

WHAT DO WE REALLY KNOW ABOUT ICD-10'S POTENTIAL IMPACT ON ANESTHESIA?

Jody Locke, CPC

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On October 1, 2015, a major change to diagnosis coding was rolled out with the International Classification of Diseases and Health Related Problems 10th revision (ICD-10), and virtually all payers (except workers compensation and auto carriers) have agreed to implement the new codes. There was serious concern that the complexity of the new code sequence (69,000 codes instead of the previous list of 14,000) would have a significant impact and increase the number of claims denied for medical necessity. Fortunately, the Centers for Medicare and Medicaid Services announced a 12-month grace period, presumably to give practices time to get up to speed with the logic of the new codes.

Curiously though, there was little or no similar guidance from other major



payers and plans. Many practices across the country have spent considerable time and resources to improve the quality of their diagnostic coding, but others have not. Some have reduced the percentage

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ANESTHESIOLOGISTS AND THE CHANGING HEALTHCARE LANDSCAPE

As we noted in our [eAlert](#) on the topic, the medical community's transition to the International Classification of Diseases and Related Health Problems 10th revision (ICD-10) has, contrary to expectations, gone fairly well so far. In fact, it has gone much better than anticipated, with rates of claims denials remaining essentially unchanged before and after the new system's initial rollout. Does this early success mean that the ICD-10 transition will be smooth sailing from here on out, now that the "grace period" has ended?

As ABC Vice President Jody Locke tells us in *What Do We Really Know About ICD-10's Potential Impact on Anesthesia?*, while it is unlikely that payers will radically alter their usual practices by beginning to hold anesthesia claims to match them against the surgical claim, we can't say this with certainty. Mr. Locke urges anesthesia practices to stay abreast of potential trouble spots and to "prepare for the worst and be relieved when it turns out payers are as reluctant to change their behavior as providers."

Another pressing regulatory issue is the second round of audits by the Health and Human Services Office of Civil Rights—now including business associates—of compliance with the Health Insurance Portability and Accountability Act (HIPAA). The audits are intended to improve compliance, writes Neda Ryan, Esq, but "OCR also maintains its right to launch a more thorough investigation into an organization that it discovers, or believes, to pose a threat to the privacy and security of individuals' protected health information."

Kathryn Hickner, Esq, delves into the Comprehensive Care for Joint Replacement Model (CJR Model), an alternative

payment program. Unlike many other programs to come out of Center for Medicare and Medicaid Innovation, the CJR Model is not voluntary. It behooves us to know more about this program, which applies to items and services provided to Medicare beneficiaries.

HIPAA, ICD-10, CJR and the plethora of regulatory requirements—and long hours clinicians spend complying with them—can sap professional passion. So can clinical responsibilities in the operating room when those responsibilities become repetitive, routine and lacking in opportunities for professional growth. In *The Perioperative Surgical Home: Invest in Good Will*, his fifth in a series of six articles, Rick Bushnell, MD, MBA, describes the potential of this care delivery model to rejuvenate the specialty, rekindle enthusiasm and reinvigorate careers.

The renewed excitement for one's specialty that can come from expanding anesthesiology's role in the delivery of value-based care is one thing; the collective soul-searching required to develop a cohesive strategic plan with colleagues in one's anesthesia group is another. It's an essential activity physicians often avoid, hoping it will magically take care of itself, either because they don't perceive its importance or because they fear it will lead to conflict, according to consultant Will Latham, MBA. To help quell these fears, Mr. Latham offers a straightforward strategic planning primer.

In *Anesthesia Mergers and Acquisitions and Post-Termination Obligations: Have You Terminated Your Future?*, Mark F. Weiss, JD, explores an aspect of group practice that is particularly relevant in the current environment of heightened merger and acquisition activity—namely, what happens when an anesthesia group

is acquired and the contract includes "post-termination obligations"—provisions, such as covenants not to compete, that survive the nominal term of the agreement. Mr. Weiss cautions anesthesia practices to "take into account exactly what it is that you are selling and what its value is."

Non-compete agreements "are crucial to securing the value of the practice," note Amanda K. Jester, JD, and Ashleigh VanLandingham, JD, in their first article for the *Communiqué*, *What Anesthesiologists Need to Know About Enforcement of Non-Compete Agreements*. "Failure of the covenant to meet technical elements for enforceability can be fatal," they warn, stressing the importance of regular reviews of applicable state statutes and case law and adjustments in covenants and the practice's overall strategy to ensure that the covenants remain enforceable.

We hope to see many of you at the American Society of Anesthesiologists annual meeting in Chicago, October 22-26.

With best wishes,

Tony Mira
President and CEO





THE PERIOPERATIVE SURGICAL HOME: INVEST IN GOOD WILL

Rick Bushnell, MD, MBA

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You trade on it every day. It may be your anesthesia group's most important asset. It's difficult to quantify, but in the accounting sense, "good will" is the value of your anesthesia group's assets above and beyond the tangible assets or the net present value of your group's future cash flows. For example, good will was a substantial portion of the calculus when Disney purchased the Star Wars franchise. Good will is embodied in your relationship with your hospitals, your surgeons and your patients. You unknowingly groom your good will every single day in order to capitalize your business environment.

In this fifth installment of the Perioperative Surgical Home (PSH) series, allow me to posit the PSH as your means of increasing your good will by increasing your value to your hospitals, surgeons and patients. Let us explore the discoveries we've made at my institution having initiated pre- and postoperative clinic appointments during this last calendar quarter.

Our PSH clinic targets the 20 percent sickest patients with appointments one week in advance and up to 14 days post-discharge. After initiating clinic appointments with those patients, we quickly noted profound patient gratitude. In most cases, PSH patients already know they are sick and anesthesia is their biggest fear. They're worried, and our 30-minute appointments result in a relaxed setting where we take the luxury of time to address their concerns. These clinic appointments are the embodiment of true patient access to anesthesiologists. The



result is a pool of happier patients and an increased reservoir of community good will toward the entire health system.

Our surgeons also noted their increased access to PSH anesthesiologists. Because of the complexities of anesthesiologist scheduling, often surgeons have no anesthesiologist to consult with concerning complicated patients. Often, the surgeon's best chance of obtaining an anesthesia consult is three minutes before surgery. Too frequently, the results are canceled cases, frustrated physicians, upset patients and global inefficiency.

On the other hand, the clinic appointment the week before surgery is a fantastic time to partner with surgeons in order to optimize their patients. Surgeons really appreciate a call from the PSH clinic anesthesiologist

preparing their next week's complicated patient.

In your operating room (OR) anesthesia colleagues will similarly appreciate receiving a PSH phone call the night before a complicated surgical patient lands on their lineup. That medical sign-out to your anesthesia colleague doing the case the next day is enormously important to them—a service to their day they have never before experienced. In calling and signing out PSH patients to my colleagues, I am personally gratified by the contribution I can make to their practice—and the feeling is mutual. I have found my OR anesthesia colleagues profoundly grateful for our PSH clearances and sign-outs.

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of claims not meeting the specific requirements of ICD-10 to 10 or 15 percent, but many have found it a herculean challenge to obtain and document the details of a patient's diagnosis to the level of specificity required by ICD-10, especially since many surgeons have taken a rather apathetic view of the new requirements. So, now that the CMS grace period has ended, what should we expect? Are we about to see denial rates increase dramatically or is this going to be another example of a policy change for which the advance press is far worse than the actual implementation?

ICD-10 has taken an aspect of clinical documentation that was vestigial and incidental and made it a focus and priority. This, in and of itself, is huge. Now, let us consider the change in structure and logic. ICD-10 introduced concepts that had never been considered before, such as "episode of care." When picking an ICD-10 code for trauma or fractures, the coder must confirm whether the procedure represented the first time a patient was being treated for the condition, a subsequent treatment, or treatment of complications or sequelae. Many of the early ICD-10 training programs simply focused on the requirement to document laterality, wherever applicable, but this is just one of many new requirements. In most cases, physicians simply have to provide a greater degree of specificity in their diagnosis. The following three examples highlight the basic nature of the new requirements:

- Most physicians used to report that the elderly patient had a cataract. ICD-10 requires the provider to indicate that it was an age-related nuclear cataract of the right or left eye.
- It is no longer adequate to indicate that the patient had appendicitis. ICD-10 requires an indication of the nature and extent of peritonitis.

- What used to be reported as a femur fracture now entails an entirely new checklist of qualifying factors as indicated in the ICD-10 Decision Tree shown in Figure 1.

When ICD-10 was implemented, it was often noted that the new codes would give payers a powerful tool to better evaluate the appropriateness of the medical necessity for each procedure. From a claims adjudication perspective, diagnosis can be defined as the reasonable justification for the service performed. In order for payment to be approved, the CPT code must be justified by an appropriate and relevant ICD-10 code. In simple terms, tonsillitis justifies the removal of the tonsils. Of particular concern to anesthesia providers was the inference that payers would have the ability to compare the ICD-10 code reported on the anesthesia claim to that on the surgical claim. In fact, this potential has consumed much of the discussion since last October. In fact, a certain paranoia has set in, that if the anesthesia diagnosis does not match the surgical diagnosis exactly, then the claim will be denied.

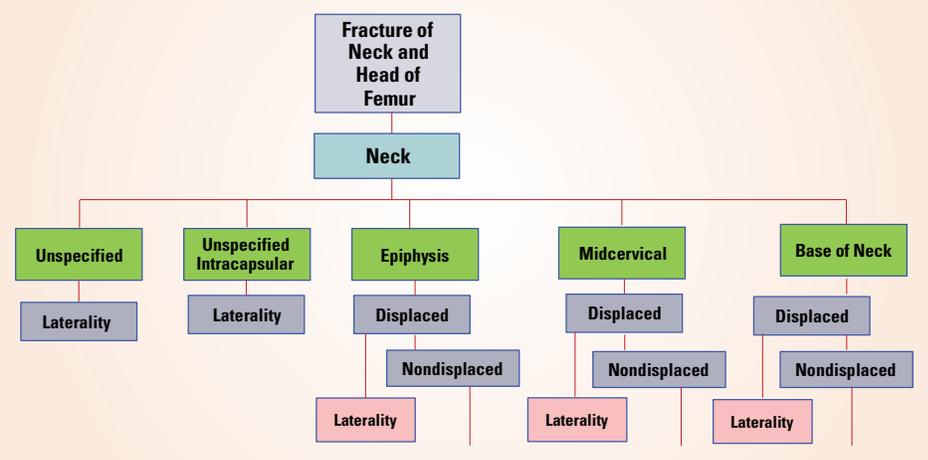
The fact is that most anesthesia claims are submitted well before the surgi-

cal claim. Typically, anesthesia claims are only held when the entire episode of care is being questioned. The prospect of payers holding anesthesia claims to be matched against the surgical claim poses significant logistical claims to payers and would, admittedly, have a material impact on anesthesia cash flow. Most observers of American healthcare do not believe this is a serious possibility, but no one knows for sure, and we cannot dismiss the possibility that payers will use ICD-10 as an excuse to deny a higher percentage of claims.

Given current standards of electronic claims adjudication, it is far more likely that payers will focus on the degree of specificity for all claims rather than on how closely they match. Herein lies one of the greatest challenges for the anesthesia provider. The irony of ICD-10 is that it requires the anesthesiologist to provide a diagnosis that could be used to evaluate the surgeon's diagnosis. How is the anesthesia provider going to get the necessary details, if not from the surgeon? Most anesthesia practices that have implemented a post-operative time-out[®] to allow the surgeon to share procedure and diagnosis have found that many surgeons simply do not understand the requirements of the new

FIGURE 1

A Typical ICD-10 Decision Tree





CPT Description	ICD10 Code	ICD10 Description	ICD10 feedback coding comment
Electroconvulsive Therapy	F29	Unspecified psychosis not due to a substance or known physiological condition	When the condition involves Psychosis, ICD10 requires documentation about the specific type of psychosis disorder: schizotypal/delusional/brief psychotic disorder/shared psychotic disorder/schizoaffective (bipolar type/manic type/depressive type/others)/other psychotic disorders. Failure to provide this level of detail results in an unspecified ICD10 code.
	F25.9	Schizoaffective disorder, unspecified	When the condition involves Schizoaffective Disorder, ICD10 requires documentation about the specific affective type of disorder of involved with schizophrenia: Bipolar type/manic type/depressive type/others. Failure to provide this level of detail results in an unspecified ICD10 code.
	F32.9	Major depressive disorder, single episode, unspecified	When the condition involves depression, ICD10 requires documentation about the specific severity of depression: mild/moderate/severe with or without psychotic features/in partial remission/full remission/others, along with mention of the episode (single/recurrent). Failure to provide this level of detail results in an unspecified ICD10 code.
	F31.9	Bipolar disorder, unspecified	When the condition involves Bipolar disorder, ICD10 requires documentation about the specific episode of bipolar disorder the patient encountered: current/in remission/single manic, etc. along with severity (mild/moderate/severe with or without psychotic features) and specific type: manic/depressed/mixed/others. Failure to provide this level of detail results in an unspecified ICD10 code.

codes, nor do they seem to care. Anesthesia providers frequently report that the surgeon’s response to their queries is this: “My office staff is responsible for picking the code.”

As anesthesia providers slowly came to terms with the implications of ICD-10, many obstacles and challenges started to come to light. Despite what one might have expected, practices with electronic medical records (EMRs) and electronic anesthesia records had the hardest time meeting the new requirements. Why? They had the least ability to review and edit the details of the diagnostic descriptor. One had hoped that the EMR would provide access to the more detailed surgical operative report, but more often than not, the report did not provide the necessary detail. In many cases, the final postoperative surgical diagnosis is simply not known by the end of the case. Questions were raised, for example, about how to treat a biopsy when the pathology report was not available. Many practices attempted to implement a postoperative time-out for the anesthesia provider to confirm the details of procedure and diagnosis, but in many cases, the surgeons were not up to speed, arguing that such details of coding were “a back office function.”

The efforts to reduce the percentage of unspecified ICD-10 codes on claims continues, but one thing has become abundantly clear: If you’ve seen one anesthesia practice, you’ve seen one anesthesia practice! Every

approach and strategy must be custom-tailored to the unique needs of the practice and the ability of its providers to master the logic of ICD-10. Scorecards do help. One cannot manage what one cannot measure. But scorecards (and detailed provider feedback) are only one piece of a much more complicated puzzle. Modifying provider behavior is no small challenge, and in the case of diagnosis, it is proving to be huge.

We are almost a year out from the initial rollout of the new ICD-10 codes, and there have been virtually no denials related to the specificity of the ICD-10 code or mismatches with the surgeon’s code. There is nothing that gets a provider’s attention as quickly as issues affecting cash flow. Because ICD-10 does not appear to have had an impact thus far, many providers have started to dismiss its significance.

Anesthesia Business Consultants has been very focused on educating providers about ICD-10 and has conducted dozens of in-service sessions in person and via web meetings. The company has also developed a coding application called *FIRSTCode* to help client providers confirm the data elements necessary to document the diagnosis.

If we draw an analogy to the administration of anesthesia, there are some useful parallels. It is often said that of the five phases of anesthesia—preparation, induction, maintenance, emergence and recovery—preparation is the most impor-

tant. The goal is to identify potential risks and prepare for them. So it is with ICD-10. We will not know what the financial impact of ICD-10 will be until it happens. The best advice we offer at this point is to reduce the potential risk areas that payers could take advantage of to deny claims. Probably, things will not change too much, but we cannot know for sure. Just because we don’t think something will happen doesn’t mean it won’t. It is much better to be prepared for the worst and be relieved when it turns out payers are as reluctant to change their behavior as providers.

If you would like more information about how ICD-10 will affect your practice, please contact your client manager and ask for your detailed ICD-10 Client Coding Feedback report (ICCF). 

Jody Locke, MA serves as Vice President of Anesthesia and Pain Practice Management for Anesthesia Business Consultants. Mr. Locke is responsible for the scope and focus of services provided to



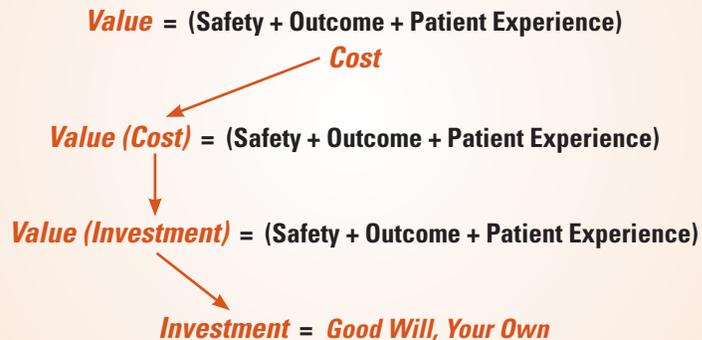
ABC’s largest clients. He is also responsible for oversight and management of the company’s pain management billing team. He is a key executive contact for groups that enter into contracts with ABC. Mr. Locke can be reached at Jody.Locke@AnesthesiaLLC.com.



THE PERIOPERATIVE SURGICAL HOME: INVEST IN GOOD WILL

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Identify and target deficits in services...
Develop your anesthesia assets to address those needs...



Hospital risk management attorneys are also discovering that the PSH is their new best friend. In our clinic, we conduct full histories and physicals, and place electronic medical record notes that dramatically improve the medical-legal environment.

In one notable case, our PSH anesthesiologist spent an hour with a complicated patient and her daughter. They had an extensive conversation about the anesthesia/surgical risks, benefits and alternatives, and he placed a beautifully detailed note. The patient went on to surgery and eventually passed away from a perioperative complication,

but the patient's family was grateful for the extensive preoperative briefing. Additionally, the detail in the PSH record resulted in near absolution and indemnification for the surgeon, the hospital and the anesthesiologist.

Our Risk Management Department became a big believer after this one case alone. Our chief financial officers and executives are delighted to follow the mounting evidence of the PSH's financial value. One study from New York University places a value of a preoperative PSH appointment with an anesthesiologist at \$1,700 due to decreased length of stay, fewer readmissions and decline in surgical cancellations. This data is being closely followed by CMS and other payers. With the implementation of bundled payments and accountable care organization (ACO) caps, this is data you will want on your side. This is data that your anesthesia group will want to "own" as you go before the ACO board to present your request for a larger percentage of fixed, capped bundled payments.

The greatest accrual of value, though, may be the motivation and stimulation afforded by the PSH. Stepping out of the OR to redeploy your anesthesia intuition

in the perioperative setting is a fantastic management and medical experience. These new challenges can rejuvenate your career by giving you a new sense of purpose. Your own good will toward your colleagues, surgeons, patients and hospital will soar. You will rediscover energy and enthusiasm that had faded with repetitive and routine OR work. It is true that your practice can be new again.

The excitement and renewed sense of purpose that comes with being a PSH clinic anesthesiologist will be transmitted to patients, staff and the hospital. That is the real value of good will. Your new sense of fulfillment will be infectious as it rolls through the health system like a shot of adrenaline, resulting in happier patients, increased rapport between services and more appreciative hospital administrators. While not directly, objectively calculable, it is money in the bank of reputation that secures your exclusive contract with those you serve. Invest in yourself first. Invest in good will. 

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TEN THINGS ANESTHESIOLOGISTS SHOULD UNDERSTAND ABOUT THE MEDICARE COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL

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For years, anesthesiologists have been acutely aware that this country's healthcare reimbursement regime is in a state of significant transition. Government healthcare programs (such as Medicare and Medicaid) and commercial payers are gradually moving away from a fee-for-service model to value-based payment programs that focus on the quality and efficiency of services provided. For example, the federal government aims to have 50 percent of all Medicare fee-for-service payments made via alternative payment models by 2018.

Anesthesiologists have also heard for several years that they need to command a seat at the table when such reimbursement changes are proposed and implemented. We know that anesthesia services provided during the perioperative period can have a significant impact on financial and clinical outcomes. By providing anesthesiologists with a seat at the table, hospitals gain from the unique perspective and insight that the anesthesiologists have to offer.

Active and collaborative participation by anesthesiologists also benefits the anesthesiologists themselves. Such involvement may provide anesthesiologists with an additional opportunity to



improve the healthcare system and patient satisfaction, experience greater fulfillment in their own practices, provide additional value to their hospitals and, under some circumstances, financially benefit from such contributions. Although the practical opportunities for doing so vary tremendously depending on the circumstances, the importance of such anesthesiologist engagement—to the specialty, the patients, the hospitals and the industry more generally—is relatively well understood and accepted.

This article provides a broad overview of certain key considerations regarding one relatively new and significant alternative payment program, the Comprehensive Care for Joint Replacement Model (the CJR Model).¹ Understanding the impact of the CJR Model on the healthcare industry is important not only for anesthesiologists who are directly impacted by the

CJR Model, but also for those anesthesiologists who are preparing themselves for success under similar value-based payment models in the future. Here are 10 facts about the CJR Model that anesthesiologists should understand.

- 1. The CJR Model aims to lower Medicare expenditures and improve outcomes related to hip and knee replacements.** The CJR Model was designed by the Center for Medicare and Medicaid Innovation (Innovation Center) to improve surgical outcomes and reduce Medicare expenditures related to hip and knee replacements (sometimes also referred to as “lower extremity joint replacements” or “LEJR”), which are common and expensive procedures.

According to the federal government, in 2014, there were more than 400,000 hip and knee replacements for Medicare beneficiaries, and the associated hospitalizations alone cost more than \$7 billion. Further, it is anticipated that such surgeries will become increasingly utilized. The Innovation Center has identified substantial variability across the country in terms of cost and patient outcomes associated with these services. That means there may be significant room for improvement.

¹ See 80 FR 73273 (November 24, 2015) and <https://www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-jointreplacement-payment-model-for-acute-carehospitals>



TEN THINGS ANESTHESIOLOGISTS SHOULD UNDERSTAND ABOUT THE MEDICARE COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL

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2. Many hospitals are required to participate in the CJR Model.

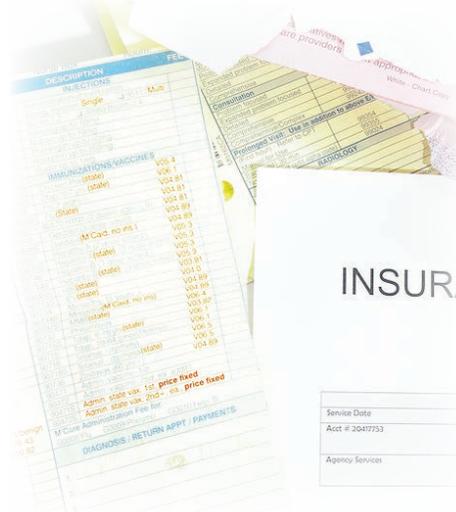
Unlike many other Innovation Center programs, hospitals do not opt into or out of the CJR Model. There is no application form or process. Rather, most acute care hospitals within the 67 designated CJR Model geographic areas (which are defined by and referred to as metropolitan statistical areas (MSAs)) are required to participate. Such geographic areas and the participating hospitals within such areas (along with an abundance of other materials related to the CJR Model) are set forth on the Innovation Center website.² As of August 1, 2016, there were approximately 790 hospitals participating in the CJR Model.

3. The CJR Model only applies to items and services provided to Medicare beneficiaries.

Only those Medicare beneficiaries who satisfy the following criteria will be included in the CJR model: (a) the beneficiary is enrolled in Medicare Part A and Part B; (b) the beneficiary's eligibility for Medicare is not on the basis of the End-Stage renal disease benefit; (c) the beneficiary is not enrolled in any managed care plan; (d) the beneficiary is not covered under a United Mine Workers of America health plan; and (e) Medicare is the primary payer.

4. The CJR Model retrospectively bundles payments for certain hip and knee replacement episodes of care.

The CJR Model is designed to hold hospitals accountable for the quality and cost of a CJR episode of care. Under the CJR Model, an



episode of care has wide breadth in terms of duration and the scope of services included. For purposes of the CJR Model, an episode of care commences upon the patient's admission to a hospital and ends 90 days after the patient is discharged under MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities).

Subject to certain exclusions that are described more specifically on the Innovation Center website, the episode covers all related items and services paid under Medicare Part A and Part B. In general, the episode of care includes, for example, the following services when they are related to the hip and knee replacement surgery: (a) physicians' services, (b) inpatient hospital services (including hospital readmissions), (c) inpatient psychiatric facility services, (d) long-term care hospital services, (e) inpatient rehabilitation facility services, (f) skilled

nursing facility services, (g) home health agency services, (h) hospital outpatient services, (i) outpatient therapy services, (j) clinical laboratory services, (k) durable medical equipment, (l) Part B drugs and (m) hospice.

5. Under the CJR Model, participating hospitals are paid in the usual manner subject to annual reconciliations that take into consideration quality and efficiency.

Hospitals that participate in the CJR Model will operate under the usual Medicare payment system, subject to an annual reconciliation at the end of each CJR Model performance year. Such reconciliation will review certain quality indicators and also a comparison of the actual spending for the episode and the Medicare target episode price.

Depending on the participating hospital's performance in terms of efficiency and quality, the hospital may receive an additional payment from Medicare or may be required to repay Medicare for a portion of the episode spending. Note, however, that there is no downside risk during performance year one, which is a partial year commencing on April 1, 2016 and ending on December 31, 2016. For subsequent CJR Model performance years (each of which is a full 12-month calendar year), stop-loss limits apply during performance years two through five, increasing from five percent to 20 percent over the course of such timeframe.

6. The CJR Model should create additional opportunities for collaboration.

In order to succeed under

² See <https://innovation.cms.gov/initiatives/CJR>.



the CJR Model, hospitals will need to foster alignment and coordination with anesthesiologists and other physicians, home health agencies, skilled nursing facilities and others. Participating hospitals will rely upon teams of professionals, including anesthesiologists, to monitor and improve performance (for example, by reducing unnecessary complications and hospitalizations) through communication, collaboration and standardization across the continuum of care. Anesthesiologists can uniquely contribute and benefit from such teamwork.

7. **The CJR Model includes safeguards designed to protect Medicare beneficiaries.** Under the CJR Model, the patients (i.e., the Medicare beneficiaries) themselves continue to have the freedom to choose their own services and providers. Accordingly, participating hospitals may ultimately be responsible for items or services within the episode of care provided by a third party over whom the hospital has little influence or control.

This dynamic creates a strong incentive for hospitals to align in new ways with physicians, home health agencies, skilled nursing facilities and others within the continuum of care to strengthen care coordination. The Innovation Center website (referenced above) includes a description of certain beneficiary notifications and forms for use by CJR Model hospitals and their collaborators. Also note that Medicare has several tools, including additional monitoring of claims data, to ensure that participating hospitals do not impermissibly stint care to achieve cost-savings.

8. **Providers impacted by the CJR Model must be cognizant of applicable regulatory constraints.** Participation in a new Innovation Center payment model that encourages collaboration does not necessarily bless all potential relationships entered by participating hospitals and their collaborators, even if such relationships are designed for the lofty goals of achieving quality, efficiency and success under the payment model. Historically, the state and federal healthcare, tax exempt, anti-trust and other regulations have intentionally created certain barriers to alignment among providers. Such constraints are designed, in part, to protect the federal healthcare programs from overutilization and associated costs. It is important for providers to understand that, in general, the relationships that they forge while positioning themselves for success under the CJR Model continue to be subject to applicable regulations.

9. **CJR Model and related federal guidance affords hospitals and their collaborators with certain increased flexibility.** To encourage the collaboration required for the CJR Model to achieve its objectives while simultaneously safeguarding the federal healthcare programs, the CJR Model itself includes certain increased flexibility for participants to structure relationships with other providers across the continuum of care.

For example, subject to certain parameters, the CJR model allows its participating hospitals to share payments received from Medicare for the provision of efficient high-quality services (and also, on the flip-side, to share financial accountability and

risk) with collaborating providers and suppliers, which could include anesthesiologists and their groups. Further, on November 16, 2015, the federal government issued limited fraud and abuse waivers for certain arrangements involving CJR Model participants. Note that such fraud and abuse waivers apply only with respect to the specific laws cited and only protect those arrangements that meet each and every applicable condition.

10. **Anesthesiologists should keep their eyes and ears open for additional developments regarding the CJR Model and other alternative payment models.** During August, 2016, the federal government issued helpful Frequently Asked Questions regarding the CJR Model that are available along with several other pieces of useful guidance on the Innovation Center website.³ Further, note that although the CJR Program is relatively new, the federal government proposed further changes to the model during July 2016.⁴ Such changes focus, in part, on aligning financial incentive policies of the CJR Model with proposed episode payment models, allowing participating hospitals to further collaborate with accountable care organizations and critical access hospitals, and modifying the pricing and reconciliation process. ▲

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³ See <https://innovation.cms.gov/Files/x/cjr-faq.pdf>.

⁴ See 81 FR 50793 (August 2, 2016). See also, <https://www.federalregister.gov/articles/2016/08/02/2016-17733/medicare-program-advancing-care-coordination-through-episode-payment-models-epms-cardiac>.



PREPARING FOR ROUND 2 OF HIPAA AUDITS

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Over the past five years, the Department of Health and Human Services Office of Civil Rights (OCR) has been more aggressive about identifying organizations that fail to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its impending regulations. Historically, OCR has taken a reactive approach to noncompliance through tips and complaints or notifications of breaches by covered entities. Recently, however, OCR has been more proactive through its use of audits to identify organizations that are noncompliant with HIPAA and its regulations.

Until now, OCR has only audited covered entities. Covered entities are health plans, healthcare clearinghouses and healthcare providers who conduct certain financial and administrative transactions electronically. Now, OCR is expanding its audits to business associates. Business associates are people or entities performing certain services involving the use or disclosure of protected health information (PHI) on behalf of or for a covered entity. Business associate services include legal, actuarial, accounting, consulting, management, financial and billing.

OCR states that its audits are intended to improve compliance within the industry by identifying vulnerabilities and developing tools to address widespread areas of non-compliance. However, OCR also maintains its right to launch a more thorough investigation into an organization that it discovers, or believes, to pose



a threat to the privacy and security of individuals' PHI. As such, all organizations should be familiar with what the recent phase of audits entails and use this as an opportunity to prepare for this round, or future rounds, of OCR audits.

PILOT AND PHASE 1 OF THE AUDIT PROGRAM

During 2011 and 2012, OCR initiated its Pilot Program during which 20 covered entities were audited. It approached the Pilot Program in three steps: (1) developing audit protocols, (2) conducting 20 audits to test the protocol and (3) expanding the audit to Phase 1 to audit 95 additional covered entities using revised protocols. The Pilot Program and Phase 1 included audits of a health plan, a hospital system, small providers, community hospitals, outpatient surgery centers and a regional pharmacy. During the Pilot Program, OCR found various

HIPAA compliance-related issues, but did not seek enforcement action against those covered entities. Most notably, OCR found that more than 60 percent of violations were related to Security Rule provisions.¹

PHASE 2 AUDIT PROGRAM

Phase 2 was launched in July 2016 when 167 covered entities received notice they were selected for desk audits. Business associates will receive notice of desk audits this fall. The focus of the desk audits is on seven controls drawn from the Security Rule, the Privacy Rule and the Breach Notification Rule. The controls are summarized in Figure 1. In early 2017, Phase 2's third wave of audits will begin with onsite audits, which will be broader in scope than the desk audits.

Entities having received, or that will receive, an audit letter from OCR under Phase 2 can expect to receive a notification email of their selection for participation in the audit. They will also receive a document request for policies, procedures and/or other

¹ Lessons Learned from OCR Privacy and Security Audits, Program Overview and Initial Analysis, Presentation to IAPP Global Privacy Summit, March 7, 2013 (https://clearwatercompliance.com/wp-content/uploads/2014/06/4-1-Lessons-Learned-from-OCR-Privacy-and-Security-Audits-Sanches_Rinker_03-07-2013.pdf).



FIGURE 1	
Privacy Rule Controls	Notice of Privacy Practices & Content Requirements [§164.520(a)(1) & (b)(1)]
	Provision of Notice – Electronic Notice [§164.520(c)(3)]
	Right to Access [§164.524(a)(1), (b)(1), (b)(2), (c)(2), (c)(3), (c)(4), (d)(1), (d)(3)]
Breach Notification Rule Controls	Timeliness of Notification [§164.404(b)]
	Content of Notification [§164.404(c)(1)]
Security Rule Controls	Security Management Process – Risk Analysis [§164.308(a)(1)(ii)(A)]
	Security Management Process – Risk Management [§164.308(a)(1)(ii)(B)]

related documentation. Covered entities will be required to provide the contact information for all business associates.

After a review of the submitted documentation, OCR will develop and share draft findings with the entity. The entity may respond to draft findings, and the written responses will be included in the final audit report. Final audit reports will describe how the audit was conducted, present any findings and contain entity responses to the draft findings. Although OCR claims the audits are “a compliance improvement activity,” OCR has the authority to initiate a separate compliance review or investigation if significant threats to the privacy and security of PHI are revealed through the audit.

HOW TO PREPARE FOR HIPAA AUDITS

- 1. Conduct Mock Audits** – OCR has published the letters it will send to auditees. OCR has also published its audit protocol.² These resources, and others, can be used to conduct mock audits.

- 2. Conduct a Risk Assessment** – HIPAA requires that entities conduct risk assessments to identify areas in which the entity is vulnerable or susceptible to violations. OCR has prepared a Security Risk Assessment Tool (<https://www.healthit.gov/providers-professionals/security-risk-assessment>) where entities can conduct their own risk assessments in evaluating their compliance with HIPAA's Security Rule.

- 3. Implement and Update Policies and Procedures** – Following a risk assessment, entities should develop and/or update their policies and procedures to ensure the areas of vulnerability are addressed.

- 4. Educate Employees and Staff** – Employees and staff should regularly be educated on their obligations with respect to the privacy and security of health information traveling in and out of the organization.

- 5. Organize Materials** – Begin to organize the materials and documents that could be requested in an audit. These materials would include policies and procedures, historical risk assessments, notifications to individuals and others of breaches, and lists of business associates and their contracts.³
- 6. Respond to OCR** – If you receive an audit letter, do not ignore it! There will be a short timeframe in which to respond. Contact an attorney or a HIPAA professional to assist in responding to the audit request and any subsequent OCR communications.

CONCLUSION

OCR's auditing activity is only increasing. What was once limited to covered entities has been expanded to business associates, and what once involved fewer than 200 entities, now involves up to 250. All entities should be prepared for the possibility of an audit. OCR has many resources to assist organizations in understanding the requirements and implementing the necessary measures to promote compliance. In today's auditing environment, entities cannot delay in complying with what is required of them. 

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² <http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/protocol/index.html>

³ A sample list of business associates is available here: <http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/batemplate/index.html>.



WHAT ANESTHESIOLOGISTS NEED TO KNOW ABOUT ENFORCEMENT OF NON-COMPETE AGREEMENTS

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On May 5, 2016, the White House issued a report citing a variety of issues with the use of non-compete agreements advocating for non-compete reform at the state and federal level.¹ According to the White House report, with respect to healthcare services (i.e., physicians, nurses, psychologists, social workers and other medical professionals), non-competes have the potential to interfere with the quality of care by restricting consumer choice.

The report acknowledged, however, that for physicians, it is plausible that there may be “legitimate business interests” that hospitals and service providers seek to protect. At the same time, many states have recently proposed or implemented legislation limiting the enforceability of non-competes, including some limitations specific to physicians and other healthcare providers. In this article, we will discuss the enforcement of non-competes generally, enforcement against physicians in the context of employment or in connection with the sale of a business and recent state legislation specific to the enforcement of non-competes against physicians.



ENFORCEMENT OF NON-COMPETES

Non-competes are generally disfavored as a matter of law and public policy. The enforceability of non-competes varies widely from state to state. In some states, such as California and North Dakota,² non-competes are void and unenforceable except in certain limited circumstances (such as in connection with a sale of a business). Even in states that do typically enforce non-competes, certain criteria must be met in order for the non-compete to be enforceable. Broadly, in order to be enforceable, a non-compete agreement must be: (a) entered into in exchange for adequate consideration; (b)

necessary to protect a legitimate business interest; and (c) reasonable in scope with regard to restricted activity, restricted time and geographic radius of restricted area. State statutes and case law vary as to how these standards are interpreted within their jurisdiction, but generally the following principles apply:

Consideration

As a basic principle of contract law, an agreement is not binding unless it is supported by adequate consideration. Consideration is an exchange of value, meaning that in the context of a non-compete, the party seeking to enforce the non-compete must give something of value in exchange for the individual's agreement not to compete. That exchange of value may be a monetary payment (e.g., a signing bonus in the case of employment or the purchase price in the case of a sale of a business) or an initial offer of employment (although some state courts, such as Illinois,³ require that the new employee remain employed for a certain amount of time in order for the non-compete to be enforceable). Once the employment relationship has commenced, states are split as to whether a mere offer of continued employment is sufficient consideration to support enforcement of a non-compete without a corresponding additional benefit to the employee.⁴

¹ https://www.whitehouse.gov/sites/default/files/non-competes_report_final2.pdf

² Cal. Bus. & Prof. Code §§ 16600-6607; N.D. Cent. Code § 9-08-06.

³ *Prairie Rheumatology Associates, S.C. v. Maria Francis, D.O.*, 2014 IL App. (3d) 140338.

⁴ Compare, e.g. *Charles T. Creech, Inc. v. Brown*, 433 S.W.3d 345 (Ky. 2014) holding that continued employment was not sufficient; with *Standard Register v. Keala*, Civ. No. 14-00291 JMS-RLP (D. Haw., June 8, 2015) holding that continued at-will employment was sufficient consideration for a non-compete.



Legitimate Business Interest

Most states will not enforce a non-compete against an individual beyond what is necessary to protect the covenant holder's legitimate business interests. What constitutes a legitimate business interest varies from state-to-state and may be defined by statute (as in Florida)⁵ or by case law. In the context of physician practices, the following have been recognized as legitimate business interests:

- Patient referral bases and substantial relationships with patients;
- Confidential business information (for example, patient lists);
- Patient good will associated with a professional practice within a certain geographic location or practice specialty;
- Return of investment on training,⁶ particularly extraordinary or specialized training.

While the value of direct patient relationships is generally recognized as a legitimate business interest, specialty practices, such as anesthesiology and emergency medicine, that provide staffing services to hospitals and other facilities, derive much of their value from these contracts with third party "customers." In that case, establishing a legitimate business interest in protecting these third party relationships may prove to be more difficult. In one Florida case, the court found that a hematology and oncology practice that purported to have an "exclusive contract" with two area hospitals did not have a legitimate business interest in protecting those

hospital relationships because they were not, in fact, exclusive.⁷ In that case, practitioners within the same specialty area were granted privileges and worked at the two hospitals in question.

The same Florida statute that defines a "legitimate business interest" also provides that in determining the enforceability of non-compete, a court may consider as a defense the fact that the person seeking enforcement (i.e., the former employer) no longer continues in business in the area or line of business that is the subject of the restrictive covenant. Similar state statutes or case law that follow this reasoning present another challenge for practices that seek to protect valuable staffing arrangements. If the contract with the hospital is terminated, arguably the practice is no longer engaged in that particular line of business and may not have a legitimate business interest in restricting its former employee's interaction with that hospital.

This scenario is particularly concerning for hospital-based physician practices, as arguably the hospital could terminate the contract with the practice, and then seek to employ the physicians itself, leaving the practice with no protectable business interest. To help protect against this scenario, a common practice is to include a liquidated damages provision in the agreement with the hospital and/or the physician employment agreement, acknowledging the value of the physicians' covenant not to compete and setting significant liquidated damages (that would likely be paid by the future employer). At a minimum, this strategy requires the future employer to make a significant investment in order to employ the physicians, and could serve as a deterrent.

In states that prohibit the corporate practice of medicine, certain entities may not be permitted to enforce a physician non-compete due to lack of a legitimate business purpose. For example, the Virginia Supreme Court has held that because a corporation could not engage in the practice of medicine, it did not have a legitimate business interest in enforcing a covenant not to compete in an employment contract with a physician.⁸ Similarly, the Illinois Supreme Court has found that where an employment agreement between a physician and a corporate employer violated the prohibition against the corporate practice of medicine, the entire agreement, including non-compete restrictions, was "void, unenforceable, and unassignable from its inception."⁹ This issue can be avoided by structuring relationships between physicians and corporate partners in a manner that complies with the applicable corporate practice of medicine doctrine.

Reasonableness

Non-compete restrictions must be reasonable in scope with regard to restricted activity, restricted time and geographic radius of restricted area.

Restricted Activity. Non-compete restrictions that unreasonably impair the ability of an individual to make a living are likely to be deemed overbroad and unenforceable. Generally, the restricted activity must be reasonable in the context of an employee's duties and activities on behalf of the employer. In the context of the sale of the business, courts generally look to the nature of the business at the time of the sale. In determining reasonableness of the restricted activity with respect to physicians, most courts look to the "particular specialty" at issue.¹⁰ If a non-compete precludes any type of practice, even in fields that do not

⁵ Fla. Stat. Ann. § 542.335(1)(b).

⁶ *Community Hosp. Group, Inc. v. More*, 869 A.2d 884, 897 (N.J. 2005)

⁷ *Fla. Hematology & Oncology Specialists v. Tummala*, 927 So. 2d 135 (Fla. 5th DCA 2006)

⁸ *Parikh v. Family Care Ctr., Inc.* 641 S.E.2d 98 (2007).

⁹ *Carter-Shields v. Alton Health Inst.*, 777 N.E.2d 948, 955 (Ill. 2002)

¹⁰ *Valley Med. Specialists v. Farber*, 982 P.2d 1277, 1284 (Ariz. 1999).



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compete with the party seeking to enforce the covenant, the restriction is likely to be deemed too broad.

In New York, however, broad prohibitions on the “practice of medicine” have been upheld including “all employment that involved treating patients, managing patients’ illnesses, admitting patients to a hospital and teaching at a hospital.”¹¹ Such broad restrictions on a physician’s right to practice medicine are prohibited by statute in several states, including Colorado,¹² Delaware¹³ and Massachusetts.¹⁴

Beyond the specific field of practice, non-compete clauses often contain a lengthy list of restricted activities, such as soliciting employees and customers,

working or providing coverage, staffing or other services to competitors, directly or indirectly owning, managing, advising or consulting with a competitor, being employed by or having a financial relationship with a competitor or engaging in the same or similar business as the party seeking to enforce the covenant. Such a broad array of restricted activities may not be enforceable. In Oklahoma, for example, a former employee must be permitted to engage in the same or similar business as that conducted by the former employer as long as the former employee does not “directly solicit the sale of goods, services or a combination of goods and services from the established customers of the former employer.”¹⁵ Thus, in one

Oklahoma case seeking to enforce a non-compete against a certified registered nurse anesthetist, the court dismissed the complaint in part because the list of prohibited activities was overly broad.¹⁶

Restricted Time. The amount of time for which an individual is prohibited from engaging in the restricted activities must be reasonable. Some states have statutory presumptions regarding the reasonableness of the restricted time. In Florida, for example, any employment-related restraint of six months or less is presumed reasonable, and any restraint more than two years in duration is presumed unreasonable.¹⁷ In the context of the sale of a business in Florida, however, the acceptable time frames are longer: Three years or less in duration is presumed reasonable, and any restraint more than seven years in duration is presumed unreasonable.¹⁸ These statutory presumptions are consistent with trends across the country. An employment-related non-compete must be more limited in duration (e.g., one to three years) than a non-compete entered into in connection with the ownership or sale of a practice (in which three-to-five-year terms are more likely to be enforceable).

Geographic Radius. A non-compete must also be reasonable in terms of its geographic limitations. With respect to physicians, the reasonableness of the geographic limitation may be analyzed in connection with the scope of the limited activity. For example, a blanket prohibition on the practice of medicine may only be enforceable within a small radius (e.g., five miles),¹⁹ while a restriction limited to a particular specialty practice may be enforceable across a broader geographic area (e.g., five counties).²⁰ Generally, courts look to see where a practice’s patients or referral sources are located

¹¹ *Gismondi, Paglia, Sherling, M.D., P.C. v. Franco*, 104 F. Supp. 2d 223, 232 (S.D.N.Y. 2000)

¹² Colo. Rev. Stat. Ann. § 8-2-113(3).

¹³ Del. Code Ann. tit. 6, § 2707

¹⁴ Mass. Gen. Laws ch. 112, § 12X

¹⁵ Okla. Stat. § 2012(B)(6).

¹⁶ http://www.martindale.com/labor-employment-law/article_GableGotwals_1728440.htm

¹⁷ Fla. Stat. Ann. § 542.335(1)(d)(1).

¹⁸ Fla. Stat. Ann. § 542.335(1)(d)(3).

¹⁹ *Mohanty v. St. John Heart Clinic, S.C.*, 866 N.E.2d 85 (Ill. 2006)

²⁰ *Karpinski v. Ingrassi*, 320 N.Y.S.2d 1 (1971)



when evaluating the reasonableness of the geographic scope. In one Wisconsin case, the court invalidated a non-compete prohibiting a cardiologist from engaging in the practice of thoracic medicine or heart surgery within a 30-mile radius of three specified cities because the geographic scope was overly broad as compared to the physical location of the employer's referral sources.²¹

Some states require that the geographic scope be defined in a specific manner. For example, a Louisiana statute requires that a non-compete agreement identify the covered parish, county or municipality.²² In *Kimball v. Anesthesia Specialists*,²³ an anesthesiologist who was a former employee and shareholder successfully challenged a non-compete provision in his employment agreement which stated that the geographic scope was "any health care facility regularly serviced by the [employer]." The Louisiana court invalidated the non-compete because it failed to adequately identify the geographic scope in accordance with the statute.

ENFORCEMENT AGAINST PHYSICIANS IN CONTEXT OF SALE OF A PRACTICE

Non-competes entered into in connection with the sale of a business are generally viewed more favorably than non-competes solely in the employment context. Even states that prohibit non-competes in the employment context, such as California, will enforce reasonable non-competes in the context of the sale of a medical practice (provided statutory criteria are met).²⁴

In addition to specific enforcement of the non-compete, other remedies may be available to the buyer in connection



with the sale of a practice. For example, the purchase agreement for the acquisition of a practice may provide that the buyer may "claw back" all or a portion of the purchase price if the non-compete restriction is violated as liquidated damages. Generally, the amount of liquidated damages must be a reasonable forecast of the damage likely to occur and may not simply act as a penalty.

In a recent Indiana case, the Court of Appeals found that the liquidated damages clause that required the selling physician to repay the exact amount the buyer paid for the practice "made sense as an estimate of damages because [the buyer] paid not just for the tangible property of the Practice but also for [the seller's] personal good will. [If the seller opened a practice within the restricted area], the good will that the community associates with his name will follow him, and the value of [the buyer's] purchase will likely suffer. Thus, the liquidated damages clause here places [the buyer] in the position it occupied before it executed the purchase agreement."²⁵ The court went even further, however, finding that

the liquidated damages provision did not prevent the buyer from also seeking an injunction to enforce the non-compete.

Acquisition-related non-competes are not always enforceable, however, and may be subject to additional scrutiny at the federal level. In one notable case, *In the Matter of Renown Health*, the Federal Trade Commission (FTC) invalidated the non-compete clauses of 10 cardiologists following Renown Health's acquisition of two competing cardiologist practices in the Reno, Nevada market. As a result of the acquisitions, Renown Health employed approximately 97 percent of the physicians providing cardiology services for adults in the Reno area at one time and approximately 88 percent at the time the FTC consent order was finalized.²⁶

Pursuant to the FTC consent order, 10 of the 32 cardiologists who were employed by Renown Health following the acquisition of their respective practices were permitted to join competing cardiology practices in the Reno area. The FTC cited several market factors in support of its complaint against Renown Health, including (a) significant barriers to entry in the market due to the cardiologists' high degree of specialization and subspecialization; (b) the dominance of Renown Health as the largest hospital system in the area; and (c) increased ability of the merged entity to unilaterally raise prices for cardiology services and demand higher rates from healthcare plans in the market.²⁷ Similar concerns may be relevant in other specialty physician practices in concentrated or consolidating markets, including the anesthesia market.

RECENT DEVELOPMENTS

Several states have recently enacted or proposed legislation limiting the enforceability of non-competes against physicians.

²¹ *Fox Valley Thoracic Surgical Associates, S.C. v. Ferrante*, 2008 WL 425648 (Wis. Ct. App. February 19, 2008)

²² Section 23:921(C) of the Louisiana Revised Statutes.

²³ 809 So. 2d 405, 413 (La. Ct. App. 2001).

²⁴ *Hill Med. Corp. v. Wycoff*, 86 Cal. App. 4th 895, 901 (2001).

²⁵ *Pinnacle Healthcare, LLC, and Patrick J. Sheets, M.D., Inc., v. Patrick J. Sheets*, 17 N.E.3d 947 (Ind. Ct. App. 2014)

²⁶ <https://www.ftc.gov/sites/default/files/documents/cases/2012/08/120806renownhealthcmpt.pdf>, at page 2.

²⁷ <https://www.ftc.gov/sites/default/files/documents/cases/2012/12/120806renownhealthcmpt.pdf>.



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New Hampshire. On June 6, 2016, the New Hampshire governor signed into law Senate Bill 417. The new law renders void and unenforceable any agreement with respect to partnership, employment or any other form of professional relationship with a physician, which includes any restriction to the right of such physician to also practice medicine in any geographic area for any period of time during or after the termination of such partnership, employment or professional relationship. The law applies to new contracts or renewals of contracts entered into on or after August 5, 2016.

Connecticut. On June 2, 2016, the Connecticut governor signed Public Act No. 16-95.²⁸ The new law, which applies to physician non-compete agreements entered into, amended, extended or renewed on or after July 1, 2016, limits restrictions on a physician's competitive activities to (i) no more than one year, and (ii) in a geographic region no more than fifteen miles from the primary site where the physician practices. The law also limits the enforceability of non-competes upon the expiration, non-renewal or termination of a physician's employment, other than in connection with a physician's voluntary non-renewal or the termination of employment by the employer for cause.

Missouri. House Bill No. 1660 (as amended),²⁹ introduced in December 2015, sought to ban covenants not to compete between physicians and any "private, nonprofit health care entity or governmental health care entity." The bill also provided for physician access to patient lists and patient medical records after termination of employment. The bill failed in the Health and Mental Health Policy Committee in March 2016.

Washington. House Bill 1173, which was reintroduced in the Washington State 2016 legislative session, would ban physician non-competes. The proposed bill provides that "A provision in an employment or other professional agreement that restricts the right of a person licensed [to practice osteopathic medicine or to practice medicine] in a geographic area for a period of time after the termination of the contract is void and unenforceable." The proposed bill did not pass the Washington House before the legislative deadline in February, so will not proceed this year.

New York. New York Senate Bill S4447A (and its companion in the Assembly, A2147A) attempts to "clarify" New York law. The bill acknowledges that "learned professionals" such as physicians have always been permitted to enforce non-compete agreements against departing physicians, but would prohibit the enforcement of a non-compete against a physician if "such learned professional was involuntarily terminated or discharged for reasons other than misconduct." The bill was amended and recommitted to the Labor Committee as of January 15, 2016.

New Mexico. Effective in July 2015, New Mexico imposed a ban on non-compete provisions restricting healthcare practitioners, including: (1) dentists; (2) osteopathic physicians; (3) physicians; (4) podiatrists; and (5) certified registered nurse anesthetists. The ban does not apply to agreements between healthcare practitioners who are shareholders, owners, partners or directors of a healthcare practice. In addition, other types of restrictive covenants are explic-

itly permitted under the statute, including non-disclosure restrictions for confidential information, and trade secrets and non-solicitation provisions with respect to patients and employees for a one-year period or less.³⁰

OBSERVATIONS / CONCLUSION

Because an anesthesia practice's success is highly dependent on two assets—the relationship with the hospital and the relationship with its physicians—its covenants not to compete with its physicians are crucial to securing the value of the practice. Failure of the covenant to meet technical elements for enforceability can be fatal. It is important to regularly review developments in applicable state statutes and case law, and adjust the covenants and the practice's strategy generally in order to ensure that the covenants remain enforceable. ▲

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²⁸ <https://www.cga.ct.gov/2016/act/pa/pdf/2016PA-00095-R00SB-00351-PA.pdf>

²⁹ <http://www.house.mo.gov/billtracking/bills161/billpdf/intro/HB1660L.PDF>;
<http://www.house.mo.gov/billtracking/bills161/amendpdf/4639H01.02H.pdf>

³⁰ <https://www.nmlegis.gov/Sessions/15%20Regular/final/SB0325.pdf>; N.M. Stat. Ann. §§ 24-1i-1 to 24-1i-5

HOPE IS NOT A STRATEGY: A PRIMER FOR ANESTHESIA GROUPS ON STRATEGIC PLANNING

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One of the most important responsibilities of any anesthesia group's governance is to develop a strategic plan for the group. For some groups this is the role of the Board. In other groups, all shareholders participate in this process.

Unfortunately, it appears that for many groups, "hope" is their strategy.

We are continually surprised to find groups that have never (or rarely) conducted strategic planning retreats on an annual or semi-annual basis. This is especially surprising given:

- Almost all of many physicians' compensation comes from their group.
- Almost all of many physicians' clinical work life is associated with their group.
- Moving ahead with significant initiatives requires the collaboration of the members of the group. There is often little that one physician can do by themselves.

And yet, many physicians won't allocate one day a year for a group planning session.

WHY IS PLANNING AVOIDED?

Why don't they? We think there are several reasons:

- Many physicians don't see the need for strategic planning. They think the group should be able to develop



plans at their monthly meetings. They don't recognize that they typically use those (overly long) monthly meetings to fight day-to-day fires.

- Many physicians are conflict avoiders. They don't want planning meetings because they fear that uncontrolled, unproductive conflict will break out.
- The idea of "planning" sounds too business-like, or the term "retreat" sounds too much like Kumbaya.

CRITICAL FOR SUCCESS

The decisions that anesthesia groups face today are significant and have long-range implications. They involve such

things as whether or not the group will stay independent, who the group might align with, the need to pursue new facilities, the addition of physicians, decisions related to billing and collections, implementation of electronic medical records, the addition of new services and a host of other issues.

Decisions related to each of these issues require substantial resources and lead times. In addition, the decisions are often interrelated. For example, the decision to add new sites of service can be directly impacted by the group's ability to recruit.

But the significance of the needed decisions is only one factor highlighting the importance of long-range planning. Without planning, physicians in

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anesthesia groups rarely have a common vision of the direction their group is moving. This can result in inefficient utilization of resources, lack of direction for the administrative staff and lack of any progress for the group.

There are other reasons that successful anesthesiology groups conduct planning efforts:

- Significant changes in the environment can hurt or help the group. Planning helps identify these issues and prepare for them.
- The planning process allows each physician to communicate their vision of the future and work to develop consensus in their objectives and goals.
- Key issues are highlighted, discussed and resolved.
- The plan provides direction and sets priorities for the administrative staff for implementation.
- The planning process and completed plan improves communication to both physicians and staff.
- If progress is tracked against the plan, performance measurement can be improved.
- Physician recruitment may be enhanced as potential recruits can quickly understand if their long-range goals are in line with the group.

THE STRATEGIC PLANNING PROCESS

Strategic planning includes the following major elements:

1. Developing mission and vision statements for the group.
2. Considering internal strengths



and weaknesses and external opportunities and threats.

3. Discussing key issues.
4. Developing objectives and strategies to achieve those objectives.
5. Creating action plans to implement those strategies.

Step 1: Mission and Vision Statements

We know that some of you will gag at the thought of developing mission and vision statements for your group. Maybe you have spent a whole weekend developing a mission statement for a hospital and come up with “We serve patients.” Maybe your group has tried to develop such statements in the past but the result has been so ethereal that individuals don’t see the connection between these statements and what the group is doing.

This is not Kumbaya stuff. Mission and vision statements serve hard-core business purposes. Mission and vision statements help the group by:

- Identifying how to properly allocate and utilize resources.

- Elaborating group thinking and identifying gaps in agreement that need to be negotiated.
- Setting the stage for all other planning.
- Serving as a guide when setting strategy and making decisions. The group’s leadership should always be asking “Is this taking us toward our vision?”
- And most important, giving the leadership something to hang their hat on when they ask a physician to do what is best for the group rather than the individual.

We have found that, in developing these statements, the best results come from working through a set of questions as outlined below:

Mission Statements

A mission statement is a statement of the group’s purpose and reason for being. Anesthesia groups develop a mission statement to help them communicate with themselves (and sometimes others) why the practice exists and to set parameters for what the group hopes to accomplish.

A mission statement answers the following questions:

- Who does the group wish to serve? Consider geographic area, types of patients, health systems, and other factors.
- What “customer” needs does the group wish to satisfy? “Customers” may include patients, surgeons, health systems and others.
- What physician and staff needs does the group wish to satisfy?
- What are the core values and

requirements for being a member of the group?

- What principles or policies guide the group?

A mission statement is intended to provide motivation, general direction, an image, a tone and/or a philosophy for the group.

Vision Statements

A vision statement addresses where a group is heading by answering the following questions:

- What is your preferred future? What does the group intend to become?
- Looking out three to five years:
 - What services and specialties do you plan to offer?
 - What geographic region do you intend to serve?
 - How many locations are you likely to serve?
 - How large will the group become? Will you grow to fill the service needs of the market, or will you set a limit on the

number of physicians in the group?

- What type of relations will you have with others? Will you remain an independent group?
- What benefits do you hope to provide for the owners and employees?

Avoiding Hallucinations

You may have heard the quip “The difference between a hallucination and a vision is the number of people who see it.”

This is why we recommended that developing these statements be a group activity. Yes, most group leaders can create vision and mission statements on their own. But when they present these statements to their group, the result is usually “that’s nice” and the group moves on to other issues.

Instead, development of these statements should be a group activity for two reasons:

- Answering the questions noted above often leads to a rich discussion about what the group is about and where it is heading.

- When the group members discuss these questions and develop these statements they are more likely to embrace them.

Once mission and vision statements are developed, the next steps are to look at the group’s strengths and weaknesses, review the environment for opportunities and threats and identify the key issues that need to be addressed in the planning process.

Step 2: SWOT Analysis

Once you have developed the group’s mission and vision statements, it is time to identify the important issues that need to be addressed in the planning process. The first step in that effort is to conduct a SWOT analysis.

“SWOT” stands for strengths, weaknesses, opportunities and threats. As part of the strategic planning process, most groups conduct this type of analysis to identify internal and external situations, events or trends that positively or negatively impact the group. Let’s further define terms:

- A strength is a capability, resource or capacity the organization can use to achieve its vision.
- A weakness is a limitation, fault or defect in the organization that will keep it from reaching its vision.
- Opportunities are any favorable situations in the environment that support demand for a service or permit the organization to enhance its situation.
- Threats are any challenge posed by an unfavorable trend or event that, in the absence of purposeful action, would lead to the stagnation, decline or demise of the group or one of its services.





HOPE IS NOT A STRATEGY: A PRIMER FOR ANESTHESIA GROUPS ON STRATEGIC PLANNING

Continued from page 19

When scanning for opportunities and threats, you are looking for three things:

- A significant need, event or trend that could positively or negatively affect the group;
- How that item will impact your organization; and
- What response might be required.

Why conduct a SWOT analysis? Most planning efforts use this information to develop plans to:

- Fix significant weaknesses.
- Pursue key opportunities.
- Avoid important threats.
- Leverage group strengths.

Therefore, by analyzing the SWOT, the group can identify the key issues that need to be addressed in the next steps of the planning process.

How do you develop the SWOT? There are several sources for this information:

- Typically the group's management and leadership are very knowledgeable about both internal and external issues that can affect the group.
- In preparing for the planning process, it makes sense to interview or survey the group physicians for their viewpoints on group strengths and weaknesses, and regional opportunities and threats.
- Sometimes research needs to be conducted to identify demographic changes, moves by competitors and specific opportunities in the marketplace.



Step 3: Key Issues

The key issues to be addressed in the planning process are different for every group. This is because the results of the SWOT analysis are different for every group.

However, we find that anesthesia groups typically need to address the following issues in their planning process:

- Relationships:
 - Is it our goal to remain independent?
 - Who should we consider affiliating with (other groups, hospitals, etc.)?
- Geographic coverage:
 - What market area are we trying to serve?
 - Should we consider satellites or new service locations?
- Providers:
 - How large should we become? How many physicians, CRNAs, other providers should we have?
 - What specialties or sub-specialties should we have?

- What is our recruitment plan?

• Opportunities:

- How can we leverage our strengths to pursue new opportunities?
- What other sites of service should we pursue?
- What type of additional services should we be offering?
- How should we best position ourselves for the future?

• Threats:

- What key threats exist in the region, and how should we avoid them?
- How can we use our strengths to counter threats?

• Internal issues:

- Governance
- Compensation system
- Call
- Operations
- Alternative work programs (part-time, shared positions)



Once the key issues are identified, the group needs to discuss the issues, develop objectives and create strategies and action plans to achieve those objectives.

Step 4: Objectives and Strategies

We have addressed setting group mission and vision and identifying key issues that need to be addressed in the planning processes. These two steps are necessary but not sufficient to move the group forward. Both vision and tasks to achieve that vision are required.

Therefore, the next step in the planning process is to work on the “task” part. This involves setting objectives, and, in turn, establishing strategies and action plans to achieve those objectives.

Objectives and Strategies

An objective is a description of some situation in the future that you would like to see come about, which you can reasonably expect to accomplish and which is in line with your group’s mission and vision.

Strategies are the major decisions, policies and/or action programs employed by the organization to meet its objectives.

Let’s look at an example.

A group we worked with recently agreed that it was their vision to stay

independent and grow in a certain region to achieve that. The group recognized that there were a number of other practices providing similar services in the region.

As part of its planning retreat, the group set an objective to attempt to merge or form other relationships with the other groups in the region over the next three years. The group’s strategy was to pursue the groups A and B, and then consider the other organizations.

Determining which objectives to pursue is a complex and challenging process. Quite often, anesthesia groups identify many objectives they would like to pursue and therefore need to prioritize those objectives.

Naturally, objectives should be developed using the “SMART” characteristics:

- Specific: Target a specific area for improvement.
- Measurable: Quantify or at least suggest an indicator of progress.
- Assignable: Specify who will do it.
- Realistic: State what results can realistically be achieved, given available resources.
- Time-related: Specify when the result(s) can be achieved.

One point of caution: Sometimes when anesthesia groups develop objectives and strategies, they get so excited that they plan for every objective to be achieved in the next three months! As you develop objectives and strategies, the group *must* keep in mind the level of resources (management and physician leaders) available to implement these plans. If there are not enough resources, then the group has only three choices:

1. Add resources.
2. Change the objective/strategy.
3. Take more time to implement.

Remember: “Nothing is impossible for the person who doesn’t have to do it.” Set *realistic* objectives and strategies.

Step 5: Action Plans

Once you have developed goals, objectives and strategies, you need to map your specific action plans to achieve them. Actions plans should address:

- What will be done?
- Who will do it?
- What will be the costs?
- What will be the benefits?
- When will it be completed?

Conclusion

A strategic plan based on these five steps will give your practice the cohesion and sense of direction needed to stay on track for years to come. 

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



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





ANESTHESIA MERGERS AND ACQUISITIONS AND POST-TERMINATION OBLIGATIONS: HAVE YOU TERMINATED YOUR FUTURE?

Mark F. Weiss, JD

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I pushed the wiring instructions across the table.

A few minutes later, I confirmed that close to \$10 million was in the account of my client, the sole shareholder.

Then we all went to lunch.

Ah, the shiny object, the more or less instant gratification. The sale of your anesthesia group and the fresh \$1 million in your pocket.

But what comes next? And has your undivided attention on the shiny object created a gap in, or, perhaps worse, a blockade against, your future?

Let's explore this through the use of a simplified example from the anesthesia mergers and acquisitions world.

Local Anesthesia Medical Group of St. Mark's County (LAM), not a real group, but a prototype, is owned by 31 physician shareholders. The group agrees to be acquired by a subsidiary of Big Anesthesia Group (BAG), which promises a rosy long-term future for the group's owners due to BAG's supposedly higher contract rates and management expertise.

Each of the LAM shareholders receives \$875,000. They enter into five-year employment agreements with BAG at \$X per year, an amount several hundred thousand dollars per year lower than their average annual compensation prior to the sale. There's a bonus structure dependent on outsized financial performance.

Each employment agreement contains various termination provisions. Each also includes a valid and enforceable covenant not to compete, effective during the agreement's five-year term and for the subsequent three years. The covenant prevents any non-BAG work in St. Mark's County, including any ownership or control of any entity providing anesthesia services.



TRUE TERM: NOMINAL, MINIMUM AND MAXIMUM

You're probably familiar with the fact that a contract has a "term," the length of time, commonly expressed in a period of years, during which an agreement is in effect.

For example, a lease might have a one-year term (the time period during which the tenant has the right to occupy the premises), or an independent contractor services agreement might have a two-year term (the time period during which the independent contractor will render services). In the case of the BAG employment agreements in our example, the "term" of each runs for five years.

We'll call that type of term provision, for reasons that will become crystal clear in a moment, the *nominal term*. That term of years is "nominal" because a contract's actual term, the length of time of actively enforceable obligations, often has other, true limits.

A contract's *minimum term* is governed by its provisions for early termination. For example, an employment contract

with a five-year nominal term and a 90-day without cause termination provision is, in actuality, a rolling 90-day agreement.

Despite the fact that it is entered into on January 1, 2017, with an ending date of December 31, 2021 (a nominal term of four years), the employer could give notice of without cause termination on, for example, February 15, 2017, causing the term to end 90 days later. The date December 31, 2021, was just a placeholder, the end of the nominal term, the outside date on which the term ends. (Or is it? See below.)

At the same time, any contract that contains provisions that *survive* the earlier termination of the agreement has a *maximum term longer* than its nominal term. In other words, despite the fact that the nominal term of the contract has ended (e.g., the lease is over and you must move out), certain provisions remain in effect and can be enforced. These are *post-termination obligations*.

An example of a post-termination provision familiar to most anesthesiologists is one commonly seen in an employment agreement or an independent contractor services agreement that provides for payment on the first day of the same month following the month of service. Drafted properly, even though the contract's nominal term ends on, say, March 31, payment for services rendered in, for example, the previous February, must still be made in the following April, and so on. The contract still exists and functions as to the obligation of payment (and perhaps much else) even though the nominal term has ended.

M&A (MERGERS & ACQUISITIONS & ANGST)

Let's return to our example of the sale of LAM's anesthesia practice to BAG.



Fast forward to year four of the shareholders' five-year employment agreements, which, as you'll recall, include a covenant not to compete effective during the agreement's five-year term and for the subsequent three years. The covenant prohibits any non-BAG work in St. Mark's County, including any ownership or control of any entity providing anesthesia services.

To date over the four years, bonus payments have not exceeded several thousand dollars per physician. The touted higher reimbursement contract rates never materialized. BAG adopted what can basically be described as a "hands off" management role and the day-to-day tasks and complications of running an anesthesia group have fallen on the former LAM shareholders.

Over the past year, BAG has begun recruiting physicians to the former LAM practice who are willing to work for significantly lower compensation than the \$X per year being paid to the former LAM shareholders.

What are the former LAM shareholders to do? What will happen in connection with their potential employment by BAG the year after next, the first year following the expiration of their current five-year employment agreements? And how is their future impacted by the presence of the post-termination obligations, notably the covenant not to compete?

Their compensation was "reduced" (actually, the "excess" amount over \$X, what it takes to recruit and retain, was sold) in the sale to BAG. They now hope that their compensation will go up. After all, BAG led them to believe that their better collection rates and better management would lead to increases in their compensation. Yet, as mentioned above, other physicians, the new recruits, are willing to work for significantly less than \$X.

Once the sale of LAM to BAG closed and the physician employment agreements with the former LAM shareholders were in place, the former shareholders ceased being entrepreneurs and became employees. They believed that they were trading potential future downside risk for current dollars—to them, a lot of dollars, taxed at

preferred long-term capital gains rates, to boot.

The reality was that they traded a swath of risk, what might happen to disrupt their *business* over the next few years, while retaining what might happen to them, *individually*, in terms of future opportunities both during their employment by BAG and following it. No longer entrepreneurs, they became what economists call "rent seekers": They traded their time, efforts and expertise for "rent," their salary from BAG as their employer.

The fact is, that despite the pitch given on the way in, very few employers of any sort, from large anesthesia groups to personal services entities of any stripe, will overpay "rent." Overpay is always measured from the *employer's* perspective.

If new employees' services can be "rented" for less, then so be it. This may be shocking to some or even to many, but that doesn't change the fact that this is how business works.

Of course, in some cases, the employer would be happy to have existing employees remain if they will work for the same "rent" as someone else. (This is a simplification because, with significant time and the formulation and implementation of the right strategy, there are ways to increase the perception of the former shareholder's value, thus driving higher "rent." But that's outside the scope of this article.)

The problem for our former LAM shareholders is that even though their employment agreements will soon end, the covenant not to compete will remain in place. That post-termination obligation is valid and enforceable for the ensuing three years.

The result of that covenant is that the shareholders have lost the option to work in St. Mark's County following the looming termination of their employment with BAG. That work could have been in the form of working independently, re-starting a local group (even one that doesn't provide services at any facility previously serviced by LAM), taking a position with (i.e., seeking "rent" from) another group in the county, or even using any of those possibilities as leverage in their negotiation with

BAG in connection with their employment beginning in post-sale year six.

The impact of the post-termination obligations of the covenant not to compete, neither seen nor appreciated when negotiating with BAG on the acquisition, is that the LAM shareholders pre-positioned themselves to be sandwiched between what might be a take it or leave it renewal offer (if one comes at all) or having to move out of the county or even out of the state to be able to practice as anesthesiologists independent of BAG.

CONCLUSION

Nothing I've written means that it's not in any one shareholder's best interest for their anesthesia group to be acquired.

The important point is that in performing the calculation of the sales price, you must take into account exactly what it is that you are selling and what its value is. All post-termination obligations must be taken into account. An appraiser or even the market itself values the *business* that is being sold.

But in the sale of an anesthesia group, just as in the sale of any professional services firm, what's being sold is more than the "business," more than its cash flow. If a covenant not to compete or other post-termination provisions is included in the deal, it's also the sale of choice, of optionality, of a slice of your future. What's that worth to you? 

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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
October 15-19, 2016	American Health Information Management Association 2016 Convention and Exhibit	Baltimore Convention Center Baltimore, MD	http://www.ahima.org/convention/geninfo
October 22-26, 2016	American Society of Anesthesiologists ANESTHESIOLOGY® 2016 Annual Meeting	McCormick Place Convention Center Chicago, IL	https://www.asahq.org/meetings/calendar/2016/10/copy%20of%20anesthesiology2016
October 27, 2016	Texas Tech University Health Sciences Center 33rd Annual Pain Symposium	Texas Institute of Medical Education Plano, Texas	http://www.ttuhsu.edu/som/cme/events.aspx
October 27-29, 2016	Becker's ASC 23rd Annual Meeting: The Business and Operations of ASCs	Swissôtel Chicago, IL	http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/
November 4-5, 2016	NorthStar Anesthesia National Neighborhood Meeting	Hilton Dallas Lincoln Center Dallas, Texas	http://northstaranesthesia.com/
November 11-12, 2016	Society of Academic Anesthesiology Associations 2016 Annual Meeting	Swissôtel Chicago, IL	http://saaahq.org/meetings/2016-annual-meeting
November 11-13, 2016	27th Annual UC Davis Anesthesiology Update Patient Safety and Quality Healthcare	Monterey Plaza Hotel Monterey, CA	http://www.ucdmc.ucdavis.edu/cme/course_pages/LIMITED/LIANS17_pagelink.html
November 19-20, 2016	American Society of Anesthesiologists Quality Meeting 2016	ASA's Headquarters in Schaumburg Schaumburg, IL	http://asahq.org/meetings/asa-quality-meeting
December 9-13, 2016	The New York State Society of Anesthesiologists 70th Annual PostGraduate Assembly in Anesthesiology	Marriott Marquis New York, NY	http://pganyc.weebly.com/

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