Introduction

Physicians face unprecedented challenges today practicing medicine in the United States. With practices founded overwhelmingly on their love of medicine, they have an unwavering desire to provide excellent care to a society in great need. However, the average physician continually struggles to balance how to deliver the highest-quality care with the need to survive economically. He or she faces the dual pressures of reduced reimbursement and higher overhead and expenses.

With the desire to deliver excellent care as the underpinning of their profession, physicians must look for options in the way they practice medicine and for other sources of revenue. This book explores ancillary services as opportunities for physicians who are under pressure to make economic sense of their work in an increasingly demanding field.

What is an ancillary service? An “ancillary service” is any service a physician practice provides over and above its basic offerings and general professional fees.

Developing and providing ancillary services is a means for physicians to realize a better return on their investments of time, resources, and capital. Many physicians have increased their net incomes significantly through these services. Types of ancillary services vary by specialty, yet most physician practices could offer additional services, perform other procedures, do more tests, and so on, within the sphere of their existing practices. Some “ancillaries” can be done by current practitioners; others can be performed by “interim” or part-time providers. Some ancillary services can be offered at “satellite” or freestanding locations.

For example, scores of surgeons are using ambulatory surgery centers (ASC) instead of, or in addition to, using traditional hospital facilities to perform surgical procedures. ASCs can either be physician owned or jointly owned by hospitals and physicians. Other investors can share in the ownership as well. An ASC can either be freestanding or an operating room in an existing building. Using these facilities can be very profitable for the physicians and time saving because of easy access.
This chapter provides an overview of ancillary services and gives a vision of why physicians should engage in additional services beyond the basics. This vision becomes the foundation for exploring specific components of developing a successful ancillary program strategy. The objective is to provide physicians and other readers with useful tools for achieving their goals and objectives for their medical practices.

Overview of Ancillary Services

Expanding on the previous definition, “ancillary services” are those services offered by a physician practice or a hospital, beyond its core services, that generate additional revenue. An example of ancillary services would be an orthopedic surgeon who provides consultations and evaluations of diseases and injuries affecting the bones and skeletal system. Most of this physician's revenue is from professional fees charged for performing surgical procedures. Historically, those surgical procedures have been performed within the local or area hospital's operating room (OR) facilities. Physicians are becoming more accustomed to performing these services at independent, stand-alone ASCs or, in some instances and depending upon the specialty, at their own offices.

Hospitals, on the other hand, have traditionally emphasized inpatient care along with their operating room and other surgical services. Although continuing in this mode, hospitals are also looking at services that they can provide other than room, board, and professional care. They have developed outpatient centers, including ASCs, which allow them to provide at least some of these services outside the hospital's walls.

The following are a few examples of ancillary services:

- X-ray services laboratory
- Anesthesia (in certain settings)
- Physical therapy
- Diagnostic testing
- Diabetes and weight management programs
- Wellness centers
- Retail product sales (e.g., eyeglasses, hearing aids, etc.)
- Freestanding ASCs
- Dialysis centers
- Antiaging centers
- Skin care centers
- Infusion therapy centers
- Catheterization laboratories
- Sleep centers
- Endoscopy centers
- Antiaddiction centers
- Psychotherapy centers
- Weight loss centers
- Geriatric centers
- Urgent care centers
- Pain management

Practically every physician specialty has the opportunity to add ancillary services. Figure 1-1 (following) is a partial list of services by specialty, and some examples of ancillary services that might fit well with those specialties.

Ancillary services can assist with the ultimate goal of providing quality medical care, often in the physician's office, and generate a profit for his or her efforts. The orthopedic surgeon, for example, can establish a successful private practice by providing patients with pre- and postoperative care and consultation. That same orthopedic surgeon may establish an ASC “attached” to the outpatient practice. For example, any single room within the physical plant can be converted to a surgical suite, operate under a different tax identification number, and be used by the physician to offer more convenient services to benefit both the physician and his or her patients. The orthopedic surgeon performs all surgical procedures at the ASC unless the procedure requires an overnight hospital stay. Even then, if the hospital is nearby, the surgeon may use the ASC and then transport the patient to the hospital for overnight care.

This is an excellent example that can be found duplicated throughout the United States. Forming ASCs and establishing other ancillary services is not done without constraints, however. Many states govern such ventures by requiring prior approval, which usually means that the entity must receive licensure through
satisfying the requirements for a “certificate of need” (CON). This authorization provides the physician, or anyone else developing the ancillary service, with the right to build and operate based on the fact that the community needs the service. Some states do not have CON regulations; therefore, launching an ancillary venture is quite easy. Other states have very stringent requirements; others lie somewhere in between. Some states allow single specialty, small ASCs or ancillary services, as in the example of the orthopedic practice mentioned previously, to be built as long as the cost is within a certain threshold.

The ancillary service, like the orthopedic surgeon’s ASC, often benefits the patient by offering convenience, the same or reduced costs, and as good or better quality and continuity of care.

<table>
<thead>
<tr>
<th>Ancillary Services</th>
<th>Examples by Specialty</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>Pain management center</td>
<td>The Cleveland Clinic Pain Management Centers, Neurological Associates Pain Management Center</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Renal center</td>
<td>Silver Cross Renal Center, The Gloria York Renal Center</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>X-rays, physical therapy, diagnostic center, ASC</td>
<td>The Cleveland Clinic Rehabilitation Institute, Vision Surgery &amp; Laser Center, LLC</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Stress testing, nuclear testing, cardiorespiratory care, catheterization laboratory</td>
<td>Minneapolis Heart Institute, Hendrick HeartSaver Network Heart Catheterization Lab</td>
</tr>
<tr>
<td>Radiology</td>
<td>Mammography diagnostic center, basic radiology imaging centers</td>
<td>Women’s Diagnostic Center, Radiology Associates</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>Lab, X-rays, diabetes management, spa, retail products</td>
<td>Diabetes Management and Training Centers, Inc., INTOUCH diabetes management software program from LifeScan</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Retail products, skin care centers</td>
<td>The Cosmetic Skin and Surgery Center, Essentials Skin Care Center</td>
</tr>
<tr>
<td>Hematology/ oncology</td>
<td>Infusion centers, radiation centers</td>
<td>Lourdes Ambulatory Infusion Center, Synchrotron Radiation Center</td>
</tr>
<tr>
<td>Neurology</td>
<td>Sleep study centers</td>
<td>Carilion Sleep Center, The Center for Sleep Disorders at Johnson City Medical Center</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>Hospitalist program, sleep study center</td>
<td>Ochsner Clinic Hospitalist Program, Cheshire Center for Sleep Studies</td>
</tr>
<tr>
<td>Family Practice</td>
<td>X-rays, lab, diabetes management programs, geriatrics centers</td>
<td>Geriatrics Center of Excellence (COE) at Cambridge Health Alliance</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Endoscopy center</td>
<td>Three Rivers Endoscopy Center</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Nutrition education programs</td>
<td>Friedman Foundation</td>
</tr>
<tr>
<td>General Surgery</td>
<td>ASC</td>
<td>Virtua Ambulatory Surgery Center</td>
</tr>
<tr>
<td>Urology</td>
<td>ASC, continence centers</td>
<td>The Hennepin Faculty Associates Continence Center</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Lab, X-rays (subspeciality may have asthma and allergy center, etc.)</td>
<td>East Tennessee Children’s Hospital</td>
</tr>
</tbody>
</table>
Why Consider Ancillary Services?

Physicians, hospitals, other providers, and investors that are considering whether to invest in ancillary services should base their decisions on the following important issues:

- Declining third-party reimbursement for standard services
- Their need to diversify and increase revenue
- In reaction to the final Stark regulations
- To broaden their ability to offer ancillary services
- To achieve more control over all aspects of patient care available
- Their desire to improve their quality of care, usually with improved efficiency
- To augment revenue and enhance bottom line results

Unless most of these factors apply, reconsideration of the entire proposed venture is recommended.

Physicians who develop ancillary services are under continual pressure to maintain the highest standard of quality care, and yet are regularly forced to take less reimbursement for their services. Physicians’ costs of providing services is ever increasing, as labor, rent, malpractice coverage, supplies, and other practice expenses have climbed steadily over the last 10 years. During the same period, reimbursement, (i.e., what the physician gets paid for his or her services) has not increased commensurately. Even when adjusted for inflation, increases in revenue have fallen far behind expenses in most areas of the country. Increased expenses and lower reimbursements place huge hardships on physicians—to the extent that many have questioned whether to continue to practice medicine. Sadly, many have left the profession in which they invested so much, and others are finding the need to diversify.

The Stark laws and other federal regulations have inhibited physicians and hospitals since their introduction, but the 2003 final Stark rulings provide new opportunities that broaden the ability of health care providers to offer and invest in ancillary services.

Although economic factors are among a physician’s top priorities for considering investing in or developing ancillary services, quality of care is of equal concern and the major “driver” in the decision. Quality of care cannot be compromised.

In the same way one would ask questions about financial issues, the following are specific questions to consider relative to quality of care and an ancillary service venture:

- Will the service add to or detract from patient comfort and security?
- Will patients be compliant with the care plan?
- Does the physician have the ability to supervise the delivery of ancillary services?
- Will care be of comparable quality to the traditional way the service is provided?
- Will the service be reimbursed by third-party payers?
- What are the revenue possibilities on a per case or per procedure basis?
- Is there a possibility of an acceptable return on investment?

Although other questions should be answered, these are the most important and should be top priorities in determining whether an ancillary service makes business and clinical sense.

There are several guidelines to follow before deciding to develop an ancillary service. First, do exhaustive “due diligence” on financial, management, and legal compliance matters. Each of these three facets will be addressed more comprehensively in subsequent chapters of this book. A feasibility study and business plan (i.e., the due diligence process) is an essential component of your planning. You will also require competent management of your entity or your service. Otherwise, the ancillary service initiative will get off to a slow start or fail completely. Your ancillary service venture must comply fully with all the rules and regulations that govern it throughout the establishment of the entity and during all operational phases. The consequences of non-compliance are significant.

Start with a clear business plan and prepare a comprehensive budget with a series of “pro forma” (as if)
projections. Preparation and planning is the subject of Chapter 4.

Gather an experienced team to structure the transaction and operate the business. This team should include representatives from your existing management staff and outside resources, such as consultants, attorneys, accountants, and other advisors who can assist in various areas and stages of the process. Some will be called on in the preplanning and planning stages, and others need to be on board for the management of the entity.

Another concept that is important during the development phase of the ancillary service is to have an idea for the source of patients, or customers. Part of the due diligence (as addressed in Chapter 3) will include devising an effective plan to market the services. Understanding referral sources is essential, especially for ancillary services like an ASC that are dependent upon the referrals of other physicians (as well as those who are owners of the venture) for success, if not survival. A demographic analysis of your existing patient base can also be a huge factor to consider in planning and marketing your services.

You will also need to hire competent outside assistance including knowledgeable legal counsel. Seek an attorney who has years of experience in health care law. Another important consideration is to hire an experienced health care consultant familiar with the complexities of outpatient medical practice and ancillary ventures, especially at the beginning or preopening phases. After the venture is up and running and a strong internal management team is in place, your need for an outside consultant should be limited if you get off to a good start. You may, however, decide to outsource all or some aspects of your management. Some considerations for possible functions to outsource are billing, coding, and compliance.

If establishing an ancillary service involves construction or modification of a facility, you must meet all the requirements for structural planning and coordination of design. The investors must take the time to think through all aspects and stages to anticipate needs, problems, and challenges. Otherwise you will regret mistakes and be compelled to make changes as a result of a lack of efficiency or misuse of space.

Another rule to follow as the ancillary venture is considered is the need to develop an implementation timeline and assign specific responsibilities to those that are taking part in the preopening and preplanning processes. Individuals should be assigned due dates as well as responsibilities to assure the process will be completed effectively. It is highly unlikely that timelines will be met unless specific assignments are made.

Thus, the key components of ancillary service development include the design of that service to serve a specific medical need of a targeted population whose profile shows a high demand for the service. The service should be located in an area where demographics identify it as having a high density of the targeted population. It is both acceptable and advisable to have the ancillary service mirror the existing outpatient practice, if indeed the physician is the investor.

Other good options for investment in the ancillary service include joint ventures among hospitals and physicians as well as private investors. Hospitals and physicians are often at odds with each other and not amenable to working together. However, when a hospital and physicians are committed to working together based on a fair and objective business plan, and neither party takes advantage of the other, the community benefits greatly. The result will be the success of the joint venture, as it is much easier for both parties to focus on providing quality care when they know they are not trying to compete with each other. The community then enjoys the benefits.

Another option is to hire a management group to set up and run the ancillary venture within the practice location. Many competent management companies provide these services. Some will want to share ownership, which may or may not be a good idea for the physicians or hospitals. Each situation should be reviewed upon its own merits.

Some providers have the opinion that no one can take as good care of a business as the owner. This viewpoint often proves true when services are turned over to a management company where there is the risk of it managing in absentia. On the other hand, a management company may provide expertise that is needed in specialized areas of service. In this regard each situation should also be considered based upon its own merits.
Still another option in creating an ancillary service is to have a member of the medical group become the medical director of the ancillary service, and in so doing stay closely involved in the clinical services being performed and the quality of those services.

Day-to-day management and oversight may also be administered to some extent by personnel from the existing staff. This is usually only a temporary arrangement and should not be a long-range solution. From a business standpoint, it is best not to comingle staff among business entities; however, it does make sense in some instances to have crossover tasks, as when the functions are complementary.

## Current Environment and Players

Ancillary services are the hot topic among virtually all participants in the provider service chain, which includes hospitals, physicians, private companies and investors, and various combinations of the foregoing.

Hospitals have long strived to determine the best model, both economically and in terms of patient care. The practice of medicine generally is based upon traditional delivery models, not on appropriateness of the delivery. The consequences of inappropriate delivery can result in the difference between life and death. Continuing with historical ways of taking care of patients can stymie thinking, lead to operations that foster inefficiency, and constrain the quality of patient care. Delivery models should, therefore, be carefully couched within the context of "this is the way we do it" versus "this is the way we might be able to change it" to derive at the "right way."

Hospitals, which traditionally are bureaucratic and slow to change, have been looking “outside the box” for ways to deliver services, including ancillary services. Conventional wisdom says not to redesign a program until there is a problem. Nevertheless, in the fast-moving health care environment, waiting for a bona fide problem results in being at a disadvantage. It takes time to plan dramatic changes, especially when a hospital has a heavy investment in equipment and supporting services, such as personnel. One area where hospitals are rethinking their delivery systems is cardiovascular services (CV). CV services is one of the major service lines within most hospital’s provision of care, and our country’s aging population supports this for the future. Therefore, hospitals must focus on this program now and consider it in the context of services that can be performed outside of the four walls of the hospital. Although CV surgeries are rarely, if ever, performed outside of the operating room because of the seriousness of the procedures, many other services that support CV care are performed outside of the hospital facility. For example, interventional cardiology is a major consideration in lieu of surgery, a trend which likely will continue based on technology and clinical outcomes. Hospitals, as a result, are compelled to consider pulling out some of their most profitable and stable components of revenue, that is, cardiology and catheterization lab services. Traditional delivery must change. Physicians, cardiologists, and others are thinking about performing noninvasive and noninterventional cardiology within their own freestanding facilities. Although interventional cardiology is not accepted in an ancillary, stand-alone setting, less serious procedures performed away from the hospital are the “rule of the day” for many cardiologists. At a minimum, hospitals must plan for these scenarios as they inventory the skills, talents, and services they will provide or want to provide in the future. Not surprisingly, such consideration must include the physician as either a competitor or, preferably, as a partner.

Now, more than ever, hospitals must organize programs based on the considerations of ancillary services for their maximum positive impact on patient services, and to achieve good physician and medical staff relations. This calls for a commitment to design a CV ancillary services program. Throughout this book, areas are considered with a degree of specificity that both hospitals and others must consider in this context. If hospitals do these things correctly, they can protect at least a significant portion of what before has been exclusively their revenue stream. Sharing in revenue that used to be solely theirs may be disappointing; nonetheless it is becoming the rule of the day.

“If done properly, there are numerous opportunities and examples (some in place, some yet to be designed) that can change the way we care for patients.
Given the rising cost of health care and our current demand for health services, this entire situation takes on some urgency. It is not only about cardiovascular surgery, but all cardiac services, and not only about hospitals, but how those hospitals provide a potpourri of services to a community, at the hospital, but also in other locations, not only about cardiovascular specialists, but also about the competing imperatives of so many constituencies that characterize the health care landscape—constituencies who should have the patient as their ultimate concern.

“If a man…make a better mouse-trap than his neighbor, tho’ he build his house in the woods, the world will make a path to his door.”—Ralph Waldo Emerson (attributed)

As discussed, physicians are another major player in the current health care environment. Physicians are one of the major components in the development of ancillary services. It is amazing that physicians have gone as long as they have in allowing private industry and hospitals to build, manage, and operate ancillary service entities. ASCs have only been in existence the last 10 to 15 years. Prior to that time, there was rarely, if ever, a thought given to performing surgeries outside of the hospital operating room, mostly because of the technology required and what was perceived to be best for the patient. Technology is a driver in this dynamic, and without advances in technology it is unlikely ancillary services would be a topic of discussion. However, without question, technology has moved the physician into a more entrepreneurial position. Inherent to their training, physicians learn the skills to perform surgeries or most other ancillary services. It makes perfect sense for physicians to adopt a more entrepreneurial attitude in the development of such ventures.

Using the previous example of CV services, most cardiologists are trained to perform highly technical and life-or-death services. Although not surgeries per se, CV services are often invasive or semi-invasive procedures. The patient's life is on the line (if not at that time, certainly later as the diagnosis for his or her heart condition is defined). As a result, physicians have always borne the liability or the risk for performing such services. To relocate the delivery of these services to an outpatient catheterization laboratory is really not changing the level of liability for the physician, or if so, only slightly. Often the cardiologist believes that he or she can perform such services in his or her own lab under better controls, and with as good if not better quality outcomes. Therefore, in some respects, the risk may actually be perceived to be less.

From an economic standpoint, the physician sees the ability to garner a portion of the revenue “pie” that was never before available. The technical or facility fee, which is a genuine component of the services being rendered, can now be a part of the physician's base of revenue. This is not only alluring, it is in some respects essential for the maintenance of a level of income commensurate with the risk for providing such services by the physician.

Thus, physicians will continue to be strong and active players in the market place, relative to ancillary services—they are not going away. They will be a part of the process and, logically speaking, this is not surprising considering they will still be the ones providing the key components of clinical care.

Private companies and investors are not new to the scene either. For-profit hospitals have been around for many years, and some of the best hospitals in the United States are operated by for-profit entities that are public companies listed on the New York Stock Exchange. In addition, many other companies specialize in the provision and/or investment in these ancillary services. Figure 1-2, “Ancillary Services Management Companies,” shown following, is a list of some of the publicly held and privately held entities and their market focus.

Figure 1-2 shows there are numerous private companies that specialize in the development of ancillary services, which take on different shapes and forms. For example, some private entities will build, develop, and manage AS centers. They may also partner with physicians, or simply contract for professional services. Hospitals can also be partners in these ventures.

The business model of a private investor delivering care can be questioned. The inevitably concern is whether proper care is being provided, or if quality is being sacrificed for the “almighty dollar.” Most private investor companies deliver excellent care and insist on meeting the highest possible standards for the delivery
AmSurg partners with physicians to develop or acquire and manage single-specialty ambulatory surgery centers.

Gambro Healthcare offers a full range of hospital-based services to acute renal failure patients (ARF), chronic kidney disease (CKD) patients, and pre-CKD patients.

Fresenius Medical Care is the world's largest integrated provider of dialysis products and services for patients with end-stage renal disease (ESRD).

DaVita provides dialysis services for those diagnosed with chronic kidney failure, a condition also known as end-stage renal disease (ESRD).

InSight Health Corp. is a leading national provider of diagnostic imaging and therapeutic services.

Sentara Advanced Imaging Center has advanced outpatient imaging capabilities, featuring image sharing and voice recognition software.

Centers for Diagnostic Imaging (CDI) is a unique, physician-led national radiology practice. CDI is a leader in providing high-quality, cost-effective diagnostic and therapeutic radiology services and patient-centered care through its freestanding outpatient imaging centers across the country.

The Physicians Outpatient Surgery Center, Ltd. is an ambulatory surgery center developed by physicians to provide state-of-the-art surgical care in a comfortable environment. This facility is the first freestanding ambulatory surgical facility in southeastern Ohio, with two operating rooms capable of general anesthesia and a designated laser suite.

Cirrus Health is a multidiscipline health care development, facilities development, and management company, and delivers comprehensive ambulatory surgery center development, hospital development, imaging center development, oncology center development, and medical office building development.

UHS is one of the country's largest hospital management companies. It is a leading operator of acute care hospitals, behavioral health centers, ambulatory surgery centers, and radiation oncology centers.

LabCorp's national network of clinical laboratories reaches virtually every part of the United States to offer physicians and their patients leading edge testing technology.

PacLab has become one of the most successful laboratory/hospital ventures in the United States. PacLab operates in conjunction with eight separate hospital facilities.

Quest Diagnostics is one of the nation's leading providers of diagnostic testing, information, and services.

Sleep Centers of America is a provider of state-of-the-art diagnostic testing and sleep lab facility management.

Virginia's NeuroCare is a nonprofit community-based rehabilitation center, including residential services for persons with acquired brain injury.

LonkKnight is a full-service, nationwide sleep consulting firm with offices on the east and west coasts.

U.S. Oncology cancer centers offer all forms of outpatient cancer care, from the most advanced laboratory and radiology diagnostic capabilities to chemotherapy and radiation therapy.

Oncology Management Consulting Group offers a full range of oncology services to the cancer community including interim direction and leadership, education and mentoring, and classic consulting.
of their services. Many will get the best doctors, surgeons, and other health care providers to perform services. In general, investor entities do not sacrifice quality.

Without question, the motivation of these entities is to show a profit on the bottom line of their income statements. However, we should also question whether or not this is also the motivation with other provider investors, including physicians and hospitals. Everyone, including private investor companies are focused on quality outcomes. Without quality outcomes, they will not survive simply because the market will not allow it. Further, managed care companies will not contract with entities of questionable quality. The conclusion is that private investor-owned ancillary services are as reliable as others; although there are exceptions to every rule. This is also true for hospital and physician-owned entities.

The private investor in health care is here to stay. Health care makes up at least one fifth of the entire US gross national product (GNP). We are talking about trillions of dollars. The assumption is that private investors will always be a part of the delivery of care, which is good, particularly when one considers the cost of the delivery of these services. “Profit” is not a four-letter word in the health care industry. It is the drive for profit that has yielded the tremendous advances in technology which make the health care delivery system in the United States unparalleled anywhere else in the world.

The current environment includes three major players: hospitals, physicians, and private companies and investors. These can be combined in a joint investor entity or in a competitive environment for the development, operation, and management of ancillary services.

Market conditions also have an effect on the environment. In the early 1990s it was assumed that a more restrictive form of managed care would be pervasive and that this would eventually envelop the entire payer side of the US health care delivery system. Capitation seemed to be the trend and if not for capitation, providers (hospitals and physicians) would be under a system directed by the government or private insurance carriers as to where they could perform and what they could do. The patient side of care assumed a similar dynamic.

Predictions were that patients would only be directed to certain physicians and facilities for providers to be reimbursed for even a portion of their services. Further, the rule of the day was that contracts would encompass entire populations and all health care for that population would be controlled by those contracts. Although such drastic measures did not fully materialize, many aspects of this model are characteristic of our current health care delivery system.

Market conditions are definitely less extreme than expected in the early 1990s; however, health care providers are greatly restricted. Further, the marketplace puts providers under pressure to provide the same quality of care as their competitors. Just because capitation and global contracting have not become as pervasive as predicted does not diminish the many remaining restrictions on health care providers. Correspondingly, patients are also restricted in their access to services. Access to health care services is still largely driven by a market-based environment; that is, the desired combination of low cost and high quality remains the strongest force in the marketplace. Physicians, hospitals, and private investors in ancillary services must understand and adapt to the low-cost, high-quality paradigm or their venture will likely fail, regardless of how well the ancillary service is managed and operated.

Many books have been written about the dynamics of managed care and how to exist in such an environment. The purpose of this book is not to focus on managed care, yet it would be remiss if it did not point out the importance of this phenomenon as a major consideration in the decision-making process for putting together an ancillary service.

Further, many of the attitudes of payers and market conditions themselves are confined to local conditions, with one area of the country varying greatly from another. Each situation, therefore, must stand on its own merit and consideration. One general plan will not apply throughout the country because of the conflicting dynamics at work from one area to another.

The evaluation process should begin with payer attitudes and relations, which are primary reasons why physicians are such an important component of the ancillary service initiative. Physicians and hospitals have the relationships with the payers, and presumably good
relationships will carry over to the ancillary service. This is especially true if that service is well planned and coordinated, and if the payer is convinced it will provide equal service and quality of care in a cost-efficient manner as a hospital or other venture. Thus, the payer relations element should be completed early on in the evaluation process to understand the opportunity for performing procedures within the specified ancillary service.

### Characteristics of Successful Ventures

Examples of ancillary services are listed previously in this chapter. As with any other business initiatives, some are very successful, others providing the same service line are less successful, and some fail totally. What then are the characteristics of successful ventures? A successful outcome is an outgrowth of four important stages in the implementation of the ancillary service. These four stages of implementation are as follows:

1. Planning
2. Development
3. Operations
4. Continued assessment

When looking at each of these stages in greater detail, keep in mind that the successful development and implementation of each of these stages is the prescription for success.

#### The Planning Stage

The planning stage is completed before any investment and, to some extent, before any long-term commitment is made for the ancillary initiative. The first order of business is to develop a flexible and customized business plan. Moreover, prior to the business plan a feasibility analysis also may be needed depending upon the situation. If, for example, the potential investors or participants in the ancillary service are somewhat uncertain as to the overall viability of the ancillary service development, more detailed feasibility analysis should be completed first. Chapter 3, “Preparing the Feasibility Study,” addresses the feasibility study in detail.

Both the business plan and the feasibility analysis call for a demographic review prior to completion to analyze the market for the types of ancillary services that are both needed and wanted. The demographic analysis will relate key elements, such as competition, socioeconomic standing, population (current and expected growth rates), and other pertinent information relative to such an analysis.

For example, an orthopedic practice is flourishing within a certain area near a hospital. However, within that area the surgeon is starting to see an erosion of volume as more primary care physicians move to outlying areas within the service area. Further, most of the competing surgeons in his specialty are concentrated in the same area as his practice. The question that then arises is where a surgery center should be placed. Should it be near the campus of the orthopedic surgeon's existing practice, or should it be in an outlying area, perhaps where the community is growing and the demographics indicate positive trends? The answers to these questions would come through a demographic analysis that is either a part of the business plan or the feasibility study. Consider the information in Chapters 3 and 4 for a detailed analysis of both a feasibility study and business plan.

Although it takes considerable time, the importance of the demographic study cannot be underestimated. It may cause the potential investor physician (in this scenario) to completely reverse the location decision, yet the time would be well spent when contrasted to spending time, energy, and capital to build a surgery center in an area that would soon become oversaturated or where the patient population was shifting elsewhere. A venture like a surgery center is a long-term venture that must stand the test of time over an extended period of at least 5 to 10 years and perhaps longer.

Another integral part of the planning stage should be the preparation of the “pro forma” income statement and cash flow projection. These are examined in much greater detail in Chapter 3. It is essential to understand that the very core of any ancillary initiative lies in the revenue and expense assumptions, which must be based on realistic figures and calculations. Financial projections are often best completed by an outside independent
party (along with the business plan and demographic studies) as a level of independence is essential.

Sample revenue assumptions should be broken down based upon individual procedures and specific procedures that will be performed. Likewise, expenses should be documented based upon a line-by-line projection of each of the overhead components. Later chapters in this book address how proforma income and cash flow statements are completed.

**Development Stage**

The second phase of implementation is the development stage, which follows the completion of the initial feasibility study (at a minimum) and business plan, and when it is assured that the ancillary venture is a go. Several areas should be addressed, including the following:

- Establishing a legal entity
- Procuring financing as necessary
- Securing a location
- Purchasing necessary equipment and supplies
- Completing third-party reimbursement credentialing requirements
- Hiring and training staff
- Setting up scheduling, billing, and reporting functions
- Instituting regulatory compliance protocols
- Developing written policies and procedures
- Establishing a management structure (both provider and nonprovider)

In essence, the development stage is that period prior to opening wherein key decisions related to the planning, operations, and ongoing organizational structure of the ancillary service entity will be completed. It is an area of critical importance and must be well-thought. Most of the remainder of this book is devoted to a detailed discussion of each of the areas within the development stage. To complete these areas effectively, we recommend an organized outline of the task be completed, assignment of the individuals who are responsible for the tasks, and a timeline for completion. Figure 1-3, the “Development Plan Worksheet” (following), provides a sample list of initiatives that are to be completed with columns for assignments and timelines.

As in Figure 1-3, we suggest three major initiatives within the development stage.

First are the “structural initiatives,” which consider the legal structure, equity, ownership, pertinent agreements that memorialize the ownership, and the administrative processes.

Next, are the “organizational and management initiatives” that define the organizational chart, the individual physicians and job descriptions, an outline of reporting responsibilities and protocols, management consulting, legal and accounting assistance, administrative processes and the marketing plan, and other related documentation and functions.

Finally, the “operational start-up initiatives” summarize the major areas of operational start-up projects that must be completed prior to the actual opening. Naturally, variations occur within each situation. Some ancillary services may be able to rely to a large extent on the existing practice structure and infrastructure, and some of these areas may not even be necessary as such. However, given the fact that all of these tasks will need to be done in one form or another, it is best to stay organized and make sure that nothing is overlooked.

**The Operating Stage**

Once the ancillary service business is up and running, the operational aspects that will make it a success should not be neglected. Requirements include constant monitoring and management of clinical operations, providing continuing clinical and productivity training for staff members, monitoring of coding and submission of collection of claims, monitoring of compliance with regulatory agencies, and constant analysis of financial performance. Monthly financial reports should be completed and interpreted regarding performance. Strategic planning should be ongoing. Once the ancillary service is operative and has some track record of performance, the historical data will serve as a basis for good decisions in the future, and will help in strategic planning relative to expansion, divestiture, dilution, or even contraction.

**Continued Assessment**

The final stage in the successful implementation of the
### Figure 1-3  Development Plan Worksheet

<table>
<thead>
<tr>
<th>Task</th>
<th>Person(s) Responsible</th>
<th>Completion Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural Initiatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decide on legal structure</td>
<td></td>
<td></td>
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<tr>
<td>Agree upon equity ownership</td>
<td></td>
<td></td>
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<tr>
<td>Complete pertinent agreements</td>
<td></td>
<td></td>
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<tr>
<td>Complete operating agreement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete buy/sell agreement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete employment agreements for providers and technologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Define administrative processes and structural form (administrative services as a part of the institute versus an independent management services organization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organizational/Management Initiatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outline organizational chart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Define individual physicians and develop job descriptions</td>
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<td></td>
</tr>
<tr>
<td>Outline reporting responsibilities and protocols</td>
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<td></td>
</tr>
<tr>
<td>Procure management consulting, legal, and accounting assistance</td>
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<td></td>
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<tr>
<td>Determine administrative processes and responsibilities  (i.e., billing, personnel management, compliance, etc.)</td>
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<tr>
<td>Develop a marketing plan</td>
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<td></td>
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<tr>
<td>Design marketing materials as a part of the marketing plan</td>
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</tr>
<tr>
<td><strong>Operational Start-Up Initiatives</strong></td>
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<tr>
<td>Determine effective date for opening the institute</td>
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<tr>
<td>Select and register the corporate structure</td>
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<tr>
<td>Apply for hospital privileges</td>
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<tr>
<td>Apply to managed care organizations</td>
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<tr>
<td>Negotiate office lease</td>
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<tr>
<td>Design renovations</td>
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<tr>
<td>Order equipment</td>
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<tr>
<td>Select furniture</td>
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<tr>
<td>Select information system, including paperless office applications</td>
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<tr>
<td>Design and order telephone system</td>
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<tr>
<td>Select an insurance agent/broker</td>
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<tr>
<td>Determine insurance coverage needed</td>
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<tr>
<td>Determine supply needs</td>
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<tr>
<td>Decide on vendors (clinical and nonclinical)</td>
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<tr>
<td>Determine office form needs including business cards, stationary, etc.</td>
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<td></td>
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<tr>
<td>Establish office policies and procedures</td>
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<tr>
<td>Design organization structure/determine staffing needs</td>
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<td></td>
</tr>
<tr>
<td>Analyze compliance with regulations (coding, billing, documentation, HIPAA)</td>
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<td></td>
</tr>
<tr>
<td>Apply for necessary accreditation, business licenses, and other appropriate certification for the institute</td>
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</tbody>
</table>
ancillary service is continued assessment. All of the factors that were reviewed, analyzed, and decided upon prior to opening must be continually assessed, such as the following:

- Ownership structure
- Management structure
- Review of Stark rules and compliance and other regulatory laws, including new regulations
- Continued equipment needs
- Facility layout
- Staff
- Proper coding
- Revenue goals
- Expense structure
- Ongoing training
- Service offerings relative to strategic plans and needs
- Return on investment

Running an ancillary business is not unlike running a medical practice, a hospital, or some other non-health care business. It requires a well-charted course, both prior to opening and after the business is up and running.

**Successful Planning Processes**

The need for planning cannot be overemphasized for any venture prior to the actual decision to move forward and before investing time and resources. The planning should be done in organized phases of work. Even though the ancillary service may be derived from an existing physician practice, it should have a separate identity. A definition of its mission, vision, and values is appropriate, which is included in the business plan and strategic planning processes outlined in later chapters.

Prior to completing the decision to move forward with the ancillary service venture, the investors should not only take the time to define the type of entity (mission, vision, values, etc.) but to realistically identify its capabilities and its goals and objectives. It is a mistake to believe that because the ancillary service is an adjunct to a successful practice that it too will automatically be successful. For example, a primary care physician who is operating a successful family practice and has extra space may believe that the opening of an urgent care clinic will be an automatic success; however, this is not necessarily true. Competition may already exist in this very specialized arena that will be more formidable than thought. Further, the commitment with an urgent care center to extended hours, additional staff, diagnostic equipment, and so forth entails not only a significant investment of time, but a financial investment as well. Therefore, what seems to be (and may very well be) a very logical ancillary venture for the primary care physician may encounter several obstacles to success.

Therefore, it is important that realistic and frank discussions take place among the investors as to whether or not the ancillary service will indeed be viable. Outside resources who can lend an independent viewpoint can make a viable contribution to the overall project’s probability of success.

**Conclusion**

The practice of medicine is both a profession and a business. Ancillary services present a viable way for physicians, hospitals, and independent investors to enhance existing services and operations. Virtually any medical specialty can offer a type of ancillary service as a way to generate additional revenue and improve the quality of health care offered to patients. Ancillary services will often offer advantages to patients through convenience and reduced cost.

Although there are many concerns and considerations to review before deciding to invest in an ancillary service venture, it makes good sense to approach ancillaries as an added opportunity for the existing medical practice or hospital’s services.

Consideration of regulatory matters is essential, and a multitude of resources for this purpose are available. Chapter 2, “Facing Legal and Regulatory Issues” is a helpful start. Consult an experienced health care attorney for counsel for your specific situation before entering into a venture. A complete due diligence process
is appropriate, followed by a detailed business plan and pro forma income and cash flow statements. Prior to the completion of the business plan, and before a decision is made to enter into the ancillary service venture, a feasibility analysis may be necessary. Questions that should be answered include the source of the patients (or customers), the opportunities for revenue growth and expansion, and competition within the area. Demographics and the overall socioeconomic standing within the area in which the service will be provided are essential to know and understand prior to going into the actual ancillary service venture.

This chapter provides a basic outline of the key elements that should be considered prior to deciding to undertake an ancillary health care service venture and further, it reviews key functions that are necessary prior to and after opening.

The remainder of this book will consider many of these same specific elements. It will closely review and analyze the various key components that need to take place prior to the actual opening of the ancillary service venture.

It will also explore some specific case examples, based on the following criteria:

- Type of ancillary service—Ambulatory service center
- Location—Atlanta, GA (major metropolitan area in the Southeast)
- Specialties—Pain management, orthopedic surgery, urology, otolaryngology, ophthalmology (multispecialty)
- Number of operating rooms—Two, plus separate endoscopy
- Makeup of the ASC—Stand-alone building with attached (separately owned) medical office building
- Ownership structure—49% by physician who represent the previously noted surgical specialties (the physician ownership could be equal or non-equal among the physicians’ 49%; 51% owned by a local partnering hospital
- Organizational and administrative structure—ASC manager, surgical nurse manager, billing office manager

- Medical director—One of the physician owners
- Staff—Approximately _______
- Expansion capacity—Ability to expand to an additional two ORs
- Total initial square footage—ASC: 8000; MOB: 10,000
- Total initial investment of construction and initial equipment—$3 to $4 million
- Diagnostic equipment—X-ray, CT/MRI units, other

Endnotes