

# WHAT'S THE PROBLEM? PROVIDERS' WAIVERS OF PATIENT COPAYS OR DEDUCTIBLES

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Most health insurance plans are cost-sharing arrangements between the individual patient and the patient's insurance payer. Depending on the plan's structure, the patient is typically responsible for some combination of a monthly premium; a deductible; coinsurance; and/or copays. With the patient's financial obligation established, the plan is then responsible for the balance of costs for covered healthcare services.

Plans and healthcare providers establish rates and fee schedules for covered healthcare services by contract. Such rates and fee schedules are the result of extensive negotiations and are based on a number of factors. Despite the existence of such contractual arrangements, healthcare providers sometimes waive patient copays, coinsurance and



deductibles (generally referred to as a "waiver" or "waivers" in this article). This happens with in-network and out-of-network healthcare providers alike, and they do so for different reasons and under varying circumstances.

Regardless of the rationale, healthcare providers who grant waivers should

*Continued on page 4*

## ► INSIDE THIS ISSUE:

### What's the Problem?

<b>Providers' Waivers of Patient Copays or Deductibles</b> .....	<b>1</b>
<b>On Waivers, ASCs and Independent Anesthesia Practice</b> .....	<b>2</b>
<b>Six Years On: The Growing Pains—and Remarkable Growth—of the Perioperative Surgical Home</b> .....	<b>3</b>
<b>Ambulatory Anesthesia: Everything You Wanted to Know But Were Afraid to Ask.</b> .....	<b>11</b>
<b>How Much Call is Too Much?</b> .....	<b>18</b>
<b>Anesthesia Services RFPs: Reality, Unicorns and Cognitive Bias</b> .....	<b>23</b>
<b>Independent Anesthesia Group Practice: A Short Manifesto</b> .....	<b>25</b>
<b>Event Calendar</b> .....	<b>28</b>

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# ON WAIVERS, ASCs AND INDEPENDENT ANESTHESIA PRACTICE

The rules pertaining to waivers of copays are certainly worth understanding. “It is an understatement to say the consequences of inappropriate waiver practices are significant,” write returning authors Frank Carsonie, JD, and Nathan Sargent, JD, in their lead article for this *Communiqué*.

In the current era of increased federal and state governmental scrutiny, anesthesia practices must do all they can to avoid the appearance of impropriety. The safest course is to avoid granting copay waivers as a matter of policy, except in cases of well-defined and documented hardship. “There are ways for healthcare providers to grant waivers compliantly,” they note, but “the critical point is to understand what is permitted and what is not.” Mr. Carsonie and Mr. Sargent address the finer points of this topic.

Also in this issue:

- Howard Greenfield, MD, of Enhance Healthcare Consulting and Jody Locke, MA, of Anesthesia Business Consultants explore strategies for success in today’s market as an anesthesia provider in ambulatory settings. Circumstances are not what they once were. “Never has it been so important to exercise rigorous due diligence and to objectively evaluate the potential benefits and risks,” they stress. “In the past, relationships with most ambulatory facilities would only enhance an anesthesia practice. This is no longer the case. The three rules of success are: 1) know what you are getting yourself into; 2) make sure the numbers make sense; and 3) monitor performance closely and continuously.”
- Roseanne M. Fischhoff, MPP, economics and practice innovations executive with the American Society

of Anesthesiologists, shares stories and lessons learned from participants in the ASA’s Perioperative Surgical Home (PSH) Learning Collaborative, an initiative launched in 2014 to further the team-centered, patient-centered model of care that is gaining traction within the specialty and expanding the anesthesiologist’s role. Improvements made using this innovative paradigm in different types of facilities continue to show it to be “a viable and effective care model that can be incorporated into institutions of any size and for a wide variety of procedures and modalities,” she writes. The ASA program’s third iteration, the PSH Learning Collaborative 2020, soon to begin, will assist participants in PSH pilot implementation, optimization, expansion and the transition to value-based care.

- Robert Johnson, MBA, of Enhance Healthcare Consulting looks at call responsibility among anesthesiologists—a subject about which very little is really known. Mr. Johnson reviews the findings of a recent survey and outlines his firm’s plans for future research in this area.
- Mark F. Weiss, JD, offers perspective on dealing with the anesthesia services request for proposal (RFP), stressing the importance for anesthesia practices of reinforcing group cohesiveness and developing “a true business that is broader than based simply on one hospital, so that you can negotiate from a place of strength.”
- In an era of widespread consolidation within anesthesia, Will

Latham, MBA, of Latham Consulting Group, speaks out in support of independent anesthesia group practice and explores how groups that wish to remain independent can do so. First, realize that it won’t be easy, he states: “If your goal is to stay independent, there is work to be done.” Strengthen group governance, develop a cohesive strategic plan, consider mergers, build effective relationships with hospital leaders, deal quickly and decisively with disruptive group members, and pursue new business opportunities, Mr. Latham recommends.

Again this year, the Advanced Institute for Anesthesia Practice Management will offer a wealth of learning and networking opportunities on group practice strategy, compliance, billing and coding, and other topics. We look forward to seeing many of you in Las Vegas.

With best wishes,

Tony Mira  
President and CEO





# SIX YEARS ON: THE GROWING PAINS— AND REMARKABLE GROWTH—OF THE PERIOPERATIVE SURGICAL HOME

**Roseanne M. Fischhoff, MPP**

*Economics and Practice Innovations Executive  
American Society of Anesthesiologists*

- One regional medical center saved \$1.5 million in the first year.
- A Midwest academic center reduced average length of stay (LOS) for total joint replacement patients from 4.6 to 2.1 days.
- A pediatric institution reduced the 30-day readmission rate from 8.3 percent to 7.5 percent for laryngeal cleft patients while reducing average cost by approximately 20 percent.
- An academic center reduced costs for cystectomy cases by an average of \$10,000 per case.
- A major health system improved room turnover by approximately eight minutes, reduced LOS for hip/knee arthroplasty cases from an average of 110 hours to 51 hours and cut the readmission rate for hip/knee arthroplasty cases in half.

Having devised and championed the concept of the anesthesia care team in the early 1980s, anesthesiologists have been at the forefront of team-based, collaborative care for decades. As healthcare increasingly transitions from an emphasis on volume to one of value, the importance of teamwork becomes ever more crucial.

The American Society of Anesthesiologists (ASA) formally introduced the perioperative surgical home (PSH) in 2012 as an innovative patient-centered



model of care designed to achieve the triple aim of improving health, improving the delivery of healthcare and reducing costs.

Perhaps the strongest core feature of the PSH model is the team. Alongside the many thousands of individuals who have been involved in PSH programs throughout the country, the PSH model—and the ASA's first two PSH Learning Collaboratives—are being increasingly embraced by a variety of influential healthcare organizations. In March 2018, the PSH Learning Collaborative was accepted by the American Board of Medical Specialties Multi-Specialty Portfolio Program, meaning that Learning Collaborative participation will be recognized for Maintenance of Certification Part IV credit by 24 specialty boards, including the American Board

of Surgery. Notable PSH partner organizations include the American Academy of Physical Medicine and Rehabilitation (AAPMR), the American Academy of Orthopedic Surgeons (AAOS) and the American Urological Association (AUA).

Practice improvement examples like those at the beginning of this article continue to demonstrate that the PSH is a viable and effective care model that can be incorporated into institutions of any size and for a wide variety of procedures and modalities.

In 2014, the ASA teamed with Premier, Inc., a leading healthcare improvement company, to establish the first PSH Learning Collaborative, which brought together subject matter experts and leading institutions from across the

*Continued on page 8*





## WHAT'S THE PROBLEM? PROVIDERS' WAIVERS OF PATIENT COPAYS OR DEDUCTIBLES

*Continued from page 1*



know that there are serious healthcare fraud and abuse implications under federal and state law. It is an understatement to say the consequences of inappropriate waiver practices are significant.

The questions and answers below provide an overview of key laws and legal concepts, operational considerations and risk mitigation strategies related to healthcare providers granting waivers.

### UNDER WHAT CIRCUMSTANCES ARE COPAYS, COINSURANCE AND DEDUCTIBLES TYPICALLY WAIVED?

A patient's deductible is the amount of healthcare-related costs the patient must incur before the patient's plan begins to pay for healthcare services. Coinsurance is typically calculated as a percentage of the total cost of a given healthcare service for which the patient remains responsible. A copay is a fixed amount that the patient must pay for a specific healthcare service. A copay amount can vary based on the specific service or procedure and is often collected at the time of service. However, a copay can be collected at a later time or date.

Given the nature of when and how coinsurance, deductibles and copays are paid, providers typically grant waivers during patient intake (i.e., prior to service) or after a service has been provided and the patient has been deemed delinquent with payment. A waiver can be a full fee waiver, a partial fee write-down or discount, or a write-off once the patient obligation has been referred to collections.

As mentioned above, healthcare providers grant waivers for various reasons, such as to accommodate individual circumstance (e.g., financial hardship), as a professional courtesy or for marketing and business development purposes. The fraud and abuse concerns exist regardless of the reason for granting the waiver.

### WHAT LAW APPLIES TO PATIENT COPAY OR DEDUCTIBLE WAIVERS?

At the federal level, healthcare provider waivers implicate civil monetary penalties under the Social Security Act as well as the Federal Anti-Kickback Statute.

#### Civil Monetary Penalties

According to Section 1128A(a)(5) of the Social Security Act, any person (including an organization, agency or other entity) that offers, or transfers, remuneration to an individual eligible for Medicare or Medicaid benefits, and such person knows or should know the remuneration is likely to influence an individual to order or receive a covered Medicare or Medicaid service from a particular healthcare provider, is subject to a civil monetary penalty (the CMP Law).

The penalty under the CMP Law can be up to \$10,000 for each item or service, plus an assessment of "not more than three (3) times the amount claimed for each item or service."<sup>1</sup> In addition to the financial penalties, the Secretary of Health and Human Services has the ability to exclude such person from participating in the Medicare and Medicaid programs. A waiver can be considered remuneration likely to influence an individual to do business with a particular provider.

#### Federal Anti-Kickback Statute

The Federal Anti-Kickback Statute imposes criminal and civil monetary penalties on any person (an entity or individual) that knowingly and willfully pays or offers to pay any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person to purchase, lease, order or arrange for any good, service or item for which payment may be made, in whole or in part, by a federal healthcare program, such as Medicare and Medicaid.<sup>2</sup> The Federal Anti-Kickback Statute also prohibits a person from arranging for or recommending the

<sup>1</sup> 42 U.S.C. §1320a-7a.

<sup>2</sup> 42 U.S.C. §1320a-7b.



### OIG-Published Inappropriate Practices:

- Advertisements that state, “Medicare Accepted as Payment in Full,” “Insurance Accepted as Payment in Full” or “No Out-of-Pocket Expenses.”
- Advertisements promising that “discounts” will be given to Medicare beneficiaries.
- Routine use of “financial hardship” forms that state that the beneficiary is unable to pay the coinsurance/deductible (i.e., there is no good faith attempt to determine the beneficiary’s actual financial condition).
- Collection of copayments and deductibles only where the beneficiary has Medicare supplemental insurance (Medigap) coverage (i.e., the items or services are “free” to the beneficiary).
- Charges to Medicare beneficiaries that are higher than those made to other persons for similar services and items (the higher charges offset the waiver of coinsurance).
- Failure to collect copayments or deductibles for a specific group of Medicare patients for reasons unrelated to indigency (e.g., a supplier waives coinsurance or deductible for all patients from a particular hospital in order to get referrals).
- “Insurance programs” that cover copayments or deductibles only for items or services provided by the entity offering the insurance. The “insurance premium” paid by the beneficiary is insignificant and can be as low as \$1 a month or even \$1 a year. These premiums are not based upon actuarial risks, but instead are a sham used to disguise the routine waiver of copayments and deductibles.<sup>1</sup>

<sup>1</sup> OIG Notice: Publication of Special Fraud Alerts (December 19, 1994).

purchase of goods or services for which payment may be made, in whole or in part, under a federal healthcare program in exchange for remuneration. A waiver can be considered remuneration to induce a patient to arrange for a service with the granting provider.

A violation of the Federal Anti-Kickback Statute may be prosecuted as a criminal action and is classified as a felony, punishable by fines of up to \$25,000 per violation and imprisonment for up to five (5) years. Like the civil monetary penalties, a violation of the Anti-Kickback Statute may result in exclusion from participation in Medicare and Medicaid and the imposition of civil monetary penalties in an amount equal to treble damages plus \$50,000 per violation. A violation of the Federal Anti-Kickback Statute may also result in collateral claims against the violator

under the False Claims Act<sup>3</sup> brought by enforcement authorities or through whistleblower actions, potentially resulting in additional civil monetary penalties of up to \$10,000 per violation, plus treble damages.

#### State Law

In addition to federal authority, states often have their own healthcare fraud and abuse laws. Some states even have statutes and regulations that govern the specific practice of healthcare provider waivers. Others address the issue in provider disciplinary rules and standards of professionalism, expressly prohibiting a licensed practitioner from waiving patient insurance obligations except under certain circumstances. Regardless, it is critical to understand the federal and state requirements and limitations related

to healthcare provider waivers prior to granting them.

### WHAT WAIVER PRACTICES ARE PROHIBITED? WHAT PRACTICES ARE PERMITTED? AND WHY?

Despite the foregoing, there are ways for healthcare providers to grant waivers compliantly. The critical point is to understand what is permitted and what is not.

#### Permissible Activity Under Civil Monetary Penalties

As it relates to the CMP Law, “remuneration” is specifically defined to include the waiver of coinsurance, copay and deductible amounts (or any part thereof). However, a waiver does not become remuneration subject to the CMP Law prohibitions if:

- The waiver is *not* offered as part of any advertisement or solicitation; and
- The healthcare provider does not *routinely* waive or reduce coinsurance, copay or deductible amounts; and
- The healthcare provider (a) waives or reduces the coinsurance, copay or deductible amounts after determining, in good faith, that the individual is in financial need *or* (b) fails to collect after making reasonable collection efforts.<sup>4</sup>

The Office of Inspector General (OIG) has published a Special Advisory Bulletin that addresses many facets of the CMP Law as it pertains to gifts and other inducements to Medicare and Medicaid beneficiaries. For waivers, the OIG has provided exceptions for: “Non-routine, unadvertised waiver of copayments or

<sup>4</sup> 42 U.S.C. §1320a-7a(i)(6)(A).

<sup>3</sup> 31 U.S.C. §§3729-3733.



## WHAT'S THE PROBLEM? PROVIDERS' WAIVERS OF PATIENT COPAYS OR DEDUCTIBLES

*Continued from page 5*



deductible amounts based on individualized determination of financial need or exhaustion of reasonable collection efforts.”<sup>5</sup>

A key element to implicating the civil monetary penalties is that the remuneration is *likely* to influence the beneficiary to order or receive items or services from a particular healthcare provider. No specific intent is required; deliberate ignorance or reckless disregard could trigger the inducement element.

In addition, valuable goods and services offered as part of a marketing or promotional activity is a way specifically recognized by the OIG to qualify as an inducement. The OIG has pointed out that “even if a provider or supplier does not directly advertise or promote the availability of a benefit to beneficiaries, there may be indirect marketing or promotional effects or informal channels of information dissemination, such as ‘word of mouth’ promotion by practitioners or patient support groups.”

The OIG has noted that such waivers occur in a wide variety of circumstances, some of which do not present a significant risk of fraud and abuse. The OIG has encouraged the use of its advisory opinion process to confirm appropriateness of healthcare provider practices.

### Federal Anti-Kickback Statute Safe Harbors and Required Intent

The Federal Anti-Kickback Statute is recognized as a broad regulatory framework. Seeing that many reasonable arrangements might implicate the statute, the OIG has periodically issued regulatory “safe harbors” that define business arrangements that would be considered non-abusive to federal healthcare programs. There is a safe harbor for waiver of beneficiary copays, coinsurance and deductibles; however, the safe harbor contemplates specific healthcare providers and suppliers, such as inpatient hospitals, pharmacies and ambulance providers (among others).<sup>6</sup> Each provider type has specific elements that must be satisfied for the safe harbor to apply.

Note that all elements of the applicable safe harbor must be satisfied in order for an arrangement to be protected. Business arrangements that do not satisfy all of the requirements of a safe harbor are not *per se* illegal. Such arrangements are reviewed on a case-by-case basis, in light of all relevant facts and circumstances, and may be deemed by the OIG not to violate the Federal Anti-Kickback Statute.

Parties to an arrangement that falls outside the scope of a safe harbor will only violate the Federal Anti-Kickback Statute if they “knowingly” and “willfully” entered into an inappropriate arrangement. An arrangement that is outside the scope of safe harbor protection will be found to be in violation of the Federal Anti-Kickback Statute only if the purpose of the remuneration is to induce referrals or the arrangement or recommendation of the purchase of goods or services covered under a federal healthcare program. Note, however, that the sole purpose of the arrangement does not have to be inappropriate or illegal; the presence of a legitimate purpose will not alone shield a healthcare provider from liability.

To mitigate the risks of enforcement, it is critical to understand if the safe harbor applies based on provider type and what elements must be satisfied to fit squarely within safe harbor protection. This should be determined prior to granting such waivers. If no safe harbor applies, the provider will need to assess the enforcement risks with any waiver practices. Adopting best practices or guidance from government enforcement authorities, such as the OIG, in consultation with regulatory counsel will help to mitigate risks.

<sup>5</sup> OIG Special Advisory Bulletin: Offering Gifts and Other Inducements to Beneficiaries (August 30, 2002).

<sup>6</sup> 42 C.F.R. §1001.952(k).





### Integrity of Rate-Setting Process


In addition to fraud and abuse, the integrity of the rate-setting process remains an important consideration when it comes to healthcare provider waivers. As mentioned above, plans and healthcare providers negotiate rates and fee schedules based on a number of factors: usual and customary charges, utilization data, underwriting, geography and patient populations, to name a few. Systematic or recurring waivers can amount to a healthcare provider's misrepresentation or manipulation of actual service and procedure costs. Depending on the language in each applicable payer/provider agreement, such practices could be considered inappropriate and result in breach of contract or even a violation of state-specific insurance fraud statutes and regulations. Infrequent or non-routine waivers are far less likely to fall under such scrutiny, especially if granted based on financial need or after good faith efforts to collect due fees, as described above.

### WHAT STEPS CAN BE TAKEN TO MITIGATE FRAUD AND ABUSE AND OTHER RISKS ASSOCIATED WITH SUCH WAIVERS?

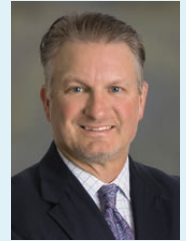
A number of steps can be taken to help guard against fraud and abuse and other inappropriate waiver practices, such as:



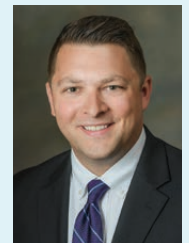
- **Develop or update policies and procedures.** All waivers should be granted consistent with established policies and procedures. This should include non-customary waiver approvals. Such policies and procedures should be compliant with applicable federal and state law and take into account the healthcare provider's plan agreements.
- **Conduct ongoing employee training.** Employee education and training is a critical component of any effective compliance plan. Waiver policies and procedures should be part of the compliance training and education curriculum, as should the underlying legal authority. Special attention should be paid to staff involved in marketing/business development, patient intake, accounting and billing.
- **Periodic, routine reviews and audits.** Healthcare providers should conduct periodic internal reviews or audits of waivers and waiver practices to ensure appropriate documentation and compliance with policy and procedure. This should occur at least once per year.
- **Maximize use of technology.** Technology platforms used for billing and accounting should include checks or prompts to ensure waivers are granted and documented consistent with policy and procedure.
- **Engage outside counsel.** Outside legal counsel can be engaged to assist in the development of policies and procedures, employee training and ongoing consultation to help providers ensure they are planning, developing and implementing compliant waiver practices.

Irrespective of when a waiver is granted, there are serious ramifications that must be duly considered. If you have questions about any past, current or proposed waiver practices, you should consult experienced healthcare regulatory counsel. 

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## SIX YEARS ON: THE GROWING PAINS—AND REMARKABLE GROWTH—OF THE PERIOPERATIVE SURGICAL HOME

*Continued from page 3*

country to learn from each other. The first Collaborative featured 44 groups, and the recently completed Learning Collaborative 2.0 comprised 57 organizations that shared insights about PSH strategies compatible with alternative payment models, including Bundled Payments for Care Improvement, Comprehensive Care for Joint Replacement, the Medicare Shared Savings Program and Accountable Care Organizations.

The nearly 100 institutions and healthcare professionals who participated in the first two Learning Collaboratives reported positive outcomes that have benefited their organizations and their patients in sometimes surprisingly short periods of time. However, no matter how successful any of these nascent PSH models turned out to be, all experienced challenges that informed their actions going forward and served as learning opportunities for their peers.

The individuals below recently shared the successes and challenges of incorporating a PSH model into their institutions.

**Christopher Steel, MD**  
**White River Health System**  
**Batesville, Arkansas**

Early in their PSH program, Dr. Steel and his group formed preoperative, intraoperative and postoperative teams. They found that in team meetings, each team wanted to focus solely on outcome measures rather than consistently following the established protocols. As a result, they accomplished very little in the first few meetings. Subsequently, the team focused on precision and accuracy. The precision efforts focused on reproducibility of the protocol rather than outcomes. As a result, they were able to create PSH-



driven protocols. The accuracy efforts were focused on making small changes to the protocols over time based on the patient outcomes.

Like many other organizations developing PSH models, the White River Health group quickly learned how important it was to name the right leaders. Dr. Steel was originally designated as sole director of the PSH, which he later called “short-sighted.” When his group added orthopedic surgeon Jeff Angel, MD, as co-director, the other orthopedic surgeons became more engaged and the program began building momentum.

A mobile phone app helped to solve their problem of disseminating protocols to team members. This content was at first put on paper and filed in binders strategically placed throughout the hospital. When changes were made, they had to find the appropriate papers and make the change in each binder. Later, a shared computer drive proved unsuccessful because finding a local computer was difficult and the log-in process was

too cumbersome. The mobile phone app turned out to be the best way for everyone involved in the patient’s care to access and review up-to-date information.

Dr. Steel indicated that identification of a payment mechanism should be a top priority for institutions that develop a PSH. It’s not necessary to have one at the outset, but eventually everyone must figure out a way for the hospital and providers to be reimbursed for the effort required to accomplish care design. Otherwise, sustained efforts and growth are unlikely.

For Dr. Steel and the White River Health System, the PSH model has, so far, delivered on its core principles. “It doesn’t matter what you call it. Every hospital should strive to improve quality and improve the experience of patients and providers,” he said. “By reducing variation, a PSH or similar model can simplify the delivery of care for the patients and the providers while meticulously ensuring improved quality and usually a decreased total cost of care.”





**Leslie Garson, MD**  
University of California, Irvine

Dr. Garson was an early adopter of the PSH model at his institution and has been fine-tuning his program for several years. Like Dr. Steel and the White River Health System, identification of PSH champions was crucial for success. In Dr. Garson's case, a surgeon champion and senior leadership support were essential. Non-physician support is also necessary as well. Preferably, this is someone with experience working with clinical pathways who can shepherd the project through the writing of clinical pathways, working with committees and completing order sets.

While leadership support and champions are critical, they are perhaps less important to continued success than collaboration and buy-in from the entire spectrum of team members. Too much reliance on a particular champion—whether a surgeon, anesthesiologist or administrator—can be disastrous if that person leaves and the clinical pathway goes with them.

Dr. Garson emphasized that clinical pathways need to be as hard-wired as possible. This means explaining to the

entire team, again and again, that clinical pathways are not “cookbook medicine,” but rather a scaffold or skeleton of evidence-based care that can be endlessly modified and customized for the 20 to 30 percent of patients who need more individualized treatment protocols.

“A PSH program provides the ability to implement a continuum of care plan in the perioperative period for a patient's episode of care—be it joint replacement, colon resection or any of a myriad of other procedures—that is developed in a multidisciplinary, collaborative manner ensuring good communication and seamless care management across all touch points by all providers for that patient.”

**Gary Stier, MD, MBA**  
Loma Linda University

Dr. Stier and his group at Loma Linda found out early in their PSH journey that they had underestimated the difficulty of navigating the byzantine information technology (IT) landscape typical of a large medical institution. IT support is crucial, but with limited available resources at their institution, gathering data, creating analytic tools and customizing their electronic health record (EHR)

for enhanced workflow presented significant challenges. In response, they mapped the IT structure and governance to better understand who in IT to talk to and how to navigate the system. Frequent communication with appropriate IT staff helped to build crucial relationships, leading to a better overall understanding of the PSH model and how it fit into the organization's mission.

The importance of adequately sharing the vision of the PSH does not stop with IT staff. Dr. Stier stressed the necessity of educating administrators and other surgical colleagues about the PSH model, calling the process “an uphill journey.” Surgeons, for instance, are surely aware of and most likely pushing for the development of enhanced recovery after surgery (ERAS) programs and the institutional resources needed to develop them. The PSH champion must focus on educating all stakeholders that the PSH model is, in fact, a *more comprehensive* ERAS delivery model developed to enhance both surgical service line care and to facilitate, create and implement procedure-specific ERAS protocols.

The group also found it imperative to emphasize to their department members that the PSH model is a *complementary* part of the anesthesiology group's practice. They created a voluntary anesthesiology PSH team that embraced the model and talked positively about its value to department members. By demonstrating positive outcomes, such as reduced LOS, patient satisfaction and surgical team satisfaction, and presenting an acceptable *pro forma*, they were better able to obtain faculty support and funding for the PSH. Regular meetings with key stakeholders ensured ongoing awareness of and support for the program.

As with any new patient care paradigm, the reality of implementing a PSH lies in the conflict between the time and resources required to perform clinical





## SIX YEARS ON: THE GROWING PAINS—AND REMARKABLE GROWTH—OF THE PERIOPERATIVE SURGICAL HOME

Continued from page 9



and administrative duties. In response to the challenge, Dr. Stier and his group initially performed needed administrative activities on personal time; however, once organizational funding for the PSH program was secured, the finances needed for the administrative duties were no longer an issue.

For those thinking of developing their own PSH model, Dr. Stier recommended acquiring at least a basic knowledge of project management, process improvement, study design, statistical analysis and data gathering methods, much of which can be attained through existing institutional programs, books and online resources.

Dr. Stier also recognized that focusing group efforts early on in creating and implementing timely protocols and order sets for the surgical services they partnered with would have allowed them to more effectively reduce surgical practice variation and improve outcomes sooner. In addition, publishing a paper on their PSH outcomes likely would have moved the program forward much sooner.

As the PSH Learning Collaborative moves toward its third incarnation (PSH Learning Collaborative 2020), Dr. Stier emphasized the characteristics that make it patently unique: “The number-

one advantage of participating in the PSH Learning Collaborative is the collaborative nature of membership—sharing resources and building relationships. PSH teams can clearly become experts in the development and implementation of perioperative care coordination programs, perioperative chronic disease management, facilitating the creation of clinical pathways and order sets, navigating the IT landscape and financial management of such programs. Creating successful PSH programs can ensure job security and career.”

### THE PSH LEARNING COLLABORATIVE 2020

Recruitment for the PSH Learning Collaborative 2020 is now under way. The collaborative will begin in May and run for two years. This iteration of the collaborative will assist facilities in PSH pilot implementation, optimization and expansion into new service lines or system-wide conversion.

It will also help facilities overcome the challenges they face with making the change to value-based payment. Organizations will be guided through participation in mandatory and elective bundles and understanding the impact that the Quality Payment Program (QPP) of the Medicare Access and CHIP Reauthorization Act of 2017 (MACRA), including the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) will have on their organization.

This effort is important because value-based payment is quickly being adopted by private as well as public payers.


To meet the unique needs of organizations interested in healthcare redesign,

institutions can choose from two participation options:

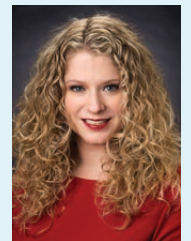
The first, the Core Collaborative, is designed for organizations interested in learning more about the PSH model of care and those in the early stages of implementing a PSH pilot.

The other, the Advanced Cohort, is designed for organizations looking to optimize or expand their PSH pilot. Advanced Cohort participants also can be part of the Bundles Payment Add-On option, which allows them to assess their facility’s benefits and risks in participating in the various bundled payment programs.

Regardless of which learning track an organization chooses, institutions will complete the program with the confidence, tools and resources to begin the next phase of PSH pilot implementation.

To learn more about the PSH Learning Collaborative 2020, visit [asahq.org/psh-learn](http://asahq.org/psh-learn) or email [PSH@asahq.org](mailto:PSH@asahq.org). 

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# AMBULATORY ANESTHESIA: EVERYTHING YOU WANTED TO KNOW BUT WERE AFRAID TO ASK

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The steady migration of surgical cases from traditional inpatient to non-traditional outpatient and ambulatory venues has required anesthesiologists and CRNAs, the quintessential service providers, to continuously reinvent themselves to adapt to evolving market conditions and customer expectations. The assumptions and strategies that helped many anesthesia groups build successful partnerships with hospitals may no longer serve them well in today's dynamic ambulatory environment.

Today's medical mantra is "value proposition." Anesthesia providers are no longer being asked simply to provide safe and effective anesthesia care. They are also expected to create value for the facility. The ability to generate this value requires close collaboration with the facility's leadership, staff and surgeons.

If there is one overarching distinction between traditional hospital agreements and ambulatory agreements, it is the availability of subsidy money. While most hospitals are willing to provide financial support for unprofitable business lines, this is rarely, if ever, the case in the ambulatory environment. This reality of ambulatory anesthesia means that the anesthesia practice must make sure the arrangement with an ambulatory surgery center (ASC) makes financial sense before proceeding.

Is it time for anesthesia practices to evaluate and pursue ambulatory oppor-



tunities? The answer is yes, but *caveat emptor*: buyer beware. Never has it been so important to exercise rigorous due diligence and to objectively evaluate the potential benefits and risks. In the past, relationships with most ambulatory facilities would only enhance an anesthesia practice. This is no longer the case. The three rules of success are: 1) know what you are getting yourself into; 2) make sure the numbers make sense; and 3) monitor performance closely and continuously.

## TYPES OF AMBULATORY PRACTICES

While we tend to think of ambulatory anesthesia as a generic term, the fact is that no two ambulatory facilities—and

therefore, no two ambulatory anesthesia agreements—are the same. To understand the challenges and opportunities associated with this new anesthesia frontier, it is useful to think in terms of five subsets of facilities and types of cases. These categories offer a framework for the key financial and strategic issues that anesthesia practices should consider before signing an agreement with a new facility:

1. Hospital-owned outpatient facilities that are physically part of the hospital campus, billed with a place of service code -22;
2. Freestanding ASCs that represent a joint venture between a hospital and surgeons, billed with a place of service -24 modifier;
3. Surgeon-owned freestanding ASCs, also billed with a -24 modifier, but which may have different financial objectives than the hospital joint venture facilities;
4. Single specialty centers, such as an endoscopy center, an eye center or a center for reproductive medicine, billed with a -24 modifier;
5. A doctor's office, billed with a place of service -11 modifier. Anesthesia provider to be asked to cover dental or plastic surgeons' offices.

*Continued on page 12*





# AMBULATORY ANESTHESIA: EVERYTHING YOU WANTED TO KNOW BUT WERE AFRAID TO ASK

*Continued from page 11*

## A RANGE OF REALITIES

The challenges of successful anesthesia practice management in any of these types of facilities can be significant. The fact that ambulatory cases are shorter, of lower acuity and turn over faster may seem advantageous, but these characteristics create an entirely different set of customer expectations than those in hospital operating rooms (ORs). To understand this difference, think of email and texting. When people talked on the phone and sent documents by mail or messenger there was no expectation that things would happen instantly. The advent of texting and email has created an expectation of an instant response. Today's well-run surgery center epitomizes the application of business principles to medicine, where the real measure of success is customer service, efficiency and profitability.

Smaller facilities with smaller staffs tend to require and encourage a collaborative approach to care delivery. Some anesthesiologists and CRNAs perform better than others in an environment where efficiency and throughput are a primary objective. These high-velocity facilities require high-velocity providers. Anesthesia practices will find that only a select subset of anesthesiologists and CRNAs work well in such settings. This is the place for skilled providers with proficiency in regional anesthesia and acute pain techniques. Contracts can easily be lost because of incompatible staff assignments.

Beyond these staffing considerations, the anesthesia practice must also deal with the economic realities of an ambulatory environment. Logistics and resource deployment can be far more challenging, especially if the practice covers multiple outpatient facilities in addition to its primary hospital. In the main hospital OR, a team of providers can be assigned

to cases as needed, with an expectation that, on average, there are enough cases or subsidy to cover staff costs.

This is not the case with outpatient and ambulatory facilities, especially if they need anesthesia only a few days a week or if anesthesia is needed for only a few cases per day. Large practices with multiple outpatient relationships often create a separate scheduling function to ensure that their providers meet their obligations at the various facilities in a timely manner. The economics of ambulatory anesthesia are not always as favorable as one might expect. Practices often focus on general production data that does not allow the practice to compare business lines or assess their profitability. Standard billing reports that simply show basic anesthesia values such as cases, units, charges and payments by month—even if they include a breakdown by facility—will never be adequate to manage an expanding and dynamic book of ambulatory business.

## NUMBERS TELL THE STORY

The use of normalized data is essential for understanding each ambulatory setting's value to the practice as a whole.

The fact that collections at one facility are twice as high as at another says nothing about their real value. As any manager responsible for multiple business lines will attest, business lines must be compared using the same criteria and benchmarks. This consistency is especially important in practice management in anesthesia. There is discussion in the field about which type of normalized metric is most useful. We will discuss common examples and weigh their value, including yield per unit, yield per hour and yield per provider day.

Table 1 provides a high-level example. The table shows data for 766 ABC client ambulatory facilities across the country for calendar year 2017. The first two metrics—units per case and yield per unit—are the revenue drivers that determine the next three metrics. Yield per hour can be a useful comparative metric if the objective is to compare business lines. However, many find the last two metrics of most value in assessing a coverage agreement's potential profitability. Based on this sample, only two types of facilities cover the cost of a physician anesthesiologist.

There are three main challenges in ASC staffing:

**TABLE 1**

**Overall Average Ambulatory Metrics for ABC Clients**

Overall (All Facilities in the Sample)						
Type of Facility	# of Facilities Considered	Units per Case	Yield per Unit	Yield per Hour	Units per Provider Day	Yield per Provider Day
Hospital Outpatient	320	11.2	\$33.12	\$304	39.9	\$1,323
Freestanding ASC	272	9.2	\$37.27	\$425	53.2	\$1,983
Office	89	8.9	\$44.57	\$651	48.3	\$2,152
Single Specialty (Endo)	56	7.4	\$40.17	\$638	79.0	\$3,173
Single Specialty (Eye)	18	6.7	\$33.05	\$441	79.8	\$2,636
Single Specialty (Ortho)	11	14.1	\$36.00	\$450	70.0	\$2,519
<b>Overall (All Facilities)</b>	<b>766</b>	<b>10.3</b>	<b>\$34.67</b>	<b>\$346</b>	<b>44.4</b>	<b>\$1,540</b>



- The number of days per week that coverage is required. While it can be advantageous if a facility generates a few extra cases that can be done during down time, often these cases are performed during peak morning times, which means extra resources are needed for additional morning starts.
- The consistency of production. An anesthesia practice needs a guarantee of revenue to cover manpower costs. Unpredictable weekly coverage and daily swings in case volumes create a potentially risky situation.
- The average yield per clinical provider day. Production metrics must be calculated as averages over time. A few profitable days does not make for a profitable relationship.

As indicated in Chart 2, most physician-only practices find it difficult to profitably staff ambulatory facilities. The cost of a physician-only practice in the current environment is simply too high, at \$2,100 per provider day. Even if the average cost can be driven down to \$1,700 or \$1,800 with the use of a care team model, that is still higher than the average value of \$1,540 shown in Table 1. There may be offsetting strategic or tactical reasons to incur such a loss, but it is still a loss.

## MAKING THE MOST OF A GOOD THING

Given all these challenges, then, what is the upside? The difference between a profitable arrangement and an unprofitable one hangs on three key factors: consistency of production, consistency of collections and cost of providing the requested coverage.

### Consistency of Production

A practice cannot manage what it does not measure. For example, consider

CHART 1

### ASA Units Billed per Location Day

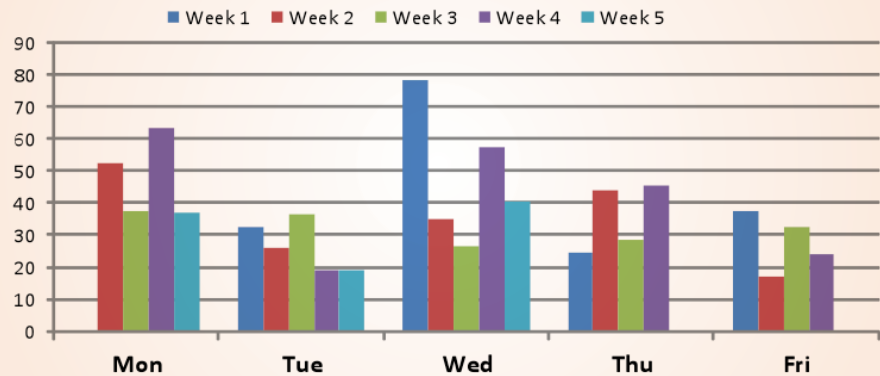
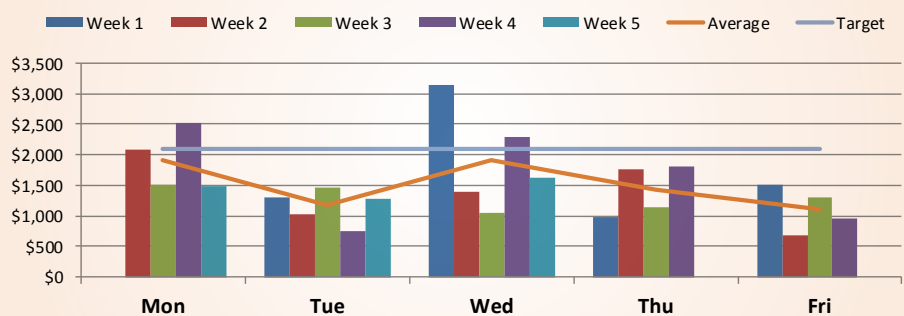


CHART 2

### Yields per Provider Day



production consistency. In an ambulatory environment this metric should be monitored by day. Chart 1 provides a typical example. Typically, an anesthesia practice staffs for a daily number of 7:30 am starts, meaning that first-case starts determine the staffing needed for the facility. The hope and the assumption are that sufficient activity in the OR will cover the cost of the providers. While this is not always the case in the hospital, it is definitely not always the case in the ambulatory environment. The smaller the facility, the greater the challenge.

### Consistency of Collections

Billed ASA units are the most useful production metric in anesthesia. Conventional wisdom holds that an optimally run hospital OR suite should consistently generate 50 billed units per location day. Table 3 represents actual production data based on date of service (DOS) for January, 2018 for a randomly selected ABC

client facility. Note that most rooms do not meet the target threshold.

### Cost of Providing Coverage

For this reason, it is useful to monitor actual collections per provider location day (see Table 2). While Chart 1 may bear a striking resemblance to Chart 2, the financial scale of the data makes it far more relevant to the management of the practice. The target here is based on the daily provider cost of a physician-only practice. If we assume that the total burdened cost (base compensation plus overhead and benefits) is \$490,000 and that the physician works 231 days a year, then the cost would be \$2,100 per physician day. This number might be high for some practices and some parts of the country. Actual target yields will vary based on region. Practices applying this analysis are advised to use actual data.

*Continued on page 14*



## AMBULATORY ANESTHESIA: EVERYTHING YOU WANTED TO KNOW BUT WERE AFRAID TO ASK

Continued from page 13

What value does this information have for a practice? If specific business lines are underperforming, the practice has three choices:

- Accept the loss for broader strategic reasons.
- Identify opportunities to increase revenue. Subsidies are rarely an option in an ASC, but there may be other ways to enhance revenue. For example, some practices have added 10 percent to their revenue with the inclusion of additional services such as the appropriate use of nerve blocks and ultrasonic guidance in orthopedic facilities.
- Consider ways of reducing the costs of care.

In the example provided, the practice can manage with physicians only, since the average daily collections are roughly equal to the cost of the physicians (see Table 2). However, as shown in Table 3 this is rarely the case. Many factors determine the cost per anesthetizing location. Table 2 shows the basic elements of the calculation: the total cost of each category of provider, the number of weeks each

works and the number of clinical location days to be covered.

This represents an ideal situation, in which a practice has the opportunity to dedicate three CRNAs under the direction of a physician. This is very rarely the case. However, changes in the staffing model may be problematic for some practices for a variety of philosophical and practical reasons. Many anesthesiologists prefer to work alone and not medically direct CRNAs. Until recently, private anesthesia groups in California rarely employed CRNAs, despite the fact that they were routinely used in academic centers, Kaiser hospitals, the military and small, rural facilities.

Qualified CRNAs may not be readily available in certain markets. As some of the nation's largest staffing companies convert to a medical direction model, which has increased the demand for CRNAs, the supply has yet to catch up. A number of practices considering hiring CRNAs report that it is not easy to find providers who are willing to work where the practice needs them.

Changes in staffing model or the development of a new staffing model for a facility must be carefully evaluated.

An anesthesia practice can't change its culture or mode of delivery quickly. New entities are being formed on a regular basis to target the ambulatory market. Almost without exception, these entities are based on a care team model, where anesthesiologists supervise CRNAs or anesthesiologist assistants.

### Critical Metrics

In this era of rapid change, metrics matter. There can be no doubt about the value of clinical data in the OR. Most providers pride themselves on being able to make timely and accurate clinical decisions in a matter of seconds. Why, then, do so few practices fail to apply this same principle to the management of their practices? It is probably the result of a perception that, unlike anesthesia delivery, anesthesia practice management is not a time-critical exercise. No one talks about hours of boredom punctuated by moments of sheer terror in the anesthesia board meeting. However, practices that don't monitor key metrics closely can make some costly mistakes.

Three distinct management metrics are often confused in the assessment of anesthesia staffing: provider productivity, OR utilization and profitability. Each has its place in the ongoing evaluation of any coverage arrangement.

### Provider Productivity

Provider productivity is the term most commonly misused. Technically, it is a measure of the manner in which a provider completes their assigned cases. In other words, if there are only three cases on the schedule and the anesthesia provider completes them all satisfactorily, then they have achieved 100 percent productivity. This said, different

**TABLE 2** Calculation of Cost per Anesthetizing Location

Physician only	Annual	Weeks of work	Cost per week	Rooms	Cost per week	Annual cost (51 weeks)	Cost per Location Day
Physician cost	\$490,000	46	\$10,652	3	\$31,957	\$1,629,783	\$2,130
<b>Care Team</b>							
Physician Cost	\$490,000	46	\$10,652	0	\$10,652	\$543,261	
CRNA Cost	\$200,000	46	\$4,348	3	\$13,043	\$665,217	
					\$23,696	\$1,208,478	\$1,580
					Savings	\$421,304	26%



**Table 3** Projected Collections per Anesthetizing Location

	Provider Days		Units	Yield per Unit	Units/ Provider Day	Projected Collections	Collections per Provider Day
Hospital outpatient facility	86	51%	3,137	\$48.53	36.48	\$152,248	\$1,770
Surgeon-owned single specialty facility	42	25%	1,655	\$40.71	39.41	\$67,391	\$1,605
Surgeon-owned single specialty facility	22	13%	1,148	\$42.79	52.17	\$49,114	\$2,232
Surgeon-owned single specialty facility	13	8%	808	\$45.08	62.16	\$36,428	\$2,802
Surgeon-owned single specialty facility	4	2%	141	\$121.42	35.15	\$17,072	\$4,268
Surgeon-owned single specialty facility	1	1%	20	\$118.00	20.00	\$2,360	\$2,360
All ambulatory sites	168		6,909	\$46.98	41.13	\$324,613	\$1,932

providers may generate more or fewer units in the completion of the same number of cases than their colleagues, which could be considered a measure of productivity, but very few practices seriously monitor such measures.

#### OR Utilization

Most practices are actually interested in OR utilization. This is a comparison of actual to potential production. If an OR is open for cases for eight hours a day, then the optimal utilization is typically considered to be six hours. Utilization metrics are normally calculated as a percentage of potential. Six hours of billed anesthesia time during an eight-hour shift would represent 75 percent utilization. It can be useful to compare actual billed hours of anesthesia time to coverage requirements. This is especially useful in that manpower and staffing is always a function of the facility's coverage requirements.

#### Profitability

Profitability is not always an easy concept to apply to an anesthesia practice in which providers simply get paid based on collections net of expenses. If it costs you \$.50 to make a hamburger and you sell it for \$2.00 then your profit is \$1.50 per burger. While most practices do not think this way, profit is defined as revenue generated minus the expense of providing the service. If it costs the practice \$2,130 per provider day and



the practice generates \$1,700 per day, then the arrangement is unprofitable. However, if the cost can be reduced to \$1,580, then the same level of revenue would result in a profitable arrangement. However, unless you have this information you cannot really know whether the arrangement is profitable or not.

It used to be that success in anesthesia was defined simply in terms of collections. A favorable payer mix and busy ORs were all a practice needed to be successful. Life is no longer so simple. Anesthesia providers must now learn the arcane science of cost accounting. For each venue or line of business, the practice should be able to clearly monitor both the revenue potential and the actual cost. Table 3 is an example of what this might look like. It is based on actual data for a practice in the western United States. Because this is a physician-only practice that allows providers to work as much or as little as they want, the cost part of the equation has yet to be established. Even so, this data clearly demonstrates the financial value of each facility.

#### Strategic Considerations

The five categories of ambulatory practices shown in Table 1 represent a continuum of management opportunities and challenges. Increasingly, anesthesia practices are actively pursuing new venues and lines of business to diversify. The good news is that well-managed outpatient venues can increase the yield per day and offset hospital coverage and call obligations. The problem is that not all outpatient venues are such a good fit. Adding venues and case volume for the sake of growing a practice can be a very bad idea, especially if new venues require additional manpower and staffing whose

*Continued on page 16*

## AMBULATORY ANESTHESIA: EVERYTHING YOU WANTED TO KNOW BUT WERE AFRAID TO ASK

*Continued from page 15*



costs are not covered by additional revenue potential.

Most American hospitals now provide care on an inpatient and outpatient basis. This is considered essential in the current environment. How they achieve the objective or provide a more customer-friendly environment for healthy patients undergoing relatively minor procedures may vary greatly. Some will try to create the look and feel of an ambulatory environment in existing ORs. When this occurs, anesthesia is essentially a captive participant to the change. The hope is that the facility restructuring will increase cases and improve the payer mix.

For the anesthesia practice, such developments tend to represent a difference of degree rather than of kind. The outpatient unit's focus and business objectives may be more specific, but the outpatient ORs are typically managed by the same people and in the same manner as the inpatient rooms.

The freestanding surgery center that is a hospital joint venture with a group of surgeons represents the next step in the migration of surgical cases from the hospital to the freestanding environment. Various factors may motivate such an arrangement. Every administration

is competing for surgeon allegiance. The establishment of a patient-friendly facility with convenient ingress and egress may be one way to accomplish this. The joint venture may be a preemptive strike to keep the surgeons from building their own facility and competing with the hospital.

There is a critical management concept at work here that can have a significant impact on anesthesia. Hospitals must serve a range of customers and, therefore, strive to develop policies that provide a consistent level of service. The hospital will try to schedule cases together as efficiently as possible to maximize the return for a day's work. They want surgeons to complete cases as expeditiously as possible. Surgeons, by contrast, may want to do a couple of cases in the morning, go to their office and then come back for a case or two in the afternoon. The result can be a significant amount of unproductive downtime for the anesthesia providers.

Each of these types of facilities must be evaluated on its own merits. It can be dangerous to assume that what worked at facility A will now have the same results in facility B. Herein lies one of the trickiest aspects of the ambulatory anesthe-

sia market. How do you determine that covering a facility will be a good deal?

It all starts with the data. If the facility can provide reliable payer mix and volume information, the practice can project revenue. Clearly defined coverage requirements will allow for the formulation of a staffing model. However, such detail often is not available. This can be a big problem. Miscalculating revenue can be very serious. Facilities in ramp-up mode tend to be overly optimistic in projecting the likelihood of achieving an optimum run-rate.

Working in a doctor's office, which does not have all of the equipment and recovery drugs for general anesthesia as a hospital or ASC, poses its own set of challenges. The doctor's office is the extreme end of the convenience/safety continuum. Most of the resources and safeguards that make a hospital OR a safe place to provide anesthesia are typically absent in the doctor's office. If there is an anesthesia machine, the anesthesiologist may have to provide it. The doctor's office is the ultimate example of bowing to the surgeon's needs. Agreeing to provide general anesthesia under such circumstances assumes that one has a very good relationship with the surgeon, that the patients are consistently healthy, and that the payer mix and volume cover the costs of the provider's





time and the unusual risks associated with such an environment.

As in so many aspects of business, deciding whether to provide anesthesia outside of the hospital involves a risk-benefit calculation. The specialty prides itself on its safety. Morbidity and mortality related to anesthesia are at an all-time low. The tragic story of Joan Rivers is a constant reminder that such standards should never be compromised.

## THE REAL QUESTION

Most anesthesia practices now understand that they have only three options to survive: expand, merge or sell out. There are very few practice situations where the status quo will work. Hospitals are merging. Customer expectations are changing. The economics of anesthesia are becoming increasingly more challenging. More than 75 percent of all group practices need some level of financial support to survive. So there are many reasons to actively explore practice options. The question is what options actually make sense? The logical tendency is to follow the cases as they migrate into non-traditional venues. It has become inevitable, but is it a good thing?

The answer depends on the following factors:

**An appropriate culture and structure is a prerequisite.** Many small practices (fewer than 10 providers) simply do not have the depth of staff or the flexibility to expand, which is a limitation they may ultimately have to deal with. Other practices consist of providers who are risk-averse and therefore disinclined to take on additional coverage responsibilities. There are practices that simply feel comfortable with the practice they have and have no desire to complicate things.

**The financial objectives of the members can be an essential determinant but may also be a source of great debate or conflict.** For example, younger members may be very eager to expand

the practice and position it for the future, while older members with an eye on retirement may not be so inclined. Obviously, any decision to expand the practice must have membership support. Many practices have watched opportunities come and go as they debated the merits.


**At issue is whether the additional venue will enhance partner or shareholder compensation.** This is where practice demographics really come into play. Millennials with medical school loans and big mortgages are more inclined to assume risk than those who are closing in on the end of their career. This places a special burden on management to demonstrate the value of the additional cases.

**The local market is also a critical factor.** Some locations are more target-rich than others. Many practices feel they must pursue every anesthesia opportunity in the local market in order to fend off potential competitors. However, not every practice that wants to expand has the ability to do so without looking at venues that are distant to the primary sites. Careful environmental scanning is an essential prerequisite for any level of expansion. Management must be aware of any and all opportunities and have the ability to assess them objectively.

**A practice's structure and infrastructure will either facilitate or complicate a successful expansion.** Some practices are run in a more business-like manner than others. A decision to take on another facility requires decisiveness and strong management. The practice must have a clear chain of command and the ability to manage remote sites effectively. The practice has to be able to clearly demonstrate its ability to meet customer expectations and requirements consistently.

One of the distinct advantages that the nation's largest staffing companies can demonstrate is their organizational structure. This allows them to prepare

more impressive proposals, present more compellingly and monitor ongoing performance more consistently. It is not uncommon for an inexperienced management team to mess up the first few proposals.

Strategic thinking is a relatively new discipline for anesthesia practices. How will a practice position itself to survive in the current environment? The answers and options are not always clear. This can be the most complicated issue of them all. 

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both hospitals and anesthesia providers. Throughout his career, he has worked with hospitals and providers to align incentives and develop cost-effective and timely solutions for OR management. In addition, he has expertise in optimizing anesthesia group and OR performance by working collaboratively with hospital administration, surgeons, OR nurses and anesthesiologists nationwide. He was a founding partner of Sheridan Healthcare and served as chief of anesthesia at Memorial Regional Hospital, Hollywood, FL. Dr. Greenfield received his training at Temple University School of Medicine and Jackson Memorial/University of Miami. He can be reached at [hgreenfield@enhancehc.com](mailto:hgreenfield@enhancehc.com) or (954) 242-1296.

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# HOW MUCH CALL IS TOO MUCH?

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Anyone who has had to leave in the middle of a family dinner because of a call from labor and delivery or tried to sleep in the call room knowing that a recently completed case is bleeding and likely to come back that night probably also wonders whether they should be working somewhere with less call responsibility.

Working on call is part of the responsibility of being an anesthesiologist. It can also be an annoyance that can interfere with work/life balance. Driving back to the hospital for the second time on a beautiful Saturday afternoon, you may start to wonder whether you are on call more than others and possibly working in the wrong place. But how would you know? Your job may pay well and offer generous retirement benefits, but perhaps a job without cardiac, obstetric or trauma unit call responsibilities would make your life easier.

You might find an opportunity that pays less with fewer call days. Should you take the trade-off or keep looking?

The lack of published data on the frequency of required call responsibility among anesthesiologists makes it hard to compare professional opportunities. Surveys of compensation and time off are not hard to find. The same is not true for call.

Data is also lacking on the various types of call, including call from home (beeper call) and in-house call for hospitals that require 24/7 on-site coverage. The number of hours spent on call at the hospital also matters to many. If a position doesn't require an obstetric beeper call rotation every other weekend, but requires in-house trauma call for the entire weekend, but only once a month, which is better? What are other anesthesiologists in your area required to do?



Colleagues often ask about the “typical” or “average” amount of call and how much call is “too much.”

The lack of national published data prompted Enhance Healthcare to conduct its own survey utilizing Survey Monkey in order to gather information about the frequency and types of call taken by anesthesiologists across the United States.

Our initial assumption was that there are two basic types of call about which to ask: 1) call from home (beeper call) and 2) in-house (restricted). We wanted to understand what circumstances led to various on-call requirements and whether and where call was provided by anesthesiologists compared to CRNAs. Finally, we wanted to see whether there were any significant relationships between specialty considerations and amount or type of call. We were particularly interested in 1) obstetric services (and the number of deliveries); and 2) trauma services and trauma classification level (I, II or III).

The survey consisted of eight to 13 questions, the total number of questions

depending on answers to conditional questions (see Table 8 at the end of this article). Of 155 responses received, 21 responses were eliminated due to a lack of appropriate information.

We believe, but cannot demonstrate, that the remaining 134 respondents were all affiliated with different facilities. Therefore, the survey would represent 134 providers at 134 facilities. The surveys were distributed to anesthesia professionals across the country, so we believe the results are not skewed to any particular geographic area. We also stress that the results discussed in this article were not statistically validated at the time of publication. However, we intend to do so in future articles utilizing more sophisticated analyses, such as analysis of variance (ANOVA).

## **BEEPER OR IN-HOUSE**

The first four survey questions asked respondents to report whether they take weekday and/or weekend call from home (beeper call) or in-house. The data revealed little or no difference in weekday

**TABLE 1** Average Call Days per Month

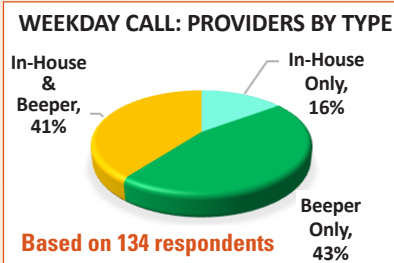
	In-House Only	Beeper Only	Beeper & In-House	All In-House	All Beeper
Weekday days on call	4.3	6.4	8.3		
Weekend days on call	1.7	2.6	4.0		
Combined	6.1	9.0	12.3	5.0	7.8

All in-house and all beeper represent 57 percent and 85 percent of respondents, respectively.

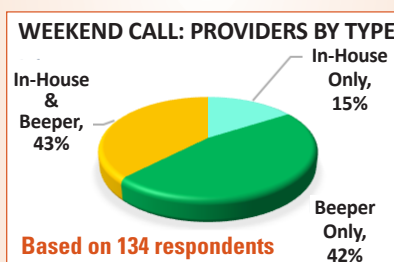
versus weekend for either type of call (see Charts 1 and 2). The lack of difference between weekday and weekend values is probably due to the fact that, except for a few respondents, the same individuals who take weekday call also take weekend call.

The data did show that there were three categories of call: 1) beeper only; 2) in-house only; and 3) a mix of beeper and in-house. Approximately 57 percent of respondents have (weekday and weekend) in-house call an average of five days per month. (See Table 1.) Approximately 85 percent of respondents have (combined weekend and weekday) beeper call as some component of their call an average of 7.8 days from home per month.

**CHART 1** Type of Weekday Call (%)



**CHART 2** Type of Weekend Call (%)



The combined results show that a typical provider taking in-house call could expect their facility to require an average of six days per month on-site in the hospital. A provider at a facility requiring beeper call could expect, on average, to spend eight days per month on beeper call. A limitation of the survey was that it did not ask respondents to indicate first call versus second call; however, the results suggest that the average provider at a typical facility has slightly more than one call day weekly (presumably first call) and one weekend per month.

Taking only in-house call and only beeper call represent 57 percent and 85 percent of respondents, respectively.

Along with the number of days spent on call, time spent continuously on-site is also an issue. Since the in-house providers who responded to the survey were working an assigned shift (i.e., only 24 hours), only respondents taking call from home were



asked how long they spent on-site when called in from home. Tables 2 and 3 show that, on average, anesthesiologists spend a little over four hours on a weekday and over seven hours on a weekend day on-site when called into the facility from home. The authors note that, to their surprise, the total hours spent on-site did not appear to differ significantly by specialty being covered at the facility. We are planning a follow-up study on this topic.

### IN-HOUSE ON-CALL CHARACTERISTICS

We asked participants whether their facility required in-house call (on-site presence 24/7). Hospitals typically refer to in-house call as “restricted call” and beeper call as “unrestricted call.” Sixty-seven percent of respondents reported that their facilities require in-house call (Chart 3). One would expect that the percentage of respondents taking in-house call, either with or without a beeper, would be close to this percentage. However, as shown in Charts 1 and 2, the combined percentage for weekday and

**TABLE 2** Beeper Call: Weekday Hours On-Site

	Hours Spent On-Site 7 p to 7 a
Weekday	4.22

**TABLE 3** Beeper Call: Weekend Hours On-Site

	Hours Spent On-Site 24 hour
Weekend	7.9

## HOW MUCH CALL IS TOO MUCH?

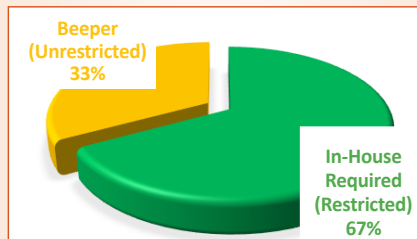
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weekend call was only 56 percent, a 13 percent difference. This may be because providers who do not take in-house call work at facilities where in-house call is required of others (e.g., obstetric anesthesiologists or CRNAs). Chart 4 compares CRNA and physician anesthesiologist providers.

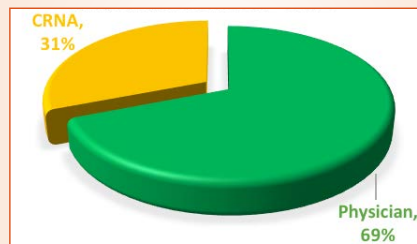
### ON-CALL CHARACTERISTICS BY SPECIALTY: OBSTETRICS

Eighty-three percent of respondents indicated that their facilities had an obstetrics program. Annual deliveries

**CHART 3** In-House Call Required by Percent of Respondents



**CHART 4** Physician % for Facilities Requiring In-House Call



**CHART 5** Trauma Level Percentage



**TABLE 4** OB: Average Call Days per Month

	In-House Only	Beeper Only	Beeper & In-House	All In-House	All Beeper
All	6.1	9.0	12.3	5.0	7.8
No OB <sup>2</sup>	5.0	9.3	13.3	5.8	9.0
<1,500 <sup>2</sup>	5.8	8.8	12.6	5.1	8.0
>= 1,500 <sup>2</sup>	5.9	7.5	12.1	4.9	6.8

**TABLE 5** Percent of Call Types with Changes in OB

	In-House Only	Beeper Only	Beeper & In-House	All In-House	All Beeper
All	16%	43%	41%	57%	86%
No OB <sup>2</sup>	4%	76%	11%	17%	91%
<1,500 <sup>2</sup>	15%	46%	38%	54%	90%
>= 1,500 <sup>2</sup>	23%	20%	57%	82%	82%

ranged from 300 to 11,000. Table 4 shows the impact of an obstetrics program on percentages of call type. Days of call type per month do not appear to differ significantly between obstetric and non-obstetric call. (Thirteen respondents indicated an obstetrics program at their institutions

but did not provide an annual number of births. Their responses were not included in calculations involving the number of births.)

However, the proportions of call types were significantly different in obstetrics, particularly in the “in-house







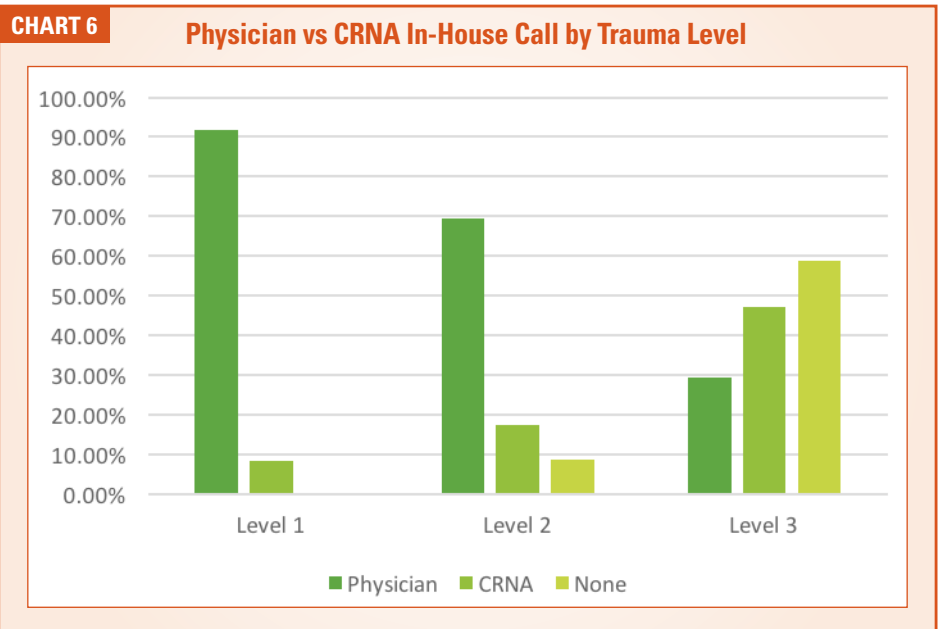
only” and “beeper only” categories. This is consistent with our finding suggesting that the size of an obstetrics program would have an impact on whether or not it had an in-house call component. Further study is warranted to separate other variables such as trauma and use of CRNAs for in-house call.

### ON-CALL CHARACTERISTICS BY SPECIALTY: TRAUMA

Forty-eight percent of the respondents worked at a facility with a trauma program. There were few differences in the number of trauma on-call days between facilities with and without trauma programs, with the exception of a decrease in beeper-only call from 9.6 to 8.7 days. As with obstetrics, the presence of a trauma program alone does not appear to change the number of days on call. We are planning an additional study to analyze the confounding variables of obstetrics and trauma in programs with and without CRNAs.

As seen in Table 6, trauma programs do have an impact on the proportions of call type. The most dramatic difference was seen in beeper only call in institutions with and without a trauma center (28 percent and 55 percent, respectively).

Not surprisingly, there was an apparent correlation between trauma level and



**TABLE 6 Trauma: Average Call Days Per Month**

	In-House Only	Beeper Only	Beeper & In-House	All In-House	All Beeper
All	6.1	9.0	12.3	5.0	7.8
No Trauma	6.1	8.7	12.1	5.5	7.9
All Trauma	5.9	9.6	12.1	4.7	7.8

**TABLE 7 Percent of Call Types with Changes in Trauma Status**

	In-House Only	Beeper Only	Beeper & In-House	All In-House	All Beeper
All	16%	43%	41%	57%	86%
No Trauma	13%	55%	28%	45%	89%
All Trauma	15%	28%	29%	69%	85%

# HOW MUCH CALL IS TOO MUCH?

Continued from page 21



number of days and types of call. (Level I and II trauma programs require 24/7 anesthesia in-house coverage.)


A preliminary view of the differences to be analyzed in future reports is shown

in Chart 6. As stated earlier, the use of CRNAs has a large impact on the absolute number of physician anesthesiologists used for call, but the number also varies by trauma level.

## CONCLUSION

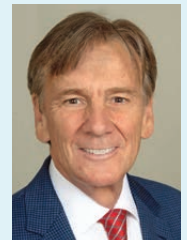
How much call an anesthesiologist takes is subject to many variables. This study looked at weekdays, weekends, obstetrics and trauma. There do not appear to be differences between weekday and weekend coverage. Neither the number of days nor the hours per day required on-site for call appear to differ much between the facilities that require obstetric and trauma coverage. However, the relative proportions of call responsibility for beeper and in-house call reveal significant differences.

Further study to analyze the covariant impact on this phenomenon is warranted, along with further review of the impact of the various trauma levels.

The answer to the question of how much call is too much call is: it's complicated! At a minimum, clinicians should carefully review call requirements for any practice they are thinking of joining, with consideration for the potential impact of obstetrics and trauma on how much in-house coverage they will be required to provide. 

### Robert Johnson, MBA,

principal at Enhance Healthcare Consulting, is a healthcare executive with broad experience in multiple healthcare environments. He started at Johns Hopkins Hospital as a perfusionist in the cardiac operating rooms and eventually became administrator of the anesthesiology department. He has also served as senior associate chief operating officer at Duke Hospital and held positions with Baylor College of Medicine, the University of Pittsburgh and Sheridan Healthcare. As a vice president for Hospital Corporation of America, he played a critical role in leading negotiations with hospital-based physician practices. He joined EHC as a principal in 2014. He can be reached at [bob.johnson@enhancehc.com](mailto:bob.johnson@enhancehc.com) or (404) 905-7014.



**TABLE 8** On-Call Survey Questions

Question	Conditional Question	
1. How many days per month on average do you take weekday in-house call?	While on weekday beeper call, average number of hours spent onsite per call from 7p – 7a?	
2. How many days per month are you on weekday call from home (beeper call)?		
3. How many days per month on average do you take weekend in-house call?	While on weekend beeper call, number of hours spent onsite per 24-hour shift?	
4. How many days per month on average do you take weekend call from home (beeper call)?		
5. Does your facility require an anesthesia provider to be in house 24/7? 1 = Y	If yes, which of the following is required: Anesthesiologists	If yes, which of the following is required: CRNA
6. Does your facility have a Trauma Program?	If yes, please provide your Trauma Designation.	
7. Does your facility have a Cardiac Program?		
8. Does your facility have an OB Program?	If yes, please provide the annual number of deliveries.	



# ANESTHESIA SERVICES RFPs: REALITY, UNICORNS AND COGNITIVE BIAS

Mark F. Weiss, JD

*The Mark F. Weiss Law Firm, Dallas, TX, Los Angeles and Santa Barbara, CA*

Think back in time to a job interview. You dressed for success, put a wide smile on your face, and were on your best behavior.

In the advertising world, they call them “reviews.” In healthcare, we call them requests for proposal or “RFPs” for short. They’re the same thing.

If you’re the incumbent anesthesia group, your relationship with the hospital or other facility, including, if you have one, your exclusive contract, is at risk. There’s little doubt about it. If you’re an outside aspirant, there’s an opportunity to expand your business to an additional location. *Or, no matter who you are, maybe you’re just being played.*

As in the course of a job interview, in an RFP situation, *everyone* is on their best behavior. On all sides.

The hospital or ambulatory surgery center (ASC) is telling lies about how great it will be to provide services at the facility, and how supportive the administrators will be. And at the antipode, the outside aspirants for the exclusive contract are puffing about the quality of their anesthesiologists and CRNAs, and about what great service they’ll provide. And, like the administrators, their representatives will be wearing suits and ties and shiny shoes, just like on a job interview.

But the incumbent anesthesia group suffers from the maxim, “familiarity breeds contempt,” that is, from the fact that it is well known to the facility’s administrators and influential surgeons, warts and all.

Being not as well known, the aspirant anesthesia groups pitching their wares are all rainbows and unicorns, sugar and



spice, with a snuggly puppy or two tossed in for good measure.

Let’s start with the truth: professional services are not, and cannot, be a commodity. But it’s also true that many have fooled themselves (or, more likely, others) into believing that they are. In fact, there’s an RFP industry ready to help.

But, even if you’re a true believer in the commodity theory of healthcare, an RFP process for anything other than fixed items (such as for 3.72 million screws meeting Mil-Spec MS51861-1C) is a ridiculous way to make a decision. A way that exists only in a world in which those bureaucrats known as facility administrators are rewarded by *visible*, yet lazy, action, situated in a universe devoid of the knowledge that *not taking visible action* can be action just the same. A way in which decisions are made based on the lies that they’re told and the lies that they tell themselves.

Are these lies moral failings? Usually not. They’re generally more akin to

resume embellishments, nicely pressed suits and shiny shoes. But either way, they’re a fiction, a phantasy *and perhaps even fraud.*

So what to do in the real world in which my thoughts about the craziness of the process have (unfortunately) little weight?

Everyone, from incumbent to aspirant to the consultant hired to “run” the RFP (and, who must assess the risk of doing so because there can be no truly effective indemnification from the facility), must assess the reality of the RFP against the three categories into which I divide them:

**1. True RFPs:** These are genuine searches for the best-quality provider with a favorable ratio of quality to cost. This type of RFP is the closest in relationship to the traditional form used in industry and government. It is commonly seen in situations in which the current or sometimes very recently former group has “blown up” and can no longer provide coverage. It’s also frequent in scenarios where the current group has completely lost the facility’s trust.

**2. Fictitious RFPs:** These RFPs belie the fact that hospital administrators are not interested in the merits of any response; they have already decided to whom they will award the contract. Yet, for one political reason or another, they’ve decided to issue a phony RFP to project a patina of “fairness” to the medical staff, to the hospital’s own board, to some third party—or perhaps to you.

**3. Fulcrum RFPs:** Consider this the weaponized RFP. As the name implies,

*Continued on page 24*





## ANESTHESIA SERVICES RFPs: REALITY, UNICORNS AND COGNITIVE BIAS

Continued from page 23



the increasingly common fulcrum RFPs are designed to create leverage. The facility intends to renew with the present group but uses the RFP as a tool to dictate terms by *fiat* and to pressure the group into negotiating against its own best interests out of fear of replacement. Nonetheless, the facility is open to competing proposals.

Although no outside assessment of category can be completely reliable, clues often abound. And *category dictates strategy*.

If you're the incumbent, you must have a strategy to avoid, deflect and defeat an RFP.

You must create an Experience Monopoly<sup>1</sup>, not just perform in a service role. You must also develop a propaganda strategy, deployed over time, to educate and sway the administrators and to continuously garner the support of key influencers.

You must develop a true business that is broader than based simply on one hospital, so that you can negotiate from a place of strength. And you must have taken action to secure the cohesiveness of the group.

Is that enough to guarantee that there will never be an RFP, or that if there were one, you'd come out on top? No. There is no such guarantee anywhere. But those actions are required just the same or you're wasting time, blowing the home team advantage (losing the headwind of confirmation bias on the part of the facility's administration) and working against your own best interests.

Optimally, you need to have the ability to walk away, to say to the facility's CEO, "no thanks, we won't be submitting a proposal. But hey, good luck with that unicorn!" Developing the required structure takes time. It takes playing the long game. If you haven't already started playing it, start today.

If you're a hospital administrator reading a copy of *Communiqué* as background research for an RFP, remember what Richard Feynman, the famous physicist, said: people are easily fooled, and the easiest person to fool is yourself. Cognitive biases abound. And that unicorn may just be an ass wearing a fake horn.

If you're on the outside looking at the opportunity that exists to expand your business to another facility, understand how to play to the administrators' cognitive biases (e.g., "the existing group is dysfunctional," and, for new CEOs, "you need to demonstrate leadership"). *But be very careful about what you promise*, because in the event that you "win," you'll actually have to deliver. It takes more effort to continue to play the unicorn *after* the audience knows it's a trick.

Yes, you can count on a honeymoon period, again cognitive bias (it's confirmation bias) on the part of the administration, but at some point your unicorn horn will fall off, you'll be seen

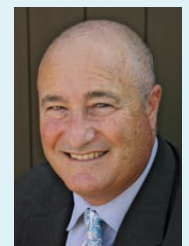
in the harsh light of reality, and, damn it, there's probably a wart or two where that horn used to be.

Then, you'll need to be on the lookout for yet another cognitive bias—buyer's remorse. If it kicks in, know that the administrators are incapable of blaming themselves, so they'll naturally have to blame you. Your only hope is that there's some junior administrator to throw under the bus as a sacrifice to the hospital's board. (In my experience, this is usually the CFO, but sometimes it's a vice president.)

Whether you're the incumbent or on the outside, if you "lose" the RFP, then, if you've developed the larger business that I advise is required, it might turn out to have been a win in disguise, for winning the race to the bottom is like a participation trophy at the local recreation center: it isn't a real win.

And there's also always a chance that you were defrauded in the course of the RFP, either by the facility or by the consultants brought in to stage the RFP process. Don't want to be a direct party to the legal imbroglio? Then consider that, depending on the facts, "bid rigging" and misrepresentation in a fake or fraudulent RFP can lead to criminal prosecution under various state and federal laws. ▲

**Mark F. Weiss, JD**, is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at [markweiss@advisorylawgroup.com](mailto:markweiss@advisorylawgroup.com).



<sup>1</sup> An Experience Monopoly<sup>™</sup> is the overall combination of the way that your group delivers services and the experience that you provide to the facilities, to the other members of the medical staff, to their patients and to the community at large, that creates a benefit that competitors, even if they understood what was being provided, would not be able to duplicate.



# INDEPENDENT ANESTHESIA GROUP PRACTICE: A SHORT MANIFESTO

**Will Latham, MBA**

*President, Latham Consulting Group, Inc., Chattanooga, TN*

*“Most people will choose unhappiness over uncertainty.”*

–Tim Ferris

Anesthesia groups are facing great challenges in today’s environment. I am sure you are aware of these various challenges so I won’t belabor them.

The question is: What do we do now?

Some groups are throwing in the towel and selling out. It seems as though every few weeks another independent anesthesia group has sold out to one of the national companies. I wonder if they are “choosing unhappiness over uncertainty.”

But other groups continue to pursue independence. Why do they want to follow this path?

## **BENEFITS OF INDEPENDENCE**

*Liberty* – from the Latin *libertas*, meaning freedom of the people to participate rather than be ruled.

Over the past year I have worked with many anesthesia groups as they develop their strategic plans or negotiate mergers. One question that is often expressed by some group members is “why should we work so hard to stay independent? It feels like I am an employee already, so why don’t we go ahead and sell out?”

While this sentiment is typically expressed by those nearing the end of their careers (who are often attracted by the financial pay-off they will receive if the group is sold—money that they might not otherwise have received), sometimes younger physicians express the same thought.

Here are some of the key reasons that these groups are choosing to pursue independence:



1. **Elect your leaders:** In an independent group, you get to decide how your governance system is structured and are able to vote on who will lead the group. As an employee you have no say in selecting group leaders (no matter what they tell you).
2. **Decide with whom you will practice:** As an independent group, you get to decide who to add to your practice. As an employee, you don’t get to decide and may not even be asked for input.
3. **Retain control:** As an independent group, you maintain control over the operation of the group, including such items as staffing levels, use of mid-levels, scheduling, vacation, compensation plans and retirement plans. As an employee, you have a “boss,” and that individual has hiring and firing authority over you. If you are

terminated, for whatever reason (even standing up to the employer for mistreating members of the group), don’t expect your associates to stand up for you. If they do so, they risk their position and have to go home and tell their spouse that they are moving.

4. **Undiluted contact with the hospital:** Hospital relationships are always challenging. As an independent group, you contract directly with your hospital (sometimes using external resources to help). You choose how much risk to take in these negotiations.

But if you are employed, someone else does much of the negotiating. Naturally, they don’t want to lose the contract or relationship, but if they do, what happens to you? You have to move, because that is what your non-compete agreement requires.

5. **Protection from being arbitrarily fired:** Most group shareholders are protected from being arbitrarily fired from their group. (Being fired typically requires a super-majority vote, which is sometimes a good thing and sometimes a bad thing.) If external organizations want a group member fired, the group ultimately makes the decision. As an employee, the “boss” makes that decision.

Many will take exception to these benefits of independent practice. But when you speak to such individuals, ask

*Continued on page 26*



## INDEPENDENT ANESTHESIA GROUP PRACTICE: A SHORT MANIFESTO

*Continued from page 25*



them how they make their money, and you will likely find that they make it by getting you to sell out. Almost everyone out there who offers advice on whether or not to sell your practice is incentivized for you to do the deal.

### WHO IS IN CHARGE?

Some of the group members advocating selling out make the argument that “control is just an illusion—we are getting so big that I already feel like an employee of a big corporation—so why don’t we go ahead and sell out now?”

It is true that many groups are growing (and need to grow larger, as I discuss below). Growth typically results in the need for a more “corporate-like” atmosphere (more formal, more organized, more policies and procedures, etc.). However, I believe the real question is not “will we get more corporate-like?” but instead “who do you want to have at the top of the corporation?”

Who do you want on top:

- A hospital executive (whose goal is to appease the surgeons)?

- A “stock” executive (whose goal is to cash out)?
- Other physicians who you get to elect and who will more likely have your interests in mind at all times?

### INDEPENDENCE REQUIRES WORK

*Liberty means responsibility. That’s why most men dread it.*

– George Bernard Shaw

Making the decision whether or not to continue to be independent is an important first step. However, if your goal is to stay independent, there is work to be done. As the old saying goes, “even if you are on the right track you will get run over if you stand still.”

So, what are anesthesia groups doing to create more robust organizations? Here are some of the steps that we have seen anesthesia groups take to improve their prospects for the future:

1. Improve governance: The most successful groups create a culture where all group members agree to support group decisions (or, if

they don’t, are driven out of the organization) and then develop a governance system that:

- a. Creates a right-sized decision-making body.
  - b. Specifies the authority (hiring/firing, spending money, entering into contracts, deciding on key strategic issues) of each part of the governance structure.
  - c. Enhances group communication using multiple communication tools.
2. Develop strategic plans: Many anesthesia groups are now using a well-known business process called strategic planning to help them set their practice’s future direction. “Strategic planning” is a buzzword for a relatively straightforward process of defining the purpose of the group (why it exists), setting objectives (where it wants to go), and mapping a plan to meet those objectives (how it plans to get there). The most effective groups develop such plans and review and update them on an annual basis.
  3. Get bigger: In today’s healthcare market, bigger is often better in terms of providing cost-effective care and retaining autonomy. Single specialty mergers offer one of the few ways that anesthesia groups can “fight back” against a threatening environment. I believe that you can never be too rich, too thin or too big. Yes, growth will entail compromise and change, and you will have to give up some control in a larger group, but what’s the choice—employment? Circle the wagons and shoot out.





4. Play politics: Plato is reported to have said “Those who are too smart to engage in politics are punished by being governed by those who are dumber.” Good works alone won’t protect you from threatening forces. This is why the most effective groups support their leaders with the time to be as fully involved with the hospital as possible.
5. Pursue lucrative business: Some anesthesia groups get comfortable providing service at one location or in one system, even though having all the eggs in one basket puts them at great risk. Other groups receive substantial stipends that can put their hospital relationship at risk.

Anesthesia groups that are working to strengthen themselves for the future are actively looking for new business all the time, even if it is “inconvenient.” Such business is often in the form of ambulatory surgery centers which, if obtained, can improve the group’s payer mix, add staff to decrease call frequency and potentially reduce dependence on the hospital stipend.

6. “Simulate” the predators: Progressive anesthesia groups are paying attention to what predatory groups are doing (or say they are doing) so they can preemptively simulate their offerings. This does not mean the anesthesia group has to do everything the predatory groups are doing, but the group does have to show progress to hospital leadership to avoid the dreaded “request for proposal.”
7. Deal with disruptive physicians: While this may seem to be a minor point as compared to the other initiatives outlined above, disruptive physicians create three enormous challenges for groups:
  - a. Disruptive physicians threaten the entire group’s relationship with the hospital. Frankly, predatory groups do not allow this to happen and terminate or transfer disruptive physicians quickly.
  - b. Disruptive physicians sap leadership time that could be spent on more valuable activities.
  - c. Other members of the group become demoralized when they see that nothing is done to deal with disruptive physicians.

Therefore, the most effective groups have systems and processes to quickly and effectively deal with disruptive physician behavior. This could include creating a code of conduct by which the group can measure behavior, establishing an internal review process, and creating a formal process to deal with disruptive situations (see “[Disrupting the Disruptive Physician](#)” in the Winter 2018 issue of *Communiqué*).


## TIME FOR ACTION

*“Many a false step was made by standing still.”*

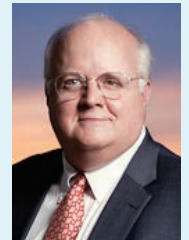
– Fortune Cookie

Is there a risk in staying independent? Of course there is.

However, look at the historical track record of companies that acquire medical practices. If you are too young to remember the acquisition activities of the 1990s, take a few minutes and Google such companies as PhyCor, MedPartners and OrthoLink.

To achieve the benefits of independence outlined above, it is time to move from worrying to working. Review these steps to determine what your group needs to work on to secure its future. 

**Will Latham, MBA,** is president of Latham Consulting Group, Inc., which helps medical group physicians make decisions, resolve conflict and move forward. For more than 25 years



Mr. Latham has assisted medical groups in the areas of strategy and planning, governance and organizational effectiveness, and mergers, alliances and networks. During this time he has facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; helped over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of over 120 medical practices representing over 1,200 physicians. Mr. Latham has an MBA from the University of North Carolina in Charlotte. He is a frequent speaker at local, state, national and specialty-specific healthcare conferences. Mr. Latham can be reached at (704) 365-8889 or [watham@lathamconsulting.com](mailto:watham@lathamconsulting.com).



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## What You Don't Know Can Hurt You.... Understand and Meet the QPP Requirements

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) marked the end of Medicare payment's fee-for-service model and the beginning of a performance-based payment system, the Quality Payment Program (QPP). The QPP offers the choice of two tracks: the Advanced Alternative Payment Models (APMs) or the Merit-Based Incentive Payment System (MIPS). Most anesthesia practitioners participating in the QPP in 2018 will utilize MIPS.

As CMS transitions to a pay-for-performance methodology, it is easy to get lost in the acronyms and the policy. The co-sourced **MACRA MadeEasy** certified Qualified Clinical Data Registry (QCDR) platform guides clients through these changes and provides a structured and practice-specific

platform to ensure that a practice is not only protected from penalties, but puts itself in line for incentive payments.

The pioneering **MACRA MadeEasy** platform can help usher you into the future of healthcare and walk you through the steps utilizing:

- Plexus TG's Anesthesia Touch™ certified electronic health record (EHR) featuring easy data capture;
- Anesthesia Business Consultants' **FIRST Anesthesia** practice management technology and analytics; and
- MiraMed's QCDR, a CMS-approved Qualified Clinical Data Registry

Join the 6,000+ anesthesia clinicians already reporting their performance for 2,000,000 patients through the MiraMed QCDR, a MACRA-compliant registry. Call the **MACRA MadeEasy** hotline today at (517) 962-7301.

## PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
April 27-29, 2018	University of Kansas Medical Center 68th Annual Postgraduate Symposium on Anesthesiology	InterContinental Kansas City at the Plaza Kansas City, MO	<a href="https://kumc.cloud-cme.com/Ap2.aspx?EID=4304&amp;P=1">https://kumc.cloud-cme.com/Ap2.aspx?EID=4304&amp;P=1</a>
April 28-30, 2018	Advanced Institute for Anesthesia Practice Management Conference	The Cosmopolitan of Las Vegas Las Vegas, NV	<a href="http://www.aiapmconference.com/">http://www.aiapmconference.com/</a>
April 28-May 1, 2018	International Anesthesia Research Society 2018 Annual Meeting and International Science Symposium	Hyatt Regency Chicago Chicago, IL	<a href="http://www.iars.org/education/annual_meeting/">http://www.iars.org/education/annual_meeting/</a>
May 14-16, 2018	American Society of Anesthesiologists Legislative Conference	Hyatt Regency Washington on Capitol Hill Washington, D.C.	<a href="http://www.asahq.org/meetings/legislative-conference">http://www.asahq.org/meetings/legislative-conference</a>
May 29-June 1, 2018	Medical Users Software Exchange 35th Annual 2018 International Conference	Gaylord Palms Resort & Convention Center Kissimmee, FL	<a href="http://info.museweb.org/Events/2018-International-MUSE-Conference">http://info.museweb.org/Events/2018-International-MUSE-Conference</a>
June 1, 2018	American Society of Anesthesiologists International Forum on Perioperative Safety & Quality	Bella Center Copenhagen Copenhagen, Denmark	<a href="https://www.asahq.org/ifpsq">https://www.asahq.org/ifpsq</a>
June 8-10, 2018	Florida Society of Anesthesiologists 2018 Annual Meeting	The Breakers Palm Beach, FL	<a href="https://www.fsahq.org/meeting/">https://www.fsahq.org/meeting/</a>
June 12-13, 2018	American Society of Anesthesiologists Professional Development: The Practice of Anesthesiology	ASA Headquarters Schaumburg, IL	<a href="http://www.asahq.org/meetings/professional-development-the-practice-of-anesthesiology/registration-info">http://www.asahq.org/meetings/professional-development-the-practice-of-anesthesiology/registration-info</a>

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