's experience to be the premium in elective surgery and to separate ourselves from the hospital mindset. Have I been successful? I hope so, but I know there is always room for improvement.

This in no way would equal the compensation I would expect as an ASC owner/operator, but right or wrong, I tell myself that the financial reward is not worth the headache, potential marginal compromises to care, and time commitment required for me to start my own center. Compounding interest aside, the benefits of convenience and flexibility win out, and I feel that I am able to make my daily surgical experience similar to what I could expect at a surgeon-owned facility. In general, I can comprehend the value of running your own ASC and the benefits that come with ownership, but I also see the potential disadvantages of such a responsibility.

Young ophthalmologists all face this decision, and if the circumstances arise where ownership will provide some flexibility, efficiency, and financial reward, then they should go for it. Should they find that that opportunity, for whatever reason, escapes, then they can consider the alternatives and make the best of their situation. In the meantime, I will continue to do my thing and field opportunities. Now, should a better ownership opportunity come my way, then maybe I will take it. ■

1. CY 2016 Hospital OPPS and ASC Payment System Policy Changes and Payment Rates final rule. https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-27943.pdf. Accessed December 18, 2015.

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