

# LEVELING THE PLAYING FIELD

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Traditionally, three factors have determined the value and profitability of an anesthesia practice: case volume, payer mix and appropriateness of staffing. Because case volume and payer mix are essentially determined by the location and reputation of the facility, the only factor in which the practice actually had any influence was staffing; but, even here, culture, tradition and the coverage expectations of the facility tend to be the effective determinants of staffing model and number of providers.

Each practice is unique in its case volume and mix of surgical and obstetric procedures. Each is also unique in the percentage of patients whose insurance pays at significantly discounted rates set by federal and state regulators. Then there is the question of coverage requirements and the facility's willingness to subsidize the practice's financial loss in providing the necessary services. All of this indicates the potential for great disparity in



the financial viability and ongoing potential for success of American anesthesia practices. Some practices claim to have more leverage in negotiating contract rates with commercial insurance plans, and this may result in a strategic advantage. This is certainly the claim of some of the nation's largest practices and staffing

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# UNDERSTANDING THE NEW NORMAL

There was a time in the history of anesthesia practices when the biggest question was whether the practice should explore new clinical opportunities and/or merge with other practices in the area. Anesthesia practice management in those days tended to be very strategic and tactical. What we are seeing now makes us think those were the good old days. This issue of the *Communiqué* provides a useful overview of the new set of challenges practices must understand and address to remain viable.

Much has been made of the recent balance billing laws and the national No Surprises Act. Our own Jody Locke, MA helps put the recent regulations in perspective. As is so often the case, the advance press paints a more dire picture than the actual implementation. Leveling the playing field puts the key issues in a new and interesting perspective.

Dan Reale, JD, MBA has many years of experience managing small and large anesthesia practices across the country. No one is more qualified to address questions about the future of private anesthesia practice. His careful review of some very relevant data about the evolution of hospital perspectives on the specialty of anesthesia is quite informative. His article provides a very cogent caveat emptor about the future of hospital employment of anesthesia providers.

Mark Weiss, JD shares his thoughts on the challenge of the RFP. Mark's article, *Anesthesia Services RFPs: Cognitive Biases and Hidden Opportunity*, challenges the current and prevailing perspective of RFPs. One man's problem may just be another man's opportunity.

As always, Will Latham, MBA brings us down to earth with some very pertinent and useful observations about executive boards and their limitations. His piece contains a particularly proba-



tive discussion of board challenges and opportunities. After 30 years in the anesthesia practice management business, Will has learned some important lessons that we should all take to heart.

Kathryn Hickner, Esq., along with Chuck Mackey, share some critical insights into the world of cybersecurity. Their article, *Three Cybersecurity Safeguards to Implement in your Organization Today*, provides a wealth of specific, technical information about the current cybersecurity environment and how it may impact your practice. Her piece provides an invaluable glossary for all of us.

And finally, Bart Edwards, MHS, MBA digs into the impact of the shift of cases from inpatient to outpatient. His data and focus give us much to think about and highlights the trends we should be tracking.

As always, we have given considerable thought to the trends facing our client practices. We hope these articles will give you a new perspective and some

useful suggestions as you navigate today's perilous healthcare market. Please feel free to give us some feedback and insights from your specific practice.

With best wishes,



Tony Mira  
President and CEO





# THE FUTURE OF INDEPENDENT ANESTHESIA PRACTICE

**Daniel S. Reale, JD, MBA**

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Much has been written over the past decade on the supply and demand for anesthesia services, and how it relates either to the acquisition of anesthesia practices or to the direct employment of anesthesia providers by hospital systems. These crosscurrents need to be analyzed in the context of the overall trend in physician services in the United States.

An analysis prepared by Avalere Health in June 2021 provided an in-depth view of overall trends among physician practices. Among the key findings of the analysis, which was conducted over a two-year period between January 1, 2019 and January 1, 2021, were the following:

- 48,400 physicians left independent practices and became employees of hospitals or other corporate entities, with 22,700 of those physicians moving after the onset of Covid-19.
  - 18,600 became hospital employees (11,400 made the shift after the onset of Covid-19)
  - 29,800 became employees of corporate entities (11,300 made the shift after the onset of Covid-19)
- Over the two-year study period this shift resulted in a 12 percent increase of employed physicians.
- Importantly, the study indicated that 69.3 percent of all U.S. physicians were either employed by hospitals or corporate entities as of January 2021, versus 62.2 percent as of January 2019.



- Interestingly, the study indicated that as of January 2021, 49 percent of all U.S. physicians were employed by hospitals and health systems and 20 percent of U.S. physicians were employed by corporate entities.

Avalere's analysis well documents the national trend in the consolidation of physician practices and the increasing momentum from independent practices to employed models—clearly exacerbated by the economic dislocations associated with the pandemic. This article will examine the trends within physician practices in general and examine how these trends apply to anesthesia practices in particular.

It is difficult to obtain data similar to the above solely for anesthesia. Surveys conducted by Enhance Healthcare

Consulting (EHC) does provide some evidence of employment trends in anesthesia. EHC conducted surveys of hospital C-suite executives in 2016 and in 2021. The 2016 survey results indicated that 49 percent of the respondents “actively sought an alternative to their current anesthesia provider” and 25 percent of respondents made a change. In 2021, these results were 42 percent and 87 percent, respectively. The 87 percent change in anesthesia providers in 2021 seems to reflect the underlying tumult in the anesthesia services space. The primary reason cited by the hospital executives for seeking a new provider was the subsidy level (40 percent in 2016 and 33 percent in 2021). “Inadequate service level” was cited for initiating the anesthesia review process by 34 percent of the respondents in 2016 but only 20 percent in 2021.

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companies; but the reality is that, for a variety of reasons, this advantage is diminishing. The fact is that while many smaller practices have felt somewhat disadvantaged in the past, this may be changing. One might even argue that we are seeing a leveling of the playing field. In other words, when we take a close look at the impact of the recent surprise billing rules, they may actually be good news for small and moderate practices.

Those of us who have been monitoring public policy changes impacting anesthesia over the years can clearly document a consistent theme: the advanced press of most policy changes has always been more concerning than the actual implementation. When the Health Care Finance Administration (HCFA) changed the way payment would be divided between medically directing physicians and medically directed CRNAs in the 1980s, many anesthesiologists expressed concern that this would result in a loss of control and revenue when, in fact, the revised Medicare payment rules actually made billing simpler. It is true that the implementation of Resource-Based Relative Value System

(RBRVS) in the 1990s did impact anesthesia more profoundly than other specialties, but most compensated for the drop in revenue by cost-shifting to commercial plans and by requesting higher subsidies from hospitals. The implementation of ICD-10 had the potential to increase claim denials and disrupt practice cash flow, but it turned out to be a non-event. And so, it may well prove to be with the No Surprises Act. The reality is that the economics of anesthesia are increasingly complex, and the impact of changes to one variable in the equation becomes less and less impactful.

### ANESTHESIA ECONOMICS 101

Let us first assess the potential financial impact of the proposed changes on the typical anesthesia practice. Public payers—Medicare, Medicaid and workers compensation—are not affected by the new rules, and they represent 40 to 60 percent of the units billed by the average practice. The commercial insurance plans with which practices contract are also not affected, and they may represent another 30 percent of billed units. When a prac-

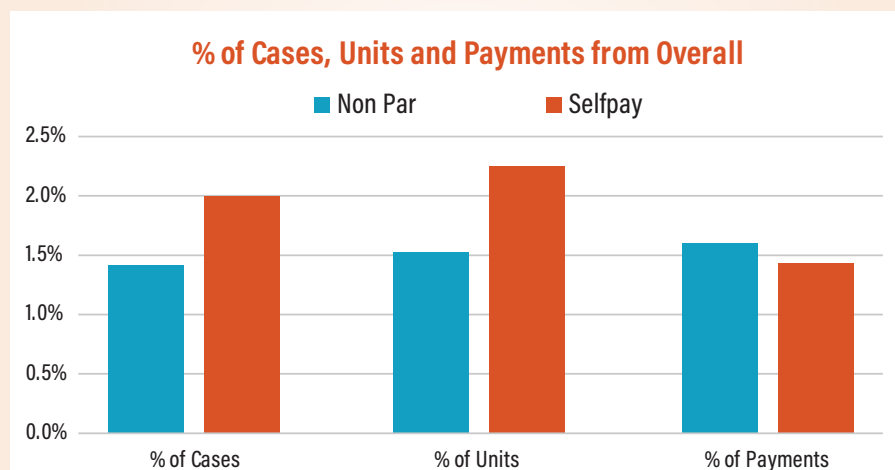
tice contracts with an insurance plan, the contract defines the patient responsibility, which is usually about 20 percent of the allowable payment amount. Let us be clear here: the No Surprises Act applies only to patient situations where there is no contractually defined allowable payment. For example, if the contract rate with a particular plan is \$60, then this amount, multiplied by the billable units, determines the allowable amount, and there is no surprise. Some patients may not understand the impact on actual insurance payments of deductibles and co-insurance, but this is not what the legislation was intended to address.

The No Surprises Act only affects two categories of charges: charges for out-of-network patients and those who have no insurance. The data used for Chart 1 is a composite of that from all Anesthesia Business Consultants (ABC) clients across the country. It demonstrates the number of cases and units billed in 2021 to each category of patient. In 2021, the percentage of the average practice impacted by the No Surprises law is relatively small, at about three percent. While it is unknown how much the percentage may increase in the years to come, this has to be our point of reference for now.

There is an important distinction demonstrated here. In 2021, the average practice collected fairly well for out-of-network patients (1.5 percent of charges resulted in 1.6 percent of payments), whereas they have collected less for patients with no insurance (1.8 percent of charges resulted in 1.4 percent of payments), which should come as no surprise. For most practices, when a patient has no insurance, there is no expectation of a meaningful payment. There are very few practices that collect more per unit for out-of-network cases than their average yield per unit. Based

CHART 1

### Anesthesia Business Consultants (ABC) clients





on this analysis, two things are clear. First, no practice is collecting an unusual or exorbitant amount per unit for out-of-network cases. Second, the implementation of the new law should not have a material impact on any ABC anesthesia practice.

### THE IMPACT ON CONTRACTING

Let us suppose that a client has a contract with an insurance plan that the client wants to renegotiate to a higher rate per unit. Typically, this process involves submitting a request for a higher rate. When the plan pushes back, there ensues a negotiation, the outcome of which depends on two factors: the value of the group's participation in the insurance plan's network and the provider group's market leverage. Insurance plans need to be able to demonstrate their subscribers can access key specialists; that is an important aspect of their marketing plan. The fact is that, depending on the particular market, some practices are more valu-


able than others. Consider for example, Blue Cross of California. Being able to offer its subscribers access to any of the University of California hospitals is considered very important, which is why the anesthesia practices get a favorable rate. Market leverage is usually a function of market share. This is where size matters. A practice with a large share of a given market can usually use this leverage to their advantage and there are definitely examples of mega anesthesia groups that have negotiated higher unit rates than those given to smaller practices. It is important to understand, however, that their leverage was often based on their threat to opt out and bill patients as out-of-network providers. The reality is that No Surprises Act provisions essentially eliminate this leverage. Under the new rules, an out-of-network provider would only be paid at an average rate for the geographic area.

### THE LONG VIEW

The net effect of most market developments over the past few years has been to constrain practice revenue, and the No Surprises Act is entirely consistent with this trend. The average practice is seeing its Medicare population grow at a rate of about one percent, per year. This means that an ever-higher percentage of units gets paid at Medicare rates, over which providers have no control. As the cost of healthcare continues to rise, insurance plans are pushing back and limiting rate increases. Many plans have not agreed to contractual rate increases for a number of years. Since the ability to cost shift has been the advantage of many large practices, the impact of this act will constrain revenue options. In other words, only two factors will determine the revenue potential of a practice: volume and payer mix. What this also means is that anesthesia practices will have to shift gears

and change their focus from revenue generation to cost management.

Most providers are aware of a basic reality, which is that it is easier to get paid by insurance plans than patients. This has been especially true during the pandemic. Collecting money from patients has always been a particular challenge for which there is no good solution. Collection agencies used to rely on a "dialing for dollars" approach to encourage patients to pay, but caller ID has effectively undermined that strategy. Many providers may have been concerned that the No Surprises Act would further erode the ability to collect from patients, but this is not true. As demonstrated above, only a small percentage of practice revenue has ever come from patients affected by this act.

The reality of managing a practice in the United States is that things never get simpler; they only get more complicated over time. We tend to get excited and focus on each new policy change or payer development. Each new development is just one more factor in the overall challenge of getting paid. This is why practices need timely and reliable data so that they can assess and respond to the evolution of the market. 

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



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(Note: “Desire to change staffing model” gained 40 percent of the vote in 2021 and no votes in 2016, but this may have resulted from a change in the format in 2021.) While this survey is not an exact parallel to the Avalere survey, it is indicative of the level of discordance between hospitals and their anesthesia groups. The survey also did not indicate whether the current provider group was part of a national consolidator or an independent group. The survey’s primary importance is that it provides insight into current thinking of hospital administrations and their levels of dissatisfaction. This certainly reflects a sense of continued uncertainty within the provision of anesthesia services at hospitals in the United States. Such dissatisfaction could suggest overall risks and potential opportunities for consolidators and independent practices as well as opportunities for groups to become employed.

## INITIAL EFFORTS AT CONSOLIDATION

For a number of years, large corporate entities, often funded by private equity firms, have attempted to further consolidate the anesthesia practice space. Among the consolidators are North American Partners in Anesthesia (NAPA), Mednax, US Anesthesia Partners, and Envision Healthcare. Consolidation has been going on for over a decade. I am personally aware of a large private New England group having been approached by Pediatrix (predecessor corporation of Mednax) in 2007. As one of the first consolidators, Mednax’s experience with anesthesia services is enlightening with the results of the operation of anesthesia services proving to be disappointing to the acquirer. Mednax reported an operating loss for its Anesthesiology Services Medical Group for the year ending



December 31, 2020 of \$716.3 million (this included the loss on sales of \$663.7 million). This loss followed an operating loss for Anesthesiology Services Medical Group for the year ending December 31, 2019 of \$1.23 billion dollars (this included a non-cash goodwill impairment charge of \$1.33 billion dollars). Mednax’s anesthesia assets represented an investment in excess of \$1 billion dollars but were sold to NAPA in May, 2019 for \$50 million in cash with retained accounts receivable and a contingent economic interest in future success of these sites under NAPA. Mednax cited (in its SEC filings) some of the difficulties associated with its practice of anesthesia as the following:

“During the time that it operated as part of Mednax, and particularly since 2017, American Anesthesiology experienced multiple business challenges, including inflation in unit labor costs and other expenses, constraints to revenue growth based on adverse changes in payer mix, and a difficult reimbursement environment where unit revenues grew at levels meaningfully below unit cost.”

Mednax is an example where a company with tremendous success in hospital-based physician services, i.e., the pediatric neonatal intensive care space, had difficulty translating that success to the anesthesia marketplace for the above reasons. Mednax’s experience highlights the difficulty of large-scale acquirers successfully operating in the anesthesia space. Later in this article, we will discuss this further in the context of the independent anesthesia practice and the future of the independent anesthesia practice versus consolidation.

## HOSPITALS GET INTO THE ACT

As the private equity firms have moved into the anesthesia marketplace, hospital systems have also made aggressive efforts at employing groups. Hospital systems have moved to absorb all or most of the anesthesia groups at their member hospitals, e.g., MassGeneral Brigham in the Boston area, McLeod Health in South Carolina, Southcoast Health in southern Massachusetts, Steward Healthcare (a for-profit system started in Massachusetts and now in multiple states), Cedars Sinai



Hospital in Los Angeles and Rhode Island Hospital in Providence, Rhode Island. Other systems have dipped their toes into the anesthesia services space by employing anesthesia providers as a subset of their system, e.g., Piedmont Healthcare. In our experience, the systems have paid greater amounts to support their anesthesia groups when employed as opposed to when they were independent.

### PONDERING A LOSS OF INDEPENDENCE

What would motivate an independent group to either sell to a consolidator or to become employees of a hospital system? First, let's look at why a group would consider a sale to a national consolidator. Speaking with practitioners who have either entertained offers from a consolidator or have, in fact, consummated a sale with a consolidator, we have a good sense of how the economics of these transactions are structured. The consolidators essentially are paying out future earnings to the owner-providers through the buy-out process. Typically, the owner-providers income is reduced by an agreed upon formula, and that reduction in the previous compensation is paid back to the owner-providers in the form of a buy-out that is calculated as a

negotiated multiple of said adjusted "earnings." In some cases, the earn-out is subject to holdback, growth-related incentives and other potential earning enhancement opportunities. The question, of course, is how the acquirer can get an economic return by "pre-paying" these future earnings. The previously quoted analysis from Mednax provides some light on how consolidators "expected" to be able to work the post-acquisition environment to their economic advantage. For example, the consolidator would look to leverage higher commercial rates including, in some cases, going non-par with commercial payers. (The No Surprises Act may significantly reduce this potential.) A consolidator would look for labor substitution, e.g., using lower cost new graduates of anesthesia medical programs or nurse anesthetists or anesthesia assistants. The consolidators would also look to leverage other potential expense areas regarding overhead including lowering revenue cycle management costs, quality assurance costs and malpractice costs. On the providers side, the motivation is clear—prepayment of future, uncertain income. In addition, being part of a larger system may create opportunities for certain physician leaders within these groups, to take on

larger roles in the clinical and business sides on a regional and national basis. Given the potential economic upside to the owner-provider, what are the downsides? Clearly, the Mednax example points to one downside—the inherent uncertainty in future prospects of the acquirer relative to the anesthesia marketplace. A second downside related to the providers could be related to the earlier discussed "hold-back" with that payment potentially being at risk depending on the success of the consolidator in the marketplace, as well as the group's attaining its pre-negotiated objectives. The underlying contracts with the institutions could also be at risk, and depending on the terms of the employment contract, the providers ability to stay at that particular location post-termination could also be at risk. Young providers within the group, not yet risen to the owner status level, may become dispirited. It is no surprise that a provider's motivation changes when they move from an independent practice status, with attendant incentives to work hard to become an owner and be rewarded no longer in play.

Macro-economic factors have a significant impact on the anesthesia business. Covid and the consequent downturn in elective cases in 2020 had a major, negative economic impact across all levels of anesthesia—whether independent practice, corporate or hospital employed. The recent No Surprises Act has seen an impact on anesthesia contract rates and on payment rates for non-par payers. Covid-related retirement/employment expectation changes among anesthesia providers has resulted in increased demand for services among a smaller base of anesthesia providers. A recent review of Gasworks suggested there were over 3000 openings for anesthesiologists and over 7000 openings for nurse anesthetists. Supply and demand suggest that wages will increase. Consequently, groups





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that we manage are experiencing pressures for higher wages from their existing staff and from potential new hires. With the possibility of decreases in commercial reimbursement and the ever-present threat of further reductions in the already very low governmental payer rates, the primary mechanism to attain their earnings expectations is to look to the hospitals (and in some cases ambulatory surgical centers) for financial support. Already, over 80 percent of hospitals provide some form of stipend to their anesthesia providers. For the consolidators, these market forces place even greater pressure on their potential for economic returns. When a consolidator approaches a hospital for an increase in stipend, the administrators understand that an economic driver for the increase is support for the return on investment for the owners of the consolidators. This may become a factor in hospitals looking to terminate contracts with physician groups run by consolidators (or independent groups, for that matter) and choose to either select a new independent group or employ the current group.

## HOSPITALS LOOKING TO HIRE AND ACQUIRE

In looking at hospital motivations for acquiring groups, one can see both economic and non-economic justifications. The changing demographic of the United States as a result of the aging baby boomers and the concomitant increase in the Medicare population has had a significantly disproportionate impact on anesthesia providers. (Medicare pays anesthesia at rates which are one-quarter to one-third of commercial payers.) One expert in the anesthesia revenue cycle space has estimated that the percentage of Medicare will increase by one percent per



year over the next decade as the population continues to age. As indicated earlier, it is estimated that 80 percent of hospitals currently provide stipend payments. The increase in the Medicare population will place more pressure on hospitals to continue to supplement those stipends. Moreover, shortages of anesthesia providers and increased compensation create a double-whammy effect.

Hospitals may believe that, through employing anesthesia groups, they can exert more control over staffing models and coverage arrangements, as well as obtaining higher reimbursement rates from commercial payers, so they can theoretically provide a lower support to an employed group—as opposed to the stipend required by an independent group. Our experience in working with groups that were formerly independent and are now employed suggests otherwise. In fact, we have seen the required support paid by hospitals in order to cover their anesthesia services go up many multiples over what they were

paying the independent groups. This, of course, may relate to the inherent incentives of a private group to work more hours than an employed provider. An employed provider has less incentive to work the additional hours unless they are paid for those additional hours. An independent provider will work additional hours because of the benefits of operating at a “reduced” staffing level, i.e., the ability to not hire an additional body but absorb that work within the existing complement of staff translates into additional compensation that can be shared with the core provider group. It will be interesting to see how the recent movement to employ anesthesia provider groups continues into the future given the potential for unforeseen additional costs associated with the employed model.

Of course, there are other motivations for a hospital wanting to acquire the anesthesia group. The hospital may believe they can lower the overhead costs, such as taking revenue cycle in-house or by being better able to leverage less for






outside revenue cycle companies. The hospital may be able to lower other administrative costs, such as benefit costs and administrative overhead costs by absorbing those types of administrative services into its existing infrastructure. Moreover, the hospital may be able to implement policies that may not be cost effective for a private group (e.g., flip rooms) but would be very attractive to surgeons in the hospital as part of a hospital's policy to increase its surgical case load.

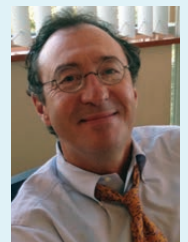
The market forces, including provider supply/demand dynamics, demographic changes, the No Surprises Act repercussions and recent "failed" consolidations, will require continued observation in assessing the future direction for anesthesia services. Will increased costs to the hospitals after employing the independent groups create a backlash and potential reversal of this practice? Similarly, as with Mednax, will some of the larger consolidators realize that the return on investment is not in the anesthesia space? We have recent evidence of another large consolidator agreeing with some of the acquired groups to relinquish contracts to those groups and waive their non-competes. These recent examples suggest there may be more underlying economic turmoil in the acquisition model than has been apparent heretofore. The core motivations for independent groups continu-

ing their independent status exist as much now as they did before with their ability to control their revenue streams, select their colleagues, create a positive culture and select the types of locations they prefer to practice. In addition, those physicians have the ability to work the most flexible staffing models, the ability to control their vacations to the greatest extent and control care team environment and call burden in ways that are determined by the group and its members. From our working with independent practices throughout the United States, the level of internal satisfaction in independent groups continues to be largely positive. As discussed earlier, the healthcare market has seen earlier waves of acquisition of physician practices. In the nineties, these were primarily driven by hospital systems and their physician practice management companies. The earlier efforts were largely unsuccessful. Most recent consolidation of physician practices is now often led by health insurance companies, such as United Healthcare, Humana and BCBS of Texas. As discussed, the private equity firms have made a full commitment to consolidation of a broad range of physician practices. It is unclear where anesthesia services will fit given some of the issues discussed herein.

The overall trend in the healthcare marketplace is for increasing employment of physicians either by hospital systems or by large corporate entities. This trend has accelerated during the pandemic, not surprisingly as a result of the increased amount of uncertainty surrounding the drop in patient volume and attendant incomes. This movement has translated into the anesthesia provider services as well. As noted, the large health systems have moved to employ physicians on a large-scale basis. We have also seen, perhaps, the beginning of a negative trend resulting from those consolidations (e.g., Mednax and other national providers) fully abandoning anesthesia or selectively aban-

doning anesthesia sites. Other hospitals have slowed plans to employ anesthesia groups as they see the increased costs associated with an employed model. In the meantime, salaries for independent and employed anesthesia providers are increasing significantly due to staffing shortages. For the independent practice of today, there are multiple avenues of support including external practice management companies that can assist in maximizing economic return to the group through commercial contract negotiations, expert revenue cycle management and expertise in hospital negotiations. Will this be a repeat of the nineties where the momentum of physician practice consolidation was reversed as a result of dissatisfaction with the resulting practices? We do not know. It is a trend we will continue to watch while this process unfolds. The old adage seems to apply to the ongoing anesthesia practice environment: "May you live in interesting times." 

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Mr. Reale has 30+ years of experience in managing healthcare services and biomedical operations. Previous experience includes a public, biomedical company that develops medical devices for urological and oncological applications, a biotech company responsible for the development and opening of manufacturing operations for an autologous colon cancer vaccine and a venture-based company outsourcing hospital blood-banking and blood collection services to hospitals throughout the United States. His education includes both a Juris Doctor degree from Northeastern University, Boston, MA; as well as a Master of Business Administration degree from the University of North Carolina at Chapel Hill. He can be reached at [dreale@PlexusMG.com](mailto:dreale@PlexusMG.com).



# ANESTHESIA SERVICES RFPs: COGNITIVE BIASES AND HIDDEN OPPORTUNITY

Mark F. Weiss, JD

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At a recent anesthesia conference, I heard speakers address the avoidance of, and observed audience members nearly quivering in fear of, three rather insignificant symbols, the letters: R, F and P.

Yes, it's true that "RFP" is the acronym for a "Request for Proposal," the *commodity* buying tool that's been morphed into a *services* buying tool by midlevel bureaucrats and lazy thinkers. Ah, but such is life, and there's no upside in pretending that it isn't so.

But if the world is full of lemons, why not think lemonade?

## RFPs AND COGNITIVE BIAS

Fear is a driver of action, and I don't blame speakers, authors or experts for driving home the point that, for an incumbent anesthesia group, an RFP can be a calamitous event, one to be avoided at nearly all cost. In full disclosure, as a speaker, author and expert, I, too, often drive home that exact same point.

After all, if you're the incumbent anesthesia group, your relationship with the hospital or other facility, including your exclusive contract, if you have one, is at risk. There's little doubt about it, even if the outcome, a little form of death, isn't completely certain.

But it *might* be certain for your group, thus the entirely rational fear of an RFP on the part of the average anesthesia group leader, or perhaps even on the part of close to all anesthesia group leaders.

When you think of it, the fear of RFPs is akin to the fear of snakes. The fear is so ingrained that we see general things that might possibly be snakes, like sticks on a hiking path, as snakes. After all, that



cognitive bias makes perfect sense: there's little to no downside in seeing a stick as a snake, but a potentially calamitous downside in seeing a snake as a stick.

Anesthesia group leaders generally see the entire topic of RFPs from the point of view of being bitten by one. That's the cognitive bias that RFPs, like snakes, are dangerous and to be avoided.

Yet others eat snakes and (carefully) go looking for them, which takes us to the jumping off point of this article: Maintain a healthy fear of RFPs that seek to bite you, but develop a careful approach to hunting for RFPs that *you* can bite into.

After all, snake meat can be delicious. Let's go get some.

## FLIPPING THE COGNITIVE BIAS: LET'S GO SNAKE HUNTING

To recap what we've discussed so far, if you're the incumbent anesthesia group, an RFP puts your relationship with the hospital or other facility at risk. But, if

you're an outside aspirant, RFPs as to *other facilities* present opportunities to expand your business to additional locations. And even better, the facility issuing the RFP is *probably* (see below) considering a change.

Instead of fearing the RFP process as you do in defending your existing facility relationships, embrace it in seeking to respond to other RFPs.

In the way of thinking that I urge you to consider (don't worry about the competition, most won't consider it), you'll see RFPs as a way to hedge against your existing facility side bets, not as betting your facility.

## BUT IS THE RFP FOR REAL?

Let's examine the RFP process from a simple starting point: is any particular RFP real, or is it something else?

But even before doing that, it pays to start with the truth: professional services are not, and cannot, be a commodity. But



it's also true that many have fooled themselves (or more likely, others) into believing that they are. In fact, there's an RFP industry ready to help.

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

Are these lies moral failings? Usually not. They're generally more akin to resume embellishments, nicely pressed suits and shiny shoes. But either way, they're a fiction, a fantasy and perhaps even fraud.

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

You must first assess the reality of the RFP against the three categories into which I divide them:

- 1. True RFPs:** These are genuine searches for the best-quality provider with a favorable ratio of quality to cost. This type of RFP is the closest in relationship to the traditional form used in industry and government. It's commonly seen in situations in which the current, or sometimes very recently former group, has "blown up" and can no longer provide coverage. It's also common in scenarios where the current group has completely lost the facility's trust.
- 2. Fictitious RFPs:** These RFPs belie the fact that hospital administrators are not interested in the merits of any response; they have already decided to whom they will award the contract. Yet, for one political reason or another, they've decided to issue a phony

RFP to project a patina of "fairness" to the medical staff, to the hospital's own board, to some third party—or perhaps to you.

- 3. Fulcrum RFPs:** Consider this the weaponized RFP. As the name implies, the increasingly common fulcrum RFPs are designed to create leverage. The facility intends on renewing with the present group but uses the RFP as a tool to dictate terms by fiat and to pressure the group into negotiating against its own best interests out of fear of replacement. Nonetheless, the facility is open to competing proposals.

Although no outside assessment of category can be completely reliable, clues often abound. And, *category dictates your strategy moving forward—or not moving forward.*

### SOME MORE COGNITIVE FLIPS: YOU'RE A BUYER NOT A SELLER

Groups seeking to protect themselves against an RFP being issued, and, certainly, those seeking to protect themselves against an already issued RFP, generally see themselves as the *seller* of services.

After all, if the group is dependent upon that facility relationship for its existence, they have little choice, that is, unless they are the rare outlier that would rather disband than be forced into a bad deal.

But in connection with hunting down other RFPs, you must adopt a *buyer* mindset.


Note that I said "mindset" to distinguish the concept of inner talk and expectations from the fact of the matter that you will still engage in activities to, in essence, "sell" the deal, *as you desire it*, to the potential facility deal partner.

Understand how to play to the administrators' cognitive biases (e.g., "the

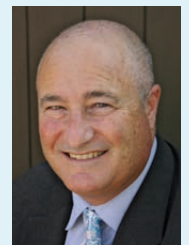
existing group is dysfunctional," and, for new CEOs, "you need to demonstrate leadership"). *But be very careful about what you promise* because, in the event that you "win," you'll actually have to deliver.

However—and here's the important point—if the deal doesn't look attractive to you, or if you think it's not real (*i.e.*, that it's a Fictitious RFP or a Fulcrum RFP), or if you "lose" the RFP (which might turn out to have been a win in disguise, because winning the race to the bottom is like a participation trophy at the local recreation center: it isn't a real win), so what! Just don't "buy" it; move on to the next deal.

As an offensive weapon, pursuing RFPs can be a powerful strategy to exploit. Yes, time and effort and a governance structure that allows you to take advantage of it are all required; however, properly strategized, you control your group's timing, you control how much effort to devote, and you control if and when to pull the plug, protecting your downside.

You will have flipped the usual RFP paradigm on its head: even if the odds of not obtaining the contract are high, the costs and effort can be controlled. But the upside of obtaining the right deal can be tremendous. And, since you are thinking like a buyer, not a seller, if the deal isn't right, don't buy; just walk away. 

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

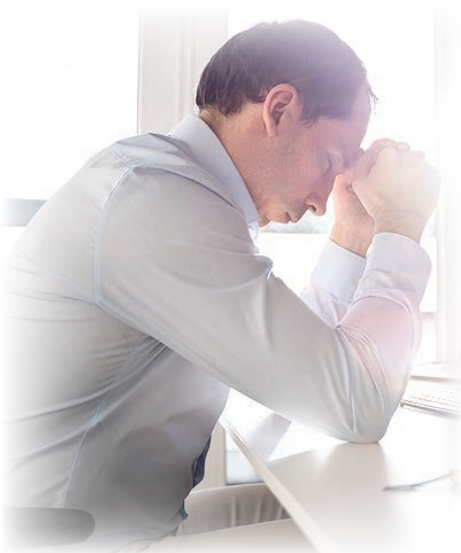




# IS YOUR BOARD OVERLOADED?

**Will Latham, MBA, President**

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



Many anesthesia group boards meet late in the day after a full clinical load. Exhaustion can set in, and board members can be overloaded. This may result in work not getting done or make it more difficult to find individuals to serve on the board.

Many anesthesia group governing boards often get mired down while addressing important group issues or trying to make decisions. They also have a tendency to micro-manage rather than govern. Following are some ways to overcome these challenges.

## SEND IT TO COMMITTEE

We have found that the best medical group boards use their committees to process information prior to the board addressing an item. When an item is raised at the board level, the first step of the committee is to:

- Define the scope of the issue.
- Gather needed data.
- Analyze the data.
- Recommend a solution.

Once the committee has developed a solution or recommendation, this information should be presented to the board. However, the board must be *extremely careful* to *not* redo the work of the committee. If the board feels the committee has not completed the assignment, it should be sent back for further work.

In addition, the board should make every effort to accept the committee's recommendation. Why? If the board mem-

bers always reject the recommendations or re-does the work, the committees will reach the conclusion that their thoughts are not being considered and stop doing the work.

Naturally, the above assumes that the group has done a good job in establishing committees to get group members involved and share the administrative workload. The board should create a committee "Charter" for each committee

### EXHIBIT 1

#### Example Committee Charter

<b>Committee</b>	Finance
<b>Responsibility</b>	<ul style="list-style-type: none"> <li>• Supervise and develop the annual operating and capital budgets. Recommend periodic revisions to the budget.</li> <li>• Supervise the financial matters of the group and its subsidiaries.</li> <li>• Review and monitor the financial performance of the group.</li> <li>• Advise the Board on all financial aspects of the practice.</li> <li>• Ensure appropriate filing of all applicable tax returns.</li> <li>• Ensure evaluation and annual compensation review for all staff members.</li> <li>• Assist in negotiation of contracts with third parties. Chairman participates on contract negotiation team.</li> <li>• Conduct periodic review of professional relationships (accountants, attorneys, etc.).</li> </ul>
<b>Authority</b>	Advisory only.
<b>Chairperson</b>	Dr. Jones
<b>Members</b>	Dr. Thomas Dr. Brit Dr. Peters
<b>Meeting Frequency</b>	Monthly
<b>Compensation</b>	Budgeted 2 hours of meeting time each month. Compensated \$200 per hour.
<b>Annual Work Plan</b>	<ul style="list-style-type: none"> <li>• Evaluate reduced work program.</li> <li>• Revise capital budgeting system.</li> <li>• Develop cost accounting system.</li> <li>• Analyze supplies expense for reductions.</li> </ul>



## EXHIBIT 2

## Example Policy on Professional Practice Committee

### MEMBERSHIP

Three physicians elected annually by the Board in July.

### QUORUM AND ACTION

Quorum is two of the three physicians.

Action on a matter may be taken on a simple majority.

In the event that a member of this Committee instigates or is subject to action by this Committee, the other two Committee members should appoint a member of the Board to serve as interim Committee member for that issue only.

### MEETINGS

This Committee meets monthly to consider issues brought to its attention.

### RESPONSIBILITIES

This Committee exists to consider physician conflict, physician performance and quality assurance concerns for the practice. The Committee will either work to resolve issues on its own or bring matters to the attention of the Board for resolution.

### PROCESS

1. If a "concerned physician" has a grievance with another physician (the "physician in question"), or is concerned about

quality issues related to another physician, his first step is to discuss his concerns directly with the other physician.

2. If the matter is not satisfactorily resolved in step 1, the concerned physician should handwrite his concerns and present this information to a member of the Committee.
3. At the next scheduled meeting, the Committee will discuss the issue and take one or more of the following actions:
  - a. Decide if the issue has merit for further action, and if not, communicate this information to the concerned physician.
  - b. Establish any necessary data-gathering process to determine if the concern has merit and what further action should be taken.
  - c. Meet with the concerned physician and physician in question, together or separately, to gather information or counsel the physician.
4. If the matter is not satisfactorily resolved in step 3, the Committee should develop a recommendation to the Board for further action to resolve the issue. Such recommendation could include discipline up to and including expulsion from the group.
5. The Board will consider such issues at its next regularly scheduled meeting.

(an example of such a charter is found in Exhibit 1) and outline:

- What are the on-going responsibilities of the committee?
- What authority does the committee have (for example, can they spend money, make certain decisions, etc., without coming back to the board)?
- Who is the chairperson and who are the members?
- What is the timeline of work being completed? If the answer is "whenever," you may want to seriously consider whether or not the committee is even needed.
- What is the compensation for serving on the committee?
- What is the annual work plan for the committee? This is where the board can outline its expectations for specific projects they would like the committee to work on in the coming year.

### DISRUPTIVE BEHAVIOR

Many medical group boards get bogged down dealing with physician behavior issues. Hours and hours can be spent investigating and discussing disruptive behavior.

Although the board is typically the final decision maker in regards to fining

or terminating a physician, much work can and should be done by a "Professional Practice Committee."

This committee exists to consider physician conflict, physician performance and quality assurance concerns for the practice. The committee will either work to resolve issues on its own or bring matters to the attention of the board for resolution. In most situations, this committee does not have the power to censure or take action against a physician. Instead, it serves as an intermediary step or process to try to resolve the issues before significant steps are taken.

A policy for such a committee may be found in Exhibit 2.

*Continued on page 14*

## IS YOUR BOARD OVERLOADED?

Continued from page 13



### AVOID MICROMANAGEMENT THROUGH SETTING POLICY

As a board tries to do its work, it's often tempted to move from "governance/oversight" to micromanagement of the organization. The best way to avoid this is to focus the board on setting "policy" rather than on making specific decisions.



A "policy" is a statement which guides and constrains the subsequent decision making. In setting policy, you try to *specify the end rather than the means*.

In setting policy, the board should identify what is to be accomplished and a range of acceptable and unacceptable means for achieving the objectives. This could include a set of directives for how the group will operate in the future or instructions for management to implement.

To help the board avoid micromanagement, it's often helpful to remind them that they don't have to (and shouldn't) make each and every decision. The board has options, which include:

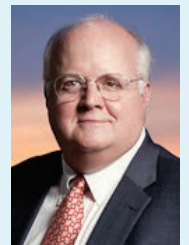
- Request proposals and recommendations from management prior to making a decision. Example: "We need to avoid problem X. Management, please develop a set of alternative methods to achieve this end."
- Delegating decision-making authority with constraints. Example: "We need to avoid problem X.

Management, please develop a set of alternative methods to achieve this end, but it must cost less than \$50,000."

- Delegating decisions with exceptions. Example: "We need to avoid problem X. Management, please develop a set of alternative methods to achieve this end, but it must be a process solution rather than a technology solution."
- Retain authority and make decisions itself.

The best boards always think: "is this something that management or a committee should decide once we've provided guidelines?" The best boards spend most of their time setting policy. ▲

For more than 30 years, **Will Latham** has worked with medical groups to help them make decisions, resolve conflict and move forward. During this time he has: facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; assisted over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of over 135 medical practices representing over 1,300 physicians. Latham has an MBA from the University of North Carolina in Charlotte. He is a frequent speaker at local, state and national, and specialty-specific healthcare conferences. He can be reached at [watham@lathamconsulting.com](mailto:watham@lathamconsulting.com).







# SURGICAL SERVICES ON THE MOVE

**Bart Edwards, MHS, MBA**

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Medical care has been shifting out of inpatient venues and into outpatient and ambulatory sites. Advances in clinical approaches and technology, including new developments in anesthesia and pain control as well as minimally invasive surgical procedures, have enabled numerous procedures to migrate into outpatient and ambulatory settings.

Patients increasingly express a preference for hospital outpatient and ambulatory service center (ASC) venues for surgical care. As consumers, patients are more satisfied with the faster access, shorter stays and better service, versus inpatient stays. Given the option, most patients have an understandable desire to recover outside of the inpatient environment. Patients may appreciate an ASC's more intimate environment to the hospital, giving them a greater sense of personalized care and contact with their care team. These underlying consumer preferences have only been reinforced by COVID-19, as patients and even some providers are significantly less comfortable returning with inpatient stays in light of the pandemic.

With the rise in narrow networks and high-deductible health plans, consumers are increasingly cost-conscious in their medical choices. Lower overall costs for outpatient and ASC services can provide an added benefit in the form of reduced deductible, copay and coinsurance to the patient.

In addition to hospital outpatient settings, physicians often also prefer ambulatory surgery center operations because they can see patients in more service-oriented settings. Costs can be significantly less at ASCs, as they are often configured at a lower cost base across staffing, space and some types of supplies. In addition, there are a number of ASC financial models that convey financial alignment with physicians, including ownership.

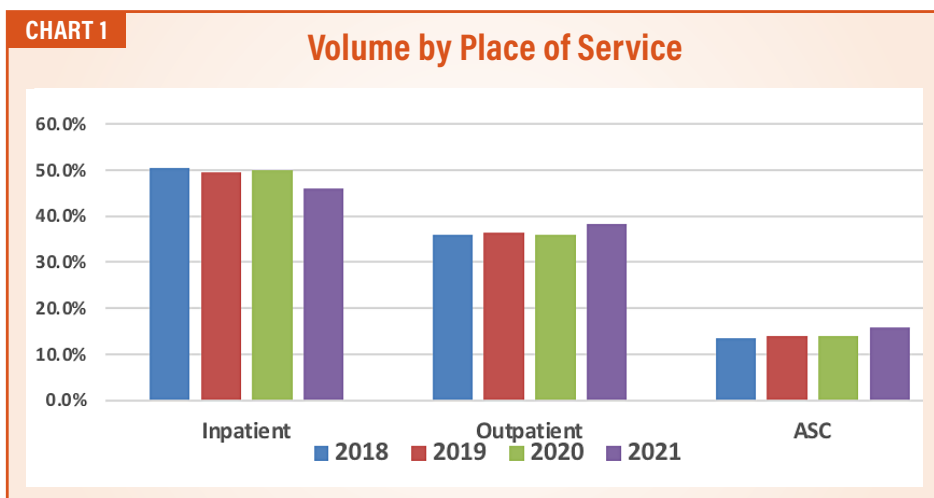
Procedures have been excluded from outpatient and ASC locations via the CMS Inpatient Only (IPO) list, a list of services that, due to their medical complexity, Medicare will only pay when performed in the inpatient setting. In its 2021 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center

Payment System Final Rule, CMS proposed elimination of the IPO list over a three-year period and immediately removed the restriction on 298 services. The rule also revised the long-standing criteria that were historically used to add covered surgical procedures to the ASC Covered Procedures List (ASC CPL). As a result, 267 new procedures moved onto the ASC CPL.

To get a sense of the impact on anesthesia services, a sample of surgical data from 15 large client practices, billed by Anesthesia Business Consultants, who are providing services across inpatient, outpatient, and ASC place-of-service codes were reviewed for calendar years 2018 through 2021. The data showed some interesting trends overall, and specifically related to the 2021 revisions to the regulatory controls on where procedures were allowed.

Consistent with the national conversation regarding the move toward outpatient and ASC services, our clients saw a gently decreasing trend in the inpatient volume, and a corresponding increase in outpatient and ASC services as percentage of total volume. Excluded from this data due to its relative size, there was also an increase in office-based anesthesia services for this sample of practices—but the volume was less than one percent of the sample (See Chart 1).

Drilling down to governmental payers helped illuminate how much of the shift is due to the change in regulation. An overall increase in procedures permitted in outpatient and ASC places of services for Medicare patients resulted in the expected shift in service locations. The volume of inpatient services decreased as



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## SURGICAL SERVICES ON THE MOVE

*Continued from page 15*

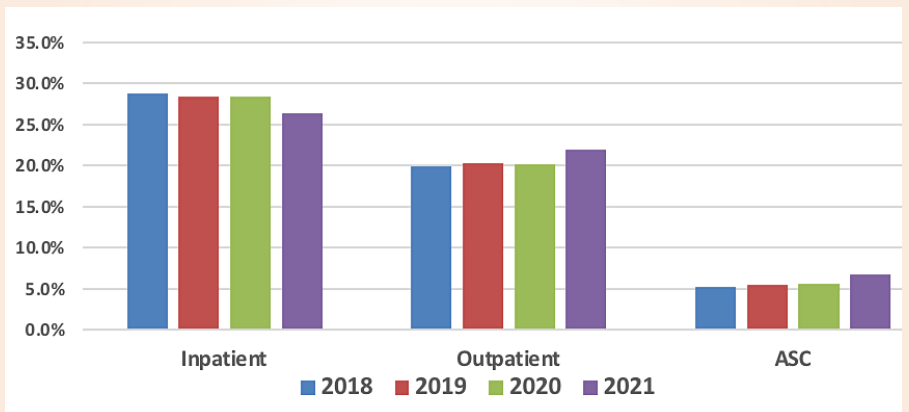
a percentage from 28.4 percent in 2020 to 26.4 percent in 2021. This is particularly concerning for anesthesia, as the differential between commercial and governmental rates is more material than most specialties (See Chart 2).

Further focusing on a specific procedure; total hip arthroplasty was moved off the IPO list in 2020, and then moved onto the ASC CPL in 2021. A review of overall volume for that procedure by place of service shows the immediate and dramatic impact of each regulatory release. Note the marked increase in the percentage of services moved to the outpatient venue in 2020, and continued growth in 2021. ASC's were also quick to respond to the 2021 addition of these procedures to their CPL with an immediate increase in volume (See Chart 3).

A review of the average ASA physical status classification for 2021 total hip replacement patients from our practices suggests that physicians guide patients to the place of service that is consistent with their risk profile. The lowest average ASA physical status value was for patients with services in ASCs. The patients with highest average ASA classifications were served in an inpatient setting, due

**CHART 2**

### Governmental Volume by Place of Service



to the potential need for complex anesthesia or increased clinical backup. With the expansion of potential venues, the graph (See Chart 4) shows the reduction of less-risky (lower ASA physical status rated) patients from the inpatient place of service.

Independent of the clinical and service-related benefits of this opportunity, the impact on anesthesia practices should be discussed. One result of this regulatory change may be reduced utilization in hospitals, and poorer reimbursement in ASCs. The redirection of cases out of hos-

pitals reduces the total revenue potential, but does nothing to relieve the burden of coverage for off-hour surgeries and call. Most hospitals are already providing a subsidy to finance these coverage requirements, the additional stress from reduced volume will exacerbate an already demanding financial scenario. Outpatient services (and ASCs in particular) historically benefitted from a favorable payor mix. The addition of governmental payor cases at ASC's will make those sites less favorable from a reimbursement standpoint. In addition, the horizontal expan-

**CHART 3**

### Total Hip Volume by Place of Service

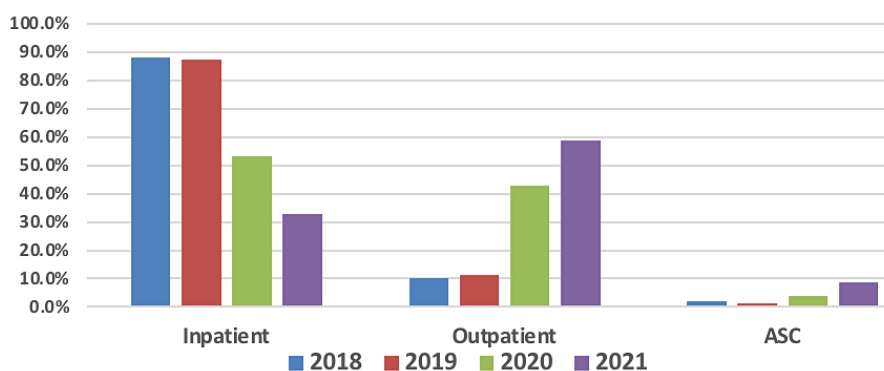
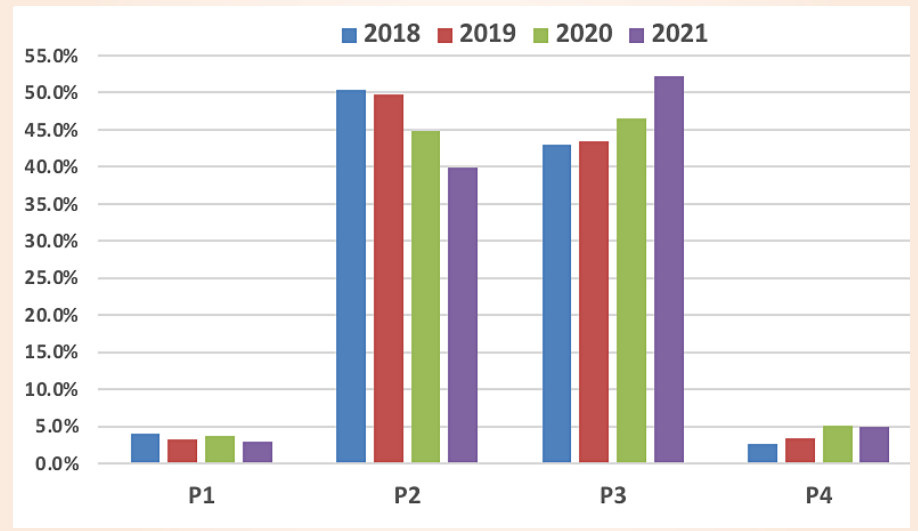




CHART 4

Total Hip Inpatient Physical Status % by Year



sion of anesthetizing locations may create additional coverage challenges in an employment environment already experiencing provider shortage (See Chart 5).

Recent policy changes in the 2022 Outpatient Prospective Payment System Final Rule will make 2021 a unique window into the impact of the healthcare regulatory environment on this trend. After beginning the planned three-year transition to eliminate the IPO List in 2021, CMS reversed course in 2022 and

reinstated most of the procedures eliminated in 2021. The agency also withdrew 258 of the 267 procedures newly added to the ASC CPL in 2021 as part of its revised procedure nomination process.

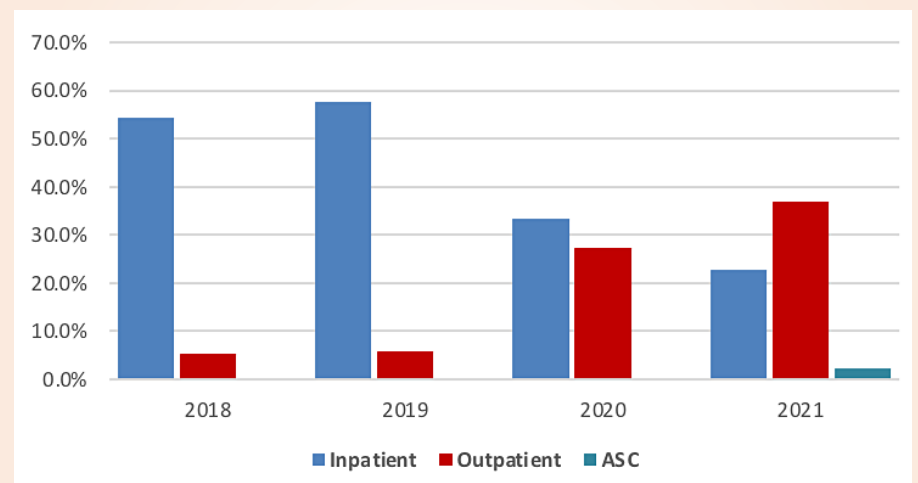
CMS will reassess how it evaluates procedures for removal and its longer-term plan for the IPO and ASC CPL. As seen by the regulatory changes in 2021, surgeons and patients have taken advantage of the flexibility to select the most desirable clinically appropriate venue for



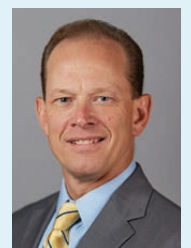
services based on individualized patient plans. The movement driven by changes in the Inpatient Only list and ASC Covered Procedures list demonstrates the impact of the agency’s regulations on the site of service selection. When released from regulatory controls, the market has shown a preference for outpatient and ASC services versus the traditional hospital inpatient experience. While this may be a positive development for patients and overall system costs, it presents challenges to anesthesia practices that will require deliberate planning and adjustment to financial and staffing models. The reversal on the IPO and ASA CPL changes provides a temporary reprieve during which anesthesia practices can consider the best course of action to address the coming inpatient exodus.

CHART 5

Governmental Payor % Hip Replacements by Site



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





# THREE CYBERSECURITY SAFEGUARDS TO IMPLEMENT IN YOUR ORGANIZATION TODAY

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Within the past few months, we have worked with large and small physician groups, hospitals, home health agencies, laboratories and others that have been the subject of data breaches due to failures in security policies and procedures, as well as devastating ransomware and phishing attacks. Every physician practice and healthcare organization is a target for cybercriminals. No business is too small.

Healthcare attorneys and cybersecurity professionals recommend that physicians, hospitals and others in the healthcare industry take prompt and meaningful action to mitigate the risk of a cyberattack. Luckily, in this space, legal compliance and business interests are aligned.

## **SAFEGUARD #1: UNDERSTAND THAT CYBER RESILIENCY IS BUSINESS RESILIENCY**

In order for an organization to adopt and implement an active and robust data privacy and security compliance program, it's imperative that leadership understands that protecting the organization from cybercriminals not only mitigates legal risk and financial liability, but it is also good business.

Cyber resiliency is an organization's ability to anticipate, withstand, recover from and adapt to adverse conditions, stresses, attacks or compromises on cybersecurity resources. This standard definition of cyber resilience was created by the [National Institute of Standards and Technology](#), and we believe it is spot-on.



Cyber resiliency is also business resiliency. A business that is cyber resilient can defend itself against cyberattacks, limit the negative impact a security incident can have, and ensure business continuity and uninterrupted operation during and after the attack. Being cyber resilient also helps organizations withstand and recover from other business interruptions, such as natural disasters, hardware failures, data loss and power outages.

There is a distinct difference between cybersecurity and cyber resiliency. Cybersecurity is preventing a cyberattack using tools such as endpoint detection and response (EDR), firewalls, malware detection software and improving security behaviors with employee anti-phish-

ing email training and timely security patch updates.

Being cyber resilient is letting go of the belief that an organization can create an impenetrable barrier between it and cybercriminals. Instead, cyber resiliency assumes that attacks will happen, and operations will be disrupted, so safety precautions must be implemented to respond to, and recover from, cyberattacks.

A cyber and business resiliency mindset seeks to identify the parts of a business that can be disrupted, and once identified, is focused on limiting the impact of a disruption. As an example, if a power outage occurs, are there data backups in place for critical and non-

critical business systems? How soon can systems be restored? Are there multiple backups in different locations in the event of a natural disaster?

Not until measures are put in place to minimize the impact of disruptions can a business consider itself resilient.

There are three main elements of cyber resiliency: **cybersecurity protection, continuation of normal business and adaptability.**

- Cybersecurity Protection is putting security measures and tools in place to prevent unauthorized access to your systems and network. It includes using EDR, firewalls, VPNs and staff training to defend against cyberattacks.
- Continuation of Normal Business is the point at which an organization is operating normally after a security incident or can continue operating during an incident. This includes the time it takes to restore all systems from backups.
- Adaptability refers to how easily the organization can defend against ever evolving and changing cyberattacks. The more adaptable an organization is, the more cyber resilient it is.

Achieving cyber resiliency is like seeing a city on a map—you know where it is, but the important question is, how do you get there?

In particular, there are at least six key steps to cyber resiliency that can help your organization become more business resilient:

#### 1. Plan

Create an incident response team and response plan. Test your security and practice what to do in the event of a security incident.



#### 2. Protect

Put cybersecurity tools in place, such as EDR, SIEM and firewalls to create a defense system that can withstand most cyber threats your organization may face.

#### 3. Defend

With an active cybersecurity framework established, your security tools can defend your business against most security threats and disruptive events and allow you to keep operating during an incident.

#### 4. Restore

Have a plan and safety measures in place to restore your critical and non-critical business systems from onsite, offsite or cloud-based data backups.

#### 5. Observe and Analyze

Implement software tools that report, log and repel cyber treats in real-time. These tools rely on machine learning, artificial intelligence and automated threat hunting and can learn and adapt to prevent future cyber threats.

#### 6. Adapt

Always assess your threat-readiness and cybersecurity protection to maintain normal operations now and in the future.

Cyber resiliency takes work but is essential for business survival in the information age. It's also important to know that it's OK to ask for help from healthcare attorneys, information technology and cybersecurity professionals and others. Based upon our recent experience, one of the most important things you can do today is to educate yourself and your workforce to appropriately respond to phishing attacks.

### **SAFEGUARD #2: KNOW HOW TO RESPOND IN THE EVENT OF A PHISHING ATTACK**

Phishing is an online scam where cybercriminals send messages that appear legitimate to get the recipient to click a link and enter confidential information. Once a phishing link is clicked, the criminals can steal personal information, gain



# THREE CYBERSECURITY SAFEGUARDS TO IMPLEMENT IN YOUR ORGANIZATION TODAY

*Continued from page 19*

access to a computer network or download malware.

Phishing is a serious cybersecurity issue; 65 percent of U.S. organizations experienced a successful phishing attack last year and only 49 percent of U.S. workers can answer the question, “What is phishing?” correctly. (ProofPoint, 2020.) Phishing is going mobile—87 percent of phishing attacks on mobile devices use social media apps, games and messaging as the attack method of choice. (Wandera, 2020.)

As the awareness of phishing increases and its effectiveness decreases, hackers have developed increasingly sophisticated and personalized phishing attacks.

This guide to phishing is meant to illustrate the many ways cyber criminals attempt to access your information so that **you** and **your business** can remain cyber-safe.

## Spear Phishing

Spear phishing is a targeted attempt to steal information from a specific person. Spear phishing uses information specific to the target to appear legitimate, often gathered from social media or “About Us” sections of company websites.

*Real World Example: An email is sent to the parent of a youth soccer team’s player from a cyber criminal posing as the coach of the soccer team. The email is personalized and advises that the soccer game had been cancelled and the recipient should view the attached file for the updated schedule. BOOM.*

## Whaling

In a whaling phishing attempt, the unknowing target is typically a member of a business’s senior leadership team.



Whaling emails used spoofed “from:” fields to trick other employees of the company into sending sensitive data.

*Real World Example: An email is sent to the HR department of a large technology company that appears to come from the company CEO asking for salary information, social security numbers and home addresses of dozens of employees. The HR team, believing the email was legitimate, proceeded to unknowingly send the required confidential information to the cyber criminal. BOOM.*

## Vishing

Phishing attempts that happen on the phone are known as vishing attacks. The scam attempts to create a sense of urgency and panic, making the victim want to act quickly and without thinking. Vishing attacks use spoofed caller ID numbers to add to the believability of the scam.

*Real World Example: A call appears to come from a local bank. The caller says they have noticed fraudulent activity on the potential victim’s account and need to*

*verify account information to prevent further fraud. The criminal will ask for account numbers and passwords to “verify” the account. Never provide this info. Call your bank to verify.*

## Smishing

Smishing uses SMS text messages to target victims.

*Real World Example: A text is sent from a parcel delivery company with a tracking number and link to “choose delivery preferences.” Clicking the link takes the user to a fake Amazon site which asks for a username and password to claim a free gift card “reward” for taking a customer satisfaction survey.*

## Zombie Phishing

Zombie phishing is when a hacker gains access to a legitimate email account, resurrects an old email conversation, and adds a phishing link.

*Real World Example: A months-old email thread between two company employees appears in the victim’s inbox, with*



a message like “Message truncated, click to view entire message.” The link takes the user to a fake company webmail portal and when the user logs in, the cyber criminal has gained network access.

### Evil Twin

Evil twin phishing uses wi-fi to accomplish its goals with a wireless access point that looks like a legitimate one. Once an unsuspecting user logs onto the evil twin wi-fi, the criminal can gather personal or business information without the user’s knowledge.

*Real World Example: A victim sets up his laptop in a coffee shop and logs into the “Starbuck5” wi-fi, not noticing that the business name was misspelled.*

### Search Phishing

Search phishing uses legitimate keywords in search engines to offer unbelievable sales or discounts on popular products. This scam uses fake webpages as the phishing link.

*Real World Example: A search for a popular portable music player returns a link to an incredible sale on the product. When the link is clicked, the victim is taken*

*to a fake web site that asks for a credit card or bank account to create an account. A different version of this scam creates a fake warning in your web browser saying your computer has been infected with malware, with a link to download software to “fix” it, or to download an updated version of your web browser.*

### Angler Phishing

Social media offers cyber criminals a whole new way to exploit people with angler phishing, which uses social media posts with links to cloned websites that look legitimate, malicious links in tweets and instant messaging.

*Real World Example: A bank customer tweets about the bank’s lackluster service. A fake bank customer service account DMs the customer and offers immediate assistance; all the user must do is click the enclosed link, which downloads malware, or asks for personal bank account information.*

### Tiny URL

While not a phishing attack per se, another way to hide phishing links is by using a link shortening tool, like bitly or ow.ly.



### Misspelled URL

Cyber criminals also buy domains that sound or look like popular websites, hoping you click the link, not noticing the misspelling or wrong URL. One of the best examples is hackers using the domain `arnazon.com`, which looks very much like `amazon.com` because, when placed together, `rn` looks very much like `m`.

### THE BOTTOM LINE

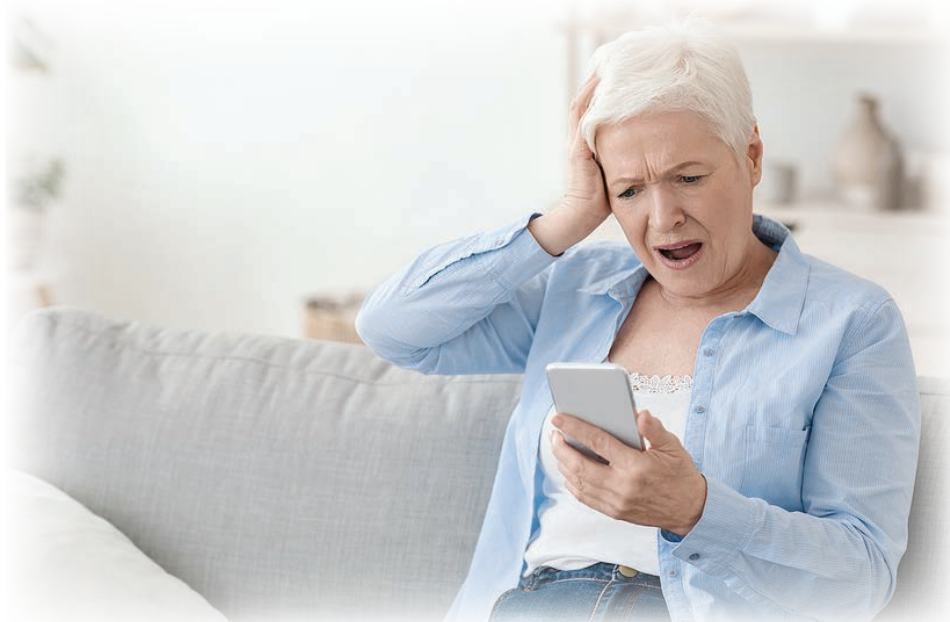
Why is the awareness of phishing tactics important? Phishing attacks account for more than 80 percent of reported cybersecurity incidents (Verizon, 2019) and attackers use phishing as an entry point for almost one-third of all cyberattacks (IBM, 2019). Knowing the various ways cyber criminals attempt to gain access to your account logins and passwords, download malicious software to your computers and network devices, and ultimately separate you (or your business) from your hard-earned money, can help keep you cyber secure, and the online world a safer place.

### PHISHING TIPS TO KEEP YOU SAFE

Think, don’t click! Slow down and really examine a suspicious email or text. Here are some red flags to look for:

- **Bad Spelling.** If there are obvious spelling mistakes or grammar errors, delete the message.

*Continued on page 22*



## THREE CYBERSECURITY SAFEGUARDS TO IMPLEMENT IN YOUR ORGANIZATION TODAY

*Continued from page 21*



- **Hover Over It!** Even though a link may appear to be real, hover over it to reveal the link's actual destination.
- **Greetings!** If the salutation is “valued customer” or “Hello, friend!” and not your name, chances are good it is a phishing attempt.
- **Request for Information.** Your bank already has your information, so there is no need for them to ask you for it.
- **Threats.** “Your account has been suspended” or “payment required” are red flags.
- **Attachments.** Never open an attachment from someone you don't know, or that you aren't expecting.
- **Email Address.** If the email address is from an email service and not a legitimate business email address, take no action.

Feel free to use and distribute the accompanying infographic, “[Let's Go Phishing! A Guide to Phishing Attacks](#)” to raise awareness of phishing with your co-workers, colleagues, friends or family.

As cyberattacks and successful breaches, particularly via ransomware, continue to increase, it's no longer a question of “if” an organization will be a victim, but “when.” And it is important to note that organizations can be sued for data breaches. There are cases that seem to offer a legal precedent for individuals to sue businesses that have not put the proper security protections in place to prevent data containing personal information from being accessed.

A cyberattack or data breach can be devastating. Not only does the breached organization suffer the cost of remediating the damage done by the attack and perhaps paying a ransom to recover stolen data, but being temporarily inoperable can cause lost sales, in addition to the incalculable reputational damage the organization will experience. The latest estimate of downtime to a business because of a cyberattack is 21 days.

Add to that a potential one-two punch of lawsuits and regulatory sanc-

tions targeting the breached organization, and it adds up to a profoundly negative impact on its long-term viability.

Responsible organizations that maintain personal information commit themselves to protect their network systems through dedicated or outsourced cybersecurity teams, robust security tools and continuous staff training. But breaches will happen, no matter how diligent an organization is with its cybersecurity.

### SAFEGUARD #3: TAKE ADVANTAGE OF STATE LEVEL SAFE HARBORS

To incentivize organizations to be proactive with their cybersecurity, several states have introduced data breach litigation “safe harbor” laws that provide an affirmative defense to liability caused by data breaches. To be eligible for safe harbor protection, an organization must protect its data by implementing and maintaining cybersecurity programs that meet industry-recognized standards and be able to show reason-





able compliance with them at the time of the breach.

#### Which cybersecurity frameworks are typically recognized for meeting safe harbor requirements?

Standards that are acceptable include:

- [NIST CSF \(National Institute of Standards and Technology Cybersecurity Framework\)](#)
- [NIST 800-171](#)
- [NIST 800-53](#)
- [FedRAMP \(Federal Risk and Authorization Management Program\)](#)
- [ISO 27000](#)
- [CIS \(Center for Internet Security “Critical Security Controls for Effective Cyber Defense”\)](#)

Businesses already regulated by the following frameworks must reasonably conform to them and do not need to add the additional burden of complying with another standard:

- [PCI DSS \(Payment Card Industry’s Data Security Standards\)](#)
- [HIPAA \(Health Insurance Portability and Accountability Act\)](#)

- [GLBA \(Gramm-Leach-Bliley Act\)](#)
- [HITECH \(Health Information Technology for Economic and Clinical Health Act\)](#)
- [FISMA \(Federal Information Security Modernization Act\)](#)

#### Exactly what does “reasonably conform” mean?


The definition of “reasonably conform” is partially satisfied by adhering to the above-mentioned industry-recognized security frameworks but also takes into account: 1) the size and complexity of the organization; 2) the nature and scope of its activities; 3) the sensitivity of protected information; and 4) the cost and availability of tools to improve data security and reduce vulnerabilities.

#### Is cybersecurity safe harbor absolute?

No. If an organization was aware of a threat or vulnerability and did not act in a reasonable time to fix the issue and it resulted in a data breach, safe harbor cannot be used as a defense.

Safe harbor is a legal remedy for cyber-responsible organizations that provides them an affirmative defense to liability caused by data breaches if they

implement and maintain a cybersecurity program that meets an industry-recognized standard and can show compliance at the time of the attack.

No one wants to spend significant money, time and resources on defending against a cyberattack. However, the reality of today’s world requires that such measures be part of an organization’s overall business plan. Such attacks will happen, and their consequences can be catastrophic. Implementing an adequate defense, through appropriate infrastructure and protocols, is no longer an option. It is an overriding priority. 

#### Kathryn (Kate)

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Date	Event	Location	Contact Info
September 8–11, 2022	Texas Society of Anesthesiologists 2022 Annual Meeting	Kalahari Resort Round Rock, TX	<a href="http://www.tsa.org/professional/meetings.php">http://www.tsa.org/professional/meetings.php</a>
October 1–2, 2022	Colorado Society of Anesthesiologists 2022 Annual Meeting	Denver Inverness Denver, CO	<a href="https://csa-online.org/meeting-information/">https://csa-online.org/meeting-information/</a>
October 21–25, 2022	American Society of Anesthesiologists ANESTHESIOLOGY Annual Meeting	Ernest N. Morial Convention Center New Orleans, LA	<a href="https://www.asahq.org/annualmeeting">https://www.asahq.org/annualmeeting</a>
October 27–28, 2022	Beckers ASC The Business & Operations of ASCs	Swissotel Chicago, IL	<a href="https://events.beckershospitalreview.com/ascannual2022/p/1">https://events.beckershospitalreview.com/ascannual2022/p/1</a>
December 10–11, 2022	The New York State Society of Anesthesiologists, Inc. 73rd Annual PostGraduate Assembly in Anesthesiology	New York Marriott Marquis New York, NY	<a href="http://www.pga.nyc/">http://www.pga.nyc/</a>

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