Communiqué
VOLUME 26, ISSUE 2
SPRING 2021
ANESTHESIA BUSINESS CONSULTANTS

Dissecting the Impact of Covid-19 on the Specialty of Anesthesia

Bart Edwards, MHS, MBA
Executive Vice President of Client Services
Anesthesia Business Consultants, LLC, Jackson, MI

Jody Locke, MA
Vice President of Anesthesia and Pain Practice Management Services
Anesthesia Business Consultants, LLC, Jackson, MI

2020 was the year everything changed. Early in the year, a few cases of the coronavirus were detected on the west coast. Not long thereafter the virus was expanding in the northeast. By March it was abundantly clear that we were experiencing a full-blown pandemic. At first, most people thought it would be a short-term phenomenon. The reality was that March and April were only the first wave. Cases, hospitalizations and deaths would continue to grow through the year. It is now 2021, and while there is now a vaccine, the virus is still our greatest health and economic challenge. Unlike previous health scares, Covid-19 has dramatically impacted the health of the nation in more ways and more dramatically than anyone could have ever imagined.

We tend to think of healthcare issues as isolated phenomena. We get a cold and it eventually goes away. We break a bone,

Continued on page 4

➤ INSIDE THIS ISSUE:

Looking for Opportunity in the Face of Adversity

For many of us, 2020 was the year that wasn't. None of the usual and familiar family rituals happened. Nothing was the same after March 15. There was no Memorial Day barbeque, no Fourth of July fireworks, no Labor day celebration of the end of the summer. Thanksgiving and Christmas were somehow a virtual imitation of once important days of celebration and joy. No, 2020 was the year we stayed at home, practiced social distancing and never left home without a mask. Let us hope that vaccinations bring hope and reunification.

In a strange way, 2020 was also a wakeup call, a time to step back and take stock. We have often said that the goals of an anesthesia practice are stability, predictability and security; but for a period of months there was no stability, no predictability and little security. As the pandemic unfolded, the world of anesthesia seemed to descend into chaos. Contracts were canceled. Companies talked about filing for bankruptcy and the rest us scrambled to keep the doors open.

Isn't it interesting how such challenges often give rise to great new beginnings? It is a great tribute to the American spirit of innovation and enterprise that we not only survive such times, but come out stronger.

It is to this spirit of taking stock, assessing options and rebuilding anew that we dedicate this issue of the *Communiqué*. We view this as a time of opportunity and renewal. To this end, we have compiled an interesting collection of articles to help you assess your current situation and your future options.

Bart Edwards and Jody Locke lead off with an exhaustive review of the financial and strategic impact of the Covid virus on the specialty of anesthesia. Will Latham shares some very practical advice about managing a large group in times of dramatic change. Attorney Mark Weiss then explores some of the critical dimension of management strategy we should all be pondering. Attorneys Jenna Singleton and Askey Watson provide some very important updates on a very technical issue relating to clinical opportunities you might want to explore. Jeff Peters and Derek Fine, MD share a wealth of insights about ways to enhance your value to the hospital. And lastly, George Kanaly and Jody Locke walk you through the complex issues related to practice aggregation.

I am especially grateful to all our authors for the wealth of information they have shared with us. I hope you find these interesting articles as compelling and relevant to our current situation as I do.

With best wishes,

Tony Mira
President and CEO

Strategic Planning for Larger Groups

Will Latham, MBA
President, Latham Consulting Group, Inc., Chattanooga, TN

Is bigger better? To cope with external threats and challenges, many healthcare organizations have answered this question with a resounding "yes!" Hospitals, healthcare systems and managed care organizations have pursued enormous consolidation to strengthen themselves in the marketplace.

As an organization grows, internal challenges always arise. Yes, it would be great if an anesthesiology group can stay small and control its own destiny, but that appears to be less and less of a possibility given, once again, the external threats anesthesiology groups now face.

One challenge for larger anesthesiology groups is to get "the herd roughly moving west." Physicians' independent nature is such that getting a large group of physicians to agree on a unified strategic direction is a significant challenge for group leadership. The best performing groups conduct periodic strategic planning efforts to map out their strategic direction. I believe that as the world gets a better handle on Covid-19, it is time for many groups to develop or reconsider their future.

However, once a group grows to a certain size (say 35-40) it becomes increasingly difficult to conduct a planning retreat that meets the following desires:

1. All physicians attend the retreat.
2. There is an *in-depth* and complete discussion of the important issues.

The problem is group process—with so many people in the room, it is nearly impossible to have the complete debate and discussion among all group members. What often happens is that five or six individuals debate the issues while everyone else watches. Many such meetings end up with a vague idea of what the agreed upon plan is.

If your group *has to* have all the physicians in the room, these problems can be mitigated by:

1. Using the retreat as an information-sharing-only meeting.
2. Using sub-groups to discuss issues.
3. Using a rigorous process to discuss and debate motions that were developed prior to the retreat.

However, we have utilized the following approach to large group strategic planning efforts that *balances* the desire for involvement with the ability to have beneficial in-depth discussion on the issues.

Through this process groups are trying to satisfy the reasonable members of the group. A "reasonable" group member wants to have input into the planning process, but recognizes they won't always get exactly what they want.

An "unreasonable" group member expects the group to do exactly what they want and either torture the other members to get what they want, or go so far as to sabotage group decisions. I wish that there was another alternative, but the only ways to deal with "unreasonable" group members is to either ignore them or ask them to join other groups where there behavior is tolerated.

So here is a set of steps that a larger anesthesiology group can follow to conduct their strategic planning effort.

Step 1: Survey/Interviews

Typically all physicians are surveyed to obtain their input on:

- Strengths and weaknesses of the group.
- Opportunities and threats the group faces.

Continued on page 10

Dissecting the Impact of Covid-19 on the Specialty of Anesthesia

Continued from page 1

it gets set and then it heals. Some conditions are life-threatening, but only the victims suffer. In this sense, the coronavirus is unique. One person's infection puts us all at risk. The cure no longer involves just the infected, but all those who could possibly become infected. Never has a cure involved the marshalling of such a vast array of resources. We used to look suspiciously at people who wore masks in public, but now it is the norm. No one had heard of social distancing until last year and now we are reminded of it everywhere we go. So many of the activities we used to take for granted like flying, going to the gym and hanging out with friends are now viewed with suspicion. Whoever thought that holiday get-togethers with family members had the potential to become super-spreader events? By the fall, people were lining up for PCR tests. Who would ever have thought that the government would impose lockdowns and quarantines in the United States? By the end of the year, not only had we elected a new president, but the question on everyone's mind was how long would we have to live with this virus? Would life ever return to normal?

Those of us who work in healthcare used to smugly assert that our industry was recession-proof. That may have been a pre-Covid reality, but it is definitely no longer true. Never has our healthcare delivery system been so challenged. Whoever thought that state governors would limit patient access to elective surgery? Not only did case volumes drop off for anesthesia practices, but the physical constraints put in place to contain the virus disrupted many links in the revenue cycle chain. Never have medical groups needed the kind of financial support provided by the CARES act. Ultimately, Covid-19 and its financial implications have undermined the very fabric of hospital relations with hospital-based practices. The specialty of anesthesiology has experienced some very dramatic developments over the past decade such as practice aggregation and the infusion of venture capital, but these were just preamble to the tectonic events of 2020.

Anesthesia practice managers will be scratching their heads for a long time as they attempt to strategize a profitable and successful path for the future. Dissecting the issues and trends will require lots of data, careful analysis and an open mind. The specialty is haunted by its sacred cows: those beliefs providers have taken for granted for years. Now is the time to rethink previous assumptions and explore new options. As is often said by strategic planners, very often the beliefs and strategies that got us to where we are today, will not get us to where we need to be tomorrow. Covid-19 may well prove to be the ultimate wake-up call for the specialty as a whole.

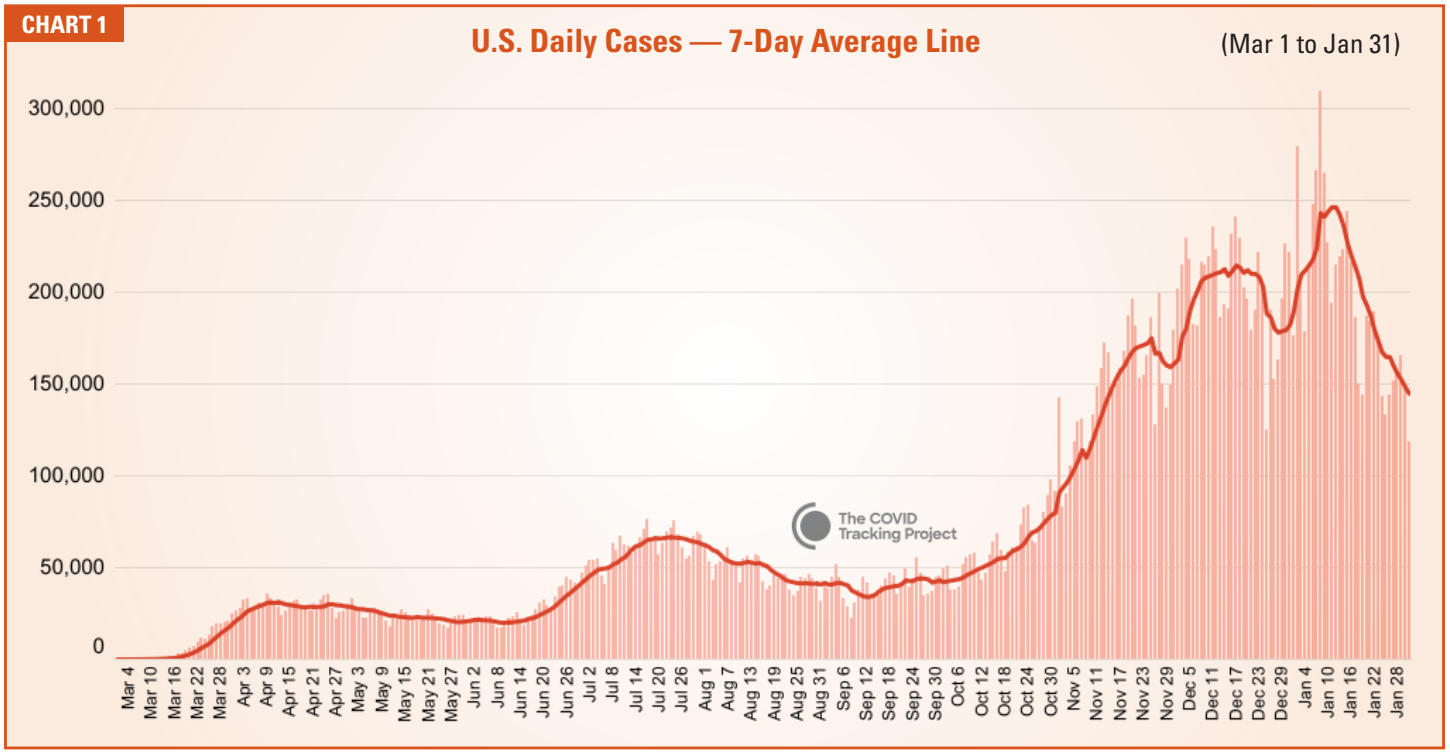
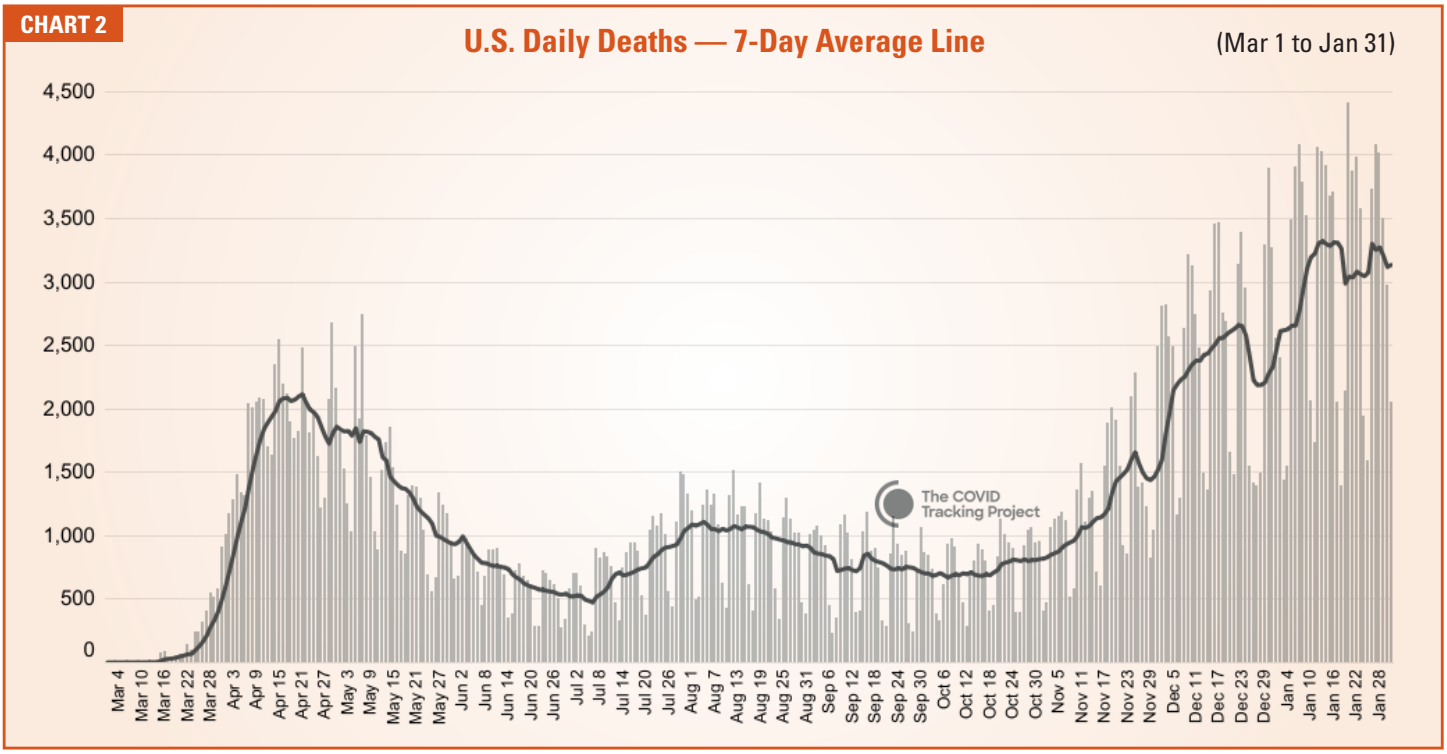


CHART 2



The Evolution of the Virus

The coronavirus has proven to be one of the most significant healthcare crises in the history of the country, dwarfing both the Spanish flu and the AIDS crisis in its rate of expansion and impact.

Voluntary social distancing guidelines and lockdowns worked initially to isolate people and flatten the curve of infection, but these measures had many unintended consequences that only exacerbated the situation. Unfortunately, there was no national strategy for managing the pandemic and the variety of local responses only encouraged the expansion of the pandemic. As Chart 1 indicates, the average number of new daily cases continued to increase through the end of the year. With each wave of new infections the aggregate impact kept rising to new levels.

There are many ways to monitor and measure the impact of the virus. New infections are just one measure, but most patients who become infected are asymptomatic. This has been one of the most disconcerting impacts of the pandemic. Because Covid-19 is a respiratory infection that can be transmitted just by breathing hard, it has posed a whole new set of containment challenges. Even those with no symptoms can infect those they come in contact with, and, hence the need for masks. Many observers have come to view the growing death rates as the definitive indicator of the seriousness of the crisis. As indicated in Chart 2, while many Americans got infected and survived, many others did not.

The Economic Impact

Without a doubt, the combined effect of lockdowns, quarantines and the fear of becoming infected had the economic effect of a serious financial blood-letting. As is so often the case with such dramatic responses to unanticipated events, the shock value of the measures taken was as significant as the impact of the virus and the lack of a clearly coordinated national strategy created significant chaos and confusion. Although the U.S. economy reached a peak in monthly financial activity in February, that month would also mark the end of the longest recorded economic expansion. The economy suffered its worst decline since the great depression in the second quarter of 2020, representing a decrease in economic activity of 9.1 percent. The most dramatic example of the impact can be seen in the increase in unemployment (see Chart 3).

Concern about getting infected caused many patients to defer procedures that had been scheduled after March 2020. Such fear had a pervasive and profound impact on surgical case volumes and anesthesia production across the country. State orders to cancel elective case schedules were especially impactful. From a visual perspective this is what resulted in the "Covid Canyon" in March and April (see Chart 4).

The impact of the virus must be seen through a national and a local lens, which determined the seriousness of the response to the pandemic. Some communities were far more aggressive in their response than others. Indoor dining

Continued on page 6

Dissecting the Impact of Covid-19 on the Specialty of Anesthesia

Continued from page 5

CHART 3

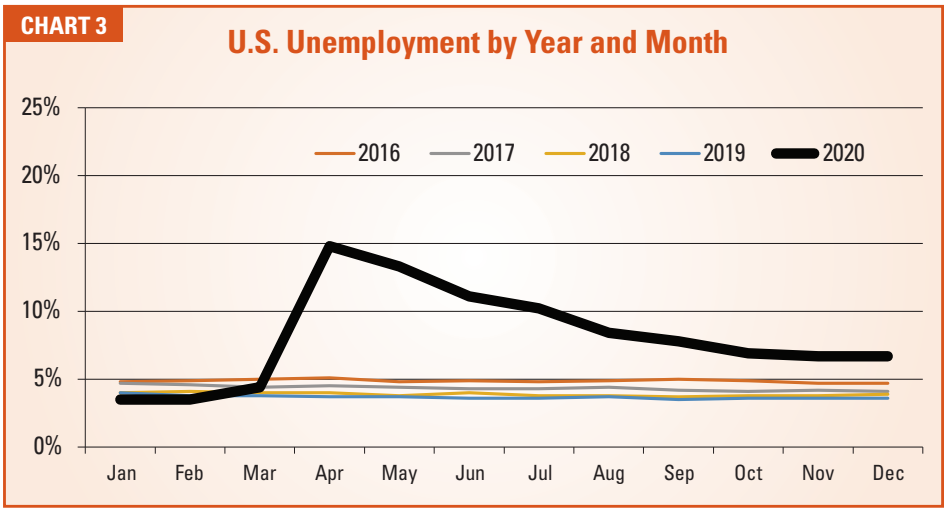


CHART 4

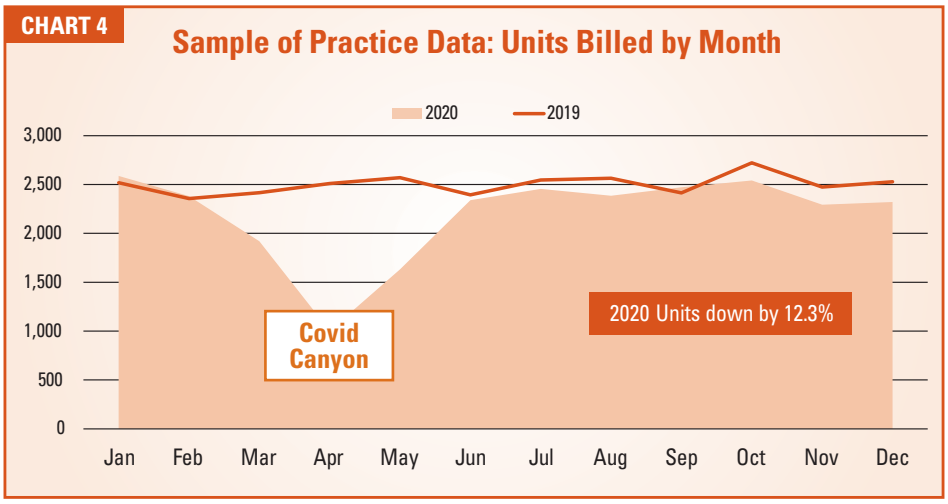
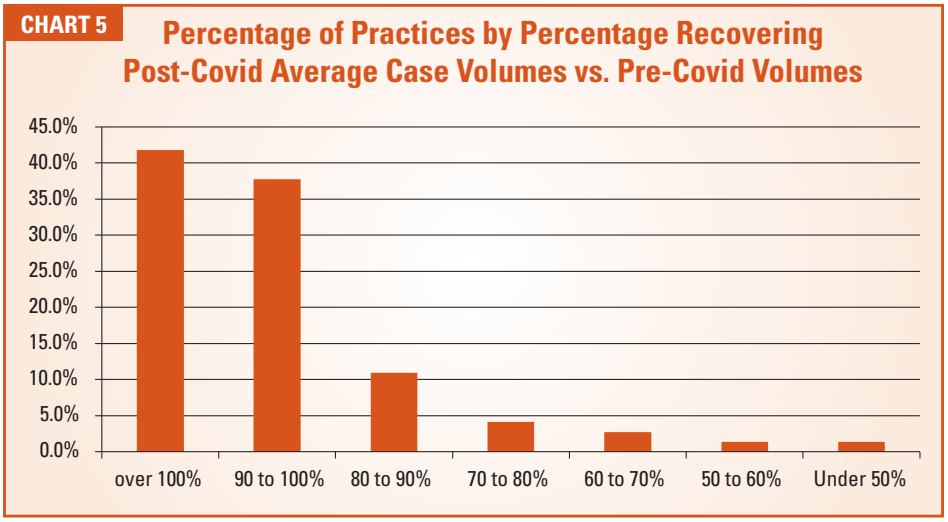


CHART 5



might be permitted in some parts of the country, but not others.

The location of a practice clearly drives its payer mix and revenue potential. Successful suburban practices with a relatively low Medicare and Medicaid population almost always result in a more profitable practice than an inner city practice with a high public payer population. Successful anesthesia practices typically represent a mutually advantageous partnership with the facilities they serve where new business and growth are essential to a positive market position. When the economy goes into recession, it ultimately impacts healthcare delivery services. Perhaps the greatest irony has been that so many of the courageous first responders, who have worked tirelessly to fight the virus, have become many of its victims.

Anesthesia Production Patterns

Conceptually, it is useful to think of activity in three phases: pre-Covid, Covid and post-Covid. For purposes of this analysis, we have assessed the impact of case volumes as they compare to the average of the previous year. In most localities, hospitals stopped booking elective cases on March 15. As Chart 4 indicates, case volumes started to drop in March, bottomed out in April and began to recover in June, the period we define as Covid. The post-Covid recovery can be seen as starting in June or July. Ultimately, what matters most is the relationship between production patterns and cash collections, but let us first explore the various factors that impacted production. We begin with a high-level overview.

It has often been said that if you have seen one anesthesia practice, you have seen one anesthesia practice. The sample of anesthesia practices included in this study represents a cross section of prac-

tices and practice types across the country. As Chart 5 indicates, most practices saw their case volumes return to pre-Covid levels by October, but a significant percentage did not. If your practice is one of those that did not, then you might want to ask why and examine what venues or lines of business have not recovered, or which may not recover.

Each anesthesia practice is unique in its scope and complexity; some venues and lines of business enhance the value of the practice, while others are loss leaders. Typically, we look at practices through two lenses: lines of business and places of service. In terms of the impact of Covid, we often look at the following lines of business: obstetrics, endoscopy, cardiac, orthopedics and other general surgery. Place of service can also be significant, especially the distinction between inpatient and outpatient or ambulatory facilities. Ideally a practice will evaluate the impact and potential of each, the goal of which is to predict how they can be balanced for an optimal long-term strategy.

- **Lines of Business**
  - **Obstetrics** – For the most part, OB cases remained fairly consistent throughout the Covid period. In many practices, obstetric anesthesia may have a higher Medicaid population, in which case consistent OB volumes may not be so positive. For those practices with a very strong payer mix in OB, this could be a real plus. (There is a theory that the impact of lockdowns and quarantines in March, April and May 2020 may result in a spike in deliveries in January, February and March of 2021.)
  - **Endoscopy** – This line of business tended to drop off fastest and come back slowest. These tended to be elective cases; and many patients, especially those covered by Medicare, have tended to defer the screenings. Most practices saw a drop in the percentage of Medicare patients in April and May, which can be directly attributed to the drop in endoscopy cases.
  - **Cardiac** – A recent study published by *Becker's* showed a 53 percent drop in cardiovascular surgery during the Covid period. Most clients appear to have recovered most of this volume.
  - **Orthopedics** – This is often the most profitable line of business for two reasons: better payer mix and the ability to perform nerve blocks, which are separately payable.
  - **Other (General Surgery)** – All other cases tend to fallow the usual pattern.
- **Place of Service**
  - **Inpatient** – Cases done on an inpatient basis tended to be more emergent cases and not get deferred.
  - **Outpatient** – Many outpatient and ambulatory facilities shut down in March. Some were slow to reopen.

Collections

Getting paid for medical services in the U.S. is more complicated than anywhere else in the world. Each payer and insurance company can have its own rules, which can be especially arcane for anesthesia services. Individual payer policies determine how much of the allowable will be paid by the payer, and how much is the responsibility of the patient. Deductible and co-insurance policies represent a further level of complexity that is patient-specific. The typical claim is processed electronically without delay, resulting in a patient co-payment. If something is missing or questionable on the claim, then the payer may issue a denial, which causes a delay in processing and may result in non-payment. There is some evidence that certain payers experienced delays in processing and increased levels of denials as a result of Covid. A review of practice data across the country reveals that many major payers experienced significant disruption to their processing patterns in the April to June timeframe, but most seemed to be back on track by August.

As a general rule, collections should ramp back up as production increases. In most practices there will be about a 45-day lag. Because of the impact of

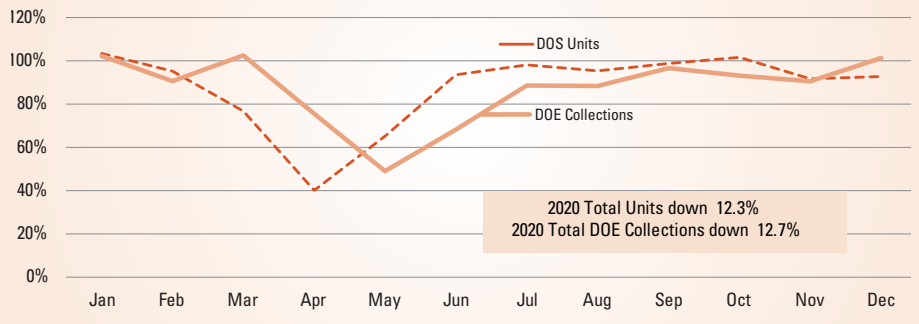
Continued on page 8

Dissecting the Impact of Covid-19 on the Specialty of Anesthesia

Continued from page 7

CHART 6

Typical Unit Production versus DOE Collections (Percentage of 2019 Average)



economic factors such as unemployment and payer mix, collections may not quite have reached pre-Covid levels by the end of the year. The higher the percentage of allowable expected from the patient, the more pronounced the decrease may have been. Chart 6 provides an example of how production patterns could be compared to collections trends.

Again, it must be noted that not all practices in this sample experienced the same performance pattern. Location, payer mix and the types of services being provided were significant factors in both case volume recovery and collections patterns. While the overall average variance in this sample was a 0.5 percent lag for collections, 38 percent of the practices actually collected money faster than case volumes recovered and 62 percent saw a slight lag. The expectation is that they will make most of this up with time, as insurance and self-pay balances get resolved.

Fortunately, most practices were not entirely dependent on fee-for-service collections to cover the cost of providing the services needed. Most clients received a regular stipend from the hospital and, for the most part, these remained the same throughout the year. Support arrangements are generally structured as either a set subsidy amount or a supplement to achieve a revenue target deemed necessary to support a set level of service capacity. Not many hospitals came back to their groups asking for a reduction in subsidy based on a reduction in case volume.

There was also monetary support available through several government initiatives, such as the CARES act. This involved the Medicare Accelerated and Advance Payments Program, three rounds of Provider Relief Funds, and the Payroll Protection Program (PPP). The irony is that the combination of these funds and some creative staffing adjustments actually allowed some practices to improve their profitability through the summer of 2020.

The Tipping Point

In his 2000 debut book, *The Tipping Point*, Malcolm Gladwell lays out a theory that small issues may converge to create great changes. It is an interesting concept in this discussion of the impact of Covid-19 on the specialty of anesthesia because, to a large extent, the various aspects of the coronavirus have proven to be a tipping point for the specialty. We predict that when historians of the specialty look back on 2020 they will see clearly the origins of so many dimensions of the current thinking and perspective and how and why things had to change.

It should come as no surprise to anyone that most hospitals were operating with razor thin margins prior to March 2020; and that the drop in cases and revenue affected them as profoundly as it did their anesthesia practices. Health systems were critical of how anesthesia practices assessed and responded to these

changes in volume, demand and revenue. Logically, it follows that anesthesia subsidies suddenly came under closer and more intense scrutiny. What has always been an ongoing challenge and source of great anxiety for anesthesia practices is now being viewed in a new light.

For a number of practices this additional financial stress tipped decisions by practices and facilities toward hospital employment. Private practices large and small are ensnared in the trend. Published articles announced new hospital employment agreements with independent anesthesia practices in Pennsylvania, Massachusetts and Missouri. Discussions with impacted practices indicate it was driven both by financial risk exposed by the Covid reality and also by frustrated hospitals who are becoming more focused on control than profitability. This trend is not just hearsay and speculation; a number of major health systems have announced their plans to cancel contracts with the existing provider groups and companies in order to directly employ the anesthesiologists and CRNAs.

Victims of the volume and revenue reductions were not limited to independent practices; corporate entities were exposed as well. Envision announced in April of 2020 that it had hired restructuring advisers and was contemplating a bankruptcy filing. A *Bloomberg* article indicated that Envision made cuts in early April that equated to roughly one-third of the annual physician compensation. They were not alone in considering drastic action during this time of financial stress. TeamHealth asked for voluntary furloughs from anesthesiologists.

Companies with stronger cash positions were able to go bargain hunting. American Anesthesiology was sold by Mednax to North American Partners in Anesthesia in May. Ambulatory Surgery Center management company Surgery Partners sold their anesthesia services division to Northstar Anesthesia in September.

And these are just the transactions we know about. The financial shock of the impact of the pandemic on production patterns across the country is sure to have triggered a wide range of draconian responses. For many hospital administrators, Covid-19 was the last straw in a long history of contentious negotiations with their anesthesia practices. Obviously one cannot run operating rooms without a reliable anesthesia service, they reasoned. Maybe the time has come to just employ all the providers. Anyone who has carefully analyzed the impact of such a transition from independent practice to employed providers can affirm that it never results in a cheaper solution: that it can be very disruptive, and that it undermines the very entrepreneurial spirit that makes so many private practice successful. But such is the nature of decisions that are based on the belief that the definition of insanity is doing the same thing and expecting different results. If working with an independent anesthesia practice on an arm's length contractual basis did not result in a cost-effective and predictable solution, then it is time to do something different. Based on past history, this is the effect of a pendulum swinging from one extreme to the other. Time will only tell when it will swing back.

Final Thoughts

Anesthesia providers have always striven for the highest quality of clinical care. It has been a point of pride that anesthesia morbidity and mortality statistics are so impressive. Providers often remind nervous patients that they are at greater risk driving to the hospital than undergoing general anesthesia. Anesthesia practice managers often argue quite compellingly that anesthesia does more to determine the quality of the surgical experience than the surgeon. Versed is a wonderful drug. The problem is that too many providers have been more focused on what happens inside the operating room than what happens outside, which is now where most of the critical decisions about the practice are being made. No single event in the history of the specialty has made this clearer than the unfolding of the Covid-19 pandemic. This virus has completely changed the context of anesthesia practice—from its manpower and staffing requirements, to its revenue potential to the relationship with its customers.

For many providers, this is the beginning of the end of the kind of practice they envisioned when they started out in the specialty. For others, the chaos and confusion of the current environment represents a window of opportunity. Hospitals will always need anesthesia so they can attract and retain surgeons. Finding the right solution is never obvious or easy, but the reward doing what is right can be significant.

Bart Edwards, MHS, MBA serves as an Executive Vice President of Client Services for Anesthesia Business Consultants. Bart directs a team of Analysts, Managers, Directors and Vice Presidents who are the liaison between clients and all the resources, skill and experience that ABC offers. Bart can be reached at Bart.Edwards@anesthesiallc.com.

Jody Locke, MA serves as Vice President of Anesthesia and Pain Practice Management Services for Anesthesia Business Consultants. Mr. Locke is responsible for the scope and focus of services provided to ABC's largest clients. He is also responsible for oversight and management of the company's pain management billing team. He is a key executive contact for groups that enter into contracts with ABC. Mr. Locke can be reached at Jody.Locke@AnesthesiaLLC.com.

Strategic Planning for Larger Groups

Continued from page 3

- How they would like to see the group evolve.
- The issues that should be addressed during the planning process.

In addition to the surveys, we typically conduct individual interviews with those that will attend the "Board+" Retreat (discussed below).

Step 2: "Board+" Retreat

A sub-set of the group then meets to discuss key issues and develop plans for the group. Typically this group is composed of the Board and other key leaders. It is best to keep this group to 15 or less. The meeting typically lasts a day or two, with a day and a half being the most common. This group develops what we call the "draft" plan for the group. At this meeting the attendees:

a. Develop or update the group's mission statement, vision statement and values statement. These are "high-level, big picture" statements that should be used to guide subsequent decision-making.

b. Review environmental opportunities and threats the group faces.

c. Discuss internal strengths and weaknesses of the group.

d. Create clear goals and objectives.

e. Work to resolve key issues facing the group

What are the key issues to be discussed? That depends, of course, on the circumstances of each group. We find that groups often discuss:

- Market area to serve – expansion
- Goals for size of group

- Recruitment
- Affiliation with others
- Governance
- Workload and compensation
- Call
- Operations

Subsequent to the retreat, a "draft" plan is developed that is a written summery of the conclusions reached at the retreat.

Step 3: Full Group Meeting

Following the Board+ Retreat, a meeting of all physicians is conducted and the results of the planning retreat presented. At this time all physicians will be able to give their input and feedback about the results of the planning process.

This step is usually completed at an evening dinner meeting. *It is important to note that the goal of this step is not to re-do the work at the retreat.* Instead the larger group is asked to answer 3 questions:

1. What plans or objectives are you most pleased with?
2. What changes/improvements would you suggest to the plan?
3. What key issues were not adequately addressed in the draft plan?

Operationally, the physicians sit at small tables of six or so, with at least one person who was at the retreat at each table. You also should try to spread out the "nay-sayers" so they don't get negative momentum going.

Once again, this meeting is to allow the shareholders to have one more chance to provide input into the planning process.

Step 4: Board Adoption

At a Board meeting the Board members review the results from full group meeting and decide whether or not the "draft" plan should be adjusted. The final plan is then adopted by the Board.

If the Board does not have the authority to adopt the final plan, it can recommend the plan for adoption at the next Shareholder meeting.

This process balances the need for input, in-depth discussion and decision-making.

For more than 25 years, **Will Latham, MBA** has worked with medical groups to help them make decisions, resolve conflict and move forward. 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 more than 135 medical practices representing over 1,300 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 healthcare conferences. He can be reached at WLatham@LathamConsulting.com.

Anesthesia Group Size and Governance: Bigger is Obviously Better—Until You Hit an Iceberg

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

You *do* know that big provides the ultimate safety, right?

Just refer to the expertise of P.A.S. Franklin, the Vice President of the White Star Line. "We place absolute confidence in the Titanic. We believe the boat is unsinkable."

Or consider the wisdom of the famous public company chief executive, Rick Wagoner. "We've said this before: we have no plans whatsoever than to continue to run the business."

Yet when Mr. Franklin uttered those words, the Titanic was already at the bottom of the sea.

At least Mr. Wagoner had several months of wishful thinking left until his sacking as General Motor's CEO and the company's bankruptcy filing.

In this *short* article, we're going to examine the subject of size as it impacts anesthesia groups.

No, I Am Not a Sizeist

In certain discrete areas, notably in dollars driven to top line revenue, and in total earnings to drive higher valuation multiples, bigger is itself better in business.

And, absolutely, it's vital that today's anesthesia groups have contractual relationships with multiple facilities. Being limited to one hospital, no matter how large, is a sign of tremendous weakness in that the facility knows that if the group doesn't bend to its demands in connection with the next renewal of the contract, there's no further reason for the group to continue to exist. Yes, some groups would respond with the equivalent of the contractual middle finger and elect to dissolve, but most groups don't walk; most groups cave.

In other words, in some domains, the binary choice of big versus small is clear: go with big.

But business is multifaceted, not binary. Bigger, as a broad concept, is better only as long as you remain in business. In that regard, size is not the thing at all; success is.

Size is an element of success, but it is not success itself. In fact, size itself is both a blessing and a curse.

Analogizing to the Titanic is Trite, but True

The unsinkable ship. The former USSR. The 1,275 physician anesthesia group that can't stay financially afloat and is dumped off on a competitor.

All large, but their size came with a heaping dose of fragility.

But how can that be? Size is supposed to provide strength, and it does, to a certain extent. Yet it also comes prepackaged with the fragility of centralized control, the fragility of unmaneuverability, the fragility of *ineconomy* of scale, and, in business terms, the fragility of defending against highly mobile and highly targeted opponents.

It's exactly what Robert Taber, in his book, *The War of the Flea*, the seminal work on guerrilla warfare, wrote about in describing how a small band of guerrilla fighters could emerge victorious in a conflict with a larger, well-organized enemy.

Continued on page 12

Anesthesia Group Size and Governance: Bigger is Obviously Better—Until You Hit an Iceberg

Continued from page 11

"Analogically," Taber wrote, "the guerrilla fights the war of the flea, and his military enemy suffers the dog's disadvantages: too much to defend; too small, ubiquitous, and agile an enemy to come to grips with."

From the organizational perspective, as in a guerrilla war, change within the organization, as well as within a domain in which the organization interacts, can occur as a result of agitation by a vocal minority or, as we well know, as the result of a microscopic virus.

Just as no vote was required for a dictator like Castro to take over Cuba, no long and drawn out process among "stakeholders" is required to topple the status quo.

What you think is permanent is only temporary. *How temporary* is the question.

The Dancing Elephant

To survive, then, the anesthesia group elephant must learn to dance.

The dance can be observed both externally and internally, but it all takes place on the inside and is a product of governance. The idea is to take advantage of size and power in the marketplace, while protecting against its inherent fragility through increased maneuverability.

And maneuverability takes us to John Boyd and the OODA loop.

Just as we're discussing maneuverability for anesthesia groups, the late Air Force Col. John Boyd was instrumental in advocating maneuverability in the design of jet fighter aircraft.

At the time, the thinking was that maneuverability was outdated; in favor was a design for speed. Yet, over time, Boyd's thinking prevailed.

Boyd wasn't a technician, an aeronautical engineer. He was a strategist,

considered by many to be the second greatest military strategist to have lived, right behind Sun Tzu, author of *The Art of War*.

Maneuverability was key to Boyd's strategic thinking, represented most famously by his concept of the OODA loop.

In simplified form, the loop consists of observing, orienting, deciding and acting. (The OODA loop is actually much more complex with various internal feedback mechanisms). The point, however, is that the competitor who can cycle faster through the loop gains a tremendous strategic advantage over its opponent.

Similarly, unless your business in general is set up to take advantage of faster cycling through the loop, it's a prisoner of its current direction. And, that necessitates that decisions, quick decisions, be made by one or a very small number of leaders—there's no time to take a vote or seek a consensus. Decision making itself plays out on the top level of a large group as well as on the division and site levels: there must be a balance of authority and control across all levels or the group risks becoming too centralized in terms of decision making to effectively understand the terrain in which it operates.

For entrepreneurial medical groups, relatively smaller size can be a tremendous advantage in an uncertain and unclear market. But large groups, groups with the benefits of size, can balance out the defects of size, the fragility of size, in the same way: by maintaining a high degree of maneuverability.

But for any group, that's the case only if its leaders have in place the governance structure to enable it to make and implement decisions quickly. Those structures must be nimble. They must empower a handful of leaders, not an unwieldy, bloated Board. Decisions must be made by those elected to do so, not subject to fully collaborative decision-making, and not subjected to required, or *de facto*, consensus.

But, of course, that's the case only if those in leadership roles have the time, ability and inclination to *actually* exercise their power, which is another story entirely.

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 is also the co-founder of a healthcare mergers and acquisitions advisory firm, Steering Advisors. He can be reached by email at markweiss@advisorylawgroup.com or at markweiss@steeringadvisors.com.

Value-Based Care Advances: CMS Issues New Final Rules for Stark and Anti-Kickback Statutes

Jenna M. Singleton, Esq.
Brennan, Manna & Diamond, LLC, Columbus, OH
Ashley B. Watson, Esq.
Brennan, Manna & Diamond, LLC, Columbus, OH

The Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issued two highly anticipated (and quite extensive) Final Rules to reform the Stark Law and Anti-Kickback Statute (AKS) regulations. The Final Rules generally take effect on January 19, 2021.

The Final Rules include new safe harbors for the AKS and new exemptions to the Stark Law to allow for greater flexibility. According to the HHS, the goal of updating both laws is to make it easier for providers to engage in care coordination and value-based care programs without running afoul of the statutes.

Stark Law Final Rule

The Stark Final Rule creates new, permanent exceptions to the Stark Law for value-based arrangements. The Final Rule is meant to enhance innovation by permitting physicians and other healthcare providers to design and enter into value-based arrangements without fear. The exceptions apply regardless of whether the arrangement relates to care furnished to people with Medicare or other patients. In order to qualify for these exceptions, the relationship must be a compensation arrangement between an entity and a physician. Existing value-based arrangements that already comply with an exception are not required to use one of the new exceptions.

The new Stark Final Rule exceptions include:

- Full financial risk (§ 411.357(aa)(1))
  - Applies to value-based arrangements in which the participants have assumed "full financial risk" for the cost of all patient care items and services covered by the applicable payor for each patient in the target patient population for a specified time period (e.g., capitation payments or global budget payments from a payor).
- Value-based arrangements with meaningful downside financial risk to the physician (§ 411.357(aa)(2))
  - Physicians will qualify for the exception where no less than 10 percent of the total value of the remuneration the physician receives under the value-based arrangement is at risk.
- Value-based arrangements § 411.357(aa)(3)
  - Permits monetary and nonmonetary remuneration within compensation arrangements that qualify as value-based arrangements, regardless of the level of risk undertaken by the value-based enterprise. Additional safeguards include the requirement of a signed writing,

Continued on page 14

Value-Based Care Advances: CMS Issues New Final Rules for Stark and Anti-Kickback Statutes

Continued from page 13

as well as annual monitoring requirements to track the value-based activities and related impact and progress of such activities.

CMS also finalized at § 411.354(c)(4)(iii) (the Stark indirect compensation exception) that the value-based exceptions are available to protect the physician's referrals to an entity when an indirect compensation arrangement includes a value-based arrangement to which the physician (or the physician organization standing in the shoes of the physician) is a direct party. Note that the exception only applies if the link closest to the physician is not an ownership interest, and the compensation arrangement must meet the definition of value-based arrangement.

The Stark Final Rule provides additional guidance on several key requirements that must often be met in order for physicians and healthcare providers to comply with the Stark Law. For example, compensation provided to a physician by another healthcare provider generally must be at fair market value. The Stark Final Rule provides guidance on how to determine if compensation meets this requirement. Finally, the Stark Final Rule also provides guidance and updates on fundamental Stark terminology including "designated health services," "transaction," "commercial reasonableness," "indirect compensation arrangement," payments "set in advance," and "group practice," among others.

Anti-Kickback Statute Final Rule

The AKS Final Rule implements seven new safe harbors, modifies four existing safe harbors, and codifies one new exception under the Beneficiary Inducements in Civil Monetary Penalties (CMP) law. The AKS Final Rule also expands the new safe harbor for cybersecurity technology and services to cover remuneration in the form of cybersecurity-related hardware.

- Value-Based Arrangements.
  - Care Coordination Arrangements to Improve Quality, Health Outcomes, and Efficiency (§ 1001.952(ee)) – The exchange of in-kind (not monetary) remuneration is permitted under this safe harbor where the parties establish legitimate outcome measures to advance the coordination and management of care for the target patient population; the arrangement is commercially reasonable; and the recipient contributes at least 15 percent of either the offeror's cost or the fair market value of the remuneration.
  - Value-Based Arrangements with Substantial Downside Financial Risk (§ 1001.952(ff)) – In this safe harbor, participants are required to "meaningfully share" in downside risk. The OIG has defined this to mean that the participant must share at least 5 percent of the risk. If parties use the "Shared Savings and Losses Methodology" of this safe harbor, the risk threshold the parties must assume is 30 percent. There is a 20 percent risk threshold for Episodic Payment Methodology.
  - Value-Based Arrangements with Full Financial Risk (§ 1001.952(gg)) – Full Financial Risk is defined as responsibility for all the costs of all items and services covered by a payor for each patient in the target populations for the term of one year. This safe harbor protects both monetary and in-kind remuneration.
- **Patient Engagement and Support** (§ 1001.952(hh)) provides protection for certain tools and supports furnished to

patients to improve quality, health outcomes, and efficiency. Protection is limited to in-kind remuneration up to $500 per year provided by value-based enterprises to patients to assist with the patient's engagement in their care.

- **CMS-Sponsored Models.** A new safe harbor (§ 1001.952(ii)) for certain remuneration provided in connection with a CMS-sponsored model, which should reduce the need for separate and distinct fraud and abuse waivers for new CMS-sponsored models.
- **Cybersecurity Technology and Services.** A new safe harbor (§ 1001.952(jj)) for donations of cybersecurity technology and services.
- **Electronic Health Records Items and Services.** Modifications to the existing safe harbor for electronic health records items and services (§ 1001.952(y)) to add protections for certain cybersecurity technology, to update provisions regarding interoperability, and to remove the sunset date.
- **Outcomes-Based Payments and Part-Time Arrangements.** Modifications to the existing safe harbor for personal services and management contracts (§ 1001.952(d)). To be protected, outcome-based payments must be based on the achievement of measures with clinical evidence or credible medical support and that payments for any such arrangement must measurably improve or maintain care or materially reduce costs. In addition, the OIG removed the current safe harbor requirement that the aggregate payment for a management or services arrangement be set out in advance. Now, only the methodology need be set in advance. Finally, the OIG removed the requirement that part-time arrangements have a schedule of services specifically set out in the written agreement.
- **Warranties.** Modifications to the existing safe harbor for warranties (§ 1001.952(g)) to revise the definition of "warranty" and provide protection for bundled warranties for one or more items and related services, provided the items and services are all paid for by the same payor and under the same payment.
- **Local Transportation.** Modifications to the existing safe harbor for local transportation (§ 1001.952(bb)) to expand and modify mileage limits up to 75 miles for rural areas and eliminated distance requirement for transportation for patients discharged from an inpatient facility or released from a hospital after being placed in observation status for at least 24 hours.
- **Accountable Care Organization (ACO) Beneficiary Incentive Programs.** The new safe harbor at 1001.952(kk) protects incentive payments made by an ACO to an assigned beneficiary under a beneficiary incentive program established under Section 1899(m) of the Act if the incentive payment is made in accordance with the requirements found in Section 1899(m) of the Balanced Budget Act of 2018.
- **Final Exception Regulations Under the Beneficiary Inducements CMP.** The final exception regulations under the Beneficiary Inducements CMP protect:
  - **Telehealth for In-Home Dialysis.** An amendment to the definition of "remuneration" in the CMP rules at 42 C.F.R. § 1003.110 interpreting and incorporating a new statutory exception to the prohibition on beneficiary inducements for "telehealth technologies" furnished to certain in-home dialysis patients.

The Final Rules recognize the inherent overlap of the Stark law with the AKS and try to align the two so they can better encourage value-based arrangements.

Jeana M. Singleton, Esq., is a member of Brennan, Manna & Diamond, LLC's Executive Committee and serves as its General Counsel. She has a national healthcare law practice focusing on healthcare operational matters, including state and federal regulatory compliance, healthcare transactions, healthcare policy, public health initiatives, corporate law, and business-legal strategy. Ms. Singleton's depth of experience on a wide range of healthcare matters provides the knowledge and skill necessary to help her clients navigate complex legal issues in a highly complex industry on matters that impact their business performance. Singleton is licensed in Ohio and Michigan. You can reach her at 330.253.2001 or jmsingleton@bmdllc.com.

Ashley B. Watson is an attorney in Brennan, Manna & Diamond, LLC's Columbus office who works with nonprofits, hospitals, trade associations, healthcare practices, individuals and businesses. She is experienced in healthcare and hospital law, contract review and negotiation, government affairs, compliance, probate and intellectual property law. Ms. Watson can be reached at 614.246.7518 or abwatson@bmdllc.com.

The Role of Anesthesia Leaders in Driving Perioperative Performance

Jeffry Peters, MBA
Founder & Chairman, Surgical Directions, LLC, Chicago, IL
Derek Fine, MPH
Business Consultant, Surgical Directions, LLC, Chicago, IL

"Since we recruited a new System Medical Director of Anesthesia and Perioperative Services, our ORs are running better than they ever have before. She recruited new anesthesia providers and changed the entire culture. Surgeons are happy, the OR staff are happy, and our volume and margin have grown."

– President, East Coast Hospital

Surgical services generate up to 75 percent of total hospital margin[1], making it a critical service line for health system profits and losses. Particularly in these trying times, keeping perioperative services running smoothly is essential to a health system's financial health, and anesthesia departments are optimally positioned to drive this process. As such, hospital leaders have learned that strong anesthesia leadership is a prerequisite for success.

To illustrate this point, it's helpful to consider the example of an east coast hospital that was in dire financial straits because of its OR's chronic underperformance. There were frequent delays in starting cases, OR nurses and CRNAs felt unappreciated, and surgeons did not feel valued. Hospital leaders knew that a significant change was required to jumpstart the OR's moribund performance, and they decided that a new anesthesia leader would be an essential part of this process. Eager to turn things around, they recruited a new Medical Director of Anesthesia and Perioperative Services and worked closely with her to craft a perioperative transformation plan centered around the following pillars:

- Implementing Collaborative Governance
- Rightsizing Block Time
- Improving OR Efficiency
- Making Data-Driven Decisions
- Creating a Culture of Respect

Implementing Collaborative Governance

Before the transformation could occur, the hospital needed to empower its anesthesia department to lead the change process. To do so, it created a Surgical Services Executive Committee (SSEC) that brought anesthesiologists, key surgeons, perioperative nursing leadership and administrative leadership together to govern the OR collaboratively. The SSEC was responsible for overseeing the transformation, and its inclusive composition allowed it to build consensus for necessary changes. To signal their commitment to the transformation work, the hospital's president, CNE and CMO were on the SSEC and attended every meeting.

Crucially, this committee was co-chaired by the newly hired Medical Director of Anesthesia and Perioperative Services. By making her a co-chair (along with a surgeon), the hospital's leaders sent a clear signal to the organization that its anesthesia department was expected to play a leading role in the day-to-day governance of the OR. Along with her administrative responsibilities, the Medical Director continued to practice clinically, which allowed her to take the pulse of the OR while modelling the changes required during the transformation.

Rightsizing Block Time

In addition to playing a leading role in hospital governance, anesthesia leaders must also be empowered to facilitate responsible utilization of the OR by surgeons. As is frequently true at underperforming hospitals, surgeon block time at this facility was not appropriately allocated and monitored. Surgeons were given block on days when they rarely operated, and surgical schedules that could be accommodated in one room were

[1] Resnick, A. S., Corrigan, D., Mullen, J. L., & Kaiser, L. R. (2005). Surgeon contribution to hospital bottom line: not all are created equal. Annals of Surgery, 242(4), 530–539. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1402352/

commonly performed in two. OR time is a precious resource, and this misallocation of staffing and demand drove up both anesthesia and nursing costs while creating a barrier to giving block time to new surgeons recruited by the hospital.

To address this, the hospital invested in predictive analytics that dove deeper than the traditionally used "% utilization of block" methodology. While % utilization is useful as a high-level snapshot of how a block is being used, it frequently masks lulls in utilization that can occur throughout the day. At this hospital, while overall block utilization was around 40 percent, this concealed significant variations in utilization throughout each day. Data on *hourly* utilization of each room was able to demonstrate that half of the ORs were sitting empty after 1 PM on most weekdays. Hour by hour, day by day, these more precise predictive analytics can shed light on previously unobserved gaps in the schedule and offer solutions for more appropriate block scheduling.

Armed with this more accurate data, the anesthesiologist Medical Director was able to have frank conversations with surgeons about their usage of the OR, facilitating the construction of a block schedule that was matched precisely to surgeon needs.

Improving OR Efficiency

While rightsizing the block schedule is a critical initial step in transforming the OR, this updated block must be built on the back of efficient perioperative processes. To help facilitate this, the hospital chartered a performance improvement team (PIT) that was led by an outside nursing consultant and the anesthesiologist Medical Director. Staff from the hospital's pre-surgical optimization department, central sterile processing, and the OR were all included in the PIT, with representation from both frontline staff and department leadership. The inclusion of frontline staff on this team was particularly critical, as these staff had an acute understanding of the hospital's inefficiencies, but had not previously been given a seat at the table to help craft solutions.

With this diverse roster in place, the PIT quickly identified that patients were often showing up on the day of surgery with clinical issues that should have been resolved prior to the patient's arrival. Surgery was also frequently delayed because the anesthesia department needed additional lab tests and clearances, and case carts with missing instruments also contributed to delays.

After the group identified that more proactive management of patients was required prior to surgery, the hospital established a collaborative daily review with all relevant departments (anesthesia/nursing/CSP/pre-surgical optimization) to anticipate and resolve potential problems. At the daily review, the group confirmed the presence of H&Ps, consents and antibiotic orders and checked that the necessary equipment and implants were on hand, working quickly to resolve any issues that arose. By working three days out to mitigate the most common causes of case delays, this collaborative review helped to lower average turnover time by almost 30 percent while significantly reducing same-day cancellations, which minimized disruptions to the daily schedule and increased patient and staff satisfaction.

Making Data-Driven Decisions

In the past, the perioperative data the hospital shared was frequently questioned by surgeons, who lobbied for the reporting to be done in ways that inaccurately documented their performance. Surgeons were shown to be on time if they entered the OR within five minutes of a case's scheduled start time, and they artificially doubled their block utilization numbers by ignoring flip rooms in the calculation. Led by its co-chairs, the SSEC established monthly perioperative metrics dashboards and tightened the definitions of the metrics it reported to align with national best practice. Information was presented both in aggregate and by surgeon for case volume, block utilization, first case on-time starts, turnover time, and same-day cancellations, and low-performing surgeons were held accountable.

Even though this basic information is tracked by most ORs, it is rarely displayed clearly and accurately, which is an essential part of improving OR utilization and persuading recalcitrant surgeons that

Continued on page 18

The Role of Anesthesia Leaders in Driving Perioperative Performance

Continued from page 17

changes are needed. As part of this process, the SSEC invited the hospital's data professionals into its meetings to present the data and explain the methodology behind it, building consensus for the dashboards and eliminating surgeons' frequent complaints about data accuracy.

Creating a Culture of Respect

In the past, inappropriate behavior by the hospital's surgeons, anesthesiologists and staff was left unaddressed. There was a culture of finger pointing, yelling and general disrespect for other care team members. This led to higher staff turnover and risk of losing surgeons and their case volume to competing facilities.

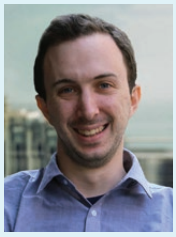
To address the issues on the physician side, the anesthesiologist Medical Director and her surgeon co-chair worked to set and enforce behavior standards, with the full backing of the hospital administration. After some initial discontent, surgeon and anesthesiologist behavior markedly improved, and most nurses and CRNAs now felt respected and supported. On the staff side, there were additional communication and effective escalation paths established, which allowed issues to be addressed immediately in a respectful manner. As the culture of the OR improved, staff engagement went up, surgeons felt better supported, and turnover declined.

Conclusion

The hospital described above is one of hundreds of examples of organizations that have benefited from strong anesthesia leadership. Whether it's leading hospital governance, championing reforms, or working on the front lines to change outdated processes, anesthesia professionals play a critical role in driving strong performance in the modern OR. As such, the choice of a Medical Director of Anesthesia and Perioperative Services is one of the most critical that hospital leaders can make. A successful candidate typically has strong interpersonal skills, is clinically active and respected, and has demonstrated the ability to effect organizational change. With the right candidate in place, the incentives of the hospital and its anesthesia department should be fully aligned, with both parties growing together as the OR's performance improves.

Surgical Directions is a national consulting, leadership and analytics partner to hospital systems and medical groups who seek to improve their perioperative and anesthesia services. Our team of experienced practitioners tackle critical operational problems and are committed to achieving the target financial, operational, and clinical outcomes. Surgical Directions has successfully helped more than 400 healthcare clients nationwide increase patient access, optimize governance, reduce cost and, most importantly, improve patient care. Additional information is available at www.surgicaldirections.com, and the firm may be contacted at info@surgicaldirections.com.

Jeffry Peters, MBA is Founder & Chairman of Surgical Directions. Mr. Peters has led the operational, clinical and financial improvement of over 300 hospitals across the country. He is an experienced healthcare business strategist with more than 25 years of experience collaborating with physicians and hospital executives. Leading teams of specialists, Mr. Peters has established a consistent track record of enhancing healthcare service delivery through the optimization of workforce, strategy, performance and the supply chain. Heis an expert in addressing the operational, financial and political issues within hospital systems—from rural community hospitals to quaternary academic medical centers. Peters has worked with hundreds of surgical and procedural departments, and he understands the complexities and importance of these services to an organization's financial performance and reputation. Mr. Peters is a national speaker, and he has published numerous articles on anesthesia support and negotiations, OR operations, perioperative benchmarks, block scheduling, physician & hospital relations and hospital organizational issues. He is a leader in healthcare consulting, sought out by healthcare organizations looking to transform services delivery, improve patient outcomes, control costs and ultimately achieve a sustainable competitive advantage in their markets. Mr. Peters can be reached at jpeters@surgicaldirections.com.



Derek Fine, MPH serves as business consultant for Surgical Directions, LLC. Mr. Fine supports clients by organizing and visualizing data to produce actionable insights and drive sustainable change. Prior to joining Surgical Directions, he interned in the Office for Excellence in Patient Care at Mount Sinai Hospital in New York City, where Fine worked on quality improvement initiatives and gained experience working with C-suite executives and key hospital stakeholders to optimize performance. Mr. Fine has a bachelor of degree in Neuroscience and History from the University of Michigan and a masters degree in Public Health, specializing in health policy and management, from Columbia University. He can be reached at dfine@surgicaldirections.com.

Is Big Better? The Pros and Cons of Practice Aggregation

George W. Kanaly, Ph.D., MCHA
President and CEO, George Kanaly & Associates, Riverside, CA
Jody Locke, MA
Vice President of Anesthesia and Pain Practice Management Services
Anesthesia Business Consultants, LLC, Jackson, MI

Empires come and go, and so, too, do the leaders that inspired their growth and managed their strategic focus. We think of Rome, Greece, Germany and England and we are reminded of visionary leaders, grand visions, great struggles and, ultimately, a long, slow demise. Why should it be any different among today's anesthesia practices? We see so much time, energy and money being spent on creating mega-groups and large corporate entities, but do they all survive or even fulfill their original missions? These are critical questions as today's anesthesia practices struggle to make sense of an ever-changing marketplace for medical services. There appears to be an elusive belief that *big is always better,* but history appears to underscore the inherent risks and perils of such a belief.

The History of Anesthesia Group Practice

The concept of an anesthesia group practice has become the norm today, but it was not always so. Even most of the oldest anesthesia group practices only date back to the early 1990s. Prior to that, anesthesia departments consisted of individual fee-for-service entities. Peter McDermit, a former ASA president, was once quoted as saying that an anesthesia group was an anachronism, because it was like herding cats.

Given the independent nature of anesthesia practice and the prevailing mindset of anesthesiologists, forming group practices in the 1980s and 90s required no small amount of patience and finesse. The concept of "group practice" was the least amount of structure one had to create to get a collection of independent providers to agree on a set of common objectives. While there were some groups formed because they saw the advantages of a unified structure, many were formed at the request of the facility they serviced. The term "shotgun marriage" was often used as a reference to the rationale for the merging of practices. These circumstances still exist today in which anesthesia groups, revered for their clinical excellence, are luckily able to retain their exclusive services agreement with their facility client. However, this is only true where the group agrees, at the stern direction of the hospital they are serving, to become a more orderly, disciplined and responsive medical business. Others, with lesser clinical acumen and galled relationships, lose their exclusives agreements frequently due to the appointment of an inadequately committed anesthesia medical director, who through sins of commission or omission, endangers this major asset relationship for all members of the group.

Forming a group practice was the only practical way to negotiate and establish contracts with facilities and payers. It was certainly preferable from the perspective of a hospital administration to deal with one entity that spoke with one voice than with a variety of individual practices. In fact, by the end of the 1990s very few anesthesia practices did not have exclusive contracts with the facilities they served. Most of these new entities represented fairly loose arrangements; and, in many cases, the individual physicians continued to get paid on a fee-for-service basis, as they always had. The establishment of common-unit compensation plans would be a later development. The need to negotiate financial support arrangements would also come much later.

It was really payer contracting that ultimately justified, changed and refined the strategy of most groups. As Medicare rate cuts started to materially alter the collections potential of so many practices. they needed a way to recoup what was being lost. Managed care contracting and the concept of cost shifting was seen as the key to survival since the fundamental challenge of all practices was to generate enough revenue to recruit and retain the necessary providers to facilitate the services required by the contract. Commercial payer contracting turned out to provide a substantial revenue opportunity, especially when successfully executed.

Market changes and the economics of anesthesia imposed a new reality on the specialty. Groups had to evolve from professional fraternal organizations to serious business entities. In 1994, the ASA, which had historically only conducted clinical meetings, conducted its first practice management conference in Phoenix. This was considered a significant development in the history of the society as it reflected a new reality: group practices needed to do more than provide quality care to survive. This and subsequent practice management conferences offered participants an opportunity to discuss com-

Continued on page 20

Is Big Better? The Pros and Cons of Practice Aggregation

Continued from page 19

mon concerns, hear about new practice management strategies and put the changes that were transforming the specialty in perspective. The conference has since become one of the most well attended each year, after the annual clinical conference.

Perhaps the hottest topic among anesthesia practices in the 1990s was the issue of practice mergers. Fueled, to an extent, by the successes of consolidation, growth and public offerings in the multispecialty practice arena by physician practice management companies, such as MedPartners, PhyCor, and Pacific Physician Services, and not dissuaded from pursuing such growth by their often cataclysmic failures, this was a period of merger mania that leached into the single specialty verticals. It was inspired by the basic belief that the bigger you were, the more successful you would be in negotiating managed care contracts. It was thought to be essential in order to interact with the ever-increasing incidence of hospital consolidations into even larger integrated health systems, as well as creating the resource base for an expanding service area. Size was considered necessary in order to become more formidable and extensively qualified to win new facility coverage agreements, as well as successfully retain those already in the relationship inventory of the group.

By then end of the decade, there were more than 25 anesthesia practices with more than a 100 providers. These were the early mega-groups, many of which would either merge together or evolve into very sophisticated commercial entities. Practices, such as Anesthesia Services Medical Group (ASMG) in San Diego, Oregon Anesthesiology Group (OAG) in Portland, Greater Houston Anesthesia (GHA) in Houston and North American Partners in Anesthesia (NAPA) on Long Island, served as models that other practices strove to emulate. Some of them, such as ASMG, even developed consulting arms to help other practices secure more market share.

On the other hand, it is possible to grow too rapidly and without careful thought as to the service market and the legal implications of the contemplated expansion. As an example, at least one early adopter of the interest in consolidation to larger size, ORLA, Inc., immediately miscalculated. The group attempted to consolidate a contingent of the Orange and Los Angeles County California anesthesia specialty physicians. This consolidation effort raised anti-trust concerns within the U.S. Department of Justice (DOJ) due to the sheer size of the enterprise. As a possible yardstick of how big is too big, please see https://www.justice.gov/atr/response-orange-los-angeles-medical-group-incs-request-business-review-letter. This is a DOJ Antitrust Division review of one of the early joint venture expansion activities engaged in by interested anesthesia medical practices. In it, the DOJ ruled that, if the affiliation contemplated actually went through, DOJ would likely challenge it on the basis of the absence of procompetitive benefits. This DOJ review sensitized all of the participants in this project to this peril of growth; but, in particular, it severely sensitized the lead group coordinating the affiliation to the dangers of such expansion. It would require great passage of time and two additional attempts to interest the shareholders of the lead group in such expansion before a successful 2015 merger of three prestigious anesthesia medical practices was completed—achieving a group size of 130 physicians in service to nine hospitals and 30 ASCs in southern California.

Winners and Losers

The 1990s were marked as a period of challenge and aspiration. Aspiration versus opportunity because there was a lot of wishful thinking without many tangible results. Managed care was imposing new rules on all practices. The financial challenges facing the specialty seemed daunting. The ASA had commissioned Abt and Associates to evaluate anesthesia manpower needs, and the report concluded there was a surplus. For a period of years, anesthesia residents bailed to other specialties.

All across the country, providers were seriously considering their options. Group practices were being formed in every state as

providers strove to strengthen their market positions, so they could get better rates. Many new groups were formed, but few accomplished much more than a stronger relationship to the facilities they served. Once formed, many groups tried to grow larger. There was the famous case of Mountain West Anesthesia in Salt Lake City; LDS Hospital asked its anesthesia providers to form a group practice. The physicians agreed but decided that, while they were at it, they would bring in all the anesthesiologists up and down the Wasatch front. The result was a mega-group that immediately drew fire from the managed care plans, which started referring to it as the Mountain West Cartel. The belief that bigger would be better often led to new challenges. For many, the initial vision and inspiration did not sustain the reality of the new entity.

It should be noted that a number of groups and mega-groups that were formed during this period would ultimately disaggregate or lose their contracts. Anesthesia Associates of New Mexico was formed as the merger of practices in Albuquerque and Santa Fe. The initial thinking was that the group could provide more security and a better lifestyle to its members. Eventually, the Santa Fe physicians broke away claiming that the administrative costs of the group were a form of taxation without representation. After carefully assessing their specific market, they concluded that swifter, quicker, nimbler was a much more effective strategy. This was

just one example of practices that would break away to reform independent practices. All of the mega-groups experienced this to some extent. A fundamental challenge to all large entities is the challenge of constituency. If the individual members of a practice do not feel their voices are heard and their expectations will be met, they will leave the practice.

Criteria for Success

In her book, *Confidence*, Harvard Business School professor Rosabeth Moss Kanter identifies three qualities that distinguish successful businesses and sports organizations. They are:

- Accountability
- Collaboration
- Innovation

Although she did not specifically focus on medical groups, her criteria provide a very useful litmus test. Clearly today's successful practices are all founded on these three basic principles. At issue is how they are defined and how they practically guide the functioning of the practice.

Accountability

Accountability is a very general term and subject to much interpretation. Many will suggest it simply refers to transparency and will think there is accountability if they can see the financial records of the practice. While this is true, it is not the whole story. According to Dr. Kanter, true *accountability* involves not just an accounting of what is, but the setting of expectations and the measuring of results. Consider an anesthesia practice. What are the expectations of its customers? Are the expectations clear and consistently understood? Do providers know what is expected of them and are they held accountable?

Provider accountability is an interesting concept in an anesthesia practice. If you are an appropriately credentialed provider, then you are assumed to be accountable for your actions and performance. No one monitors an individual provider's performance unless given a reason to. It is the nature of anesthesia that much is left to the training, experience and judgement of the individual provider. Providing anesthesia is not like making coffee at Starbucks, where the creation of each drink is perfectly scripted for consistent results. Every anesthetic is a unique clinical experience. Some will talk about provider productivity as if there were a way to measure and improve it, but the fact is that anesthesia providers tend to be as busy and productive as their schedule allows them to be. In the current environment, it is other measures, such as customer service, that groups are more interested in. How one evaluates these non-productivity measures is the real question.

If you are coaching a baseball team and you want to win the pennant, you have to coach each player to his maximum potential. This analogy should apply to anesthesia practices which are always thinking about how to maintain their exclusive contract with the hospital, but it doesn't. The only real coaching anesthesia providers get is what they give themselves. We tend to measure providers based on the absence of negative or adverse events, not on positive achievements. This is not a strategy focused on excellence, nor one that would greatly enhance the representation of the practice.

From a hospital perspective, accountability means something quite different: the ability to terminate and remove incompetent providers. The administration wants a practice that speaks with one voice and which can make good on its commitments and enforcement of its policies. It makes hospital administrators crazy that so many anesthesia practices cannot effectively manage themselves and their providers.

There is no question that accountability is an essential element of a successful practice, but the practice must be able to define and implement it in a way that is meaningful to the providers and the group's customers. As Dr. Kanter puts it, accountability must be something that *enhances confidence in the organization*. So long as this can be achieved, it is an essential element. It is the nature of today's medical market, however, that the policies and criteria that work today may not work tomorrow. As is often said in strategic planning, very often the beliefs and strategies that got us to where we are today will not get us to where we want to be tomorrow.

Collaboration

Sports teams win championships when they play as a team, when there is good *collaboration* between the players. The same is true of businesses. Each team must understand its role and collaborate with each of the other teams to produce a consistent product with maximum efficiency. And so it should be with medical practices.

Many small practices that service a single facility epitomize a collaborative model. Like-minded providers cover for each other and make sure they provide a consistent service. In fact, many small groups self-select based on factors such as where they trained, religious views or other common denominator. From an organizational perspective, they tend to make decisions based on a consensus model like the old New England town meeting model. More often than not, this structure and mode of governance has resulted in very stable and conservative practices. They tend to eschew data and complicated performance metrics. They believe they provide a good service because of their responsiveness and attitude and, in many cases, they are right. Typically, their mode of compensation is lump and divide; they share in the work and the profits or losses.

It has often been said that what it takes to manage a small practice of up to 20 providers does not work so well when the practice begins to grow to 30 or 40 providers covering multiple facilities. This is the fundamental challenge of growth. The form of the practice must be modified to accommodate the function of the practice. There is no specific roadmap for the process of merging multiple practices into one entity; and, based on a review of the nation's largest anesthesia practices, the key ingredient is leadership. Someone must motivate and guide the process. Most of today's most successful practices attribute their success to the vision and guidance of a recognized leader. One example that stands out in the history of large group management is John Zerwas, MD, who led his Houston partners to create Greater Houston Anesthesia.

Actually maintaining a collaborative approach to the management of a large practice

Continued on page 22

Is Big Better? The Pros and Cons of Practice Aggregation

Continued from page 21

is almost a paradox because to manage a large group effectively one must consolidate the governance so that business decisions can be made expeditiously and based on consistent criteria. The New England town meeting model simply does not allow this. This, then, is one of the fundamental challenges of a growing organization: balancing the need to maintain a focus on executing a clear strategic plan with the needs of all the providers to feel a sense of constituency.

The degree of true collaboration an anesthesia practice demonstrates has a clear impact on the strength of its contracts with facilities. Customer service is inevitably the primary focus of all hospital administrators. In the military they used to remind sailors that loose lips sink ships. Disgruntled or independent-minded providers can have the same deleterious impact on a hospital contract. There is no question that the larger a group grows, the more difficult it is to maintain a consistent *esprit de corps*. You know the organization is too big when disaffection becomes disruptive.

Innovation

We tend to think of technology companies when we talk about *innovation*. According to Walter Isaacson, author of a biography of Steve Jobs, both Bill Gates and Steve Jobs were legendary innovators whose innovations changed our relationship to technology. Obviously, we are not talking about creating organizations on the order of Microsoft or Apple when we talk about anesthesia practices, but the current healthcare market is extremely competitive. It used to be that most anesthesia groups were relatively immune to the competition that was impacting their hospital administrations, but this is no longer the case. Hospital administrators look to their anesthesia partners to provide consistently superb customer service, to work collaboratively with the OR staff, and to bring new services to the table that would enhance the service offering of the facility.

It goes without saying that anesthesia practices should have more and better data about what actually happens in the facility than any other department, or even the hospital administration. The question is whether and how they use this data to bring additional value to the facility. There has been much discussion about the potential for improving OR efficiency and productivity. Examples of best practices in this area are few and far behind, but this remains an area of great opportunity. As one anesthesia chairman once put it, the goal of the anesthesia practice should be to identify problems and propose solutions. Implementing process improvements that result in greater efficiency of operating utilization goes directly to the facility's bottom line.

Ever since the implementation of pay for performance (P4P) measures, there has been considerable focus on clinical and quality metrics. This has given rise to the concept of the perioperative surgical home, a concept that is the subject of much interest in the academic worlds, but which is not so enthusiastically embraced in the private practice world. The problem is an inherent challenge to today's anesthesia practices: being asked to provide more services without any commensurate increase in revenue potential. Again, there are very few examples of practices that have parlayed their anesthesia clinics into measurable improvements in either the quality of care provided or the overall profitability of the facility. The reality is that morbidity and mortality statistics for the specialty are so good already. It has been said that the average patient is at greater risk driving to the facility than undergoing general anesthesia. Today's challenge is to bring new ideas to the facility that enhance its competitiveness and the profitability of the practice. Clearly, though, what the history of innovation has shown us is that someone always finds a way to build a better mousetrap. This is the elusive carrot dangling in from of all practices. Quality anesthesia care has become a given and not a defining feature of superior groups.

How do we know when a practice is truly innovative? What determines our perception? Innovators are risk takers. Even though anesthesia providers constantly deal with the unpredictable—the specialty has been defined as hours of boredom punctuated by moments of sheer terror—they tend to be incredibly risk-averse ad this impacts their ability to secure the future of their practices. The reality is that in times of rapid change, the beliefs and strategies that got one to where they are today will not get them to where they need to be tomorrow. This tends to distinguish the doctor from the businessman and explains why so few practices actually achieve the full potential of their initial vision.

To Dr. Kanter's list of three critical features of successful organizations, we add a fourth essential: *competent leadership*. Anesthesia groups often fail to realize the value of qualified physician leadership in the arc of business development. Annual elections of Directors with staggered terms may fill the requisite Board of Director seats. However, when the officers of the Board are elected, the specialty is now well beyond the collegial "you take a turn as President or CEO" that may typify many groups. The ability to identify, empower and properly value physician leadership is critical to success in general operations, but it is an absolute imperative if the group is in growth mode. Trust and confidence in leadership is essential. The competency and effort of a capable leader should be embraced and given stability and continuity. All too often, good leaders are placed in office and then scorned and criticized by their constituency. During or after the heavy lifting of change management, they can be set aside out of petty jealousy and fear

of an individual amassing too much power or due to the acts of a hallway cabal that just wants different leadership for the sake of change, regardless of its negative impact upon the enterprise. This way of thinking is of no value and can severely and permanently damage the prospects of the group for sustained and beneficial growth.

How Big is Too Big?

There must be a purpose and a reason to grow a practice because the cost of growth can be significant. In addition to the previously mentioned "big two" reasons—revenue contracts and facility contracts—there are other very tangible reasons for growth. These include enhanced geographic deployment in markets of interest or opportunity through group solicitation of new coverage opportunities, as well as invitations from individual or system owned hospitals, and ASCs to propose services. With new medical business opportunity comes opportunity for better integration of regional resources among ideologically aligned and like-minded colleagues who can see either the offensive or defensive value of practice aggregation relative to other prevailing forces in the market of influence.

Combinations can also present opportunity for cross pollination of ideas and differing approaches to routinely similar governing or operational issues, significant cost reduction, creation and standardization opportunities for highly evolved clinical protocols. This is especially true in practices engaged in service-based global pricing. Group size similarly enhances access to better and less costly services such as billing and collection, professional liability and excess liability policies, group health benefits, vision, dental and other life insurance benefits, short-term disability insurance, long-term disability coverage designed to layer on top of any individual coverage already in place, and group umbrella policy protection for personal assets among the many possible benefits.

Medical and business expense reimbursement plans can be created and maintained in a manner which is compliant and beneficial to the combined professional staff. Additionally, group size can support much more sophisticated strategies and vehicles for pension contributions. With size also comes the ability to access nationally ranked attorneys, insurance brokers, pension design advisers, as well as tax and accounting expertise, that will enable the most favorable and compliant practices for operations and wealth protection for the principals.

However, without a doubt, the bigger the organization, the more time, energy and money it will take to simply manage the practice. While there are some successful examples of pre-COVID virtual operation of anesthesia medical groups, they are usually few and far between. These practices utilized carefully selected and vetted and intensively controlled but outsourced vendor, agent and adviser cadres. This is designed to minimize or eliminate the internal employee contingent, and ensure that the practice had access on a spot use/need basis to the best expertise and qualifications available to solve the inevitably complex issues that arise in the modern anesthesia medical group. Either way, whether internal or outsourced, all of today's large practices have had to make a significant investment in their administrative infrastructure. In some cases, the combined cost of billing and administration may approach 10 percent of net revenue. If this additional cost does not result in greater market security and enhanced shareholder or partner income, it may not be worth it. Many a subset of large practices has broken off, claiming that the cost is simply too high.

Ultimately, it is about confidence. By growing the practice, has it increased the level of confidence among employees and customers? If providers start losing confidence in the company they work for, then this is a problem. If customers lose confidence in the organization to provide a consistent service, then this is an even bigger problem. The long-term success of a practice is determined by the strength of its contracts with facilities. It used to be that a professional services agreement with the facility was somewhat of a legal formality. Now that most involve some level of financial support, it is much more of a competitive environment, and we see administrations canceling what had been long-term contracts all the time. Losing contracts is, therefore, the ultimate signal that the practice was too big and had lost its ability to provide a competitive service.

The question, then, is not is big better, but what is the right size that allows the practice to be consistently managed so that its employees and customers believe in the future of the relationship. Arriving at the right size is not guess work. It requires serious analysis, business discipline and organizational commitment. It requires the interest and ability of the owners to participate in intensive and critical self-assessment of the group, its resources, market position and surrounding with respect to potential clients, as well as other providers of anesthesia services. This is often a feature lacking in anesthesia medical groups, as many have great pride in their clinical expertise but very little understanding of the true nature and full potential of the business they have created or the need to visualize and nurture its potential growth curve to create their desired future.

George W. Kanaly, Ph.D., MHCA, is President and CEO of George Kanaly and Associates, Inc., a healthcare management and consulting firm. He has broad multispecialty and single specialty medical group practice background with extensive and successful anesthesia group practice management and operations experience in the highly competitive Southern California service market. He is an avid half marathoner and loves to fly fish. He can be reached at george@georgekanalyandassociates.com.

Jody Locke, MA serves as Vice President of Anesthesia and Pain Practice Management Services for Anesthesia Business Consultants. Mr. Locke is responsible for the scope and focus of services provided to ABC's largest clients. He is also responsible for oversight and management of the company's pain management billing team. He is a key executive contact for groups that enter into contracts with ABC. Mr. Locke can be reached at Jody.Locke@AnesthesiaLLC.com.

ANESTHESIA BUSINESS CONSULTANTS

255 W. Michigan Ave.
P.O. Box 1123
Jackson, MI 49204

Phone: (800) 242-1131
Fax: (517) 787-0529
Website: www.anesthesiallc.com

At the time of publishing, we find ourselves in mid-March and are able to look back on what has been an extraordinary time for our country and global community. Our readers, anesthesiologists, CRNAs, hospital and anesthesia group administrators, have spent the past year navigating an unprecedented set of challenges. First, there was the panic of cases being canceled and operating rooms being closed. Then, clients had a new set of financial challenges as they wondered how to manage their staff in the face of declining revenue. No one could predict how the recovery would look or how surgical volumes would ramp back up. Even now, no one quite knows what the new normal will look like.

One of things I so admire is the resiliency of anesthesia providers—there is always a solution. We saw that determination most clearly displayed in the heroic efforts of our healthcare workers, especially in the hospital sector—the front lines of the battle against COVID. At the time of this writing, we are seeing an easing of restrictions and an uptick in elective surgeries, but the danger still persists. No matter how long the threat from the virus lasts, we know we can count on our hospital employees to be there for the rest of us, providing expert healing and genuine care. We at Anesthesia Business Consultants salute you for your valiant efforts during the national health emergency, and we wish you success in all you do.

Follow Us
Like Us
Connect With Us

Connect with ABC here:
www.anesthesiallc.com/social-media

ABC offers *Communiqué* in electronic format

Anesthesia Business Consultants, LLC (ABC) is happy to provide *Communiqué* electronically as well as in the regular printed version. *Communiqué* continues to feature articles focusing on the latest hot topics for anesthesiologists, nurse anesthetists, pain management specialists and anesthesia practice administrators. We look forward to providing you with many more years of compliance, coding and practice management news through *Communiqué* and our weekly eAlerts. Please log on to ABC's web site at www.anesthesiallc.com and click the link to view the electronic version of *Communiqué* online. To be put on the automated email notification list, please send your email address to info@anesthesiallc.com.