

ALABAMA GASTROENTEROLOGICAL SOCIETY

ASC Project

From Concept to Keys

Healthcare Management Associates

September, 2026

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I have no financial relationships to disclose

Healthcare Management Associates

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● The Market

Medicare-certified ambulatory surgery center featuring four dedicated endoscopy procedure rooms. The facility addresses growing demand for outpatient GI services in Alabama, where colorectal cancer remains the second-leading cancer killer.

Designed for high throughput and exceptional patient experience, the center will perform colonoscopies, upper endoscopies, and advanced therapeutic procedures in a purpose-built environment that meets or exceeds all ASGE and CMS quality standards.



4

Procedure
Rooms

5,000+

Annual
Capacity

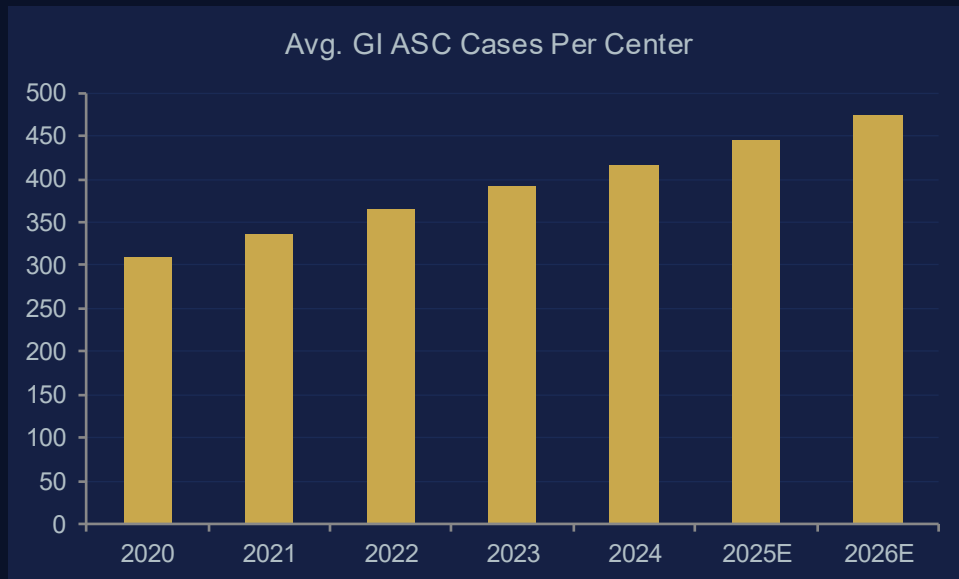
\$4.2M

Est. Capital
Investment

24 mo

Target
Timeline

Market Opportunity



Sources: HSTPathways, GM Insights, Alabama Dept. of Public Health

\$29.5B

Global endoscopy market (2024)

6.9%

CAGR through 2034

19%

GI ASC case volume growth (YoY)

#2

CRC is Alabama's 2nd-leading cancer killer

Alabama Healthcare Landscape

Colorectal Cancer Burden

Screening Mandate

Rural Access Gap

Regulatory Requirements

- Certificate of Need (CON) required
- State licensure via AL Dept. of Public Health
- Medicare certification for reimbursement
- Transfer agreement with local hospital
- 24-hour patient retention permitted with compliance
- Capital expenditure threshold: \$4M for CON review

Ala Certificate of Need Overview

One of 33 states with active process

Most states moving away from restrictive process

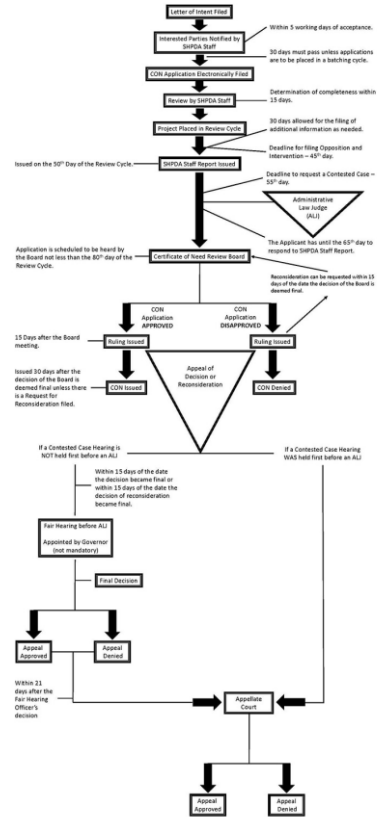
Alabama tightening process due to ALHA influence

Change in methodology

Moratorium since 2023 on multispecialty ASC without Hospital involvement

CON Board pro Physician and ASC expansions

**Certificate of Need Review Process
Flow Chart**



Ala Certificate of Need Est. Cost

Onetime filing fee of approximately \$25,000

Development of single ASC CON application \$30,000-35,000

Legal Assistance \$7,000-9,000

Contested case due to opposition Additional \$125,000-\$175,000

● Project Vision & Goals

To establish a premier gastroenterology ambulatory surgery center, delivering exceptional patient outcomes through state-of-the-art endoscopy services in a purpose-built, patient-centered environment.



Clinical Excellence

Exceed ASGE quality benchmarks: adenoma detection rate >30%, cecal intubation >95%



Patient Experience

90+ patient satisfaction scores with streamlined intake, short wait times, rapid recovery



Operational Efficiency

Achieve 70%+ OR utilization with optimized scheduling and < 5 day billing turnaround



Community Impact

Expand colonoscopy access for underserved communities, reduce CRC late-stage diagnoses

● Facility Design & Layout



Space Requirements

Component	Est. DGSF
4 Procedure Rooms	3,200
Pre-Op/Prep Bays (6)	1,500
Recovery Bays (8)	2,000
Scope Reprocessing	600
Clean/Soiled Workrooms	500
Admin & Waiting	1,200
Total Facility	~9,000

Design Principles

- Separate clean/soiled corridors for infection control
- 1:1 prep bay to procedure room ratio for scheduling stability
- 2:1 recovery bay to procedure room ratio for sedation timelines

● Procedure Rooms & Equipment

Each Room Includes

- 4K endoscopy tower (Olympus EVIS X1 or equivalent)
- HD/4K monitor with advanced imaging (NBI/BLI)
- CO2 insufflation unit for patient comfort
- Electrosurgical generator for polypectomy
- Full anesthesia workstation with monitoring
- Image capture and documentation system
- Adjustable procedure table with positioning

\$800K–\$2M typical endoscopy suite
equipment investment per facility



Primary Procedures

- Diagnostic & screening colonoscopy
- Upper endoscopy (EGD) with biopsy
- Polypectomy & therapeutic interventions

● Staffing Model

Role	FTEs	Key Responsibilities
Medical Director	1	Clinical oversight, quality, credentialing
Gastroenterologists	3–4	Endoscopic procedures, patient consultations
Anesthesia Providers	2–3	Propofol sedation, airway management
Endoscopy RNs	4–6	Pre/intra/post procedure care, monitoring
Endoscopy Technicians	3–4	Equipment handling, scope reprocessing assist
Administrator	1	Operations, scheduling, compliance
Front Desk / Billing	3–4	Registration, insurance, collections
Total Staff	17–23	Scalable based on volume growth



Staffing Guidelines: ASGE recommends minimum 1 RN per procedure room during sedation. When anesthesia is administered by a specialist, an endoscopy technician may assist without a second RN per ASGE 2020 guidelines.

Regulatory & Compliance

Alabama CON

- Certificate of Need application required
- Capital threshold: \$4M triggers review
- State Health Planning Agency review process

State Licensure

- Licensed by AL Dept. of Public Health
- Chapter 420-5-2 ASTF regulations
- Annual inspection and renewal required

Medicare Certification

- CMS Conditions for Coverage
- Appendix L survey compliance
- ASGE standards as acceptable practice

Accreditation

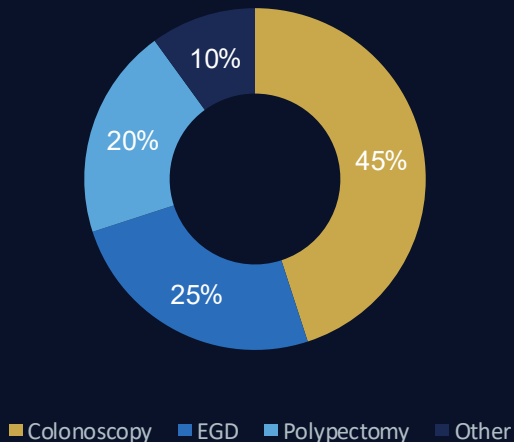
- AAAHC, Quad A or Joint Commission accreditation
- Third-party quality validation
- Required for payer contract



Additional Requirements: Written hospital transfer agreement | Complete medical history & physical on all patients | Pre/post-operative transportation policies

Clinical Quality Metrics

Projected Procedure Mix



ASGE Quality Benchmarks

Adenoma Detection Rate >30%

Key colonoscopy quality indicator

Cecal Intubation Rate >95%

Complete colonoscopy measure

Withdrawal Time >6 min

Minimum inspection time

Patient Satisfaction >90%

Post-procedure survey score

Complication Rate <0.5%

Perforation + major bleeding

Physician Productivity: Median GI wRVU: 8,700 (MGMA 50th) | 90th percentile: 13,400 | Colonoscopy: 3.18 wRVU | EGD w/ biopsy: 2.33 wRVU | Polypectomy: 4.46 wRVU

Operational Benchmarks



Proc Block Utilization

70%+

58% (national avg)



Pre-Auth Rate

100%

14% (industry rate)



Insurance Verification

100%

89% (industry avg)



Case Cancellation

<15%

22% (GI national)



Days to Bill

<5

5 days (industry avg)



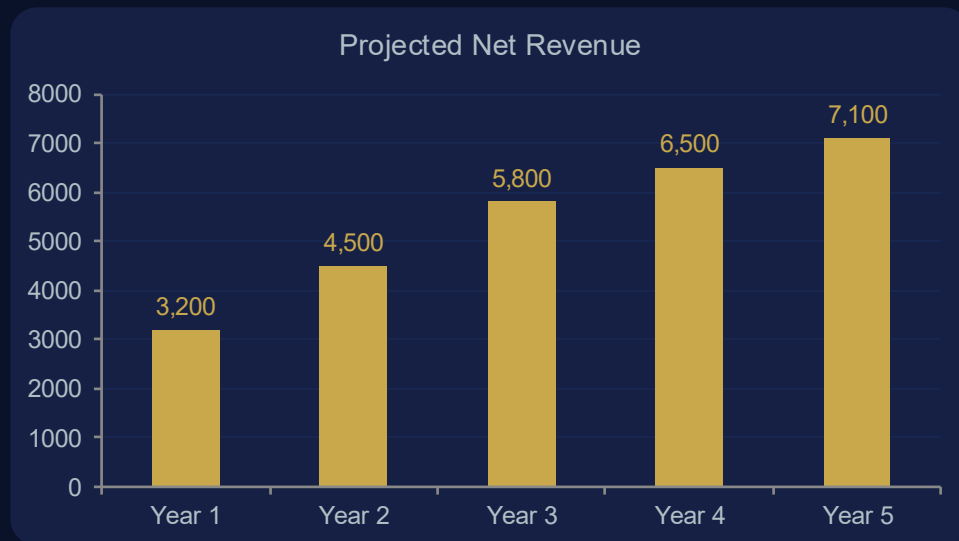
Claim Denial Rate

<5%

10% (industry avg)

Source: HST Pathways GI ASC Benchmarks (2024 data, 207 centers, 560K+ cases)

Financial Projections



Capital Investment

Construction & Build-Out	\$2.0–2.5M
Medical Equipment	\$.7–1.0M
IT, Furniture & Misc.	\$0.3–0.5M
Working Capital	\$0.3–0.5M

Revenue Model

Avg. net revenue/case:	\$1,420
Year 1 case volume:	~2,250
Year 5 target volume:	~5,000
Payer mix (Medicare):	~45%
Payer mix (Commercial):	~45%
Collection rate:	69%

2026 CMS Reimbursement Alert

CMS proposes ~8% cuts to physician payments for endoscopy in ASCs/HOPDs. Financial model includes conservative scenarios reflecting potential reimbursement pressure.

Implementation Timeline

Phase 1	Phase 2	Phase 3	Phase 4
Planning & Approval <i>Months 1–6</i>	Design & Permitting <i>Months 4–10</i>	Construction <i>Months 10–18</i>	Launch <i>Months 18–24</i>
• Business plan finalization • CON application • Site selection & due diligence • Architect engagement	• Facility design & engineering • Building permits • Equipment procurement • Staff recruitment begins	• Build-out & construction • Equipment installation • IT infrastructure • Staff training program	• State licensure survey • Medicare certification • Accreditation survey • Soft opening & ramp-up

Target: CON approval to first patient in 18–24 months

Risk Management

Risk Factor	Impact	Mitigation Strategy
CON Denial / Delays	High	Early engagement with State Health Planning Agency, strong community need documentation, political support building
Reimbursement Pressure	High	Conservative financial modeling, diversified payer mix, focus on commercial contracts, RVU-based contract renegotiation
Staffing Shortages	Medium	Competitive compensation packages, early recruitment, partnerships with nursing programs, cross-training initiatives
Construction Overruns	Medium	Fixed-price contracts, 10% contingency budget, experienced healthcare construction firm, milestone-based payments
Volume Ramp-Up	Medium	Phased opening strategy, physician referral network development, community outreach, marketing for CRC screening
Regulatory Changes	Low	Active ASCA/AGA membership, legislative monitoring, flexible operational model, diversified revenue streams

Competitive Advantages

Purpose-Built Design

Facility designed exclusively for GI endoscopy, not repurposed space. Optimized patient flow, dedicated clean/soiled corridors, and integrated technology infrastructure.

Technology Leadership

4K imaging, AI-assisted polyp detection, and integrated data systems from day one. Positions the center as a regional leader in GI endoscopy quality.

Physician Alignment

Physician-owned model with aligned incentives for quality and efficiency. Direct control over scheduling, staffing, and clinical protocols.

Market Timing

Growing aging population, expanded screening guidelines (age 45+), and increasing shift from hospital to ASC settings create strong tailwinds.

Next Steps

- 01** Finalize site selection and secure architectural firm
- 02** Prepare and submit Certificate of Need application
- 03** Develop detailed financial pro forma with payer analysis
- 04** Engage legal counsel for partnership and compliance structure
- 05** Begin physician recruitment and credentialing process
- 06** Establish project timeline with key milestones and go/no-go gates

Questions ?

