

# Jewels In The Hospital Crown:

## Ambulatory Surgery Centers as Models of Care, Efficiency and Profitability

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Siemens Financial Services, Inc. is pleased to provide you with the results of independent research conducted by Health Industry Writers, which reveals that Ambulatory Surgery Centers (ASCs) have emerged as valuable assets for hospitals, and are welcomed by both physicians and patients.

### **Introduction**

Independent research funded by Siemens Financial Services, Inc., revealed that Ambulatory Surgery Centers (ASCs) have emerged as valuable assets in the containment and reduction of hospital-related health-care costs. Much as a stent inserted into a skull might relieve pressure on an edemic brain, ASCs act as release valves for over-used hospital operating facilities. When freed of minor and low-risk surgeries, hospital ORs and their personnel can then be used for only the most complex and high-risk procedures.

In-depth interviews with executives at five hospital systems with ownership in free-standing ASCs, along with interviews of additional ASC experts, found that ASCs deliver significant benefits to all parties involved. Hospitals realize reduced overhead while gaining space for new services and procedures. Physicians value the opportunity to treat patients at a facility that has neither the bureaucracy of a hospital nor the risks of a doctor's office. Patients appreciate the increased accessibility, being able to drive in, undergo a procedure, and return home in a few hours, all without the anxiety often associated with hospital visits. This win-win scenario is contributing to the growth of ASCs throughout the United States. And while a majority of the nation's more than 5,200 ASCs are physician-owned and -operated, a growing number—now over 1,000—are owned fully or partly by community hospitals<sup>1</sup>.

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<sup>1</sup> Ambulatory Surgery Center Advocacy Committee, 2010

"Hospitals are interested in partnering with physicians in ASCs, because they are able to provide their patients and physicians with a desirable alternate care option and retain a revenue center rather than competing with a separate facility," said Jane Hyatt Thorpe, associate research professor at George Washington University's School of Public Health and Health Services in Washington, D.C., and an authority on ASCs. "All parties have the potential to benefit from this model."

Thorpe believes ASC growth will continue through national healthcare reform because the facilities are a best model for care that is safe and effective, from both healthcare-outcome and cost perspectives. Said Thorpe, "ASCs represent an opportunity to provide excellent care at a lower cost."

#### Payor Issues

The Centers for Medicaid and Medicare Services (CMS) appear to agree with Thorpe's assessment. CMS revised its Medicare payment system for ASCs in 2008 and increased the number of procedures approved for implementation at the facilities by more than 800, bringing the total to 3,400.<sup>2</sup> Ironically, however, efficiencies achieved by ASCs have become a double-edged sword: Medicare reimbursements to these facilities have grown over the past seven of eight years at a net rate of zero%.<sup>3</sup> ASCs have always been paid at lower rates than hospital outpatient departments (HOPDs) because research has shown that procedures performed at ASCs cost more than 40% less than the same procedures performed in hospitals<sup>4</sup>. But under CMS' 2011 proposed rule for ASC services, reimbursements will for the first time dip below 56% of rates paid to hospitals for the same services<sup>5</sup>.

At issue with CMS payment rules for ASCs is the method used to arrive at rate changes. As of 2010, ASC payment updates are based on the federal government's Consumer Price Index for Urban Consumers (CPI-U). The CPI-U is a measure of inflation for goods and services purchased by consumers, and weighted on energy and housing prices. Payment updates to HOPDs, in contrast, are based on the "hospital market basket," a direct measure of inflation for the goods and services purchased by healthcare facilities. The hospital market basket increase for 2011 is projected at 2.4%<sup>6</sup>.

To cope with falling payments, healthcare administrators say they are working to realize ever more efficiencies at their ASCs. Standardization of supplies and aggressive supply-chain management are increasingly common. Room turnover has become a science of its own, as has patient scheduling. And benchmarking of every conceivable metric, using data from corporate management firms and accreditation organizations is becoming standard. The following case study illuminates efficiency efforts recently implemented by a Virginia-based ASC.

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<sup>2</sup> MedPAC, October, 2009

<sup>3</sup> "Ambulatory Surgery Center Advocacy Committee Expresses Concern Over 2011 Proposed Payment Rule Released by CMS," July 9, 2010

<sup>4</sup> Ambulatory Surgery Center Advocacy Committee, 2010

<sup>5</sup> Ambulatory Surgery Center Advocacy Committee, 2010

<sup>6</sup> Centers for Medicare and Medicaid Services

### Case Study: Fredericksburg Ambulatory Surgery Center

*"We expect to make money from Medicare payments within 36 months."*

— Walt Kiwall, COO, Mary Washington Healthcare

From its setting on the campus of Mary Washington Hospital in Fredericksburg, Virginia, Fredericksburg Ambulatory Surgery Center (FASC) performs a range of outpatient surgeries, including cataract removal, joint replacement, cystoscopy, tonsillectomy and podiatric procedures. Approximately 7,000 patients receive treatment through roughly 8,500 procedures performed annually, and Walt Kiwall, chief operating officer of Mary Washington Healthcare (MWHC), says the facility is operating at effective volumes.

MWHC owns 78% of FASC; local surgeons own the remaining 22%. But this wasn't always the case. "Years ago, we had minority ownership in a surgery center that was formed by surgeons," said Kiwall. Enactment of the Physicians Self-Referral (Stark) Law later prompted the sale of the center to MWHC. Additional regulatory changes, along with surgeons' desire to invest in the Center, led to FASC's current ownership structure. MWHC owns the FASC building and its staff; both are leased to the surgery center partnership.

"The system we have now works extremely well," said Kiwall. "No one waits – when the patient is ready, we're ready. The entire process, from the patient's arrival through pre-surgical to post-surgical, is a well-oiled machine."

Efficiencies in scheduling, medical management and supply-chain management contribute to an annual ROI of 17-19%. Kiwall says the return would likely be even higher, were more ophthalmic procedures to be performed. But another local ASC "has heavy ophthalmologist ownership," he said, and captures the majority of ophthalmic surgeries.

FASC's return on investment would also be higher were Medicare reimbursements to ASCs increased. Medicare patients compose roughly half of the Center's business. But Kiwall says FASC copes with the lower payments by continually searching for and implementing new efficiencies. The Center also employs surgical nurses and other medical staff with long-term experience, enhancing efficiencies even further.

What's more, the Center—and Mary Washington Healthcare as a whole—are expected to benefit significantly from a system-wide initiative begun this year to realize a positive return on Medicare payments by the end of 2012. "We have two more years to get all staffing and materials management in place, and to dive more deeply into medical management," says Kiwall. National standards of disease management will be used to determine the tests needed for each patient and the pathways and protocols associated with each disease. A materials management system is already in place to reduce costs associated with inventory and supply-chain management. "So yes," said Kiwall. "We expect to make money from Medicare payments at the end of 36 months."

FASC's future financial health won't be based solely on its efficiency initiative, however: Kiwall says management is also conducting a feasibility review for expanded services. "Mary Washington Healthcare understands that hospitals aren't the only thing going on," said Kiwall. "We know access to care, efficiency and effectiveness are extremely important, and no one provides these things better than we do." He expects ASCs to continue to expand in scope and quantity, he said, as active medical management moves farther away from the point of care.

## Management, Outsourced

During the past decade, hundreds of ASCs in the U.S. have outsourced operations and business management to organizations specializing in these services. In certain cases, ASC management companies also develop ASCs from start to finish. Services may include the designing of facility, hiring of personnel, equipping of the facility, and help with accreditation. In exchange for these services and for ongoing expertise, the firm may require a percentage of ASC ownership.

One firm providing ASC management and development is United Surgical Partners International (USPI), of Dallas, Texas. Under the USPI model, physicians generally own approximately 50% of an ASC, a hospital or health system owns 25%, and USPI owns the remaining 25%. Physicians may invest in or just use the Center. As of August 2010, USPI had partnered in 170 ASCs in the U.S. and four hospitals in the United Kingdom.

Brett Brodnax, USPI's chief development officer, says the idea behind the company was to form an organization that leveraged the skills, attributes and experience of three types of partners: doctors, health systems, and USPI. "In our model, physicians bring the clinical leadership, USPI brings day-to-day development and managerial expertise, and the health system brings the strong brand, relationships in the community and strategic stability in the market place," said Brodnax.

Because ASCs tend to be small, independently run facilities, USPI provides resources and expertise that small businesses might have difficulty affording on their own, such as human resources and IT support. Also available from USPI: financial planning and budgeting, partnership management and administration, business-office management, purchasing and supply-cost management, and accreditation preparedness. Each ASC in which USPI is a partner has a governing body and a medical executive committee that oversees the facility.

Approximately one-third of the ASCs in which USPI partners were developed from the ground up. USPI's role in start-ups usually includes feasibility analysis, organization of the physician partnership, facility planning and construction, financing arrangements, licensure and accreditation, hiring and training of personnel, and preparation for initial operations. The company will also help hospitals convert their existing outpatient surgery departments into free-standing, joint-venture ASCs. "The advantage to working with someone like us to develop a center is that we've developed many facilities. Therefore, we have created and employ the processes, systems, and tools needed to develop facilities efficiently and effectively," said Brodnax. "Over time, you figure out what works well and what doesn't and you build the internal capabilities to help ensure that the development process goes smoothly."

In a nod to marketing, USPI has named its continuous improvement approach “EDGE,” or Every Day Giving Excellence. COO Niels Vernegaard says the approach ensures that each ASC in which USPI is a partner continually adheres to best practices for every process, from room turn-over to accounts-receivable collection. “We have an extensive set of developed procedures and proven processes around each aspect of ASC operation,” said Vernegaard. These processes could change when still more efficient and effective methods are discovered over time. “But we think they provide a sustainable difference in ASCs that partner with us,” he said.

### Ownership and Control

Not all ambulatory surgery centers seek outside management—or partnerships of any kind. Since the first ASC opened in 1970 in Phoenix, Arizona, majority or exclusive ownership of most facilities has been held by physicians. During the last decade, however, hospitals have sought to strengthen their relationship with the physicians in their communities, and this trend has led to an increasing number (20% in 2010<sup>7</sup>) of ASCs with joint hospital-physician ownership.

Large hospitals and health systems can bring important advantages to an ASC partnership, such as group purchasing contracts and access to new payors through their managed-care contracts<sup>8</sup>. Partnerships between hospitals and physicians also spread risk and often strengthen an ASC’s financial position. But philosophies differ on facility control. Administrators at certain hospitals and health systems believe an ASC will maintain highest standards of care under hospital control. Administrators at other hospitals actively pursue physicians for joint ownership and control, believing physicians will bring infusions of capital and new patients.

Following are case studies of two hospital-involved ambulatory surgery centers, one operating under physician control, the other under hospital control.

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<sup>7</sup> Ambulatory Surgery Center Advocacy Committee, 2010

<sup>8</sup> Regent Surgical Health, “Regent Successfully Partners with Both Physicians and Hospitals,” 2010

## Case Study: Surgery Center of Reno

*"We were very excited to partner with physicians, a strong hospital and a management company. The new ownership structure really turned things around."*

— Anne Roberts, Administrator

The Surgery Center of Reno (SCR) in Reno, Nevada is a joint venture between physicians, Catholic Healthcare West (CHW), and Regent Surgical Health, an Illinois-based developer of surgery centers and physician-owned hospitals. Together, 31 physicians own 75% of the Center, while CHW owns 13% and Regent owns 12%.

The 60-employee ASC is situated directly across the street from St. Mary's Regional Medical Center, itself a member of CHW. Annual patient volume at the surgery center for 2010 is projected at 4,430, having declined slightly in 2010. Factors thought to be responsible for the decreased volume include the struggling area economy and high rate of unemployment. SCR is a multi-specialty ASC with areas of excellence in spine, orthopedic, pain-management, ENT, general, and bariatric surgery. The Center also performs dental surgery and procedures in ophthalmology, urology, lithotripsy, and gynecology.

The Surgery Center's ownership arrangement is relatively new. Prior to February, 2006, St. Mary's Hospital held majority ownership, and the Center was a poorly performing out-patient center that functioned as a hospital department. Despite high case volume, cash flow was negative.

The need for change led to a new ownership structure that included Regent as the managing partner, physicians as majority owners, and CHW. Areas of focus under the new structure included efficiency in operations, revision of payor contracts, capital expenditures for state-of-the-art equipment and technology, and new leadership that recognized the need to improve staff morale and expertise.

Each partnership segment invested cash. Remaining capital required for start-up was furnished through a low-rate loan from a finance firm. During the first two years, most capital expenditures were funded through operations and thus contributed to a healthy financial status.

"We were very excited to partner with physicians, a strong hospital and a management company," said Anne Roberts, SCR administrator. "The new ownership structure really turned things around."

Investors in the new, Limited Liability Company formed under Regent's guidance realized their investment within the first year of the reorganized Center's operation—and Roberts says a new investor today would see a rate of return of 30-35%.

Despite the Center's change in name and ownership, Roberts says patients still tend to view SCR as an extension of St. Mary's Regional Medical Center. But she sees this as a good thing in that both the ASC and the hospital are known for high quality and excellent care. Said Roberts, Partnering with well-respected physicians, a quality hospital and an outstanding management company has proven to be a successful model for our ASC."

### Case Study: Owensboro Ambulatory Surgical Facility, Owensboro, Kentucky

*"We've agreed to move the Center, but we'd absolutely retain control. We'd never let that go."*

— Greg Strahan, COO, Owensboro Medical Health System

Operating from the campus of Owensboro Hospital, Owensboro Ambulatory Surgical Facility (OASF) is a free-standing structure equipped with its own staff, including anesthesiologists. Approximately 5,500 patients are treated annually, undergoing procedures ranging in type from ophthalmologic (36%) to upper and lower GI (25%), and other specialties that include orthopedics, pain management and general surgery.

The Center was originally founded by a group of physicians in 1983. Around 1985, the physicians sold a controlling interest to Medical Care International, which was later purchased by Columbia/HCA. The Columbia interest in the ASC was later sold to HealthSouth, which became the controlling owner. In 1999, Owensboro Medical Health System purchased majority ownership from HealthSouth and moved the center to the hospital campus.

As of August 2010, ASC ownership was divided between OMHS (63%), Surgical Care Affiliates (SCA, the company formed upon HealthSouth's sale of its surgery division; 29%) and physicians (8%). But a resyndication of stock was underway at the time, due to physician requests for greater ownership and OMHS' desire to build stronger relations with the physicians. The new arrangement will provide OMHS with slightly more than 50% ownership. Physicians will own 25% and SCA will own the remaining 25%.

Physician owners have also asked to move the facility to a campus that contains their offices and is approximately 1.5 miles from the hospital. "We've agreed to move it, but we'd absolutely retain control," said Greg Strahan, COO of Owensboro Medical Health System; "We'd never let that go." The rationale: health-system executives feel strongly that the system can manage the ASC best. "OMHS ranks in the top 5% in quality care by Healthgrades," said Strahan. "We want to make sure this status extends across our system." To do so, OMHS regularly reinvests ASC revenues in new equipment, new technology and qualified staff for the Center. All capital expenditures are paid from ASC operating income. Said Strahan, "Other partners might want to withdraw more money instead of funding capital expenditures."

Strahan wouldn't share specifics on OASF's return on investment. He did say, however, that physician partners are earning "a far better return than they could get in the market."

## Return on Investment

Ambulatory surgery centers generally produce healthy ROIs. Numbers reported by facilities examined for this paper ranged from a low of 17% to a high of 35% in 2009. And as of August 2010, certain companies marketing themselves on the Internet for hire as ASC administrative partners promised returns of up to 50%. In Pennsylvania, where ASC returns are publicly reported, average operating margins for ASCs serving all patients (not just Medicare beneficiaries) increased from 24.1 percent in 2007 to 26.0 percent in 2008, an increase of 1.9 percentage points.<sup>9</sup>

ASC experts contend that in a reasonable reimbursement market, a center focusing on higher reimbursement procedures, such as outpatient spinal, can be profitable with as little as 2,000 procedures per year. But with lower reimbursement cases, they say, this number can jump to 3,000-3,500 procedures. Further, in low reimbursement markets, it can be very hard to be profitable in some specialties at almost any case level.<sup>10</sup> The following case study examines an ASC that recently turned the corner on profitability.

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<sup>9</sup> Pennsylvania Health Care Cost Containment Council, 2009

<sup>10</sup> "Establishing an ASC: A Primer From A to Z," Scott Becker, Bart Walker, and Renée Tomcanin, *ASC Review*, May 12, 2010

### Case Study: Grandview Surgery & Laser Center, Camp Hill, Pennsylvania

*"We've continued to grow as we've delivered service in a high-quality, cost-effective manner."*

— Manny Evans, CFO, Holy Spirit Health System

Grandview Surgery Center (GSC) opened in 1989 as one of the first ASCs in Greater Harrisburg. From its location across the street from Holy Spirit Hospital, the facility treats approximately 5,300 patients annually. Surgeries performed include orthopedic, ophthalmic, oral and maxillo-facial, otorhinolaryngologic, plastic, podiatric, urologic, vascular, and those for pain management.

Ownership of GSC is complex. Together, HS Ventures, Inc., a subsidiary of Holy Spirit Health System, and Surgical Care Affiliates (SCA) own Camp Hill Ambulatory Centers (CHAC). CHAC has a 40% stake in GSC. Orthopedic surgeons own an additional 47%, and other physician partners own 9%. The remaining 3% is owned by CHAC Limited Partnership.

Manny Evans, CFO of Holy Spirit Health System and president of HS Ventures, credits local orthopedic surgeons with revitalizing the Center in 2007. By investing in the GSC, "They played a pivotal role in a center that was, to some degree at that time, in a difficult period," said Evans.

During the same year, SCA purchased HealthSouth's ambulatory care business and brought improved management services to GSC. "SCA has brought us a great deal of expertise and efficiency," says Evans. "We're able to access their proficiency on the supply-chain side and on benchmark activities, viewing best practices at all times."

Today, GSC is a model of ASC success. Gross revenues for 2009 stood at \$24.7 million; net operating revenue was \$7.5 million and net income was \$2.6 million. ROI for the year finished at 29.9%, more than 3% higher than Pennsylvania's statewide average for ASCs. The Center is also now debt-free. "We've continued to grow as we've delivered service in a high-quality, cost-effective manner," said Evans. "And this has allowed for additional services and program expansion." An increasingly fixed revenue stream, together with CMS' trend to approve more procedures for implementation in ASCs, make Evans optimistic about the facility's future.

## Regulation, Accreditation and the National Economy

To receive payment for procedures performed on patients covered by Medicare or Medicaid, ambulatory surgery centers in the U.S. must be certified by CMS. ASC participation in the CMS system is limited to distinct entities that operate exclusively to provide surgical services to patients not requiring hospitalization, and whose expected stay in the ASC does not exceed 24 hours<sup>11</sup>. ASCs must also comply with state Medicare and Medicaid standards and with local health department regulations. Nonetheless, many ASCs seek additional, voluntary accreditation from one of four accrediting bodies recognized by CMS for their high standards of care. These are the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF), and the American Osteopathic Association (AOA).

To receive accreditation from one or more of these organizations, an ASC must meet standards in quality of care, infection prevention and control, and facility environment. The ASC must also adhere to standards set for each type of medical procedure performed. “We go through as much scrutiny as a hospital,” said Denise Lascar, president of MedStar Surgery Center, a Washington, D.C.-based ASC owned by MedStar Health Systems of Columbia, Maryland. “We’re not just a facility that cuts on people. We have to meet strict standards and provide a very high level of care.”

Were regulatory and accreditation requirements for ASCs better understood by Congress and the public, Lascar believes the facilities would command more respect—and perhaps higher reimbursements. Until then, however, essentially flat rates paid by CMS, coupled with the still-ailing U.S. economy, have Lascar and a percentage of other ASC administrators concerned for the fiscal health of their facilities. Findings from two surveys conducted by the AAAHC Institute for Quality Improvement<sup>12</sup> place these concerns in perspective. Of 985 ASCs participating in the first study and 735 participating in the second, 58% of respondents said the economy has negatively impacted their facility’s bottom line. The greatest decreases are occurring in high-cost procedures, self-paid services and elective procedures, the surveys found. Facilities in the Midwest, Southeast and Southwest were impacted most. The following case study illustrates the situation.

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<sup>11</sup> Centers for Medicare and Medicaid, [www.cms.gov](http://www.cms.gov): “Certification and Compliance: Ambulatory Surgery Centers”

<sup>12</sup> Institute for Quality Improvement, Accreditation Association for Ambulatory Health Care, Inc., April 5, 2010

### Case Study: MedStar Surgery Center, Washington, D.C.

*"We estimate a decrease of 18 to 20% of cases at our own Center over the past year."*

— Denise Lascar, president

The MedStar Surgery Center (MSC), owned by MedStar Health System of Columbia, Md., is one of the oldest ASCs in the nation, serving residents of Washington, D.C. since 1976. Specialties include pain management, GI procedures, as well as gynecology, orthopedics, cosmetic and reconstructive surgery, general surgery, urology and ophthalmology.

Within the past year, the volume of cases at MedStar Surgery Center has decreased as patients have chosen to forgo diagnostic procedures—whether or not they have insurance coverage. MSC President Denise Lascar worries that the trend will put patients' health at risk.

"We fear this may affect their physical well-being," said Lascar. "We estimate a decrease of 18-20% of cases at our own Center over the past year." Now MSC is examining its practice patterns, recruiting new physicians and adding new services and procedures, Lascar said, to accommodate the changing needs of its patients and the health care environment.

One recent addition is "Patient Touch Point," a delivery model emphasizing personalized, hands-on care given to each patient through 13 distinct contacts. From initial patient scheduling through surgical intervention to a thank-you note presented at the time of discharge, the goal is to involve each patient and his or her family more fully in the patient's care. A MedStar Health Surgical Checklist, inspired by the World Health Organization Checklist, also ensures that each patient receives excellence in the delivery of surgical care.

Lascar says MedStar Health takes pride in providing patient-first care, and that the work done at MSC is an example of advancing health in the communities the health system serves. "There will always be a need for hospitals for ambulatory patients and inpatients," said Lascar. "But I strongly believe that in the long run, by collaborating with hospitals, the appropriate role of ASCs in the delivery of health care will grow as the nation looks for more efficient ways to deliver excellence in the care of the perioperative patient."

## Outlook

Challenged to continually increase efficiencies or compromise profitability, ambulatory surgery centers nonetheless have a bright future. Uncertainties about health care reform, along with the vacillating U.S. economy, are prompting more physicians to seek an ambulatory setting for partnership.<sup>13</sup> Hospitals, meanwhile, are moving a growing percentage of minor and low-risk procedures to outpatient environments,<sup>14</sup> many of which are ASCs.

In addition, cost savings created by ASCs are mounting. According to the most recent figures, ASCs save Medicare approximately \$2 billion annually.<sup>15</sup> That figure is likely to grow as advances in anesthesia and minimally invasive surgery techniques allow still more procedures to be performed outside the hospital setting. Advances in technology, including telemedicine, may also increase the number and types of procedures performed at ASCs.

CMS' payment update method for ASCs may also change. MedPAC recently examined whether an alternative price index—such as those used for hospitals and physician practices— would better measure changes in ASC costs. Research revealed that although ASC cost data “are not sufficient for comparing each category of costs across settings, they suggest that ASCs have a different cost structure from hospitals and physician offices. ASCs appear to have a much larger share of expenses related to medical supplies and drugs than the other two settings, a much smaller share of labor costs than hospitals, and a smaller share of all other costs than physician offices.”<sup>16</sup> Given these differences, MedPAC recommended that Congress require ASCs to submit cost data to CMS to determine the feasibility of developing an ASC-specific price index. The Commission also recommended that providers be paid adequately so that they continue to furnish ASC services. Although no legislation has yet been proposed, more than 20 members of Congress signed a letter this past August, asking CMS to reconsider its payment update method to ASCs.<sup>17</sup>

Most importantly, perhaps, ASCs are also experiencing a growing acceptance by the public. According to one study, 20% of outpatient organizations surveyed reported an increased demand for services in 2009, up from 12% in 2008.<sup>18</sup> Public acceptance of ASCs appears to be bolstered by positive patient experiences. Administrators at all of the ASCs studied for this white paper reported patient satisfaction rates above 90%, and, according to one measurement, the patient satisfaction rate for ASCs throughout the U.S. averages 92%.<sup>19</sup> With so many positive circumstances surrounding ambulatory surgery centers, it is reasonable to believe that these facilities will persist as a valuable and growing force in efforts to contain costs and maintain quality in the U.S. health-care system.

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<sup>13</sup> *SurgiStrategies*, December 22, 2009

<sup>14</sup> Jane Hyatt Thorpe, George Washington University, School of Public Health and Health Services

<sup>15</sup> Ambulatory Surgery Center Advocacy Committee, 2010

<sup>16</sup> MedPAC, “Report to the Congress: Medicare Payment Policy,” March, 2010

<sup>17</sup> Ambulatory Surgery Center Advocacy Committee, 2010

<sup>18</sup> AAAHC Institute for Quality Improvement, Accreditation Association for Ambulatory Health Care Inc., April 5, 2010

<sup>19</sup> Ambulatory Surgery Advocacy Committee, 2010

Independent research in this report was conducted by Susan Hodges of Health Industry Writers, [www.healthindustrywriters.com](http://www.healthindustrywriters.com). The white paper findings represent only a “snapshot” of views and concerns gathered during 2010 and based on the interviews conducted. The concerns addressed were those that seemed to be top of mind at this time.

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