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Strategic Ambulatory Expansion

Why Health Systems Must Be Deliberate and How to Bridge the Gaps

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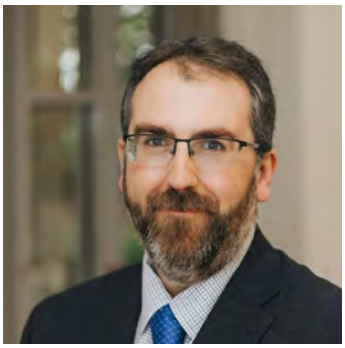
Her expertise spans healthcare administration, regulatory agencies, consulting, education, research, performance improvement, project management, and vendor and key opinion leader relationship management, with leadership roles across healthcare operations, clinical services, information technology, regulatory compliance, quality, and safety.



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As a healthcare thought leader, he founded and grew a centralized analytics services team, created new analytics consulting service lines, and pioneered risk-sharing agreements around emerging technologies. Nathan holds a Bachelor of Science in Biomedical Engineering from Northwestern University's McCormick School of Engineering and is a recognized leader in leveraging business intelligence and performance analytics to drive health system growth.

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Executive Summary

The American healthcare system is in the midst of a fundamental structural shift. Over the past decade, the center of gravity for care delivery, including provider revenue, has shifted steadily from inpatient hospitals to ambulatory settings.

57%
of total hospital revenue is now outpatient, up from 52% four years ago[1]

109.6M
ASC surgical cases projected by 2033— an 18% increase over 2023[2]

$1.1 mil
median annualized expense per employed physician FTE[3]

Yet despite this unmistakable trajectory, many health systems continue to approach ambulatory expansion reactively rather than strategically by chasing individual deals, acquiring physician practices without a coherent framework, and finding themselves financially exposed by the very investment they hoped would save them.

This white paper asserts that ambulatory expansion is a financial and operational necessity, not merely a growth opportunity, where strategy, sequencing, and execution discipline matter enormously. When done well, ambulatory expansion strengthens operating margins, improves quality outcomes, and positions a health system for long-term sustainability. However, if done poorly, it creates years of physician practice losses, regulatory exposure, governance dysfunction, and distracted leadership.

We examine the leadership debate that plays out in boardrooms and C-suites across the country: the headwinds that make ambulatory expansion difficult, the competing priorities that drain executive bandwidth, and the specific investment decisions — most notably physician employment — that can either accelerate or undermine an ambulatory strategy. We then outline how Acuvance Coker's integrated advisory capabilities help health systems navigate this journey with the rigor, discipline, and experienced guidance it requires.

EXECUTIVE SUMMARY – CONTINUED

Key Takeaways

WHAT LEADERSHIP SHOULD TAKE FROM THIS PAPER

- Ambulatory-expanded systems run meaningfully higher operating margins than hospital-only peers — a gap that widens every year.
- Physician practice losses average $1.1M per physician FTE annually, the single largest controllable headwind to ambulatory investment returns.3
- Site-neutral payment reform, IRA drug pricing changes, and H.R.1 Medicaid cuts will punish hospital-only strategies disproportionately.
- The health systems winning in ambulatory care are building strategically aligned physician enterprises around them.
- Acuvance Coker's integrated ambulatory, physician alignment, analytics, and compliance capabilities address every phase of the expansion lifecycle.

SECTION ONE

The Strategic Imperative: Why Ambulatory Expansion Cannot Wait

Health system leaders are no strangers to competing pressures. Every year brings new regulatory mandates, workforce crises, technology investments, and payer contract battles that consume executive attention and capital. Against this backdrop, ambulatory expansion can feel like a project for a future fiscal year — something to pursue once the current crisis stabilizes.

The data argue otherwise. The structural shift toward outpatient care is not waiting for health system readiness. Patients, physicians, payers, and policy makers are all pulling in the same direction, and the organizations that are not building ambulatory capacity today are ceding market share, payer mix advantage, and operating margin to those that are.

The Revenue Migration Is Already Happening

According to the American Hospital Association, using data validated against CMS Medicare cost reports, outpatient revenue accounted for 57% of total hospital revenue in 2024, up from 52% in 2020.1 Kaufman Hall's monthly tracking of more than 1,300 hospitals shows outpatient revenue growing at 13% year over year, compared with just 7% for inpatient revenue.4 Strata Decision Technology's national tracking confirms 28 consecutive months of outpatient revenue growth through August 2025, with outpatient revenue growing at 6.3% versus 4.3% for inpatient revenue.5

The message is clear: the revenue is moving, with or without any given health system. The question is not whether to participate in ambulatory expansion, but how to do so with a strategy that generates sustainable returns rather than compounding losses.

13%
outpatient revenue growth, YOY (vs. 7% inpatient)[4]

28
consecutive months of outpatient revenue growth through August 2025[5]

46%
of rural hospitals carry negative operating margins[7]

The Financial Stakes for Non-Movers

MedPAC's analysis of CMS HCRIS cost report data makes the financial stakes explicit. Health systems without meaningful ambulatory networks are overwhelmingly represented among those with the weakest financial positions.[6] Chartis Center for Rural Health's annual tracking of HCRIS data finds that 46% of rural hospitals carry negative operating margins, with 432 at risk of closure. Independent rural hospitals operate in the red at a rate of 55%, compared with 42% for system-affiliated peers.[7]

By contrast, McKinsey's analysis of provider profit pools projects that hospitals' share of total provider profits will decline from 41% in 2019 to approximately 38% by 2029, while ambulatory settings absorb the difference.[8] This is not a prediction — it is a trend already well underway, visible in the financial statements of every major publicly reporting health system..

> *"The revenue is moving, with or without any given health system. The question is not whether to participate in ambulatory expansion, but how to do so with a strategy that generates sustainable returns."*

The Policy Environment Rewards Ambulatory Investment

Regulatory and payment reform trends reinforce the financial logic of ambulatory expansion. CMS's ongoing push toward site-neutral payments will progressively erode the premium hospitals have historically earned for delivering outpatient care in a hospital-based setting. Systems that own the freestanding ASC infrastructure will be better positioned to capture this volume efficiently, while systems that do not will see their HOPD revenue compressed without a corresponding alternative.

Additionally, the Inflation Reduction Act's restructuring of Medicare Part D and H.R.1's Medicaid coverage changes will hit hospital-dependent systems the hardest, given their higher government payer mix. Ambulatory-expanded systems, with their disproportionately commercial-insured patient panels in ASCs, have a natural hedge against these headwinds.

THE POLICY SIGNAL

Site-neutral payment reform, Part D restructuring, and Medicaid coverage changes all move in the same direction: they compress the premium on hospital-based outpatient care and reward efficient freestanding ambulatory delivery. A hospital-only strategy carries policy risk that an ambulatory-expanded strategy naturally hedges.

SECTION TWO

The Leadership Debate: Real Headwinds, Legitimate Concerns

Experienced health system executives tend to proceed with extreme caution when it comes to ambulatory expansion, or even resist it. Their hesitance is not because they fail to see the market logic; they have lived through failed ambulatory investments.

The concerns raised in boardrooms and leadership retreats deserve serious engagement because understanding them clearly is the first step toward navigating them effectively. Five recur in nearly every engagement:

FIVE RECURRING HEADWINDS

- **The physician investment trap** — employment costs that outrun the volume they were meant to generate
- **Capital allocation under pressure** — ambulatory competing against IT, infrastructure, workforce, and cybersecurity
- **Regulatory and compliance complexity** — CON, CMS certification, accreditation, Stark, and Anti-Kickback exposure
- **Governance and physician alignment friction** — medical staff who read the strategy as a threat to autonomy
- **Execution risk and leadership bandwidth** — finite executive attention against an unforgiving development timeline

The Physician Investment Trap

No single factor derails ambulatory expansion strategies more reliably than unmanaged physician investment. To build a high-performing ambulatory network, health systems need aligned physicians whose procedural volume drives ASC economics, primarily specialists in orthopedics, cardiology, ophthalmology, and gastroenterology. Acquiring or employing those physicians is almost always required, and physician employment is expensive in ways that are easy to underestimate.

Strata Decision Technology's 2025 tracking data shows median annualized expenses per physician FTE have reached $1.1 million, an increase of 8.2% from 2024 and 17.5% from 2023.3 These expenses include compensation and benefits as well as the administrative infrastructure — call coverage arrangements, quality reporting systems, and facility subsidies — that employed physician practices require. Strata Decision Technology's analysis shows that health systems are collectively subsidizing their ambulatory physician networks at rates that force 7.4% year-over-year increases in investment, even as those networks are intended to generate returns.

The trap is this: health systems acquire physicians expecting them to generate ambulatory volume but fail to build the management infrastructure needed to realize that volume efficiently. Physicians practice below capacity. Scheduling and access management are inadequate. Referral patterns don't follow anticipated pathways. The ASC sits at 60% utilization while the physician practice runs at a $300,000 annual loss per doctor. The CFO flags the physician enterprise as a liability, and the board begins questioning whether the whole ambulatory strategy was a mistake.

THE PHYSICIAN INVESTMENT REALITY

- Median physician practice expense: $1.1M per FTE annually (Strata Decision Technology, 2025)
- Year-over-year increase: +8.2% in 2025; +17.5% since 2023
- Health system physician network subsidies growing 7.4% YOY
- Most physician practice losses are structural, not inevitable, and addressable with the right management framework
- The systems winning in ambulatory treat physician alignment as a strategic asset to be optimized, not a cost center to be minimized

Capital Allocation Under Pressure

Ambulatory expansion requires capital at a moment when capital is scarce. Supply and drug costs continue to climb. Labor expenses remain elevated even as contract labor costs moderate. Operating margins have compressed from the post-COVID highs of 2024 back toward historical medians in 2025. In this environment, boards are rightly cautious about committing $10 million to a de novo ASC or $50 million to a physician group acquisition without clear evidence of return.

The capital allocation debate is further complicated by competing claims. Information technology modernization is urgent. Aging inpatient infrastructure requires reinvestment. Revenue cycle optimization, workforce development, and cybersecurity all compete for the same constrained capital pool. Without a rigorous financial modeling framework that demonstrates ambulatory ROI with credible assumptions about volume, payer mix, physician productivity, and operating cost, ambulatory expansion proposals may struggle to win board approval.

Regulatory and Compliance Complexity

Building ambulatory infrastructure is not simply a matter of strategy and capital. Every new ASC requires navigating state licensing, certificate of need (CON) laws where applicable, CMS certification, accreditation (Joint Commission or AAAHC), and a maze of Stark Law and Anti-Kickback Statute requirements governing any joint venture or physician co-investment structure. Pain management and outpatient treatment center licensing adds additional regulatory layers. Payer contracting for a new ASC often requires months of negotiation before a single procedure can be billed.

For health systems without dedicated ambulatory development expertise, the compliance burden alone can delay or derail an otherwise sound expansion strategy. Many organizations attempt to manage this complexity with their existing legal and compliance resources, only to find those resources overwhelmed by the specificity and pace of ambulatory regulatory requirements.

WHERE TIMELINES SLOP

CON review, CMS certification, accreditation preparation, and payer credentialing run in sequence more often than in parallel. Organizations that map these dependencies before breaking ground routinely open months earlier than those that discover them along the way.

Governance and Physician Alignment Friction

Ambulatory expansion frequently brings health systems into direct negotiation with their own medical staff. Physicians who previously referred patients to hospital-based outpatient departments may resist a strategy that, in their view, redirects their patients and their professional autonomy into a health system-controlled ASC. Conversely, physicians who have built independent ASC equity positions may see health system entry as a competitive threat rather than a partnership opportunity.

Building a governance model that aligns physician and health system interests — joint venture structures, co-investment arrangements, or performance-based employment models — requires legal sophistication, financial creativity, and genuine relationship-building capacity. Many health systems underestimate this dimension and approach physician alignment as a transaction rather than a long-term strategic relationship..

Execution Risk and Leadership Bandwidth

Even well-capitalized, strategically clear health systems can struggle to execute ambulatory expansion while simultaneously managing their core hospital operations. The operational demands of building a new ASC — site selection, construction management, equipment procurement, staffing, scheduling system implementation, payer credentialing, and accreditation preparation — require outpatient-specific expertise that may not be as well developed in organizations primarily focused on inpatient care delivery.

Leadership bandwidth is finite. Every hour a chief strategy officer spends managing an ASC development project is an hour not spent on the five other strategic priorities competing for attention.

SECTION THREE

A Framework for Strategic Ambulatory Expansion

The health systems that have successfully built high-performing ambulatory networks share a common characteristic: they approached expansion as a disciplined strategic program, not a series of opportunistic transactions.

Strategic ambulatory expansion requires clarity on four questions before the first dollar of capital is committed.

1. Where Is the Market Opportunity?

Not every service line and not every geography justifies ambulatory investment equally. The highest-return ambulatory opportunities are often in high-acuity, high-volume procedural specialties — orthopedics, cardiology, ophthalmology, and gastroenterology — where procedures have migrated or are migrating from inpatient to outpatient settings and where commercial payer mix is favorable. Tenet's USPI, the most aggressive ASC developer in the country, reported 19% growth in total joint replacements in 2024 by focusing precisely on these high-acuity, commercially insured procedures.9

Market assessment must be grounded in real data: current and projected volume by procedure type, commercial payer penetration in the target geography, existing competitor capacity (including physician-owned independent ASCs), CON law landscape, and demographic trends that will drive demand growth over the next decade. This is not analysis that can be done with intuition and anecdote. It requires rigorous market intelligence.

2. Is the Physician Enterprise Ready?

The question of physician readiness is often asked last, when it should be asked first. An ASC is only as valuable as the physician volume flowing through it. Before committing to ambulatory infrastructure, health system leadership must honestly assess the state of its physician enterprise: Are the right specialists employed, aligned, or recruitable? Are they practicing at full capacity? Are their referral patterns consistent with an ambulatory strategy? Are there contractual, governance, or cultural barriers to redirecting volume from HOPD to ASC settings?

Physician alignment is the variable that most frequently determines whether an ambulatory investment succeeds or fails. It is also the variable that most frequently receives insufficient attention in pre-investment planning.

3. What Is the Right Structure?

Ambulatory expansion can take many structural forms: wholly owned health system ASCs, joint ventures with physician partners, management services arrangements with independent physician-owned ASCs, and hybrid models that combine elements of each. Each structure carries different financial, regulatory, and governance implications. Physician joint ventures, for example, can accelerate alignment and share development risk, but require careful Stark Law compliance review and fair market value analysis at every step. Wholly owned models offer greater operational control but place the full developmental risk and capital burden on the health system.

The right structure depends on market dynamics, physician relationships, capital availability, and regulatory environment. There is no universal answer, but there are clear principles that guide sound structural design, and organizations that skip this analysis often find themselves in costly and contentious restructuring conversations years later.

4. How Will Performance Be Managed?

The final question, and the one most often neglected, is how the ambulatory enterprise will be managed for performance once it is built. Who owns the relationship with ASC medical directors? How are quality metrics tracked and reported? What are the targets for OR utilization, case volume by procedure type, and revenue per case? How are physician productivity and compensation tied to ambulatory performance goals? What analytics infrastructure exists to surface performance gaps before they become financial problems?

High-performing ambulatory networks are not self-managing. They require dedicated operational leadership, data-driven performance management, and a culture of continuous improvement. Health systems that invest in the physical infrastructure of ambulatory care without investing equally in its management infrastructure routinely underperform their potential.

THE FOUR QUESTIONS

What Success Looks Like — and How It Fails

Strategic Question	What Success Looks Like	Common Failure Mode
Where is the market opportunity?	Data-driven service line and geography prioritization based on volume, payer mix, and competitive landscape	Opportunistic acquisitions without coherent market rationale; geographic sprawl without concentration of volume
Is the physician enterprise ready?	Aligned specialists at capacity, with referral patterns mapped and recruitment gaps identified	ASC built before physicians are aligned; volume never materializes; OR utilization stagnates at 50–60%
What is the right structure?	JV or ownership model designed for Stark compliance, fair market value, and aligned incentives	Structure designed by lawyers without operational input; physician partners feel misaligned within 18 months
How will performance be managed?	Dedicated operational leadership, analytics dashboards, physician productivity targets, quality metrics	Ambulatory performance managed as an afterthought by hospital operations leaders with competing priorities

Framework developed by Acuvance Coker advisory practice. Market data informed by Kaufman Hall National Hospital Flash Reports, Strata Decision Technology operational benchmarks, and Tenet Healthcare SEC filings.

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SECTION FOUR

How Acuvance Coker Bridges the Gaps

For more than 35 years, Acuvance Coker has served as a trusted advisory partner to hospitals, health systems, and physician enterprises navigating the most complex challenges in healthcare.

As a national consulting firm headquartered in Alpharetta, Georgia, and backed by Trinity Hunt Partners, Acuvance Coker brings together specialized advisory teams spanning strategy, finance, compliance, operations, analytics, and clinical performance. Our model is built on a clear conviction: healthcare leaders deserve advisors who roll up their sleeves, take ownership of the challenge, and show their work.

Ambulatory expansion sits at the intersection of every domain in which Acuvance Coker operates. The following section outlines how our integrated capabilities address the headwinds and strategic questions that health system leaders face.

FIVE INTEGRATED CAPABILITIES

- Strategic ambulatory planning & market assessment
- Physician enterprise alignment & workforce planning
- ASC feasibility, development & implementation
- Valuation, compliance & regulatory alignment
- Data, analytics & performance intelligence

CAPABILITY ONE

Strategic Ambulatory Planning & Market Assessment

Acuvance Coker's strategy advisors work with health system leadership to answer the foundational market question with rigor and specificity. We analyze procedure-level volume data, commercial payer penetration, competitive ASC capacity, physician supply and demand, and demographic trends to identify the ambulatory opportunities most likely to generate sustainable returns in your market.

Our strategic planning process goes beyond market analysis to address organizational readiness: governance structure, physician alignment status, capital availability, and leadership capacity. The output is not a generic strategic plan — it is a sequenced, market-specific roadmap that tells leadership not just where to go, but how to get there and in what order, grounded in the financial modeling needed to secure board approval.

CAPABILITIES INCLUDE

- **Market opportunity assessment**: procedure-level volume, payer mix, competitive landscape, and demographic projections
- **Service line prioritization:** identifying the highest-return ambulatory specialties for your market
- **Geographic strategy:** site selection and network design for ASC, urgent care, and ambulatory clinic footprints
- **Organizational readiness assessment:** leadership capacity, governance structure, and physician enterprise alignment
- **Financial feasibility and pro-forma modeling:** realistic assumptions grounded in market data and operational benchmarks

CAPABILITY TWO

Physician Enterprise Alignment & Workforce Planning

The physician investment challenge is the single most consequential variable in ambulatory expansion success, and it is Acuvance Coker's deepest area of expertise. Our physician enterprise advisors work with health systems to assess, structure, and manage their physician relationships in ways that align incentives, control costs, and drive ambulatory volume.

We begin with a physician needs assessment: a quantitative analysis of physician supply and demand within the community that defines gaps, informs recruitment priorities, and provides the evidentiary foundation for strategic physician investment decisions. From there, we design compensation structures that are fair market value-compliant, financially sustainable, and aligned with the ambulatory performance goals of the organization.

Physician compensation design is where many health systems lose the most money. Compensation packages that are not tied to productivity, quality, and ambulatory utilization metrics create a permanent subsidy with no performance feedback mechanism. Acuvance Coker's compensation modeling integrates MGMA and AMGA benchmarks with health system-specific financial data to design arrangements that reward performance, protect financial sustainability, and withstand regulatory scrutiny.

THE PHYSICIAN ALIGNMENT IMPERATIVE

A health system cannot build a high-performing ASC without aligned physicians, but physician employment without a management framework is a prescription for losses.

Acuvance Coker addresses both sides of this equation: helping health systems make the right physician investments, structure them correctly, and manage them to performance.

Our physician needs assessments have helped clients across the country make data-driven decisions about which specialties to recruit, how to structure compensation, and how to build the governance frameworks that turn employed physicians into ambulatory partners rather than subsidized liabilities.

CAPABILITY THREE

ASC Feasibility, Development & Implementation

For health systems ready to build or expand ASC capacity, Acuvance Coker provides end-to-end development advisory support, from initial feasibility modeling through launch and operational stabilization. Our ASC advisors have guided organizations through the full development lifecycle, and we bring both strategic vision and operational discipline to every engagement.

Feasibility modeling for a new ASC must account for realistic assumptions about case volume ramp-up, payer mix, per-case revenue by procedure type, staffing costs, supply chain costs, and capital depreciation. Many health systems underestimate the ramp-up period and overestimate early volume, leading to a first-year financial performance that triggers board concern and undermines confidence in the overall strategy. Acuvance Coker's feasibility models are built on market data and operational benchmarks from comparable facilities, with scenario analysis that stress-tests the key assumptions.

ASC DEVELOPMENT SERVICES

- **ASC feasibility modeling:** market-grounded financial projections with scenario analysis
- **Front-end strategy:** site selection, structural design, and partnership structuring
- **Regulatory and licensing support:** ASC, pain management, and outpatient treatment center licensure across all states
- **Joint venture and ownership structure design:** Stark-compliant, fair market value-supported partnership models
- **ASC implementation:** operational setup, staffing, scheduling, vendor contracting, and payer credentialing
- **Accreditation readiness:** Joint Commission and AAAHC preparation and support
- **ASC management:** ongoing operational and financial performance management post-launch

CAPABILITY FOUR

Valuation, Compliance & Regulatory Alignment

Every ambulatory expansion strategy touches on Stark Law, Anti-Kickback Statute compliance, and fair market value requirements. Physician employment agreements, ASC joint venture arrangements, management services agreements, and co-investment structures all require defensible fair market value analysis and regulatory review. Acuvance Coker's compliance and valuation team brings decades of experience in healthcare regulatory compliance to ensure that every transaction in an ambulatory expansion program is structured to withstand scrutiny.

We also support organizations preparing for ASC accreditation — a process that requires systematic policy and procedure development, staff training, quality metric tracking, and mock survey preparation. Organizations that attempt accreditation without structured preparation routinely extend their timelines and their carrying costs.

COMPLIANCE & VALUATION CAPABILITIES

- **Fair market value analysis:** defensible FMV opinions for physician compensation, ASC transactions, and JV structures
- **Stark Law and Anti-Kickback Statute advisory:** transaction structure review and ongoing compliance monitoring
- **Coding, documentation, and revenue integrity:** ensuring ambulatory billing practices are compliant and optimized
- **Accreditation and licensing readiness:** Joint Commission, AAAHC, and state licensing preparation
- **Payer contract management:** ASC and ambulatory payer contracting and negotiation support

CAPABILITY FIVE

Data, Analytics & Performance Intelligence

Data infrastructure is the most consistently underfunded component of ambulatory expansion strategies and among the most consequential. Health systems attempting to manage an expanding ambulatory network —multiple ASCs, an employed physician enterprise, urgent care clinics, ambulatory oncology and infusion centers — without integrated analytics infrastructure are flying blind. Physician productivity, OR utilization, case volume by procedure and payer, per-case revenue and cost, quality metrics, and patient satisfaction all need to be visible, consistent, and actionable at the operational and leadership level.

Nathan Cohen and Acuvance Coker's analytics team design the data infrastructure, governance frameworks, and performance dashboards that give health system leaders the intelligence they need to manage ambulatory performance in real time. Drawing on platforms including Acuvance DataRise™, Power BI, and Tableau, our advisors consolidate fragmented clinical, operational, and financial data into unified analytics environments that support both daily operational decisions and long-term strategic planning.

ANALYTICS CAPABILITIES FOR AMBULATORY EXPANSION

- **Unified analytics platforms:** integrating EHR, revenue cycle, financial, and operational data into a single source of truth
- **Ambulatory performance dashboards:** real-time visibility into OR utilization, case volume, payer mix, and financial performance
- **Physician productivity analytics:** benchmark-referenced productivity tracking tied to compensation and performance management
- **Predictive modeling: financial forecasting,** risk mitigation, and volume projection for ambulatory service lines
- **Quality and outcomes reporting:** tracking clinical quality metrics required for accreditation, VBP, and payer contracting

CAPABILITY SIX

Financial & Operational Performance Improvement

For health systems already operating ambulatory assets that are underperforming their potential, Acuvance Coker's performance improvement advisors provide a rapid and systematic assessment of the operational and financial gaps that are suppressing results. The most common culprits: inadequate scheduling and access management, supply chain and vendor contracts priced above market, staffing models misaligned with case volume patterns, physician productivity below benchmark, and revenue cycle workflows that leave ambulatory collections on the table.

Dima Awad's work in clinical and pharmaceutical performance transformation is particularly relevant to ambulatory systems seeking to optimize their specialty pharmacy, infusion, and clinically integrated service lines. The intersection of ambulatory care delivery and specialty pharmacy represents one of the highest-margin opportunities in healthcare and one of the most complex to execute compliantly.

Together, these capabilities form the performance improvement layer that determines whether an ambulatory network reaches its financial potential or sustains a chronic subsidy cycle.

ACUVANCE COKER'S INTEGRATED AMBULATORY ADVISORY MODEL

- **Phase 1 —** Strategy & Assessment: market opportunity analysis, physician enterprise assessment, financial feasibility modeling, structural design
- **Phase 2 —** Development & Implementation: ASC licensing, JV structuring, accreditation preparation, payer contracting, operational setup
- **Phase 3 —** Performance Management: analytics infrastructure, physician productivity management, quality reporting, financial optimization
- **Phase 4 —** Continuous Improvement: ongoing advisory, benchmarking, compliance monitoring, expansion planning

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Acuvance Coker advisors are engaged at each phase or at any single phase where a health system needs targeted support.

SECTION FIVE

What This Means for Health System Leadership

Health system CEOs, CFOs, and Chief Strategy Officers face an uncomfortable reality: the window for deliberate, well-sequenced ambulatory expansion is narrowing.

The organizations that built ASC networks five years ago are now experiencing the compounding benefits of commercial payer mix, physician alignment, and scale. Those that are starting now face a more competitive physician recruitment environment, a more saturated ASC market in many geographies, and more aggressive site-neutral payment reform that will reward freestanding ambulatory over hospital-based outpatient settings.

This does not mean it is too late. It means the margin for strategic error is smaller, and the cost of a poorly executed ambulatory strategy — measured in physician practice losses, underutilized ASCs, and governance dysfunction — is higher than it has ever been.

The Right Conversation to Have

The leadership conversation that produces the best outcomes is not “Should we expand in ambulatory?” It is “What is the most strategically sound, financially defensible, and operationally executable path for us to build ambulatory capacity that generates sustainable returns?”

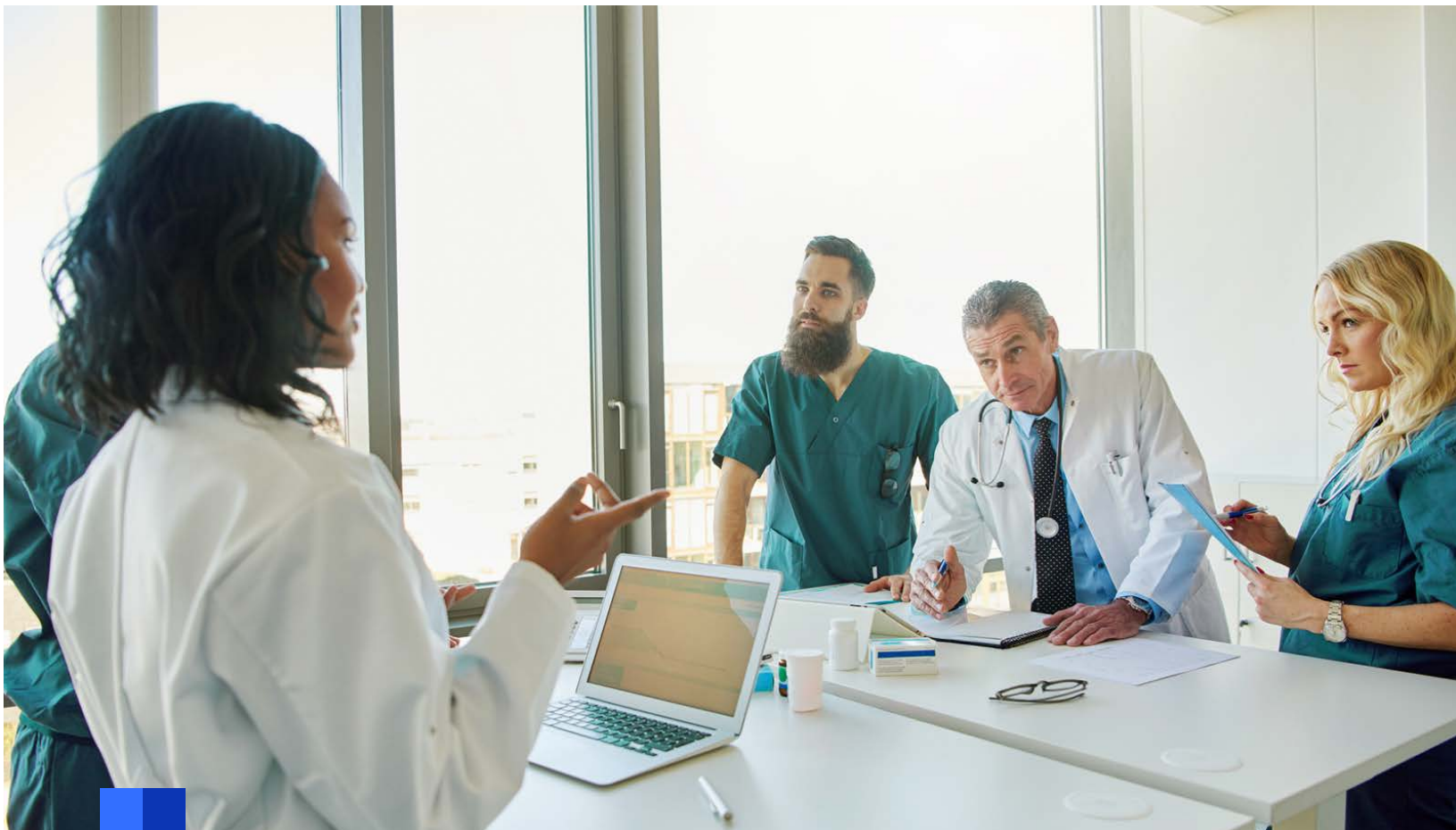
That conversation requires honest assessment of the organization's current physician enterprise health, capital position, market competitive dynamics, regulatory environment, and leadership bandwidth. It requires financial modeling that is grounded in realistic assumptions rather than optimistic projections. And it requires willingness to say no to some ambulatory opportunities in order to say yes with conviction and resources to the right ones.

The Cost of Waiting

A health system that delays physician enterprise investment is losing recruitment ground to competitors, forgoing the compounding benefit of commercial outpatient revenue, and entrenching an inpatient governance culture that becomes measurably harder to change with each passing year. The cost of waiting is not neutral. It compounds.

CMS cost reports, MedPAC analyses, and the financial statements of the nation's leading health systems are consistent on this point: ambulatory expansion is not a growth strategy. It is a survival strategy for organizations that intend to remain financially relevant in a market that is structurally rewarding outpatient investment.

> *"The organizations winning in ambulatory are not simply building more ASCs. They are building strategically aligned physician enterprises around them and managing those enterprises with the same rigor they apply to their hospital operations."*



CONCLUSION

Strategy First, Then Speed

Ambulatory expansion is the defining strategic challenge for US health systems in the second half of this decade. The evidence is unambiguous: the revenue is moving to ambulatory settings, the quality outcomes favor well-run ambulatory programs, and the policy environment will continue to reward efficient, commercially-insured outpatient care delivery over hospital-based alternatives. Health systems that do not build meaningful ambulatory capacity will find themselves structurally disadvantaged in ways that become progressively harder to reverse.

But the health systems that expand ambitiously without strategic discipline — acquiring physicians without a management framework, building ASCs without aligned volume, and structuring partnerships without Stark-compliant governance — will find that ambulatory expansion creates problems as fast as it solves them.

Moving deliberately is not the same as moving slowly. The distinction is between a strategy that compounds over time and one that simply accumulates costs.

Strategy first, then speed. Market clarity, physician alignment, structural integrity, and performance management infrastructure must all be in place before the capital flows and the construction crews arrive.

Acuvance Coker exists to help health systems get this right. Our advisors bring the strategic, financial, operational, clinical, and compliance expertise to support every phase of the ambulatory expansion journey, from the first board conversation about market opportunity to the ongoing performance management of a mature ambulatory network. We take ownership of your challenges, show our work, and measure our success by your outcomes.

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ABOUT ACUVANCE COKER

Acuvance Coker is a national healthcare consulting firm headquartered in Alpharetta, Georgia, serving hospitals, health systems, and physician enterprises for more than 35 years across strategy, finance, compliance, operations, analytics, and clinical performance.

CONNECT WITH OUR AMBULATORY ADVISORY TEAM

Let's talk about your ambulatory strategy.

To discuss your organization's ambulatory strategy or to schedule an exploratory conversation with Acuvance Coker's ambulatory and ASC development advisors, contact us:

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