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CMS FINALLY SPEAKS: THE ACCOUNTABLE CARE ORGANIZATION (ACO) PROPOSED REGULATIONS AND WHAT THEY MEAN FOR ANESTHESIOLOGISTS

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Since the passage of the Affordable Care Act¹ and the establishment of the Medicare Shared Savings Program (the “Shared Savings Program”), ACOs have become the new hot topic.

Section 3022 of the Affordable Care Act provides that Medicare shall establish the Shared Savings Program and that healthcare providers and suppliers will participate in the Shared Savings Program through ACOs. According to CMS, “ACOs create incentives for healthcare providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Shared Savings Program will reward ACOs that lower growth in healthcare costs while meeting performance standards on quality of care and putting patients first.”²



If an ACO saves money by providing patients with efficient care, then the ACOs can share in a percentage of the savings with Medicare. However, should an ACO fail to provide efficient and cost-effective care, it may be required to pay money back to Medicare.³

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MORE PRESSURE ON ANESTHESIOLOGY GROUPS TO GROW

Have you and your group been thinking about how to grow your practice? The trend toward anesthesia practice consolidation continues its momentum. Not only do groups seek more and more opportunities to merge, to acquire other groups and to join larger organizations; they are an increasingly attractive acquisition target.

Mark Weiss, Esq.'s article "The Company Model of Anesthesia Services: Will Less Money Lead to Jail Time?" is an excellent review of the development of the troublesome "company model" as well an explanation of the associated compliance issues that you don't have to be a lawyer to understand.

For a different perspective, consider AAA Executive Committee member Franc Galinanes's article "Anesthesia: The Increasing Consolidation of Our Industry." As a Senior Director for North American Partners in Anesthesia, Mr. Galinanes is in a good position to discuss the advantages of the three major types of consolidation: practice mergers, joining a larger organization and sale to a well-funded or publicly traded multispecialty group. Besides the financial benefits of size such as leverage and access to capital, consolidations may offer cross-privileging and a greater provider pool, quality data with more robust denominators, access to superior employee benefit plans and other advantages.

The form of consolidation that commands the greatest portion of our attention continues to be joining Accountable Care Organizations (ACOs). Two lawyers from the Health Law Partners, Neda Mirafzali, Esq. and Kathryn Hickner-Cruz, Esq. provide an exhaustive review of the proposed regulations released by CMS on March 31, 2011 in our lead article.

The ACO proposed regulations were a disappointment to many. According to CMS itself, the up-front costs of launching an ACO would be around \$1.8 million. Furthermore, ACO participants would be penalized for failing to keep patient costs in line with CMS targets, increasing the risk that they would not see a return on investment. Negative reactions led to CMS' announcing, on May



17, a new shared savings program, a "pioneer ACO model" that would allow physicians and hospitals to start coordinating patient care as early as October. Advance payments may be available from CMS. Applications to form a pioneer ACO are due by July 18. The requirement of a minimum of 15,000 patients makes it virtually impossible for anesthesiologists to lead a pioneer ACO, but you may read more about this initiative on the [CMS web site](#).

ASA filed an interesting "comment" on the proposed ACO regulations, suggesting that CMS expand its horizons from the "medical home" for primary care services and consider the savings and quality opportunities that would be afforded by a "surgical" or "peri-operative" home. As we have stated in a number of publications and presentations, we agree strongly with ASA that anesthesiologists have a key role to play in a surgical home. "Anesthesiologists routinely interact with providers from virtually all care settings and assess and monitor the patient from an overall perioperative perspective; thus, anesthesiologists are ideally suited to effectively assess and manage risk across the full continuum of the perioperative setting. ([ASA Letter to Donald Berwick, MD](#), CMS Administrator, June 3, 2011.)

Whether by managing risk across the perioperative setting or simply by managing operating room productivity, anesthesiologists continue to feel pressure to make the surgeons want to bring their patients to the hospital where they work. Jody Locke, CPC, ABC Vice President of Anesthesia and Pain Management Services, addresses this ongoing challenge

in his article "Getting Paid for Anesthesia: Mastering the Challenges of Viability." One of the trends discussed in Mr. Locke's article is the fact that "Some of the nation's largest hospital organizations have come to identify the improvement of operating room productivity as a key strategic objective," and that "anesthesia practices are having to develop an entirely new set of reporting and management tools to both monitor the appropriateness of operating room utilization and help hospital administrations reset surgeon expectations." Other trends are the transfer of financial responsibility from employers and health plans to patients themselves and the increasingly common insistence of hospitals on examining their anesthesia groups' books when negotiating stipends.

The financial risks are there, even for practices willing to adapt as much as possible to new demands. We are constantly engaging in strategic planning for our clients' organizations and for our own. There is much more to the process than we can convey in a newsletter, but we hope, as always, that our information is valuable to you.

With best wishes,

Tony Mira
President and CEO



THE COMPANY MODEL OF ANESTHESIA SERVICES: WILL LESS MONEY LEAD TO JAIL TIME?

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When asked why he robbed banks, Willie Sutton responded, "Because that's where the money is."

Ambulatory surgery center ("ASC") owners, often surgeons, seek to obtain a share of anesthesia fees for the same reason. But instead of a gun, many are turning to a new model of money extraction, the so-called "company model."

The abrupt bank robber approach to demanding a kickback is clearly illegal: "Bob, if you want to provide anesthesia at Greenacres ASC, you've got to pay us thirty cents on the referred dollar".

Although there are far more ASC owners willing to take the bank robber approach than the industry likely will admit, some ASCs are choosing a slightly softer approach — forcing the anesthesiologists working independently at the ASC to instead work for an ASC affiliated entity that distributes a share of the anesthesia fees back to the ASC owners.

"Bob, if you want to provide anesthesia at Greenacres ASC, you've got to become an employee of our entity, Greenacres Anesthesia Services. We'll even pay you commensurate with your production. In fact, we'll pay you the lion's share, seventy cents on the dollar!"

These entities are the "companies" of the so-called company model.

Of course, demanding 30% as a direct kickback (the bank robber approach) leads to the same economic effect as



does forcing the anesthesiologists into an entity that "rewards" them with a 70% share (the company model).

But is the company model structure legal? That's the \$25,000 fine, plus five years in jail, plus exclusion from Medicare and Medicaid question. Of course, there are also Civil Monetary Penalties to consider, but you get the point.

BUSINESS MODELS

In order to better understand the issues of the company model, it's helpful to consider the evolution of anesthesiologist-ASC business models.

Conventional Model

The conventional fee-for-service relationship between anesthesiologists and ASCs mirrors the conventional relationship between anesthesiologists and

hospitals – the anesthesiologists, directly or through an anesthesiologist-owned entity, provide services to the patients of the ASC for their own account, in the manner of the surgeons performing their cases at the facility. In this relationship, the facility charges a facility fee and the physicians, both the surgeons and the anesthesiologists alike, charge their own, independent professional fees.

In many cases, the relationship between the anesthesiologists and the ASC takes on an additional factor or factors.

One or several of the anesthesiologists providing patient care services might assume other duties such as serving as the facility's medical director. In compensation for those services, and to avoid a kickback (the provision of those services for free being an inducement to receive the referral of anesthesia cases), the ASC pays a fee, for example, a medical director stipend, in an amount equal to the duties' fair market value.

In some relationships, the volume of cases or total reimbursement to be earned from providing coverage of the ASC's anesthesia needs is not sufficient to attract or retain anesthesiologists. To obtain anesthesia coverage, the ASC pays a coverage stipend to the anesthesiologists or their professional entity in order to supplement their billings.

Over time, some ASC owners began to question the conventional model

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Accordingly, the Shared Savings Program and its ACOs are among the many examples of how the Affordable Care Act has embraced and advanced the popular notion of value-based purchasing. Through this change in payment methodology, the Centers for Medicare and Medicaid Services (“CMS”) intends to achieve its three-part aim for the Shared Savings Program: (1) better care for individuals, (2) better health for populations, and (3) lower growth in expenditures.

For over a year, the healthcare community waited patiently for guidance on ACOs and, amidst all of the speculation as to what exactly ACOs will be, what they will do and how they will qualify for the Shared Savings Program, CMS issued its notice of proposed rulemaking with respect to the Shared Savings Program and ACOs on March 31, 2011 (the “Proposed Rule”).

Although the Proposed Rule spans several pages and sets forth an abundance of detailed and mind-numbing requirements that ACOs will likely need to satisfy, those with a passion for healthcare policy and reform will find the document to be an interesting read as it sets forth a summary of the leading thoughts on these topics and a clear description of the philosophy upon which the Shared Savings Program has been built. Irrespective of whether you are a believer or a skeptic of the Affordable Care Act and its Shared Savings Program, this article provides you with a brief summary of certain key provisions of the Proposed Rule.

ELIGIBILITY AND GOVERNANCE

Although healthcare providers will be afforded substantial flexibility when structuring their ACOs, it is clear that



anesthesiologists desiring to participate in an ACO will need to do so in collaboration with others.

The Affordable Care Act provides that ACOs can take any of the following forms:

- Group practice arrangements comprised of ACO professionals (defined as physicians, physician assistants, nurse practitioners and clinical nurse specialists or practitioners);
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals;
- Hospitals employing ACO professionals; and
- Such other groups of providers of services and suppliers as the Secretary determines appropriate.

Under the Proposed Rule, the Secretary utilized her discretion to also include critical access hospitals (CAHs) using certain Medicare billing procedures that provide the data elements necessary for an ACO to operate.

Each ACO will need to be a separate legal entity recognized under state law as a corporation, partnership, limited liability company, foundation or any other legal entity permissible under state law. CMS proposes that existing legal entities meeting the ACO eligibility requirements (e.g., hospitals employing ACO professionals) may operate as ACOs without having to form a separate legal entity; however, whether this offers any additional practical option for such entities is debatable. ACOs must have their own tax identification numbers (TINs), but need not be enrolled in Medicare (in contrast to the ACO participant, which must be enrolled in Medicare).

Irrespective of the type of business entity chosen, all ACOs must be governed in a manner that provides ACO participants with appropriate control over the ACO’s decision making process (which is often referred to as “shared governance”). CMS proposes that ACOs must have governing boards (e.g., board of directors, board of managers, etc.). In an effort to ensure ACOs are provider-driven, 75% of the governing body’s control would need to be in the hands of the ACO participants, which leaves up to 25% of the governing body’s control to Medicare beneficiaries served by the ACO, non-providers and others. ACO participants would be able to achieve the integration necessary for shared governance through a variety of structures, including those that fall short of a merger.

Furthermore, the Affordable Care Act mandates that the leadership and management structure of each ACO include clinical and administrative systems. CMS expands upon this

¹ The “Affordable Care Act” refers to the Federal Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Federal Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111-152).

² CMS Medicare Fact Sheet: Improving Quality of Care for Medicare Patients: Accountable Care Organizations.

³ CMS Medicare Fact Sheet: What Providers Need to Know: Accountable Care Organizations.

requirement in the Proposed Rule by recommending that ACOs meet the following criteria:

- The ACO's operations would be managed by an executive officer, manager, or general partner, who can be appointed and removed by the governing body and whose leadership team can influence or direct clinical practice to improve efficiency processes and outcomes.
- The ACO's clinical management and oversight would be managed by a senior-level, board-certified medical director. The medical director would be licensed in the State in which the ACO operates, and would be physically present in that State.
- The ACO participants and ACO providers and suppliers would have a "meaningful" commitment (e.g., financial investment, human investment, etc.) to the ACO's clinical integration to ensure potential success.
- The ACO would have a physician-directed committee that oversees an ongoing quality assurance and improvement program. The quality assurance and improvement program would establish performance standards for quality of care and services, cost effectiveness, and process and outcome improvements, as well as establish procedures identifying compliance with the standards. The quality assurance and process improvement committee would hold ACO providers and suppliers accountable for meeting those standards.
- The ACO would develop and implement evidence-based medical practice or clinical guidelines and processes for delivering care to achieve CMS' three-part aim for ACOs, which is described further above.

- The ACO would have a collaborative infrastructure enabling the ACO to collect, evaluate and provide feedback on patient data to ACO providers and suppliers.



REACHING CRITICAL MASS

The Shared Savings Program will require each of its ACOs to be assigned at least five thousand (5,000) Medicare fee-for-service beneficiaries. When considering this requirement, it is important to understand that Medicare beneficiaries (including those assigned to an ACO) will retain their freedom of choice under the Medicare program (i.e., Medicare beneficiaries assigned to an ACO may continue to obtain healthcare from outside of such ACO). For this reason and others, it is possible that an ACO will fall below the minimum number of Medicare fee-for-service beneficiaries just described.

In the instance that an ACO's assigned population drops below 5,000 beneficiaries, CMS proposes to place the ACO on a corrective action plan for the performance year during which it was issued. If the ACO fails to meet the 5,000 beneficiary mark by the end of the following performance year, it will be terminated from the Shared Savings Program and will lose any shared savings earned in that year.

CMS notes that while an ACO may incorporate a number of specialties, for purposes of assigning beneficiaries to an

ACO, CMS will only take into account a beneficiary's utilization of primary care services (i.e., services rendered by general practice, internal medicine, family practice and geriatric medicine physicians). CMS established the following methodology for assigning beneficiaries to an ACO:

1. CMS will identify all primary care physicians who were ACO participants during the performance year;
2. At the conclusion of each performance year, CMS will determine all of the beneficiaries who received services from primary care physicians in the ACO;
3. CMS will determine the total allowed charges for the primary care services that each beneficiary identified received from any provider or supplier during the performance year;
4. Find the sum of the allowed charges for primary care services provided by the primary care physicians in each ACO; and
5. Assign a beneficiary to an ACO if the beneficiary received a plurality of his or her primary care services from primary care physicians who are ACO participants.

In other words, CMS will determine the ACOs from which a beneficiary obtains his/her primary care services. CMS will then assign the beneficiary to the ACO in which the beneficiary obtained a majority of his/her primary care services.

Since assignment of patients to an ACO is based upon the primary care physicians participating in the ACO, it is anticipated that, as a practical matter, primary care physicians (as opposed to specialists such as anesthesiologists) will have the most influence within the their respective ACOs.

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PUTTING PATIENTS (AND THE QUALITY OF THEIR CARE) FIRST

As referenced above, the Shared Savings Program hopes to elicit a renewed focus on patients. The Proposed Rule is overflowing with references to the concept of “patient-centered” care, which CMS defines as “care that incorporates the values...of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in healthcare.” To this end, the Proposed Rule would require an ACO to provide CMS in its application to participate in the Shared Savings Program with documentation regarding its plans to do each of the following:

1. Promote evidence-based medicine (i.e., describing the evidence-based guidelines it anticipates establishing and implementing);
2. Promote beneficiary engagement (i.e., patient education);
3. Report internally on quality and cost metrics (i.e., describing the process and how the ACO intends to use it and respond to patient needs); and
4. Coordinate care, which involves strategies to promote and improve integration and consistency of care.

Furthermore, the Proposed Rule set forth numerous requirements designed to achieve these high aims. To promote the goal of improving health for individuals and populations, CMS proposes the following aspects of the Shared Savings Program: (1) a beneficiary experience of care survey; (2) patient involvement in governance; (3) evaluation of population health needs and consideration of diversity; (4) implementation of individualized care plans and integration of community resources; (5) numerous quality measures assessing the quality of care an ACO furnished, which will be deemed to have been met if the ACO reported quality measures and met the applicable performance criteria for each of its three performance years; (6) requirements for ACOs to submit data on quality measures via CMS-specified data collection tools and survey tools; (7) requirements for an ACO’s public reporting of the following information: name, location, primary contact, organizational information, shared savings information, and quality performance standard scores; and (8) rewards for those ACOs achieving better performance (up to 60% of the total savings generated by the ACO, depending on the ACO’s risk model, discussed below).

CMS proposes to monitor ACO performance by analyzing specific financial and quality data, performing site visits, assessing and following up investigations of beneficiary and provider complaints and performing audits. CMS also proposes to terminate ACOs based on its monitoring efforts. Prior to termination, however, CMS proposes it take any or all of the following actions: (1) providing the ACO a warning notice of the specific performance at issue; (2)

requesting a corrective action plan from the ACO; and (3) placing the ACO on a special monitoring plan. In order to monitor the ACO, CMS proposes that ACOs, their participants, ACO providers and suppliers, and contracted entities performing services on behalf of the ACO be obligated to give the government the right to inspect all books, contracts, records, documents and other evidence sufficient to enable CMS to audit, evaluate and inspect the ACO’s compliance with the program requirements.

MAINTAINING, ORGANIZING AND SHARING INFORMATION

Efficiently and effectively sharing information will be key to the success of any ACO. As a condition of receiving Medicare shared savings payments, ACOs will need to submit information to the Secretary of HHS that is necessary to determine the quality of care furnished by the ACO. Each ACO will need to have the information technology and other electronic health record infrastructure in place to maintain, share, retrieve, and report meaningful and usable data. This requirement dovetails with the measures and incentives for the “meaningful use” of certified electronic health records technology under the Health Information and Technology for Economic and Clinical Health Act of 2009 (“HITECH”).

Not only will Medicare beneficiary data flow from the ACOs to CMS, but it will also flow from CMS to the ACOs. In order to provide ACOs with a more complete understanding of the services rendered to their assigned beneficiaries, CMS proposes that ACOs have an opportunity to request beneficiary identifiable claims data on a monthly basis in the form of a standardized data set, which will identify the services and supplies the beneficiaries

receive during the performance year, both within and outside of the ACO. CMS proposes requiring each ACO requesting such information to enter into a Data Use Agreement prior to receiving any claims data, which will prohibit the ACO from sharing the claims data with anyone outside of the ACO. Further, to participate in receipt of claims data, the beneficiaries must have the opportunity to opt out of the claims data sharing.

Further, even prior to participating in an ACO, anesthesiologists and others who desire to participate in an ACO need to acquire a solid understanding of their own financial data and performance. In order to prepare for participation through ACOs in the Shared Savings Program, it is advisable for physician groups to strengthen their own knowledge in this regard by entering discussions with their financial advisors and billing service providers to obtain the information they need to determine whether participation in an ACO under the Shared Savings Program is desirable and, if so, to maximize the benefits they receive from ACO participation.

SHARED SAVINGS DETERMINATION

Those healthcare providers and suppliers that participate in the Shared Savings Program through ACOs will receive not only traditional Medicare fee-for-service payments under Parts A and B but may also be eligible to share in available savings. To determine and share savings, CMS will establish (1) an expenditure benchmark; (2) a comparison of the benchmark to the assigned beneficiary per capita Medicare expenditures in each performance year to determine any savings; (3) the minimum savings rate, which is the percentage that expenditures must be below to account for normal expenditure variation; and (4) a sharing cap, which is the limit on the total amount of shared savings that an ACO may be paid. The Affordable Care Act provides that an ACO's

eligibility for shared savings depends on the ACO's ability to keep its average per capita Medicare expenditures below the applicable benchmark. Because the Affordable Care Act does not provide for a method by which to distribute the shared savings to an ACO, CMS proposes the shared savings be paid to the ACO directly and that ACOs be required to submit their criteria for distribution of the savings with their application to participate in the Shared Savings Program (described further below).

Payment of shared savings also depends on the amount of risk an ACO assumes. The Affordable Care Act itself does not require ACOs to take on risk but the Secretary has proposed using her discretion to require ACOs to do so (at least eventually) under the Proposed Rule. Although this approach is not surprising, many contend that it is a deterrent for participation in the Shared Savings Program.

The Proposed Rule offers incentives and disincentives to those ACOs participating in the Shared Savings Program through two modes: (1) the one-sided risk model, and (2) the two-sided risk model.

- **One-Sided Risk Model.** The one-sided risk model has limited downside risk and, as a result, it will be a viable option for smaller and less experienced groups. CMS proposes, under this model, an ACO would share savings in the first two years of the three-year agreement and would not be responsible for any portion of the losses above the expenditure target. During the third year of the agreement, CMS proposes to establish an automatic transition of the ACO into an “alternative two-sided payment model” in which an ACO would be required to share in any losses *and* savings generated during that year. Under the Proposed Rule, election to participate in the one-sided risk



model would only be an option for an ACO's initial period for participation in the Shared Savings Program. Those ACOs participating in the Shared Savings Program after the initial agreement period would automatically participate in the two-sided risk model thereafter. In other words, an ACO may only participate in the one-sided risk model for the first two years of its initial agreement with CMS.

- **Two-Sided Risk Model.** For those more experienced ACOs willing to take a greater risk, CMS proposes to allow them to choose the two-sided risk model upon entry into the Shared Savings Program. ACOs choosing this model will participate in the two-sided risk model for all three years of the ACO's agreement period with CMS and would be eligible for higher sharing rates than would otherwise be available under the one-sided risk sharing model.

CMS desires to impose a limit on how much an ACO may earn from the Shared Savings Program. CMS intends to impose a limit of 7.5% of an ACO's benchmark during the first two years of an ACO selecting the one-sided model, and a limit of 10% of an ACO's benchmark in the third year of an ACO under the one-sided model and during each year of an ACO under the two-sided model.

To protect the Medicare program against losses and to ensure an ACO has a

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mechanism by which to repay any losses, CMS proposes to withhold 25% of any earned performance payment. An ACO has the option of withholding more if its losses exceed the 25% automatically withheld. Further, if an ACO terminates its agreement, the ACO would be subject to a 25% withhold of shared savings to offset future losses under the two-sided risk model (described below). However, at the end of each agreement period, any ACO with a positive balance will have its monies returned to it.

THE APPLICATION FOR AND TERMINATION OF PARTICIPATION

ACOs will not be automatically accepted into the Shared Savings Program. To be eligible to participate in the Shared Savings Program, providers and suppliers must form or join an ACO and submit an application to CMS, which will include specific and detailed plans for fulfilling the requirements summarized throughout this article. Further, it should be noted that existing ACOs are not automatically qualified for the Shared Savings Program and must also submit an application to CMS. Approved ACOs will be eligible to participate in the Shared Savings Program beginning January 1, 2012; however, CMS still has not solidified a date on which it will begin accepting applications from ACOs.

In their applications, CMS proposes ACOs disclose whether they have participated in the Shared Savings Program in the past. If the ACO was terminated from the program, the ACO must identify the cause of its termination and the safeguards it has employed since its termination to enable the ACO to participate for the full three-year agreement. CMS proposes to deny participation to those ACOs that were terminated due to their underperformance.



Moreover, CMS also proposes that an ACO executive, with authority to bind the ACO, be required to certify, in both the ACO's application and its agreement to participate in the Shared Savings Program, that "the ACO's participants are willing to become accountable for, and to report...on, the quality, cost, and overall care of the Medicare FFS beneficiaries assigned to the ACO."

The Affordable Care Act requires each ACO accepted into the Shared Savings Program enter into an agreement with CMS for not less than three years. Accordingly, CMS proposes requiring ACOs to enter into a three-year participation agreement with CMS.

In the instance the ACO makes a "significant" change (e.g., an ACO reorganizes its structure by excluding ACO participants or by adding or excluding ACO providers and/or suppliers, an ACO deviates from its approved application, etc.), the ACO must notify CMS within 30 days of the significant change so CMS may reevaluate the ACO's eligibility to continue participation in the Shared Savings Program.

CMS may terminate an ACO from the Shared Savings Program prior to the conclusion of the agreement period for a number of reasons (e.g., avoiding at-risk beneficiaries, failing to effectuate regulatory changes during the agreement period after being given an opportunity for a corrective action plan, failure to comply with reporting requirements, etc.). Any ACO would be permitted to terminate its Shared Savings Program agreement with CMS upon 60 days prior notice but such termination would result in forfeiture of its mandatory 25% withhold of shared savings.

The Affordable Care Act provides for a number actions pertaining to the Shared Savings Program for which there shall be no administrative or judicial review. For all other actions (e.g., denial of an ACO application or termination of an ACO agreement, in certain cases), an ACO, upon written request within 15 days of the adverse initial determination, may request a review by a CMS reconsideration official. If the ACO is unhappy with the CMS reconsideration official's decision, it may submit an explanation as to why it disagrees with the recommendation and it may request a record review of the initial determination and the recommendation of reconsideration by an independent CMS official.

To ensure continuity of ACOs while also implementing standards to improve the program, CMS proposes adopting changes to the Shared Savings Program in the future and thus subjecting ACOs to new program standards, with the exception of the following areas: (a) eligibility requirements concerning the structure and governance of ACOs; (b) calculating the sharing rate; and (c) assigning beneficiaries.

OPERATION OF ACOs UNDER APPLICABLE LAW

In order to achieve the clinical and administrative coordination and sharing of information that will be necessary to the success of ACOs, physicians, hospitals, and other professionals will need to integrate, but within the constraints of applicable law, including without limitation the Federal Anti-Kickback, Stark, and Civil Monetary Penalty Laws, Federal tax exempt laws and Federal and state privacy laws, Federal antitrust laws, state insurance laws and state corporate practice of medicine doctrines.

In furtherance of CMS' efforts to prevent abuses of the federal healthcare programs, the Proposed Rule imposes numerous compliance-related requirements upon ACOs including requiring the following of each ACO: (1) a compliance plan; (2) certification of compliance with program requirements by someone legally authorized to bind the ACO; (3) a conflict of interest policy for members of the governing body; (4) screening the ACO during the application process; and (5) prohibiting certain referrals and cost shifting.

However, consistent with the foregoing, the Affordable Care Act also calls upon the Federal government to consider modifications to existing regulations that achieve that delicate balance between allowing ACOs and the Shared Savings Program to thrive while also protecting against abuses of the Medicare program under the guise of legitimate ACO activities. Accordingly, concurrent with the release of the Proposed Rule, the Federal government has issued three additional guidance documents focusing on specific aspects of the Shared Savings Program:

1. A joint CMS and HHS Office of Inspector General (OIG)

Medicare Program notice and solicitation for comments titled Medicare Program; Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center (CMS/OIG Waiver Design Guidance);⁴

2. A Federal Trade Commission (FTC) and Department of Justice (DOJ) (collectively, the Antitrust Agencies) document titled A Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (the FTC/DOJ Proposed Antitrust Policy Statement);⁵ and
3. An Internal Revenue Service (IRS) notice soliciting comments regarding the need for additional tax guidance for tax-exempt organizations (the IRS Notice).⁶

CONCLUSION

Anesthesiologists and the greater healthcare community are searching for answers. How can they be involved in the Shared Savings Program? What does it mean to participate in an ACO? How will such opportunities improve (or preserve) their bottom-line?

While much remains uncertain, anesthesiologists can be sure that Medicare payment methodologies will inevitably change. During this time of transition, anesthesiologists and anesthesia groups must actively engage the leadership of their hospitals and ASCs, and others in positions of power, to ensure anesthesia is not forgotten during this intense time of expansion and reform. Furthermore, anesthesiologists should remain attentive to Shared Savings Program developments and strategies by reaching out to their

professional organizations (such as the American Society of Anesthesiologists) and legal advisors. It is also advisable to maintain as much flexibility as possible until the Federal government issues further guidance. Anesthesiologists should remember that the Proposed Rule is just that — a proposal — and while this article focuses on the Proposed Rule, all anesthesiologists should be attentive to CMS' Final Rule, which will be available later this year. However, if consistent with CMS' historical practice, the Final Rule will not stray far from the Proposed Rule discussed in this article. ▲



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⁴ The CMS/OIG Waiver Design Guidance may be found at http://www.ofr.gov/OFRUpload/OFRData/2011-07884_PI.pdf.

⁵ The FTC/DOJ Proposed Antitrust Policy Statement may be found at <http://www.ftc.gov/os/fedreg/2011/03/110331acofo.pdf>.

⁶ The IRS Notice may be found at <http://www.irs.gov/pub/irs-drop/n-11-20.pdf>

THE COMPANY MODEL OF ANESTHESIA SERVICES: WILL LESS MONEY LEAD TO JAIL TIME?

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of their facility's relationship with anesthesiologists.

For some it was an issue of economics. Many ASCs were located in markets that were already saturated. Many were located in areas that became economically depressed. Many, even in otherwise good locations, had cost structures that reduced, or even eliminated profitability.

For others it was a question of greed. Surgeon owners saw that anesthesiologists' earnings from the surgery center could be greater than their own. Others viewed the right to provide anesthesia at their ASC as a "franchise" that had value and they wanted a share of it.

Captive Model

No matter the motivation, a second ASC-anesthesia business model took form, one that I refer to as the captive model. This model has the anesthesiologists working for the ASC as employees or as independent subcontractors – the defining characteristic being that, through one method or another, the ASC pays the anesthesiologists a fixed or production based sum. In some variants, the ASC bills the anesthesia fees under its own name; in others, it bills and collects under the name of the anesthesiologists – in any event, the anesthesia fees eventually find their way into the ASC's bank account.

Company Model

For one or more reasons in any particular situation, the captive model began to morph into the company model. Some ASCs found that payors rejected their claims for anesthesia fees when billed under the ASC's name. In states with prohibitions on the corporate practice of medicine, lay entity ASCs cannot provide medical services and therefore cannot employ the anesthesiologists or even



subcontract with them under a financial structure in which the ASC participates. Some ASCs had neither of these problems but simply wanted to separate out, perhaps for management purposes or perhaps to disguise their real intent, the anesthesia coverage arrangement into a separate entity.

In some instances, it was not even the ASC itself that sought to change the relationship with their anesthesia providers by forming an anesthesia company owned by the ASC itself or by all of the ASC's owners. Instead, it was a subset of the ASC's owners, usually one or more surgeon-owners with referral clout, who sought to skim a bit of the profit cream off of the top of anesthesia services.

KEY COMPLIANCE ISSUES

Stated in simplified terms, the federal antikickback statute (the "AKS") prohibits remuneration, that is, the transfer of anything of value, for referrals. State laws, which differ in their treatment, scope and interpretation, generally contain

similar provisions barring remuneration for referrals, sometimes expressed as antikickback or fee splitting prohibitions. Because of the variations in state laws, our focus will be on the federal concepts applicable to Medicare and Medicaid patients.

Courts have interpreted the AKS to apply notwithstanding the fact that there are many purposes for the arrangement that may be legitimate – the fact that one of the purposes is to obtain money for the referral of services or to induce further referrals is sufficient to trigger a violation of the law.

There are certain statutory and regulatory exceptions, known as "safe harbors," that define permissible practices not subject to the antikickback statute because, in the opinion of the regulators, they would be unlikely to result in fraud or abuse. The failure to fit within a safe harbor does not mean that the arrangement violates the law, there's just no free pass.

The question, then, for the company model is whether the arrangement violates the AKS.

Of course, the facts and circumstances of the structures vary and each potential deal must be analyzed carefully before it is structured. But it is possible to highlight the significant likelihood that many company model deals are illegal.

The Department of Health and Human Services' Office of Inspector General ("OIG") has issued two fraud alerts applicable to the analysis of company model deals, its 1989 Special Fraud Alert on Joint Venture Arrangements, which was republished in 1994 (the "Fraud Alert"), and its 2003 Special Advisory Bulletin on Contractual Joint Ventures (the "Advisory Bulletin"). The OIG uses the term "joint venture"

to mean any arrangement, whether contractual or involving a new legal entity, between those in a position to refer business and those providing items or services for which Medicare or Medicaid pays.

Although the OIG withdrew its once proposed sham transactions rule, it made clear in issuing the safe harbor regulations and in other documents that compliance with both the form and the substance of a safe harbor is required in order for it to provide protection. In other words, even though planners generally work to fit a company model deal into the confines of a safe harbor, the OIG's position is that if one underlying intent is to obtain a benefit for the referral of patients, the safe harbor would be unavailable and the AKS would be violated.

THE FRAUD ALERT AND THE ADVISORY BULLETIN

The Fraud Alert states:

"Under these suspect joint ventures, physicians may become investors in a newly-formed joint venture entity. The investors refer their patients to this new entity, and are paid by the entity in the form of 'profit distributions.' These suspect joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary program expenditures."

In describing examples of questionable features of suspect joint ventures, the Fraud Alert mentions, among others:

- Investors are chosen because they are in a position to make referrals



(e.g., the surgeon owners of the ASC who become the owners of the company model entity);

- One of the parties may be an ongoing entity already engaged in a particular line of business (e.g., the anesthesiologists); and
- The referring physician's investment may be disproportionately small and the returns on investment may be disproportionately large when compared to a typical investment in a new business enterprise (e.g., the company model, which requires only nominal start up capital).

It's obvious that the features of a company model include many of those stated by the OIG in the Fraud Alert to be questionable.

The Advisory Bulletin issued by the OIG in 2003 sheds even more light on the analysis of company model structures. It focuses on questionable contractual arrangements in which a healthcare provider in an initial line of business, termed the "Owner," expands into a related healthcare business by contracting with an existing provider of

the related item or service, the "Manager/Supplier," to provide the new item or service to the Owner's existing patient population. Note that the term "existing provider" as used in the Advisory Bulletin is not limited to situations in which the specific anesthesiologists have an existing relationship with the ASC at the time the company model joint venture is formed.

The Advisory Bulletin describes some of the typical common elements of these problematic structures. (See the sidebar on page 12.) They appear almost as if meant to describe a company model structure in which the ASC or some or all of its surgeon owners form the company solely for the purpose of providing anesthesia services to the ASC: Little capital is required. The anesthesiologists, not the owners, provide the actual services and, absent their engagement by the company, they would be providing anesthesia services for their own account. The company's owners capture a share of the anesthesia revenue. And, importantly, the more cases the ASC or its surgeons refer to the company, the more those company owners make.

The Advisory Bulletin states that despite attempting to fit the contracts

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The 2003 Advisory Bulletin states that problematic joint ventures typically exhibit the following elements:

- The owner expands into a related line of business that is dependent on direct or indirect referrals from, or on other business generated by the owner's existing business.
- The owner does not operate the new business, the manager/supplier does, and does not commit substantial funds or human resources to it.
- Absent participation in the joint venture, the manager/supplier would be a competitor in the new line of business, providing services, billing and collecting in its own name.
- The owner and the manager/supplier share in the economic benefit of the owner's new business.
- The aggregate payments to the owner vary based on the owner's referrals to the new business.

creating these joint venture relationships into one or more safe harbors, the OIG views the discount given within the joint venture's common business enterprise (e.g., the anesthesiologists agree to be paid less by the "company" than they would receive if they billed independent of the joint venture) as not qualifying for the safe harbor applicable to discounts.

Even if the contracts could fit within one or more safe harbors, the Advisory Bulletin states that they would protect only the payments from the Owner to the Manager/Supplier for actual services rendered, not the "payment" from the Manager/Supplier back to the Owner in the form of its agreement to provide

services to the joint venture for less than the available reimbursement, that is, the "discount" given within the joint venture.

Again, the failure to qualify for safe harbor protection does not mean that a venture is illegal. It does mean that it might receive additional scrutiny that could lead to prosecution.

In 2009, the ASA requested that the OIG issue a Special Advisory Bulletin on the company model. The ASA renewed that request in June 2010. Although the OIG has acknowledged the initial ASA request, as of this writing it has yet to act.

THE BOTTOM LINE

The bottom line is that company model ventures are fraught with kickback danger for all parties involved. Although it may be possible that a particular instance qualifies for safe harbor protection, the OIG's position as expressed in both the Fraud Alert and the Advisory Bulletin demonstrates that these arrangements are subject to special scrutiny.

As the government's focus on weeding out healthcare fraud intensifies, the need to fully understand the risks grows. Each situation must be analyzed carefully as there is a high chance of an AKS violation leading to criminal fines, civil penalties, exclusion as a provider and even imprisonment.

...AND AN IMPORTANT POST SCRIPT

The Fraud Alert and the Advisory Bulletin make clear that there is no requirement that a fraudulent joint venture be operated through a new legal entity. Captive model structures in which anesthesiologists work directly for the ASC itself, whether as employees or as independent subcontractors, are joint ventures.

The financial relationships within those captive model joint ventures are as equally suspect as those within company model joint ventures, a fact most often glossed over.

In fact, the company model format may simply be a slightly slicker variation of the captive model – slicker because it provides the ASC with an alternative way to bill for anesthesia professional fees and, in a state with a strong prohibition on the corporate practice of medicine, creates a medical entity to hold the anesthesia business. Lastly, in other instances, the company model is just a captive model with stickier fingers – instead of the ASC itself, or all of the ASC's owners, sharing in the anesthesiologists' pie, a subset of the surgeon owners take that slice for themselves.

Viewed in the light, the captive model and the company model are two sides of the same coin, one that the surgeon owners of ASCs are two sides of the same coin, one that the surgeon owners of ASCs are attempting to put into their pocket. Both models pose significant AKS dangers. ▲

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GETTING PAID FOR ANESTHESIA: MASTERING THE CHALLENGES OF VIABILITY

Jody Locke, CPC

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Some of us are old enough to remember the days when anesthesia providers got paid more or less based on what they decided to charge. It used to be that a favorable mix of patient insurance coverage (payor mix) and reasonably busy operating rooms was sufficient to ensure the financial viability of an anesthesia practice. There was a time when anesthesiologists talked about things like group formation, hospital contracts and managed care negotiations in the abstract as interesting options. Conventional wisdom held that a few persistent and disciplined secretaries would be sufficient to provide for the business requirements of the typical practice. Sadly those days

of entrepreneurial opportunity have given way to a whole new set of practice management challenges. Survival and success now have much less to do with the favorability of the payor mix or even with the clinical qualifications of the providers; today's practices must constantly monitor and manage an ever more complex balance sheet of income and expenses just to retain the opportunity to provide care. While practices in the 1980s were preoccupied with the arcane rules of concurrency and those in the 1990s worried about running afoul of HIPAA, today's anesthesia practices have become consumed by a much broader and more complex set of business issues.

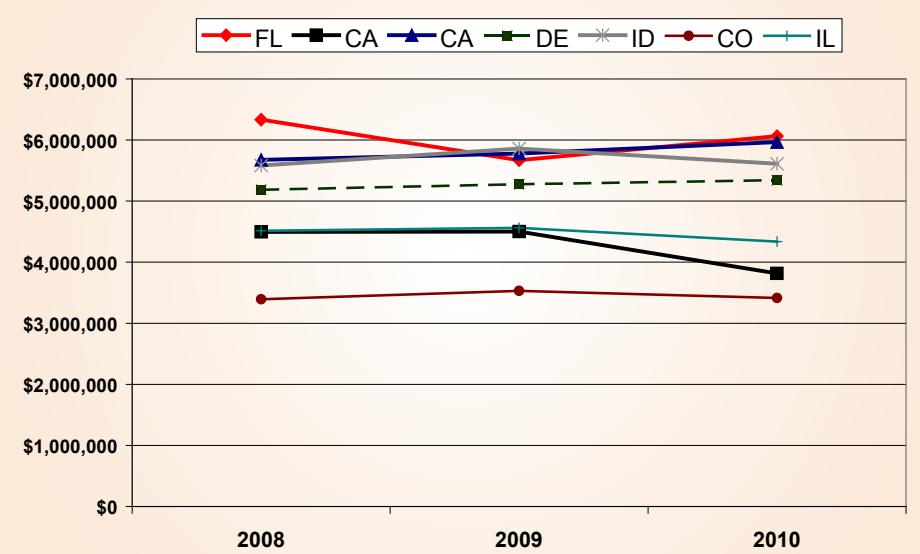
The reference data for this article were derived from a random sample of seven actual anesthesia practices all of which have experienced flat or declining revenue over the past three years. This is not intended as a statistical analysis of revenue patterns, but rather a conceptual review of the significant factors that affect the ability of moderate sized anesthesia practices to remain financially viable in today's health care environment. Table 1 on this page provides a summary of three years of total practice income, including insurance payments, patient payments and hospital subsidies.

No fewer than five separate and distinct developments have dramatically reshaped the anesthesia landscape over the past decade and the rate of change appears to be speeding up. Success in anesthesia used to be like real estate: the only three things that mattered were location, location and location. A favorable practice setting used to be the only important pre-requisite but such is no longer the case. While location can still provide a competitive edge, it has become just one factor in a much more complicated financial proposition.

Consider how anesthesia providers get paid. It is no longer enough to simply send out claim forms to insurers to ensure adequate cash flow. It is back to the future of health care; good health care coverage is no longer affordable nor adequate to cover the costs of today's anesthesia

TABLE 1

Hospital Revenue Trends for 7 Practices



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bills. The hot topic of the day is patient responsibility. And the challenge involves getting patients to pay their fair share. Aggressive managed care contracting is starting to create some serious obstacles and is greatly constraining the typical practice's ability to realize overall increases in practice revenue.

Table 2 on page 14 shows the percentage of total practice revenues that have been paid directly by patients, either in the form of deductibles or co-payments or because the patients had no insurance. Percentages appear to be going down for most of the practices in this random sample, but this is simply due to the fact that commercial insurance and Medicare rates have gone up over this three year period, as have hospital subsidies. What the table underscores, however, is the challenge created when these other sources of revenue cease to increase.

The evolution of the accounts receivable management industry over the past couple of decades has seen an increased focus on technology and



labor intensive approaches to revenue maximization. Software development has provided many options for submitting accurate claims as expeditiously as possible and powerful tools intended to confirm the accuracy of payments. These developments have moved us far from the early days of dialing for dollars to resolve outstanding patient accounts. Large billing companies now employ predictive dialers to leverage the productivity of the follow-up team but the fact remains that collecting balances from patients who may have neither the motivation nor the ability to pay for their share of health care is proving to be one of today's greatest management issues.

In addition to the obstacles of getting paid for professional services rendered, too many anesthesia practices are now finding themselves caught in another squeeze play involving unrealistic coverage expectations on the part of hospital administrators. This unfortunate development has shed light on the other side of the anesthesia practice ledger: the cost of providing the care. The basic problem is simple: when

hospitals ask for more coverage, the same revenue inevitably gets spread over more anesthetizing locations. It is a curious irony that the idea of making a hospital a more attractive place for surgeons to bring their patients has exactly the opposite effect on the anesthesia group. It is the rare practice that does not feel the effects of this squeeze play to some extent and many complain that they are constantly fighting Administration's desire to add more coverage. Few practices have yet to develop an effective strategy to reset and manage administration expectations.

There are various methods used to evaluate operating room utilization, but anesthesia has a distinct advantage based on its ability to track actual cases, units and minutes billed per anesthetizing location. Historically, 50 ASA units billed per anesthetizing location per day was considered optimum productivity. This should equate to approximately 7 hours of billable anesthesia time. From a financial perspective most observers would agree that a reasonable target is \$2,000 of gross professional fee income per location per day: this should be

TABLE 2 Percentage of Total Practice Revenues Paid by Patients

Practice	2008	2009	2010
A	5%	5%	5%
B	8%	5%	4%
C	4%	2%	2%
D	4%	4%	4%
E	13%	11%	9%
F	7%	7%	7%
G	12%	9%	6%

sufficient to compensate a physician working in a physician-only practice at the MGMA median compensation level. Staffing models based on the medical direction of CRNAs can generally reduce this revenue requirement but there are obviously a variety of factors that must be taken into consideration.

While many anesthesiologists feel helpless to stem the tide of declining operating room productivity, there are glimmers of hope across the landscape. Some of the nation's largest hospital organizations have come to identify the improvement of operating room productivity as a key strategic objective. This does not diminish the importance of attracting more surgical cases but does tend to provide some hope that an objective allocation of operating room resources and staff might be achieved. In the meantime, anesthesia practices are having to develop an entirely new set of reporting and management tools to both monitor the appropriateness of operating room utilization and help hospital administrations reset surgeon expectations.

While the most logical and proactive approach would involve a concerted effort to educate the administration with relevant data and benchmarks, few practices have made the commitment to capture the necessary utilization data. Those that have, however, can attest to the value of the investment. The most creative have even used their utilization data as the basis for creative hospital subsidy arrangements that align the incentives of the hospital and that of the anesthesia group.

The third development is directly related to the second but it has become as much a philosophical as a financial challenge. Once fiercely independent anesthesia practices are being forced to open their books in order to obtain necessary financial support from their host hospitals. The revenue a practice

can generate through its billing and collections activities is becoming less important than what they can negotiate as part of their exclusive contractual relationships. We have reached a point where it is not uncommon for a practice to receive 35% of total practice revenues in the form of hospital subsidy support. See Table 3.

Private anesthesia practices have evolved a culture that is specific and idiosyncratic to the specialty. Independence has been the hallmark of practice management strategy. Anesthesia practices have prided themselves on their ability to benefit symbiotically from their contractual relationships with hospitals. As is so often the case, however, the beliefs and strategies that got us to where we are today will not get us to where we need to be tomorrow. Nondisclosure of practice finances is proving to be a significant obstacle to fair and reasonable coverage agreements. Many hospitals have even started insisting on the right to review individual provider W2s. The reality is that there are fewer and fewer exceptional anesthesia practices from a financial perspective; rather there are those that are fairly compensated based on national benchmark data and those that need support. The hospital contract is becoming a form of specialty safety net.

As if these developments were not enough, the entire context of the anesthesia service is starting to be viewed in an entirely new light. Anesthesia providers used to thrive in the rarefied air of the operating room where their ability to make split second decisions ensured their value to the larger medical community. Little by little something changed and it was not enough to have consistently predictable outcomes. A new vocabulary of customer service has changed the nature of the service equation. Anesthesia is expected to support the overall business plan and mission of the institution. Problem

TABLE 3 Percentage of Total Practice Revenues Received in the Form of Hospital Subsidy

Practice	2008	2009	2010
A	34%	34%	33%
B	27%	27%	27%
C	34%	27%	26%
D	20%	23%	23%
E	13%	11%	14%
F	7%	10%	11%
G	0%	0%	0%

providers have become the bane of the anesthesia group during hospital contract negotiations.

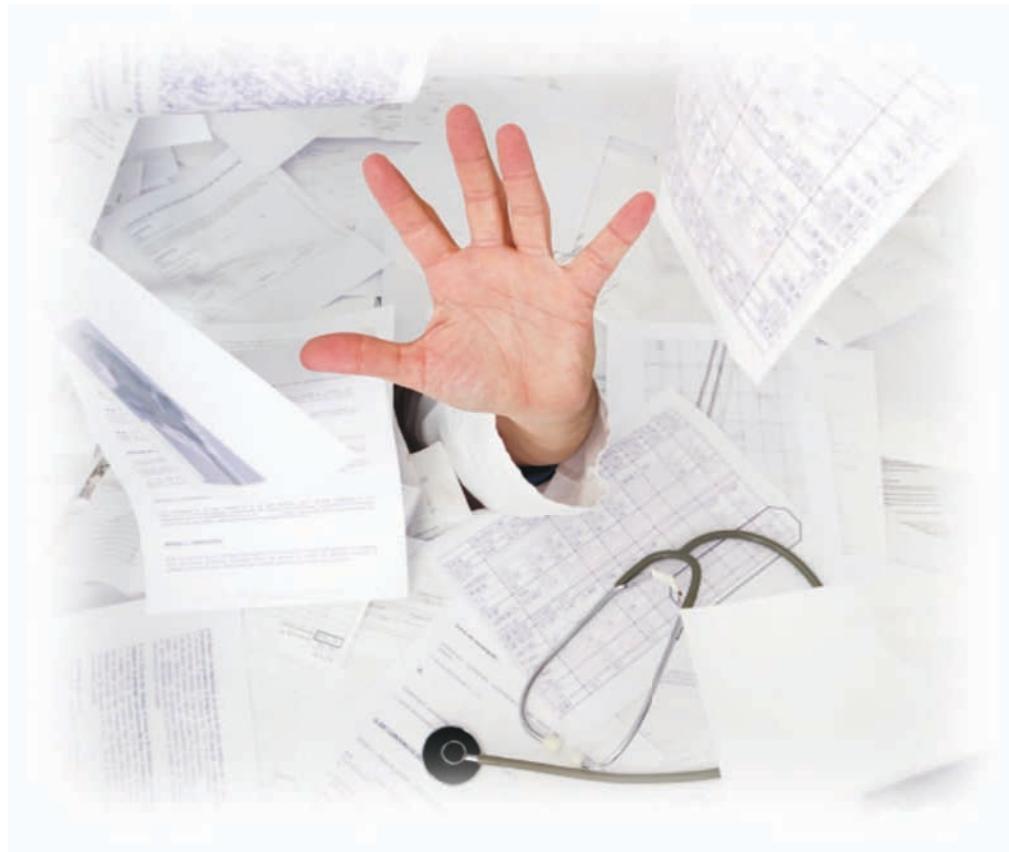
Much as group practices try to leverage their years of experience with administration and their ability to work with the surgical staff, they are being challenged by outside entities that purport to offer more services that will better support the hospital's business plan. Whether the advantages of these national services are real or illusory seems to be of little relevance. As in so many things, new and improved seems to be more appealing than tried and true. Much as many practices do not want to admit it, the typical anesthesia franchise has become an object of considerable competitive value.

As if these developments were not enough, along comes healthcare reform. One more time federal policy is changing the rules of engagement and inspiring yet another wave of restructuring. Today's vocabulary is distinctly reminiscent of that of managed care; Accountable Care Organizations (ACOs) appear to be the reincarnation of vertically integrated

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delivery systems. (See article on ACOs beginning on page 1.) Instead of paying individual providers on a fee for service basis, monies are allocated for the management of patient conditions. The more effective the management plan, the greater the profit potential for the provider.

ACOs and healthcare reform are still inchoate concepts but they are having a profound impact on the planning process. Like the high school students at the dance, the various players in the healthcare arena are starting to size each other up as they weigh their affiliation options. It is impossible to predict how this will all play out but one thing is quite clear, when it comes to health care there is no limit to the potential for complication.

These new realities are leading to the development of considerably different infrastructure and business decision-making requirements. Survival

and success are no longer simply a matter of maximizing collections; but rather a function of a more global and comprehensive mastery of the entire practice balance sheet. It is no longer enough to just have a billing office or service, now practices find they need a full range of practice management services. These are boom times for consultants and administrators as it becomes ever clearer that the key to success has less to do with clinical efficacy and more to do with financial acumen.

Many an anesthesiologist or CRNA may long for the good old days when it was enough to work hard and focus on consistent clinical outcomes, but this would be little more than wishful thinking. Too many of the variables have been changed; nothing can be taken for granted. Every aspect of the anesthesia business proposition is in a

state of transition. Anesthesia practices must now come to terms with entirely new revenue challenges and options. These options are no longer just about enhancing physician compensation, but rather a complex financial calculus to ensure the availability of qualified staff to meet customer expectations. Physicians who have spent their careers mastering arcane clinical protocols must now learn how to market their services and negotiate reasonable terms of compensation. As these developments are unfolding, government oversight and management continues to impose an entirely new set of rules on provider groups. These challenges have greatly increased the financial risks for the typical practice and traditional group practices are being displaced with increasing frequency by national management companies. Few practices are completely prepared for the new realities of healthcare, but most have the necessary prerequisites. Those who are willing and able to make the commitment, clarify the focus and implement effective strategies will certainly be players. Outdated beliefs and strategies must be replaced with new ideas. As Lee Iacocca once said: The time has come to lead, follow or get out of the way. 

Jody Locke, CPC, serves as Vice President of Pain and Anesthesia Management for ABC. Mr. Locke is responsible for the scope and focus of services provided to ABC's largest clients. He is also responsible for oversight and management of the company's pain management billing team. He will be a key executive contact for the group should it enter into a contract for services with ABC. He can be reached at Jody.Locke@AnesthesiaLLC.com.



ANESTHESIA: THE INCREASING CONSOLIDATION OF OUR INDUSTRY

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While the business of health care continues to evolve, there is perhaps no part of it changing faster than anesthesia. Numerous factors are quickly shifting the market towards an even more competitive and demanding landscape. The days of anesthesia groups simply providing clinical coverage in a hospital's operating rooms are, for better or for worse, drawing to a close.

As the expectations of hospitals for the types and levels of services to be provided by anesthesia are increasing, anesthesiologists now find themselves performing cases in non-traditional anesthetizing locations such as GI Suites, ECT and Electrophysiology. In addition, many anesthesiologists are expected to serve in roles not always seen as traditional for anesthesia, such as holding the broad responsibility for Peri-Operative Services, Pre-Surgical Testing processes, serving as leaders of hospital committees, etc.

A continued shift in payor mix, to government payors that have long undervalued anesthesia services, has forced an increasing number of anesthesia practices into either accepting a decrease in compensation or entering into subsidy arrangements with their hospitals. As subsidies have increased, with the Clinical Advisory Board reporting in 2005 that the average annual subsidy paid by hospitals had risen to almost \$120,000 per anesthesiologist, the level of competition for professional services agreements has intensified. With that increase in competition, the idea of a "local bubble" has been shattered as we've seen many



long tenured anesthesia groups lose their primary hospital contracts to new and geographically diverse competitors.

All the above, plus the continued specter of looming Medicare reimbursement cuts, have left many in the anesthesia world looking for ways to help insulate themselves from the ever increasing competitiveness and risk of the marketplace. While there are numerous tried and true methods of insuring your group's continued success, the frequency of practice consolidation has increased rapidly in the past 18 months. Consolidation can happen a number of ways. This article provides a look into many of the most frequently seen.

PRACTICE MERGERS

One method of consolidation that has been gaining popularity recently is the

merger of multiple groups into a single entity. We have seen this recently happen with the anesthesia departments at NYU Langone Medical Center and NYU Hospital for Joint Diseases (both in New York City) combining into a single unified department across their campuses, and with the creation of Greater Florida Anesthesiologists, five previously unaligned practices coalescing into one single large group.

There are many benefits to merging one practice with another; the practice is no longer a single department on its own, it will now have a larger practice base to spread fixed expenses across. With larger mass, the ability to leverage the purchase power of the newly-combined entity to drive discounts with suppliers is enhanced – leaving no stone unturned

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from photocopier leases to medical supplies. Larger groups may now have access to superior employee benefits like pension plans, group health, life and disability that may not be available to small businesses.

Other non-financial benefits will also begin to accrue to the practices. There will now be the ability to cross-privilege clinicians, leading to the possibility of vacation or sickness coverage between the new partners. Clinical information exchange will increase with the opportunity to implement best practices and establish group-wide clinical guidelines to enable better patient care.

JOINING A LARGER ORGANIZATION

There are numerous examples of independent anesthesia practices joining larger groups, but I will focus on one that I can describe firsthand. In May of 2010, the anesthesia group at South Nassau Communities Hospital in Oceanside, NY

joined NAPA – North American Partners in Anesthesia (the organization in which this author works).

The practice had been the anesthesia provider at the hospital for over 20 years, operating its own very well known and respected chronic pain management program and office-based anesthesia business. Despite all of its success, the group recognized the advantages of alignment with a larger group.

Upon integrating with a larger group, the group at South Nassau immediately had access to the well developed clinical and business management systems that a large group can develop. The Chairman of the department retains local autonomy over scheduling, vacations, daily assignments, etc., while being able to call on the larger entity for support with emergency staffing, implementing established clinical protocols and benchmarking against other like-sized hospitals within NAPA.

The larger entity provides the “Verizon Network” behind the Chairman and the department’s clinicians. The larger entity furnishes all management infrastructure and services such as billing and collections, employee benefits, human resources, credentialing and privileging services, etc. Most importantly, as part of a large group you have access to data and quality assurance programs at levels unavailable to independent groups.

The result of the combination with the larger entity has been a stronger relationship with the hospital, an enhancement of services provided to the anesthesiologists and CRNAs at the hospital and the security that comes with being part of a larger organization.

SALE TO A WELL-FUNDED MULTI-SPECIALTY COMPANY

Anesthesia has also undergone another significant change – anesthesia

is no longer just a medical specialty; it's a “space” for publicly traded and privately funded companies to invest in. Mednax, EmCare and others have begun to move aggressively into anesthesia, purchasing many large, well-established and respected anesthesia groups.

Many of these groups had already achieved some of the benefits of either merger or joining a large group and they saw the opportunity to monetize their practice and become part of even larger, multi-specialty groups. We can expect to see this happen with greater frequency in the future as more attention is paid to the investment potential of anesthesia.

Aggregation as a defensive measure is no stranger to medical practices. We've seen significant consolidation in pediatrics, OB/GYN, urology, large multi-specialty groups and, now, anesthesia. Be it through a merger, joining a larger group, sale to another entity or through other methods, the paradigm is shifting away from the small independent practice towards larger cohesive anesthesia management companies and groups.

While the thriving unaligned anesthesia practice will not fade completely from existence, the diverse pressures of a changing marketplace will make it increasingly difficult for many to continue as they are today. ▲

Franc Galinanes is a Senior Director at North American Partners in Anesthesia, a national Anesthesia Management Company and also serves as a Member at Large on the MGMA Anesthesia Administration Assembly (AAA) Executive Committee. He can be reached at fgalinanes@NAPAanesthesia.com.



TAX SAVINGS OPTIONS FOR 2011

Stephanie Zvolenski, MBA

Financial Manager, ABC

Several months ago you met with your accountant and filed your 2010 tax return. All of your debts have been paid to Uncle Sam. If you have not already done so, it is the time to make any necessary adjustments to your 2011 elections in order to maximize your tax savings and financial position in the coming year. Fortunately there exist some administrative opportunities to assist you in this goal. Provided here are some suggestions to spark your thoughts and serve as a reminder to be attentive to this very important issue.

RETIREMENT PLANS

Based on your accountant's assessment of your 2010 personal income tax return, a Roth 401(k) versus a Traditional 401(k) to accompany your practice profit sharing plan may be more beneficial to your personal tax situation and/or vice versa. It is important that you make this election as soon as possible if you have not already done so.

Also, previous issues of the Communiqué contained articles on different types of retirement plans, especially one becoming more and more popular with small businesses and medical practices called a "Cash Balance Plan" (http://www.communiqueunews.com/articles/article.php?title=Cash_Balance_Plans&id=154). Depending upon the dynamics of the practice and the providers, this may be something to consider and investigate further as a way to save significant tax dollars and boost your retirement savings.

Make sure to confirm on your payroll records that your elections are being processed correctly by your payroll service. It is much better to make adjustments early in the year than to wait until the 3rd quarter only to find out that none of your deferrals have been made. For those over fifty-five (55) years of age, be sure that your catch-up contribution is being withheld if you made the election.

Although the Internal Revenue Service annual limits for retirement plans did not change in 2011 from 2010, they are provided here for your reference. These limitations are published annually typically in the fall of the current year for the upcoming year.

Ensure that not only the practice business professionals are aware of the updates but also the individual employees.

Retirement Plan Limitations:	2011
Elective Deferral Limit for 401(k) and 403(b) Plans	\$16,500
Catch-up Contribution Limit 401(k), 403(b), SARSEP & 457	\$5,500
Annual Additions Limit for Defined Contribution Plans	\$49,000
Defined Benefit Dollar Limitation	\$195,000

MEDICAL EXPENSE PLANS

The rising cost of health insurance premiums, the federal healthcare reform legislation, uninsured, underinsured...the list of the hot topics surrounding medical coverage not only for our patients but for our practice employees and providers goes on. In an effort to maximize your tax savings and ultimately cash in your pocket, your practice may want to look at alternative health insurance plans and medical expense reimbursement options. There are a variety of plans being implemented across the country for practices of all sizes and complexities ...High Deductible Health Plans (HDHP), Medical Expense Reimbursement Plans (MERP), Health Reimbursement Accounts (HRA), Health Savings Accounts (HSA), Cafeteria/Section 125 Plans and Section 105 Plans to name just a few.

Each of these plan types carries benefits and risks for the practice and should be investigated thoroughly with your business managers in order to determine the best option for your circumstances. The dollars in tax savings could be significant.

For your reference, here are the 2011 IRS Health Savings Account (HSA) contribution limits.

H.S.A. Contribution Limits:	2011
Maximum annual HSA contribution limit – individual	\$3,050
Maximum annual HSA contribution limit – family	\$6,150
Catch up contribution limit for individuals 55 years or older	\$1,000

DEPENDENT CARE EXPENSES

In addition to deductible medical expense plans, many practices are considering and

implementing administrative plans to allow for the deduction of dependent care expenses for their providers and employees. Again, like the medical plans, the administration of these plans can be complex and thus should be discussed with your practice business advisors; however, there could be significant tax savings available to you.

DEDUCTIBLE BUSINESS EXPENSES

Medical practices and providers incur many business expenses in the course of everyday work. Discuss with your accountant and business managers those business expenses approved by the IRS for deduction from taxation. Items like dues and license fees, education expenses, publication and journal subscriptions are just a few examples that may be deductible and could save you significant money in reduced tax liability.

If you have explored any and all of the tax saving plans and opportunities with your personal accountant and business advisors and still find that you may be facing an additional tax burden in 2011, work with your business manager to estimate your potential tax liability as soon as possible. At least on a quarterly basis, your practice should be reviewing the estimated year-end profits and the residual provider wages and bonuses. It is much easier to make additional tax payments on a more frequent basis (bi-weekly, monthly, quarterly) than to pay one lump sum next spring, especially if the debt is large enough to trigger additional penalties and interest. ▲

Stephanie J. Zvolenski, MBA, is a Financial Manager for ABC. Stephanie is responsible for the financial, strategic and operational management of our financial management clients and also serves as an industry consultant and business advisor. Some of her responsibilities in this role include: provider compensation assessment and comparison to market, shareholder/employment agreements, hospital subsidy negotiation/agreements, feasibility studies for new and existing practice opportunities, governance support review and restructuring and design and administration of benefit programs. Stephanie has been with ABC for 4 years and has 15 years of experience in physician practice management including serving as an Administrative Director for a multi-specialty physician practice network within a three hospital system and as a system service line Director. She holds a BA from Washington and Jefferson College and a MBA from Waynesburg University. Stephanie can be reached at 724-952-1361 or at Stephanie.Zvolenski@AnesthesiaLLC.com.





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PROFESSIONAL EVENTS

DATE	EVENT	LOCATION	CONTACT INFO
September 9-10, 2011	Texas Society of Anesthesiology	Hyatt Hill Country Resort, San Antonio, TX	www.tsa.org
September 16-18, 2011	Ohio Society of Anesthesiologists	Hilton Cincinnati Netherland Plaza, Cincinnati, OH	www.osainc.org
September 17-18, 2011	New England Society of Anesthesiology	The Woodstock Inn & Resort, Woodstock, VT	www.nesa.net
October 15-19, 2011	American Society of Anesthesiologists Annual Meeting	McCormick Place, Chicago, IL	www.asahq.org
September 18-21, 2011	American Osteopathic College of Anesthesiologists	The Breakers Resort & Spa, Palm Beach, FL	http://www.aocaonline.org/meeting_schedule.php
November 12, 2011	2011 Midwest Anesthesia Conference	Chicago Mart Plaza, Chicago, IL	www.isahq.org
December 9-13, 2011	New York State Society of Anesthesiologists PostGraduate Assembly in Anesthesiology	New York Marriott Marquis, New York, NY	www.nyssa-pga.org