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# Why and How You Must Prepare Your Anesthesia Group for the Future

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Ah. The future. What's it have in store for your anesthesia practice and what must you do to prepare your group for it? Some think that the future will be a continuation of the present, or, even worse, a return to an idealized past. They're both wrong.

But the present does hold *clues* as to what the future will bring, and based on them, I'll make some predictions about what the future bears, and why and how you must prepare your anesthesia group for it.

Sure, I might be wrong about the *specifics*, but I'm absolutely *not* wrong about the overall direction. I'll make some concrete recommendations. And I'll raise a host of questions for you to think about.

The reality is that questions are far more important than answers. Questions that you can later ask yourself, questions that lead to other questions unique to

yourself, to your own group and to your specific circumstances, to help you discover your own particular answers.

## Setting the Stage

In order to deal with the future, we have to start with a very small bit of history in order to set the stage, to show how

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## ➤ INSIDE THIS ISSUE:

# Becoming a Cheetah and Other Survival Tactics

In her blog, *A Penned Point*, early this year, Karen Sibert, MD, president of the California Society of Anesthesiologists, asked her fellow specialists to take some time during Physician Anesthesiologists Week to celebrate the specialty's accomplishments, but also to reflect on the state of the profession today, the anesthesiologist's place in the current environment of competition and seismic change, and what being an anesthesiologist might mean 20 or 30 years from now.

"Is your group or practice running pretty much as it did 20 years ago?" Dr. Sibert asked. "If so, then my guess is that you are in for a rude awakening sometime soon. One of two scenarios may be in play: either your leadership is running out the clock until retirement and in no mood to change, or your leadership hasn't yet been able to convince your group that it can no longer practice in the same expensive, antiquated model."

She went on to note that "if the specialty of anesthesiology needs to reinvent itself—redesign what we do and how we do it—it isn't too late if we start now. The exact solutions and details of implementation will vary by location and practice setting. But inaction, and futile attempts to defend the status quo, are the biggest threats."

Though his approach differs, Mark F. Weiss, JD, of The Mark F. Weiss Law Firm, echoes Dr. Sibert's call to action in his lead article for this issue of *Communiqué*. "You must question whether your group's (and your own) current level of success and future prospects can be improved," he writes in *Why and How You Must Prepare Your Anesthesia Group for the Future,* based on his presentation at the 2018 Advanced Institute for Anesthesia Practice Management (AIAPM). "Despite your own best intentions, perhaps it's your anesthesia group's governance structure that's holding you back." Mr. Weiss offers a diagnostic tool called The Medical Group Governance Matrix™ to help groups identify their current governance structure, with the goal of moving toward the nimble, responsive structure he uses the avatar of the cheetah to symbolize.

Reaching that point involves the willingness to let go of the need to personally control almost all aspects of a group's financial affairs—a need that in some groups is so strong that it can sabotage the group's ability to function as a true business. The result is a club, and a club does not equal a business, writes Mr. Weiss.

Also in this issue:

Kelly Dennis, MBA, of Perfect Office Solutions, Inc., whose articles you've seen here before and who led several sessions at this year's AIAPM, returns with straightforward, practical guidance in her article, *The Winning Strategy for Billing Invasive Monitoring*. Ms. Dennis emphasizes the value of open communication between the coding and billing and clinical staff to ensure that questions are answered in a timely manner. "Delayed billing while waiting for either a response or additional documentation is better than not capturing payment for your service," she notes.

Will Latham, MBA, of Latham Consulting Group, offers a comprehensive guide to planning and conducting effective anesthesia group meetings, where most of a group's most meaningful discussions, debate and decision-making typically take place. In his article, *Anesthesia Group Meetings: Madness or Method—the Choice Is Yours*, Mr. Latham recommends designating a meeting manager whose job it is to keep group members on track.

ABC Vice President Jody Locke, MA, probes the intricacies of calculating provider compensation and building a case for a new subsidy request in today's complex environment. What are reasonable benchmarks? How do you justify your request? He discusses the benefits—and limitations—of the main sources of national compensation data, and the role of geographic factors, payer mix, practice revenue potential, coverage and call requirements, income and lifestyle expectations, and a variety of other factors. "It is fundamentally about mastering the art of negotiation," he asserts. "Make your case, argue its merits, but be willing to accept and appreciate administration's goals and objectives."

Kathryn Hickner, Esq., of Kohrman, Jackson & Krantz LLP provides practical advice for buying or selling a physician practice in her timely article, *Lessons Learned: Five Tips for Buying or Selling a Practice*. Clearly define the purpose of the transaction, select transaction participants with care, develop a strong team that can be responsive and nimble during the negotiation process, rely on legal advisors and ensure terms that are clear, comprehensive and flexible.

We're looking forward with anticipation to ANESTHESIOLOGY® 2018 in San Francisco. Enjoy the rest of your summer.

Tony Mira
President and CEO

# The Winning Strategy for Billing Invasive Monitoring

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When the ASA Relative Value Guide (RVG) was first developed in the 1970s it established a significant precedent with regard to what services could be billed as incidental to an anesthetic. The guide established the concept of "invasive" as the critical criterion.

Arterial artery catheters, known as A-lines; central venous catheters; and Swan-Ganz catheters were specifically identified as non-bundled services because they were used for particularly sick patients with a high risk factor and were invasive. Some years later transesophageal echocardiography (TEE) was also added to the list, even though it was not technically invasive. One might also say that ultrasonic guidance for vascular line placement has also been lumped into the same category.

This distinction has served the specialty well ever since, especially since virtually all payer fee schedules include payment for these "surgical" services, i.e., the placement of such devices. Where anesthesia providers need to be careful, though, is in ensuring that their clinical documentation completely supports a charge for each service. The requirements and exclusions are specific.

## The Nuances of 'Who'

The first question is always who provided the service? This might seem obvious, but it is not always clear whether the anesthesia provider simply took advantage of an *in situ* catheter. In some facilities, surgeons or a perfusionist may place catheters for monitoring cardiovascular function, in which case the placement of such devices is a non-billable event for the anesthesia provider.

If more than one anesthesia staff member is signed into the case—a combination of anesthesiologist, teaching anesthesiologist and resident, certified registered nurse anesthetist (CRNA) or student registered nurse anesthetist (SRNA)—documentation must clearly show who placed the line. Teaching rules have special requirements for documentation of physician participation, and although a GC modifier indicates "when the service has been performed in part by a *resident* under the direction of a teaching physician," there is no modifier to report an SRNA placing a line. Indeed, no payment is made under Medicare Part B for services provided by an SRNA. This is important to keep in mind if an SRNA solely places an arterial line, for example, without the teaching CRNA's or anesthesiologist's documented involvement.

Although an auditor is not likely to request all the records prepared by the various staff in an operating room, they might if there were a question regarding the accuracy or completeness of the anesthesia record. Ideally, any notes prepared by the OR staff should conform to the anesthesia record.

## Why and How?

Why and how was such monitoring administered? Unlike the calculation of the anesthesia charge itself, the placement of invasive monitoring is billed as surgical services. No time is involved. And payment is based on a surgical fee schedule. Although a full operative report is not necessary or expected, the medical record documentation for these ancillary services must explain the details of the procedure and its relevance to the patient's condition.

While the advent of electronic anesthesia records (EARs) has helped tremendously with clear documentation of these services, paper anesthesia records do not typically have enough room under the Remarks or Comments areas to fully describe ancillary services. The best practice for anesthesia providers is to utilize a

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we got to where we are today. We'll do this on two tracks: one track is the anesthesia group track; the other is the hospital track, because anesthesiologists are, for the most part, still hospital-based physicians.

In connection with the anesthesia track, we need only go back as far as the 1970s. Then, almost every collection of anesthesiologists wasn't a group, because there weren't any, or perhaps there were just a handful of, actual *groups*. Instead, there were collections of individuals with medical staff privileges at a hospital and with clinical privileges in the hospital's anesthesia department.

Then along came the 1980s: Madonna, managed care, HMOs, IPAs. There was a sudden need for anesthesiologists to band together in order to contract with payers. Due to antitrust (price fixing) concerns, doing so required a financially integrated entity, that is, a true *group*. At the same time, the 1980s saw hospitals seeking commitments of coverage, and of anesthesiologists seeking exclusivity in return. That, too, led to the need for true business entities, that is, to groups. But the problem was, and we'll address it in detail later, that many groups were, and continue to be, run more like clubs than as truly integrated businesses.

Now let's look at the hospital track. For this we have to go back much further in time, in fact, to before the American Revolution.

In the U.S., the first public hospital was formed in Philadelphia in 1751 by Dr. Thomas Bond and Benjamin Franklin. At that time, those who could afford medical care received it from physicians at home. The hospital was the method of providing substitute care to patients who either had no homes or were poor and could not otherwise afford medical care. This notion of caring for the public continued in the sense of the growth of religious charted institutions. Again, those who could afford care did so privately.

As time progressed, physicians often advocated for the creation of publicly owned community hospitals; and physicians began to build clinics, i.e., hospitals, as an extension of their practices. In other words, hospitals were an adjunct to medical practice; medical practice was not an adjunct to hospitals. But over the following years, and decades, hospitals became larger and larger in order to meet patients' needs. The high cost of the technology of the time made it more efficient to centralize equipment and the attendant care of patients as well as more efficient to provide observation and monitoring.

Yet there was still a clear line between the practice of medicine and related healthcare professions and the hospital itself, including the now almost quaint notion of an independent medical staff.

Then along came Madonna—the 1980's for hospitals. Large hospitals and chains developed employed staffs and related medical foundations, or more-or-less captive medical groups. But with the general collapse of the staff-based HMO model in the 1990s, many hospitals withdrew from the unprofitable business of attempting to control physicians.

Let's fast forward. Along came Obamacare, and the government chooses sides: what some may call *crony capitalism*. The American Hospital Association supports Obamacare. Obamacare cements in place prohibitions on physician-owned hospitals and favors the growth of non-physician owned hospitals with its incentives for "aligning" physicians, including accountable care organizations (ACOs) and other incentives to coordinate care, i.e., coordination via hospitals.

And so hospitals begin gobbling up physician practices. As hospitals gobbled up physician practices, hospitals began gobbling up each other as well. In 2013, there were approximately 98 hospital mergers. In 2014, about 95. In 2015, around 112. In 2016, approximately 102. And, in 2017, around 115 hospital merger transactions. Overall, since 2010, there has been a 44 percent increase in the pace of hospital mergers.

During all of those years, from 1980 to the early 2010's, the hospital business was humming along fine. And so, too,

was the traditional anesthesia group as a hospital-based practice.

## The Unfolding Future

But, as they say in the financial world, past results don't predict future performance. Yet, many ignore that fact. They are comfortable with the current paradigm. They think that the party is going to continue because it's always continued. Yet, how does this work for turkeys? The farmers love them, or so they think. All the food and all the water they want! And then, the week before Thanksgiving—off come their heads. Thanksgiving is to the turkey as a set of disruptors is to the hospital. Let's look briefly at those disruptors. [For more detailed information on them, download a complimentary copy of my book, *The Impending Death of Hospitals,* at https://advisorylawgroup.com/impendingcmnnq.html.]

In essence, the disruptor is a perfect storm of technology, technique, price, value and the willingness to take entrepreneurial risk. For our purposes, that is, in the anesthesiology context, the disruptor is embodied in the shift of surgical care from the hospital setting to the outpatient setting. We can use the ambulatory surgery center (ASC) as the avatar for the shift, the placeholder for a variety of new forms of "non-hospitals," some of which look very much like the profitable parts of hospitals but not at all like the cost-sucking parts.

Technology allows a growing number of procedures to be performed on an outpatient basis. Those procedures can be performed in an ASC at far lower prices. And, due both to their lower cost structure and the ability to provide a more patient-focused experience, ASCs provide greater value for patients (better experience plus lower copays), for payers (lower prices plus better outcomes) and for physician-owners (capturing the facility fee plus greater control over scheduling plus increased professional freedom).

The future is clear: any procedure that can be performed outside of a hospital will be performed outside of a hospital. You see this in other specialties, too: for example, Anthem announcing, and in some states already implementing, a policy that it won't pay for outpatient MRI and CT scans performed at hospitals when, according to the company's third-party review process, the patient (and Anthem) could have saved money by going to a freestanding imaging facility.

What do you know; we've made a circle back to Ben Franklin's time: hospitals will simply be for the poorest patients in addition to, now, those that are the sickest.

## ASC Growth, Hospital Retreat

In the 1990s, there were approximately 1,000 ASCs in the U.S. But by 2012, there were approximately 5,260. At the close of last year, it's estimated that the number had increased to approximately 6,150.

Note that those figures are a count of *facilities* and ignore the fact that some ASCs have grown to have large numbers of ORs. In fact, in 2010, the number of cases performed in ASCs was equal to that performed in hospitals. It's now surpassed them.

How's this climate change impacting hospitals? Well, we have a shrinking number of hospitals. There were approximately 5,010 community hospitals in the country in 2008. By 2015, there were 4,862. That number has continued to go down, in large part because of the shift of care to the ASC setting.

For example, in June 2010, New York City's approximately 400-bed, 160-year-old St. Vincent Hospital closed its doors for the last time. In late 2017, a competing non-profit opened the modern variant of a replacement "hospital" right across the street: a six-OR ASC located in a building with a separate emergency department, an imaging facility, physician offices and other healthcare services.

Other than the freestanding emergency room, which, depending on state law may or may not be possible to license (or even wanted), there's nothing in the concept of the replacement facility that couldn't be created by you as a physician-led, physician-owned for-profit venture. In fact, it's exactly along the lines of what I've termed a Massive Outpatient Center™(MOC): A combination of an ASC, a medical office building and one or more of a menu of complementary offerings.

For some, thinking becomes ossified along historic lines: "Hospitals build hospitals." "Physicians just practice medicine." "Physicians can't own hospitals." None of these are necessarily true. But, even if they were, opportunity is more malleable. What's functionally like a hospital need not be a hospital. If I were wrong about this, St. Vincent's would be celebrating its 168th anniversary. It's not. A 200-unit condo complex stands in its place.

And then, we have an actual shrinking hospital. According to a January 8, 2017 article by Evan Belanger of *The Decatur Daily*, Decatur Morgan Hospital began chopping off the top three floors of its five-story south tower. The hospital's CEO was quoted as saying that the hospital's haircut is part of its "right-sizing" efforts.

If you're amused by actual shrinking hospitals, consider the concept of a bedless hospital. That is exactly what Children's Hospital of Michigan Specialty Center-Detroit is: a licensed, Medicare-certified, bedless hospital. And it's not the only one.

In fairness, it's important to note that weakness in hospitals, their fragility, isn't completely due to ASCs and to other outpatient facilities, and to payers pushing all of the care that can be pushed out to those independent facilities. There are other factors as well. Unions. Bloated

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# Why and How You Must Prepare Your Anesthesia Group for the Future

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administration costs. Better medicines. Mergers that increased costs and didn't achieve savings. Huge overhead of "aligned" physicians. Perverse incentives in which hospital administrators have an upside only (high salaries, bonuses, perks) but no downside: no "malpractice" liability for their financial errors. (Tenet's recently failed CEO, Trevor Fetter, walked away with a $22.9 million severance package after losing almost $400 million in the prior calendar quarter alone.)

## Prepare Your Anesthesia Group for the Future

Before we move forward, even if you think that I'm full of, well, turkey poop, and that there's little chance of your hospital closing, consider the asymmetry of risk. Let's say that you think there's a 95 percent chance of no change, that things will continue as is. Then, it's a continuation of the status quo. (.95 x same thing or little increase = realistically, the same situation as today.)

On the other hand, there's a five percent chance of your hospital closing. But the impact of that happening is not a slight reduction, it could be a complete blow up. (.5 x blow up = blow up.) Harkening back to our turkey example, you're not simply a lonely turkey, you are out of work, your partners sue you, your business "blows up." You're no longer a turkey, you're lunch meat.

*Let's be clear: I'm not recommending that you jettison your hospital relationships. I'm simply telling you that you take action to prepare for a different future.*

### Prepare Your Group on an External, *Macro*, Basis

*You need to hedge within your hospital-side business bets.* If you haven't already, you need to expand to multiple hospitals. If one shrinks or closes, you want to have other sources of business.

But beware of work only with a single system. It's not the same thing. In my experience dealing with them, system-wide agreements are not a panacea. In fact, they might be a curse. Being tossed out of a system all at once is just as bad as being tossed out of a single hospital if it's your only significant place of work.

*You need to hedge against your hospital-side business bets.* Begin devoting significant focus to the ASC market as well as other emerging outpatient opportunities.

*Don't be limited to "service to facility" or "service to surgeon" mindsets.* You can become active participants, either within your group, alone or in concert with surgeons, in the formation of ASCs, or even of what I call, in my ASC development work, creating an MOC™: an ASC + aftercare + medical office building + imaging center + etc.—a hospital without the hospital.

*Incorporate what I refer to as "flex down" provisions in your exclusive contract provisions. Beware of set coverage obligations*, such as covering 17 ORs from 7:00 to 3:00 and 10 ORs from 3:00 to 5:00, and so on. If the hospital shrinks (physically or just in terms of the number of cases), you must be able to flex down any promise of specific coverage. To appease the few surgeons who haven't taken their cases to ASCs, hospitals *will* promise them more "flat" 7:00 starts with nothing for you to do in the rooms after, say, 10:00.

*The same strategy applies to system-wide agreements.* Be able to cut facilities from a system-wide contract that has you subsidizing a failing facility that might take you down with it. Or at least build in provisions triggering new stipend discussions. You can't be financially locked in long term.

At the same time that you incorporate flex down provisions, *you have to incorporate what I call "flex up" provisions.* Here are a few:

*You must be able to flex up stipend support* in the event that coverage can't be flexed down and, even then, there's some point where you become like firefighters, just standing around on call. But for you, no cases means no income generated. Similarly, when more business flows outside of the hospital to ASCs, and what's left is low-pay cases, it must *trigger renegotiation of increased stipend support.* If the stipend is not sufficient, then *you must have the ability to walk away,* to terminate.

Having negotiated anesthesia exclusive contracts since the 1980s, I'm keenly aware of the pressure on stipend support. But the times are changing and I'm also keenly aware of plummeting anesthesiologist compensation in many, if not most, markets, and of group failures. You need to have a smart negotiating strategy, not help finding jobs as hospital employees. That is the worst of all worlds. If the hospital subsequently closes, you'll have no employer, no group and no financial support.

*If the hospital owns an ASC, you must have the right to provide coverage at that ASC.* That applies to future ASCs as well, and to any facility that the hospital owns or controls. On the other hand, if the hospital doesn't have a controlling interest in an ASC in which it has ownership, then the hospital must use its best efforts to get you that contract if you want it.

*And you have to be able to provide services at other facilities without restriction.* Anything preventing you from spreading your business to other facilities has to be a nonstarter.

**Preparing Your Group on an Internal *Team* Basis**

*You can't have any salaried physicians or CRNAs whose contracts can't be cancelled on somewhat short notice.*

*You can't promise facility-specific work.* You may not be able to deliver it.

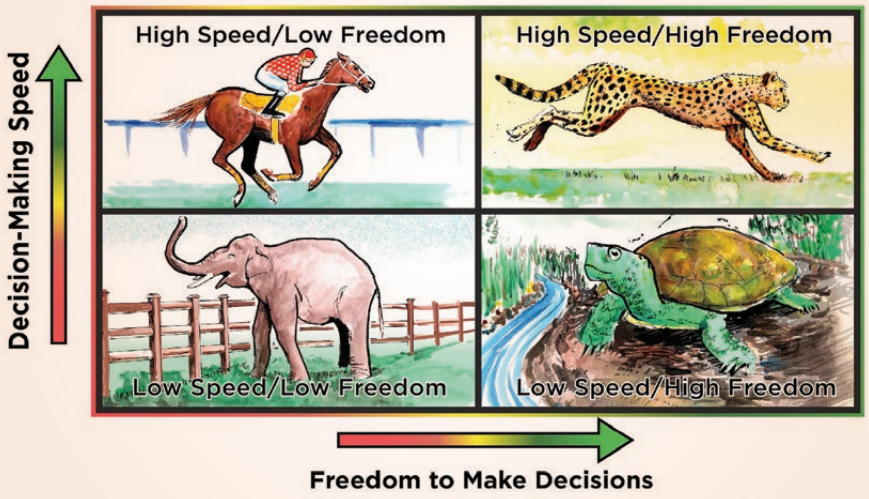
*You have to understand LIFO and FIFO.* LIFO and FIFO are acronyms from the world of wholesale and retail inventory, and for the way that a seller accounts for profit on sales. Are items accounted for as if the *last one* or the *first one* into inventory was the first one sold, that is, "Last In, First Out" (LIFO) or "First In, First Out" (FIFO)?

The same notion applies to members of your group when work slows down or a facility closes. Who is let go? How are they let go? Is it by seniority? Is it by skills needed? For example, what if the skills needed in a move from hospital-based to ASC-based practice don't match seniority? Your partnership agreements, employment agreements, and so on, all have to coordinate with your LIFO/FIFO strategy.

*Even if you're not heavily focused now toward ASC practice, you have to hire for ASC skills and personality—especially personality.* Candidates must have balanced social skills and the ability to work fast.

**FIGURE 1**

**The Medical Group Governance Matrix™**




**Preparing Your Group on an Internal *Governance* Basis**

In order to make any of the changes required, whether proactively or even reactively, your group must have a governance structure that allows leaders to lead and that allows decisions to be made quickly.

Too many anesthesia groups have painted themselves into a corner, unable to make decisions, because they allow far too many to participate in the decision-making process. If you can't come to decisions, *even the decision to not take action quickly*, then someone else—the hospital, an ASC, another group—is going to, in essence, make a decision for you, and it probably will be one you're not going to like.

I've worked with anesthesia groups with developed and effective abilities to make decisions. What was it that enabled these groups to make decisions quickly? There's a continuum of decision-making speed and freedom that's related to the group's governance structure.

It's important to note that I'm not assuming that your group isn't already successful or that you or your group is "damaged" in any way. *Rather, I'm stressing that you must question whether your group's (and your own) current level of success and future prospects can be improved.* Despite your own best intentions, perhaps it's your anesthesia group's governance structure that's holding you back.

## The Medical Group Governance Matrix™

Here's a simple four-quadrant diagnostic tool to help you find out. I call it The Medical Group Governance Matrix™ (see Figure 1).

Let's walk through the quadrants. Where does your group fall?

**Zoo Elephant:** *Low Speed/Low Freedom (lower-left quadrant)*

I use a zoo elephant for the quadrant's avatar because, although they are large, intelligent and powerful, and should be able to act decisively, they're trapped within their surroundings. They just don't have any room to run and to exhibit what could be their speed.

Unfortunately, this is the domain of too many anesthesia groups.

Zoo Elephant groups have one of three governance structures:

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1. A very large management committee or board of directors; for example, a body with 10 or more members;
2. A fully participatory governance structure in which every group member votes on, and in some cases, can veto, any group decision or proposed action; or

   Even though they have a formal, more streamlined governance system, the reality is that they fall back on a consensus system for actual decision-making. Consensus leads to compromise and waters down decisions.
3. These groups take too long to make decisions. The decisions they make are diluted by the need to obtain formal buy-in or consensus. Neither quick nor bold action is welcome.

**Race Horse:** *High Speed/Low Freedom (upper-left quadrant)*

I use a race horse for the quadrant's avatar because, although they are very fast, their ability to use that speed is constrained within the race track's barriers. There's no real freedom.

Race Horse groups have either a small management committee or board, or a solo leader. Conceptually, the leaders of a Race Horse group *could* make and implement quick decisions. However, their decisions are continually second-guessed. This can take the form of criticism or even active resistance. The leaders are blamed for their "poor decision-making" and quickly catch on that it's not in their personal best interest to stick their heads out. Maintaining the status quo receives the highest kudos.

**Turtle:** *Low Speed/High Freedom (lower-right quadrant)*

I use a turtle as the avatar for the lower right quadrant, representing low decision-making speed combined with high decision-making freedom. That's because they're free to roam. They just don't move very quickly.

Whether or not they are actually corporations, Turtle anesthesia groups tend to have a corporate-type structure. However, in practice, the officers' authority is largely micromanaged by the management committee or board of directors, which itself tends to be oversized. The officers are generally prohibited from taking *any* significant action, except as specifically authorized by the management committee or board.

From a freedom-to-lead perspective, measured by the reservation of actual authority at the management committee/board level, Turtle groups are champions. However, their often-large boards and the lack of effective delegation of power to the officers prevent quick decision-making.

**Cheetah:** *High Speed/High Freedom (upper-right quadrant)*

I use a cheetah as the avatar for the upper-right quadrant representing high decision-making speed with high decision-making freedom.

Cheetah groups have either very small management committees/boards or a fully empowered "strong leader." A Cheetah group's leaders are fully empowered to make decisions and they make decisions quickly.

The best way to describe this in everyday language is to say that even if the group's legal structure is a partnership, the governance structure is fully corporate: the leadership is either institutionalized via the governing documents or is elected on a periodic basis. The group doesn't have the right to overturn management decisions and the group's culture is not to interfere with leadership's decisions. Of course, if the structure includes periodic elections and the group loses faith in a leader, they are voted out of office.

These groups are very nimble. They can quickly respond to actions set in motion by third parties. They can quickly take action in regard to market cues. And they can quickly develop and implement proactive, market-making decisions.

## Becoming a Cheetah

If your group isn't already a Cheetah, the object is to move your medical group's governance structure into the Cheetah quadrant—that is, if your group wants to best position itself in today's and tomorrow's market.

If your group is already a Cheetah, it still takes vigilance to remain one. That said, some groups view that goal—becoming and remaining a Cheetah—as having less value than other factors, such as their desire to maintain their club-like structure. As long as that's a conscious decision, made with an understanding of the trade-off, then it's perfectly valid—*that is, as long as you don't expect both a high level of personal autonomy* and *a seriously competitive position for the group*.

Where on the matrix is your group? Is that where you want it to be? Is that where it should be?

Let's turn to a thinking concept to help you get there.

## Avoiding Governance Messes

I have a good friend who says, in the context of a physical skill, that prehistoric humans initially developed the strong, instinctual dominant-hand grip to be able to grab onto tree limbs and quickly climb in order to escape predators like saber-toothed cats. (I like my friend too much to tell him that saber-toothed cats could climb trees.)

The ensuing millennia have honed this instinct, so much so, that we instinctively grab tightly with our dominant hand even when the specific application calls for a much lighter touch. So, too, goes the vice-like grip that causes many medical group members to hang on to their personal control, even when it actually cuts against their modern-day success.

They are so unable to let go of their instinctual need to *personally* control almost all aspects of their financial affairs that they dash their group's ability to function as a true business. The result is a club. (A club of a different sort would have helped with saber-toothed cats. A physicians' *club* does not equal a physicians' *business*.)

In order for a medical group to succeed, governance power must shift within the matrix from the lower evolved quadrants—from Race Horse, Zoo Elephant and Turtle—toward Cheetah. To do so, each member must let go of the individual control instinctually believed was required to save them from the metaphorical saber-toothed cat.

The reality is that one's future in a group isn't protected by preserving individual control. When the modern saber-toothed cat, the reality of business, is charging at you, it's absolutely no time for a vote. It's absolutely no time for "consensus-getting." It's absolutely no time for "any member may veto."

Deep down inside, we all have fears—some irrational, many completely rational. But prehistoric man survived by forming groups. That's what saved them from predators, saber-toothed and otherwise.

Here's where you can start:

Use The Medical Group Governance Matrix™ as a diagnostic tool to assess where your medical group currently resides on the continuum of management decision-making speed and freedom.

Ask yourself the tough questions:

1. How quickly does your group make management decisions?
2. Who's involved in making those decisions?
3. How quickly do your group's leaders implement decisions?
4. Is your group's governance structure fast and efficient or slow and plodding?
5. Is your group a Zoo Elephant, a Race Horse, a Turtle or a Cheetah? Is that where you should be?

In closing, let me assure you once again that I'm not assuming that your group isn't already successful or that you or your group are "damaged" in any way. But it's a given that the pace of change in the healthcare industry in general, and in anesthesiology in particular, is increasing, that business competition is intensifying, and that if your group doesn't keep pace, it won't simply remain where it is, it will be propelled backwards, perhaps into oblivion.

*Author's note: This article is based on my presentation of the same name at the 2018 Advanced Institute for Anesthesia Practice Management and draws from my book,* The Medical Group Governance Matrix, *a complimentary copy of which is available to* Communiqué *readers at https://advisorylawgroup.com/matrixcmmnq.html*

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# The Winning Strategy for Billing Invasive Monitoring

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separate procedure note, which will allow enough room to include documentation required under The Joint Commission's Universal Protocol (see resources at the end of this article).

This protocol requires a date of service, patient's name and consent, start and end time of the procedure, medical necessity (reason for insertion), a description of supplies used, a procedural "time-out" (correct patient identity, correct site, procedure to be done), patient's positioning, preparation for the procedure, confirmation of using sterile technique (sterile gloves, gown, hat/cap, mask, full body drape and, if ultrasound is used, sterile gel and probe covers), confirmation of the insertion site, a full description of the procedure (including whether the line was removed with the tip intact, when applicable) and whether ultrasound was utilized. The form must also include the anesthesia provider's legible signature.

Keep in mind that documentation of the *use of ultrasound alone* is not sufficient. According to CPT® non-obstetrical ultrasound coding guidelines, "Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable." Although it does not normally need to be turned in with your billing records, a retrievable image must be available in the medical records, along with the signed procedure note describing the use of ultrasound, when applicable.

Clearly, a check box on the anesthesia record under monitors and equipment, or "Swan-Ganz" written in the remarks section, does not meet these Universal Protocol standards.

## Clarity and Communication

Your documentation must be clear enough that coders can determine, without asking for additional information, whether a pulmonary artery catheter was floated through an existing line or whether it was medically necessary to place separate lines. Your staff or billing partners must be able to determine whether additional indicated services are billable. There should be continuously open lines of communication between the coding/billing office and the clinical staff. If the information or documentation turned in for billing is not clear, questions should be asked and answered. Delayed billing while waiting for either a response or additional documentation is better than not capturing payment for your service. Educate your staff on what to look for in your practice.

Capturing these services, however, is only half the battle. Keeping or receiving payment for these services when documentation is requested is the other half of a winning strategy. It is a good idea to review the payments you are receiving for monitoring services on a periodic basis, as payers may implement new payment edits unexpectedly.

*Editor's note: ABC clients with questions about the consistency or level of payment for any of these surgical services can obtain a report upon request from their account executive. Please note that rates for each service vary by payer.*

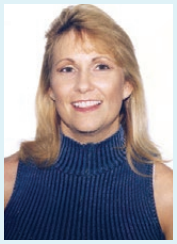
**Resources**

ASA 2018 Relative Value Guide® http://www.asahq.org/

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6706.pdf

https://www.jointcommission.org/assets/1/18/UP_Poster.pdf



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# Anesthesia Group Meetings: Madness or Method—the Choice Is Yours

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

Meetings?

With so many things going on in your practice, why read an article about a topic as mundane as "meetings?"

Here's why:

1. Regardless of size, **meetings are an important governance tool for all groups. Much of the work of governance is done in group meetings.** Yes, often a lot of background work is done outside of meetings, but the real discussions, debate and decision-making typically take place in group meetings.
2. I have observed that many **medical group meetings are chaotic and unproductive**. Much time is wasted. And if meetings don't work well, practice governance doesn't work well. The wrong issues are discussed, reasonable conclusions are not reached and decisions are not made.

Some of you won't pay attention to these ideas because either "we don't need to do that" or "we don't want to do that." However, keep in mind that, to paraphrase Albert Einstein, "Insanity is doing the same thing and expecting a different result." The bottom line is that successful anesthesia group governance requires successful meetings.

The following steps can help you dramatically improve the effectiveness of your group meetings, save time and actually get things done.

## Set a Meeting Schedule

Many groups have problems with meeting attendance. One way to increase meeting attendance is to establish a schedule of meeting dates well in advance.

The most effective anesthesia groups set up their meetings on a particular date each month (e.g., the second Tuesday) or select specific dates. The important thing is to develop this schedule well ahead of time (I suggest 12 months out) so that individuals can consider these dates as they set their own schedules.

Each group will need to determine the best time to meet, but be realistic about the start time for the meeting. Unfortunately, some individuals feel they have "won" if they are the last person to show up to a meeting, because then they don't have to sit around and wait for others to arrive. In other instances, groups will "pad" the start time of meetings, hoping that setting a 5:30 meeting time means a meeting will actually start at 6:00. The bottom line is that this is disrespectful to the people who do show up on time and can often result in a game of "who can be last."

If you know that most of the time people will be late, move the meeting start time to a reasonable time. Attendance at group meetings will improve if individuals know that meetings will start *and* end on time. You appreciation of their time will result in consideration from them.

## Set a Meeting Duration

Many anesthesia groups have lapsed into poor meeting behaviors that result in very long meetings. I have heard that some groups endure four- to five-hour meetings.

Other poor meeting behaviors include:

- Arriving late
- Arriving unprepared
- Too many issues for discussion
- No prioritization of issues
- Discussion that strays off track
- Using meeting time to present reports that could be sent in written form

The rest of this article will address these issues in turn. However, the first step to make meetings more efficient is to **set a goal for how long you would like to meet, and then do what you have to do in the chosen time frame to achieve that goal**.

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# Anesthesia Group Meetings: Madness or Method—the Choice Is Yours

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Setting a time goal forces you to consider ways to jettison inefficient parts of the meeting and put into place good meeting techniques that you might not otherwise implement.

For regularly scheduled meetings, my recommendation is to set a goal to keep meetings to two hours or less. After two hours, participants are usually exhausted and little is accomplished.

There will be times when the time goal cannot be achieved, but most groups are surprised that when they use good meeting management tools and techniques they finish more quickly. **Set a meeting duration goal and meet that goal.**

## Establish and Use Ground Rules

Think about your most recent group meeting. Did the attendees exhibit any of the following behaviors?

- Multiple people talking at the same time
- The discussion drifting off topic
- Distracting phone calls taken in the meeting room
- Participants arrive late
- Low physician attendance
- Some participate in the discussions, while others don't (until the "after-the-meeting meeting")
- Individuals raise many problems but do not pose solutions
- Participants engage in many sidebar discussions, either by talking to the person seated next to them or through texting.

Establish and use ground rules to prevent these negative meeting behaviors.

Ground rules delineate the observable behaviors that group members expect from every attendee. The focus is on *observable* behaviors.

To clarify, let me provide an example of an unobservable behavior. A ground rule that states that everyone is expected to "be open-minded" is subject to dispute, depending on an individual's viewpoint. Why? Because being "open-minded" occurs inside the brain and is not an undisputable observable behavior.

It's best to set ground rules as a group. In other words, have the attendees develop the ground rules together rather than copy the list below and say "here are our new ground rules." Individuals are more likely to adhere to the ground rules if they have had a hand in developing them.

### Focus on Observable Behaviors

Ask attendees "what observable behaviors should be expected of each attendee?" Their responses should cover the following key ground rules:

1. One person speaks at a time and everyone else listens.
2. Arrive on time.
3. Stay on topic.
4. All are expected to participate in the discussion.
5. No sidebar discussions—oral or texting.
6. If you must take a call, leave the room so work can continue.
7. Everything we discuss is confidential unless we specifically agree otherwise.

During the discussion to develop ground rules, you might have someone suggest an unobservable behavior such as "we should all focus on what's best for the group." This is not truly observable because it is happening inside an individual's brain, and each individual can claim to be acting in the best interests of the group. Thank them for their contribution (and maybe even write it down), but keep coming back to observable behaviors like those noted earlier.

Once the ground rules are created, each attendee should be asked if they will abide by the proposed ground rules.

The best performing groups take a few minutes to review the ground rules at the beginning of every meeting. This doesn't take long and the pay-off is huge. Some groups publish the ground rules at the top of their meeting agendas, while others post them on a cardboard sign displayed at each meeting.

Most groups find that group meeting performance will improve simply by verbalizing the ground rules. Attendance will likely increase as individuals begin to experience more organized and effective meetings.

The ground rules will take on even more importance when they are utilized by the group's meeting manager, which will be discussed later in this article.

## Prepare and Communicate Agendas

The anesthesia groups that have more effective meetings devote time to planning their meetings. The best way to ensure that those attending a meeting are sure about its purpose is to send them a clear agenda well in advance.

An agenda for a meeting is a list of items or issues that need to be raised and debated. It should be short, simple and clear.

Creating and using an agenda can cut down on meeting time, improve communication and serve as a useful tool for the meeting manager.

### Developing Agenda Items

Where do agenda items come from? For most anesthesia groups, the best process is for each shareholder or board member to submit an issue they would like to be discussed to the group's administrative manager. The manager may want to send out a reminder to all shareholders about the due date for agenda items.

At the appropriate time, the manager and president should meet to develop and finalize the agenda. Many groups give their president the authority to develop and set the agenda. However, those same groups typically allow a shareholder or board member to raise an issue at the meeting if it is not included on the agenda. Those issues usually drop to the end of the meeting.

To prepare the agenda, the manager and president should review potential agenda items, select those that are most important, develop an order of discussion and estimate the amount of time each discussion should take. **Be generous in estimating the time.** Yes, an issue can take five minutes if only one person talks, but an interactive discussion takes longer.

An important tip: nothing makes a board member or shareholder angrier than seeing that an item they proposed is not on the agenda, with no explanation. Therefore, I suggest that the president be charged with the task of contacting those whose submitted agenda items are not included and telling them why.

The president and manager should then total the estimated time to see if the meeting can be completed within the meeting time goal. If not, they must pare away the lower priority issues, or warn the other attendees that the meeting might last a little longer than the goal.

### Agenda Guidelines

Following are guidelines for setting an effective agenda:

- Try to restrict the agenda to one sheet of paper.
- Include details of the meeting's date, time and place.
- Specify the main purpose of the meeting.
- The time devoted to each item should reflect its priority.
- As previously noted, try to allocate time reasonably. Err on the generous side. Nobody minds if a meeting ends early, but overrunning is unpopular.
- If the total of the time allocation exceeds a reasonable meeting length, revise your plans.
- Some groups use a timekeeper. If an issue exceeds its expected time, the meeting manager should stop the discussion and ask whether the group prefers to continue the discussion or defer the remaining time to the end of the meeting or another date.
- It is unreasonable to present participants with a revised agenda as they arrive at a meeting unless last-minute events have made it necessary, for example, if a participant is not available because of illness or there is a sudden change in financial circumstances.
- Much time is chewed up in meetings with individuals providing reports from certain departments or committees. I suggest that such reports be delivered in writing before the meeting, and that oral reports be limited to asking whether participants have any questions. This, in and of itself, can save hours of meeting time yearly.

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**Information to Send with the Agenda**

One of a shareholder's or board member's most important responsibilities is to come to meetings prepared. Therefore, the agenda should be sent out several days in advance. Along with the agenda, any relevant backup information also should be sent, such as:

- Minutes of the last meeting
- Department or committee reports
- Information related to an agenda topic, such as a cost/benefit analysis
- Financial reports
- Market intelligence

Some groups find it effective to categorize this information as follows:

- Monitoring information
- Decision information
- Educational information
- Market Intelligence information

**Agenda Distribution**

If the agenda is for the board meeting, I recommend that you also send it to the shareholders as well as to meeting attendees. This will allow shareholders to provide board members with feedback about the issues to be addressed prior to the meeting.

## Utilize a Meeting Manager

A meeting manager can be instrumental in ensuring that a meeting runs smoothly. This person should be responsible for:

- Enforcing the ground rules
- Keeping order
- Ensuring that any discussion is relevant to the points on the agenda and that time is not wasted on irrelevant debate
- Repeating any motion proposed by attendees to ensure that everyone has heard and understood it
- The successful completion of business
- Summing up the discussion at the end of the meeting

In addition, it often falls to the meeting manager to remind attendees to make their decisions based on what is best for the entire organization as defined in the group's mission statement, vision, values and strategic plan.

The ideal meeting manager should have a wide range of personal skills, such as:

- Firmness in running the meetings on time and dealing with problems
- Ability to summarize points succinctly
- Flexibility when dealing with attendees' different tones and styles
- Openness and receptiveness to differing opinions
- Fair-mindedness in ensuring that all views are aired and given equal consideration

In cases in which the group expects the meeting manager to appear unbiased, the manager should not join fully in the discussion and should not vote unless a deciding vote is needed.

**Qualities of the Meeting Manager**

The meeting manager is often the group chairman or president, but does not have to be. For example, several years ago I worked with an anesthesia group that had a president who performed most of his functions excellently. However, he was unable to keep the discussion on track and moving forward. This group kept him as president and elected another physician to serve as meeting manager.

I believe that it is best for a physician rather than the group's administrative manager to serve in this role. Sometimes the meeting manager must confront a

shareholder or board member about their meeting behavior. That can be a career limiting move for a group administrator.

**Implementing a Meeting Manager**

Many groups find it difficult to implement the use of a meeting manager. Some practices don't want one. In other groups, no one wants to take on this role, because they are unsure whether they will receive the support they need.

Here's how I suggest you approach implementing a meeting manager:

1. First, ask group members if they believe that their group meetings are ineffective.
2. Then, ask group members if they think that group meetings will be more effective if they have someone who serves as a meeting manager.
3. If they say yes to #2, ask them if they are personally willing to be managed. For example, are they willing to be told, from time to time, that they have spoken on an issue multiple times and that it is time to let others speak?

   Be careful here. Many physicians will say "yes," meaning they are happy to have a meeting manager manage someone else in the group, but they themselves don't need to be managed (because, of course, they think they are never a part of the problem). So ask this question a second time to make sure that they are personally willing to be subject to the meeting manager's efforts to keep meetings on track.
4. If the answers to all of the above questions are "yes," then, and only then, is it time to ask someone if they would be willing to serve as meeting manager.

**Tips for a Meeting Manager**

Pacing the meeting correctly is an important part of the meeting manager's role.

The meeting manager should always make sure that an agenda is provided and followed, and that the speakers have enough time to make their points without the meeting overrunning its schedule.

Here are some additional tips:

- Always make a point of starting the meetings on time. If some participants are late, start the meeting without them.
- Do not waste time recapping for late arrivals unless it is vital that they possess information to make a quick decision.
- Keep things moving briskly by adhering strictly to the agenda and enforcing a strict time limit for each topic. This establishes and maintains a sense of urgency and momentum.
- Do not allow participants to waste time by wandering from the point. If the discussion does begin to stray, bring the discussion back to the main issue by saying, for example, "We are not here to discuss that today. Let's get back to the point."
- Keep tight control over proceedings, direct any debate and encourage attendees to participate.
- When people take divergent positions, remind the participants that the purpose of the meeting is to reach agreement.
- It is the meeting manager's responsibility to ensure that individual participants appreciate the interests of the whole group, that personal interests are set aside when necessary and that everyone is working toward the same aim.
- The meeting manager should close the meetings by:
  - Summarizing discussions and recapping agreements
  - Informing participants of the time, date and location of the next meeting
  - Ensuring that outstanding items are noted for inclusion at the next meeting

## Make Decisions by Voting

When the members of an anesthesia group meet (at either shareholder or board meetings) they typically deal with issues that require a decision. Unfortunately, discussion and voting don't work well in many anesthesia groups for the following reasons:

1. Some group members feel that voting is too "formal."
2. Some groups think they have a consensus because no one speaks up (or only a few speak up and the assumption is that the rest are willing to go along). These groups are fooling themselves because when people don't speak up, it typically means they disagree. In addition, if you think you have a consensus, why not vote to make sure you do?
3. Physicians tend to be conflict avoiders. Sometimes discussions go on and on because people don't want to raise their hands to vote and possibly enter into conflict with those who don't agree with them. This can make meetings last much longer than they need to.

The result of this is often the presentation of too many options and discussion that goes around and around. While it is appropriate that a group consider a variety of options to deal with an issue, at

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# Anesthesia Group Meetings: Madness or Method—the Choice Is Yours

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some point, a decision needs to be made. Therefore, I suggest that the meeting manager should always be pushing for someone to make a motion on the issue. In fact, some groups have such a problem with overly long discussions that I suggest they not allow discussion on an issue until someone makes a motion!

The following practices can be helpful in this regard:

- Introduce the issue.
- Allow some time for general discussion while encouraging someone to make a motion and someone to second the motion. The meeting manager should clarify the motion, make sure it is complete and repeat the motion so that all understand it.
- At that point the motion should be discussed. The meeting manager should keep discussion focused on the motion at hand.
- At some point, someone should call for a vote, and the group members should vote with a show of hands or by using secret ballots (discussed below).

Yes, this process is a little more formal than the one many groups currently utilize. However, it can lead to a level of clarity in decision-making that many groups have not seen for years.

## Secret Ballots

To avoid conflict, more groups have moved to voting with secret ballots. Most groups use secret ballots to elect their board and officers, but some groups use them when they need to vote on controversial issues, or, in some cases, on all issues.

Why are secret ballots useful?

- They allow individuals to "vote their conscience" with less fear of retribution.
- They avoid the opportunity for one physician to bully another physician into changing their vote.
- They often speed up a meeting because people don't delay voting to put off conflict.

There are several ways to implement secret ballots. Here are two:

1. Use 3 x 5 cards as the secret ballots.
2. I have observed some groups starting to use "audience response systems." Such systems are either stand-alone devices, such as those produced by Turning Technologies www.turningtechnologies.com or apps such as Poll Everywhere www.polleverywhere.com. (I have no relationship with either of these firms.) I spoke with a medical group president at a recent conference whose group had moved to using such a system for all votes. He said the system had cut meeting time by about 25 percent.

Groups that use secret ballot for all of their issues have told me that there is only one potentially negative outcome: people will push too quickly for a vote. Therefore, it is up to the meeting manager to make sure that the group has had a full discussion of the issue prior to voting.

## Avoiding Re-discussion Torture

Many anesthesia groups make a decision and then revisit it over and over again. This happens when a few group members do not get their way in the first vote. They use this strategy to try to torture the group into changing its decision or to paralyze it.

When other group members express their frustration about the problems that revisiting an issue will cause, the dissenting physicians often argue that additional information has come to light that should be considered. This can go on ad infinitum and the ability to pursue key opportunities (or the ability to avoid key threats) can be lost.

Many organizations suffer from this problem, but the situation is more challenging for anesthesia groups where the

shareholder physicians are equal owners of the practice. Some physician shareholders believe that equal ownership gives them the right to have a say about every issue at any time (and often to waste precious group meeting time in the process).

## Speed Bumps

Anesthesia groups can prevent this perceived "right" on the part of the shareholders from being used to torture the other group members into voting their way.

One way to reduce the use of this torture technique of revisiting issues over and over again is to use a "speed bump" to return the discussion back to the agenda.

For example, the group might consider implementing a policy that requires 30 percent of the shareholders to sign a document asking to bring an item back to the floor for re-discussion once a decision has been made.

It is important to have shareholders sign an actual document, rather than have someone say "30 percent of the group says they'd like to re-discuss this issue." This policy doesn't close the door to re-discussing an issue. If more than 30 percent want to re-discuss an issue, the group probably should. However, it can reduce the incidence of torture.

## A Super-majority to Overturn Board Votes

Anesthesia groups that have a board of directors (composed of a subset of shareholders) sometimes face the problem of individual shareholders wanting to re-discuss board decisions that are clearly within the board's authority.

You can use the speed bump strategy discussed above for board decisions. Alternatively, you can create a policy in which a super-majority vote of the shareholders is required to overturn a board decision that is within their level of authority. Such a policy can strengthen your board and increase their confidence in making decisions for the group's benefit.

A third solution is to empower the president or the Executive Committee to decide what to include and what not to include in the agenda of larger group meetings.

## Put These Ideas to Work

There are two main ways to implement the ideas covered in this article:

1. Choose two or three ideas above and implement them as soon as possible.
2. Devote one of your upcoming meetings to reviewing the ideas and agree to immediately implement as many of the recommendations as possible.

Some group members probably will fight against such changes, arguing that they won't work or that they are too formal for a group of your size. Expect such resistance, but realize that the reason they are fighting change is that they are getting something out of the status quo.

To overcome this resistance, suggest trying the new approach in the next few meetings and then re-evaluating. Soon these changes will become a part of your process.

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# What is the Right Compensation for Your Providers?

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Many anesthesia practices complain that their biggest challenge is to generate enough funds to cover the cost of a sufficient number of providers to meet the expectations and service requirements of the facilities they serve. There are many variables to the equation. What is the staffing model? How many physicians and CRNAs are employed? What are the collections for the practice and are they growing or eroding? And, ultimately, how much is each provider paid?

Knowing what is reasonable and appropriate to pay a physician or CRNA in the current environment has become one of the most difficult management issues. Often, little of the national benchmark data is relevant for individual situations. The data that we most need to make informed management decisions is the most difficult to come by.

So you are preparing for a presentation to the hospital administration. You know the current subsidy is not enough to meet your providers' expectations. You also know that any numbers in your calculation of a new subsidy request will be subjected to a fair market value (FMV) test—a process that your hospital will most likely have to use in order to satisfy their fiduciary obligations to avoid violations of the Stark Law and the Anti-Kickback Statute. You want to obtain enough to make the potential agreement fair in the short and long term. This is the greatest challenge in hospital contracting. Almost anyone can get a subsidy number right today, but chances are it will be wrong tomorrow. What are reasonable benchmarks? How do you justify your request?

Of course, the members of your practice all think they are being underpaid. Everyone has anecdotal evidence of other practices with similar workloads and a comparable payer mix that are making more. Unfortunately, these perceptions are of little value unless you can justify them empirically. And so you or your consultant look for benchmark data to bolster your case.

## Benchmarking Challenges

Taking a page out of a real estate appraiser's guide, you would like to know how your compensation compares to other practices in the local area.

First, most practices are not willing to share the details of their compensation with potential competitors and even if they were, it would probably not be all that useful.

Second, even if they were willing to do so, it is not clear they would provide sufficient detail for a reliable comparison for purposes of evaluating compensation; what might be deemed fair and reasonable to one provider might not be acceptable to another. A serious comparison of practices would involve multiple variables including the staffing mix, types of cases performed and operating room efficiency.

Third, any sharing of compensation data could have significant anti-trust implications in a competitive market. All of which explains why most consultants turn to third-party data where the data is blinded. The problem, of course, is that blinding the data reduces its potential relevance to your particular practice.

National compensation surveys are designed to provide reasonable benchmark data but they have many limitations, including sample size, timeliness and relevance to a specific geography. There are four main sources of such survey data:

- The Medical Group Management Association (MGMA), which is generally regarded as the most reliable;
- The American Medical Group Association (AMGA), another national organization of medical professionals that collects practice management data;
- Medscape.com, a similar organization but with a more limited offering; and
- Salary.com, which provides more real-time and location-specific data, but which tends to have small sample sizes.

Most independent anesthesia consultants have come to accept MGMA's compensation data in its annual *Physician Compensation and Production Survey* as the gold standard. As the nation's largest independent practice management organization, MGMA represents a significant cross-section of the American medical community and takes its mission of providing useful and relevant management metrics very seriously. While MGMA data is monitored closely for national and regional compensation trends, its breakdown is fairly general: Northeast, Southeast, Midwest and West. A typical survey may only represent a few hundred practices employing a few thou-

sand providers. By our estimate, there are currently more than 55,000 anesthesia providers working in the U.S. If you are trying to evaluate compensation for a specific location, the data may not justify your request.

## An Interplay of Factors

Geographic factors can be significant in determining a competitive level of compensation. Consider, for example, New York state. You might think the highest paid anesthesiologists work in New York City, but this is not necessarily the case. It takes more to recruit a physician to Glens Falls or the Finger Lakes than it does to Queens or Long Island. A large organization, such as North American Partners in Anesthesia (NAPA), one of the nation's largest anesthesia entities, located in Roslyn, New York, may have better contracts and can, thus, pay more than those who are not with NAPA and who cannot get the same contract rates.

National survey data only looks at who is paid what, but not why. Specifically, they do not look at issues like payer mix and practice revenue potential or the challenge of recruiting a provider to a particular location. Even with these limitations, the FMV process relies of these national benchmarks to provide a final report to the hospital. To understand the first criterion, it is useful to keep in mind that there are two types of anesthesia practices: those that require a subsidy and those that do not.

Consider the following. Every practice has a cost of providing services. Suppose the practice consists only of physician anesthesiologists. If they earn the MGMA median and receive eight weeks of vacation, then the cost per anesthetizing location day is approximately $2,100. If the practice consists of a care team with physicians and CRNAs, the cost per anesthetizing location will be less, and might be as low as $1,700 or $1,800. Subsidy payments should reflect the gap between the revenue potential of the practice and the cost of providing the service. If the practice has a favorable payer mix and is busy, then the providers do well because there is plenty of money in the equation to pay them without any support from the facility. While 75 percent of all anesthesia practices require some form of financial support from the facilities they serve, according to MGMA data, 25 percent do not and the variances can be significant. For all other practices, where the cost of providing the service exceeds what is collected in fee-for-service income, the gap must be covered by the facility hospital.

Conventional wisdom holds that hospitals will contribute an amount necessary to put the anesthesia practice on par with other practices in the area, but this is not always the case. There is a lot of pressure on hospital administrators to minimize the amount of money they pay for anesthesia and other subsidies and they will always look for alternatives to increasing an existing subsidy.

## Hospital Negotiations

It is easier to get money from insurance plans than hospital administrations. A poor payer mix impacts both the anesthesia practice and the hospital. This explains why hospital contract negotiations have become such a challenging exercise. There also tends to be a certain prejudice on the part of hospital administrators who are always suspicious of requests for more money from their anesthesia practices. It is interesting how many administrations have run out of patience with their anesthesia providers. This may explain why so many groups with longstanding contracts at facilities with high Medicare and Medicaid patient populations are being taken over by national staffing companies. The perception is that these national staffing companies speak the same language as the administrators, which may or may not be true.

Hospitals do not have unlimited resources, and in recent years have begun to request from groups alternative coverage models stating that there is only so much money to pay for anesthesia. This also often results in changes in the staffing model. Physician-only practices become care team practices and slightly leveraged care team practices become heavily leveraged care team practices. Practices that need more than 30 percent of their gross from the facility should accept that they are at risk for losing their contract.

Collections less the expenses for a practice determine how much money can be paid out to the providers, but the compensation model can have a significant impact on a physician's or CRNA's income. How your practice distributes its net income makes all the difference. Is it a "lump and divide" practice, as is more common in the East, or a productivity-based practice, as is more common in the West? If the revenue pie is divided equally, then all the physicians should essentially get the same pay. In a productivity model, however, there can be huge variability in actual physician compensation, depending upon how each member works. This is important because often the potential to earn an above average income will entice young physicians to join a practice.

## Compensation Structure

Some practices are structured such that compensation is based on one's position or tier in the practice. A buy-in for new physicians is not uncommon, resulting in limited or capped compensation for a period of years. By making partner or becoming a shareholder, they are entitled to a larger piece of the pie. Obviously, such structures are intended to enhance the compensation of the senior members at the expense of the junior members. What new members hope is that by the time they reach senior status that their compensation will increase commensurately. In such models, the physicians are buying futures in the practice.

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# What is the Right Compensation for Your Providers?

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The impact of the numerous large national staffing companies cannot be underestimated. They have redefined provider expectations. There was a time when a resident program graduate looked for a practice that would allow them to settle down and raise a family. It was a long-term commitment. New graduates now have many options. They now have the option to "shop" practices. The large staffing companies give them the option to move from one practice to another, which can be perceived as a nice benefit. Compensation levels may be somewhat lower than those offered by major established practices, but what the national firms offer is predictability of earnings and security. Lifestyle-oriented millennials like this feature.

Michael Hicks, MD, former president of EmCare, was asked if the ultimate objective of organizations such as his was to drive down the cost of anesthesia. His answer was "most certainly, yes." By controlling an ever-larger percentage of the entire anesthesia community, such entities have enormous potential to manage/control anesthesia compensation.

Ultimately, practice culture is a significant recruitment factor. Practices in the northwest may not pay as well as others in other parts of the country, but providers are drawn to the potential for a nice lifestyle with many recreational opportunities.

There is no better example than the San Diego market. Graduating residents love the idea of being able to work near the beach even if it means a lower compensation package. It is also interesting how many graduating residents prefer to stay and work where they trained. Family or religious ties may also factor into recruitment efforts. Most graduating residents are still looking for practices in locations where they can settle and raise a family.

The practice's work/lifestyle balance may be a positive, but it can also be a huge challenge. Many practices are in places where providers are not interested in living. This means that every practice must clearly and cleverly define and promote its culture and lifestyle opportunities.

## Making Your Case

Provider compensation is at the core of any hospital subsidy request, but how do you make the case that the current income potential is not enough given the current requirement that hospitals have an external FMV? It is probably less about the benchmarks than about market dynamics.

Three factors determine the need for a subsidy: the practice's revenue potential, the administration's coverage and call requirements and the providers' income and lifestyle expectations. It is a dynamic equation. The best arguments are those that look at each component separately and assess their impact on the whole. Monitor the payer mix and its impact of the average net yield per unit. Plot the slope of the line. If it is declining, then this is an important predictor of future deficits and must be addressed. It is not unusual to have a subsidy request based entirely on the change in Medicaid volume, especially for Obstetrics, where Medicaid is prevalent.

Look carefully at case volumes, operating room utilization and the expansion of non-OR anesthesia coverage requirements (NORA). As utilization declines, so does revenue potential. More 7:30 starts means more providers and a higher cost for the service. Calculate and plot the average net collections per anesthetizing location over time. If it is declining, a subsidy increase is inevitable and can be empirically demonstrated. Alternatively, a group may be able to convince the hospital to reduce its coverage requirements based on productivity. It is only after these baseline issues have been addressed that you look closely at provider compensation, but national benchmarks may not be the most useful indicator.

Typically, anesthesia providers have a certain degree of loyalty to their practice. They can tolerate minor fluctuations or drops from year to year, but only to a point. That is when they start to look at alternatives. No metric is more powerful in discussions with administration than the number of providers who have left a practice. This is your real leverage because it is generally recognized that the best providers with the best options leave first.

## Collaboration is Key

Recent experience with hospital contract renegotiations has highlighted two important themes. If you are concerned about the future of your practice, do not be afraid to share all the details of your concerns with administration. Revising the terms of a contract should be part of an ongoing dialogue and not a face-off every time it comes up for renewal. A collaborative approach is always better than a confrontational approach.

Second, anesthesia providers and hospital administrators speak a different language and work through problems in different ways. Anesthesia providers pride themselves on being able to make critical clinical decisions in a matter of seconds but quick decision-making is not the objective of hospital administrations whose objective is maintaining the status quo. This is why physicians are having to learn how to think like business people. It is fundamentally about mastering the art of negotiation. Make your case, argue its merits, but be willing to accept and appreciate administration's goals and objectives. It can be tedious and frustrating. Unfortunately, there is no alternative.

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# Lessons Learned: Five Tips for Buying or Selling a Practice

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If you are anticipating buying or selling a practice during the coming months, you are not alone. The healthcare industry is experiencing a wave of integration. In fact, it has been occurring for several years. Many transactional healthcare attorneys have negotiated and closed dozens of these transactions for clients. They have negotiated on behalf of the sellers in some cases and the buyers in others.

Even though mergers, acquisitions and divestures involving physician practices are commonplace, physicians involved with these potential transactions, including anesthesiologists, often have questions about the best way to proceed from a practical and strategic perspective. This article is intended to provide some answers. Here are five practical tips for physicians who are buying or selling a physician practice.

1. **Clearly define, communicate and remember the underlying purpose of the transaction.** In order for practice leaders to negotiate the deal and attorneys to structure the transaction in the best way possible, all need a clear vision of their side's ultimate business objective. Remembering the overarching business objective helps to keep discussions on track and to ensure that negotiators focus on what really matters instead of becoming distracted by less significant issues. This is often particularly important when a party is less sophisticated and unaccustomed to deciding what is or is not material from a business perspective. Staying focused on the business objective is also particularly important to help prevent decisions from becoming clouded by emotion or ego. For example, this can occur when a retiring physician is selling a practice that represents his entire career and personal identity.

   There are many reasons why a party may desire to buy or sell a physician practice. Sometimes the sale of a practice is necessary because the physician owners are retiring or relocating. Other times the physician owners desire to integrate with another provider to position themselves for greater success in a challenging industry. Perhaps the selling physicians find operating an independent practice to be too burdensome from a financial perspective. Consider, for example, flat or declining reimbursement rates, challenges collecting accounts receivable from patients and payers, and rising expenses (e.g., those related to employee benefits, electronic health records, quality reporting, etc.).

   Consider, too, that larger practices often have increased influence to negotiate more favorable rates with payers, to take advantage of economies of scale and to coordinate care in a manner that allows them to thrive under the changing healthcare reimbursement regime that increasingly rewards physicians for the value (i.e., the quality and efficiency) of care provided instead of the volume alone. Larger groups also often have expanded opportunities to benefit from ancillary service lines, such as imaging and laboratory services. Lastly, selling physicians sometimes perceive that practicing as an employee of a larger group practice will afford them greater

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# Lessons Learned: Five Tips for Buying or Selling a Practice

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work-life balance than they would have as a physician owner.

2. **Select transaction participants wisely.** Negotiating a successful physician practice transaction involves much more than beautifully drafted legal documents. From a business and practical perspective, it is imperative that the buyer and seller trust one another, have compatible cultures and share similar values. This is especially true in the case of an integration transaction in which physicians on both sides of the deal will continue to work together after the closing.

   Most healthcare attorneys can share stories about deals that unwound as quickly as they came together because the parties were unable to get along. Integration transactions that devolve into business divorces are often a waste of substantial resources and become emotionally draining for all involved.

   Accordingly, it is advisable for the parties to conduct not only regulatory and financial due diligence, but also reputational and cultural due diligence. In the interest of efficiency, such diligence should be conducted early in the process. There is no doubt that the acquiring entity should review and analyze contracts to be assumed, determine whether the physicians to be acquired have historically had an active and robust compliance program, and review an appropriate sample of patient charts and billing records before taking on potential Medicare, Medicaid or third-party payer overpayment liability.

   However, it is also important for the parties to discuss their respective expectations regarding autonomy, managerial control, transparency and day-to-day operational issues. Both sides have a strong interest in confirming that they can get along and that there are no significant personality conflicts. For example, if one party is accustomed to an autonomous, physician-led organization and the other expects a greater level of administrative oversight and physician conformity, they may not be compatible.

3. **Identify a strong negotiating team**. Members of the negotiating team should understand the underlying purpose and related business considerations, be responsive and nimble through the process and be on the same page as the governing bodies that will ultimately need to approve the transaction.

   Specifically, they need to understand any deal breakers in the minds of their group's leadership with respect to key terms. For example, these deal breakers may relate to the assets, contracts, real estate leases, equipment and provider billing numbers to be transferred; the clinical and non-clinical personnel who will be employed post-closing, as well as their post-closing compensation structure and employee benefits; and whether the involved physicians will be subject to restrictive covenants such as non-competition or non-solicitation provisions.

   It is incredibly disappointing when the key negotiators complete the due diligence process and finalize proposed documents with the other side only to have their shareholders or directors withhold ultimate approval of the transaction because of an unacceptable business term or degree of financial or regulatory risk. Because identifying the other party to the transaction, evaluating and comparing potential transactions and explaining the key terms to the group's leadership requires a substantial time commitment, many physician practices engage business brokers to assist those leading the negotiations.

4. **Include legal advisors during the initial stages of discussions**. Attorneys who are included at the outset of discussions regarding a potential

transaction are in the best position to mitigate associated regulatory and legal risk and to ensure that the negotiations and the transaction itself occur as efficiently as possible.

Because financial relationships that are permissible in any other industry are not permissible in healthcare, it is important to ensure that the transaction and related relationships comply with applicable law (e.g., the federal Anti-Kickback Statute; the Stark Law; tax exempt, antitrust, HIPAA and other laws; and state fraud and abuse, privacy, licensure, corporate practice of medicine and other requirements. These laws often require the sale or purchase of a physician practice to be structured in a particular manner. Further, these laws also often require that purchase price and compensation paid in connection with the transaction be fair market value, as such term is defined under applicable healthcare laws. Healthcare attorneys assist clients to understand what the fair market value requirements mean in this context and to obtain the opinion of a qualified, experienced, third-party healthcare valuation consultant, when appropriate.

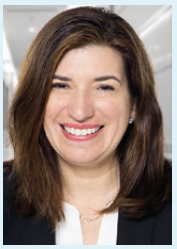
Attorneys further help their clients to understand the optimal structure for the transaction (e.g., merger, sale of assets, sale of equity, etc.) in order to achieve the underlying business objectives and mitigate legal risk. Buyers often desire to structure transactions as asset deals to mitigate the potential successor liability that is otherwise present with an equity deal. That being said, a sale of equity is sometimes desirable, for example, in order to assume the hospital-based contracts, third-party payer contracts or licenses, or other governmental approvals of the entity to be acquired. In any of the structures, attorneys can assist their clients to understand their options regarding the degree of integration and autonomy among the participating parties.

It is also often helpful for attorneys to prepare a Letter of Intent or similar documents before preparing and negotiating the transaction documents themselves. These documents typically include provisions that protect the confidentiality of information shared during discussions, prevent the parties from negotiating the same deal with more than one other potential partner, set forth a timeline for conducting due diligence and advancing the transaction, and include a clear statement of certain key business terms. By doing so, the parties are better protected during negotiations and able to confirm that they have a common understanding of the most important business terms before investing significant resources to prepare and negotiate transaction documents.

5. **Ensure that the written deal terms are clear, comprehensive and provide the desired degree of flexibility**. The parties to any integration transaction should ensure that all important terms of the deal are clearly set forth in the written transaction documents. A verbal promise made during negotiation of the transaction is generally not legally enforceable. Anything that is important should be in writing. It is also very difficult to enforce contract terms that are overly complicated or unable to be implemented from a practical perspective. For example, if an employment agreement includes a significant bonus in the transaction, it should be clear to a third party exactly how the bonus is calculated and when it must be paid. Depending upon the circumstances, side letters and special deals for one or more physicians can increase the risk of a post-closing dispute about the terms that were intended or approved by the parties.

Also, because integration transactions are sometimes unsuccessful, it is often advisable for the transaction documents to address the terms upon which an unwind transaction would occur. Sometimes selling parties maintain flexibility by retaining their provider contracts, real estate, equipment, patient records and assets, and lease them to the acquiring practice upon closing so that the sellers may return to their practice infrastructure in the event that their relationship with the buying entity terminates.

Other times, the documents set forth the terms upon which the buying entity will transfer such infrastructure back to the selling practice upon termination of the integration. In contrast, the buying party may have an interest in imposing a heavy exit penalty upon any departing physician. Whether the selling practice is able to negotiate favorable exit provisions often depends on the degree of leverage that the selling party has during negotiations.



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## Professional Events

| Date | Event | Location | Contact Info |
|---|---|---|---|
| August 10-12, 2018 | American Society for Gastrointestinal Endoscopy<br>GI Outlook 2018: The Practice Management Conference | Fairmont Austin<br>Austin, TX | https://www.asge.org/home/practice-support/courses-conferences/gi-outlook-go-the-practice-management-conference |
| September 6-9, 2018 | Texas Society of Anesthesiologists<br>2018 Annual Meeting | Hyatt Regency Lost Pines Resort & Spa<br>Cedar Creek, TX | https://www.tsa.org/apps/register |
| September 8, 2018 | Washington State Society of Anesthesiologists<br>2018 Fall Scientific Meeting | Museum of Flight<br>Seattle, WA | https://wassa.memberclicks.net/index.php?option=com_mc&view=mc&mcid=72&eventId=543565&orgId=wassa |
| September 20-23, 2018 | New England Society of Anesthesiologists<br>61st Annual Meeting | Mystic Marriott Hotel & Spa<br>Groton, CT | http://nesa.net/NESA/AnnualMeeting%20Pages/AnnMtg2018prov.html |
| September 22-23, 2018 | Ohio Society of Anesthesiologists<br>79th Annual Meeting | Hilton Columbus at Easton<br>Columbus, OH | http://osainc.org/upcoming-event/2017-aacd-perioperative-leadership-summit/ |
| September 23-27, 2018 | American Health Information Management Association<br>2018 Convention and Exhibit | Miami Beach Convention Center<br>Miami Beach, FL | http://www.ahima.org/convention |
| Sept. 30-Oct. 3, 2018 | Medical Group Management Association<br>2018 Annual Conference | Boston Convention & Exhibition Center<br>Boston, MA | https://www.mgma.com/events/mgma18-the-annual-conference |
| October 8-13, 2018 | American Association of Oral and Maxillofacial Surgeons<br>100th Annual Meeting, Scientific Sessions and Exhibition | McCormick Place West<br>Chicago, IL | https://www.aaoms.org/meetings-exhibitions/annual-meeting/100th-annual-meeting |
| October 12, 2018 | American Society of Anesthesiologists International Forum on Perioperative Safety & Quality | Hilton San Francisco Union Square<br>San Francisco, CA | https://www.asahq.org/ifpsq/asa |
| October 13-17, 2018 | American Society of Anesthesiologists ANESTHESIOLOGY®<br>2018 Annual Meeting | Hilton San Francisco Union Square<br>San Francisco, CA | https://www.asahq.org/annualmeeting/?utm_source=asahq&utm_medium=landing-page&utm_campaign=Annual-Meeting |

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