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MACRA Financials for Anesthesia Practices: What We've Learned So Far

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On March 26, 2015, the House passed the Medicare Access and CHIP Reauthorization Act (MACRA) with an almost unanimous vote. This decision set in motion a program that would change the way medical providers would be evaluated, and that would apply value-based medicine to American healthcare moving forward. The Centers for Medicare and Medicaid Services (CMS) then developed and deployed the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs) to service this legislation.

While substantial literature is available regarding the content of MACRA legislation and operational deployment of CMS's MIPS and APM models, this review will focus on the legislation's financial implications for anesthesia providers. This financial insight has been somewhat difficult for practices and business professionals to acquire, as many

sources of information are available, and in some cases, the information is conflicting. We will attempt to provide a cohesive review of the financial implications of the MACRA legislation for anesthesia and chronic pain management providers.

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Keep Reporting MIPS Anesthesia Quality Data in 2019: Here's Why

As noted in our December 17, 2018 eAlert, the budget neutrality required by MACRA for the Merit-Based Incentive Payment System (MIPS)—coupled with the high performance by the vast majority of participating anesthesia and chronic pain management groups in the Quality Payment Program (QPP)—means that providers within the specialty are unlikely to earn significant bonuses through MIPS participation for performance year 2019 (payment year 2021).

The outlook was more optimistic when the Centers for Medicare and Medicaid Services (CMS) launched the QPP, ABC Chief Quality Officer Bryan Sullivan observes in his lead article for this issue of *Communiqué,* "MACRA Financials for Anesthesia Practices: What We've Learned So Far." By allowing practices more flexibility in MIPS performance year 1 (the year of the "pick your pace" option), "far more practices were able to avoid a penalty, and thus, not fund the bonus side of the program," he writes. "The lack of funding on the penalty side deeply depressed the bonus for exceptional performers."

Despite these financial realities, continued participation "provides the most flexibility in negotiations with payers and facilities and serves as a continual performance metric," Mr. Sullivan says. In short, for those of you who have been MIPS participants: carry on. (Also see our eAlert for the 2019 anesthesia quality measures awaiting CMS approval so you can begin planning for the new year.)

Also in this issue:

- Lorraine A. Morandi, MA, director of human resources for Plexus Management Group, LLC, explores a topic we're covering in the newsletter for the first time: the vital and integral role of human resources in effective anesthesia practice management. Ms. Morandi touches on 10 top HR-related issues facing anesthesia groups in 2019, observing that practices too often neglect HR as financial planning and other practice management priorities demand their attention. She urges anesthesia groups not to lose sight of HR's value in solidifying a group's culture and reinforcing its ability to draw qualified professionals to the practice and build a productive and satisfied team.
- Will Latham, MBA, of Latham Consulting Group, probes the ways in which anesthesia groups can incentivize members to deliver value. "Given the fact that, in many cases, anesthesia group shareholders have limited expectations to do anything (other than provide clinical care), anesthesia group leaders need to look at various ways to motivate group members to focus on and provide the value that stakeholders demand," writes Mr. Latham, a frequent *Communiqué* contributor, who will be speaking at this year's ASA practice management conference in Las Vegas. He points out the problem practices often run into by assuming that money offers the most powerful motivator: "If money is the only incentive you use, people will only do the things that generate money." Engage members, support group leaders, recognize those who provide important service and establish normative behaviors via a Code of Conduct to avoid *dis*incentivizing members, he recommends.
- Jody Locke, MA, vice president of anesthesia and pain practice management services for ABC, asks us to imagine "Uberism" in anesthesia. Can the same business principles behind the wildly successful app-driven transportation service be applied to our specialty? "Hospital administrators have started to adopt an Uber mentality regarding their requirements for anesthesia services" in their desire for 24/7 coverage without having to pay providers when they are not caring for patients, Mr. Locke writes. "Like Uber, they only want to pay for actual service." What would it take for the specialty to achieve a win/win situation similar to the model that has brought new convenience and cost-effectiveness to transportation?
- Mark F. Weiss, JD, of the Mark F. Weiss Law Firm, provides an update on an area some providers have been asking about recently: the "company model," under which referring physicians, who own a facility where surgical procedures are performed, form a separate anesthesia company in order to share in anesthesia revenue. The ASA has long opposed the model as "fraudulent and abusive" to anesthesia practitioners and patients. Mr. Weiss explores the intricacies of this topic, noting that, while "it's not the case that any specific law or regulation makes, in blanket fashion, company model deals illegal . . . the bottom line is that each arrangement within the rubric of the company model must be scrutinized extremely carefully."

We look forward to seeing many of you at PRACTICE MANAGEMENT® 2019 in Las Vegas and extend our wishes for a fulfilling and productive new year.

With best wishes,

Tony Mira
President and CEO

HR Essentials for Anesthesia Groups: Keys to Finding and Keeping the Best

Lorraine A. Morandi, MA
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In the current competitive environment, long-term relationships between anesthesia groups and healthcare organizations are no longer the given they once were, and success for anesthesia practices hinges on their resilience and adaptability as market conditions and hospital requirements change. A cohesive, united group is more likely to weather the uncertainty and preserve the contracts worth keeping.

The human resources (HR) function plays a bigger role in fostering this cohesion and strength than many anesthesia practices realize. A solid HR program encompassing everything from benefits packages to policy and procedure handbooks to recruitment strategies sets a practice's cultural tone, which, in turn, helps groups find and keep clinicians and nonclinicians who fit well within the team.

What's important in HR now? These are some of the top HR issues facing anesthesia groups in 2019 and beyond. We encourage groups to begin incorporating serious consideration for these issues into their HR programs if they haven't started doing so already.

Recruitment and retention: The notion of supply and demand will be deeply challenged in the coming years, and while the aging of the United States population, the increase in chronic disease burden, the number of physicians nearing retirement age and other demographic and health trends will continue to produce more healthcare jobs than ever, including more jobs for anesthesia practitioners, this also means that worker shortages will continue to exist at all levels.

Anesthesia groups will be required to compete for a shrinking pool of qualified

providers to meet growing demand. As a result, workforce planning and the creative design of recruitment and retention tools to attract top-notch anesthesiologists and ensure adequate clinical coverage for the group's mix of hospitals, ambulatory surgery centers (ASCs) and other facilities will become increasingly important.

Recruitment and retention strategies should incorporate such elements as carefully designed benefits packages that reflect, as realistically as possible, the wants and needs of a broad swathe of candidates; consideration for work/life balance and vacation time; realistic workloads; opportunities to build community and collegiality among group members; and opportunities for leadership development on committees and through other venues. Anesthesia practices also should take the time to define the non-negotiable qualities and qualifications their group is seeking in clinicians who will be invited to join the group.

Employee engagement: As a corollary to recruitment and retention, the need to foster an environment in which people thrive and want to come to work every day and be the best they can is growing as the workforce shrinks, competition tightens and physician burnout grows. Anesthesia groups must invest time and energy in holding on to their people. You hire them for a reason, so why not find ways to keep them rather than expend the upwards of 30 percent of an annual salary required to replace them?

Sexual harassment: Anesthesia practices must adopt and enforce a zero tolerance policy regarding any and all kinds of harassment, or face dire and expensive consequences. The #MeToo movement has pushed the issue of sexual harassment, in general, and workplace sexual harassment, in particular, into the spotlight, and that is a healthy thing, since most sexual harassment incidents go unreported and uninvestigated, and an environment in which sexual harassment occurs can have serious direct and indirect repercussions.

Less than one-fourth (23 percent) of reported incidents of sexual harassment resulted in an investigation, Medscape's *Sexual Harassment of Physicians: Report 2018* revealed. Further, only 40 percent of physicians who were harassed reported the behavior. "Most places don't know how to conduct an investigation, and many HR departments don't recognize the nuances of sexual harassment issues," said consultant Susan Strauss, RN, EdD, in the report.

Seven percent of physicians said they experienced some form of sexual harassment within the past three years. Not

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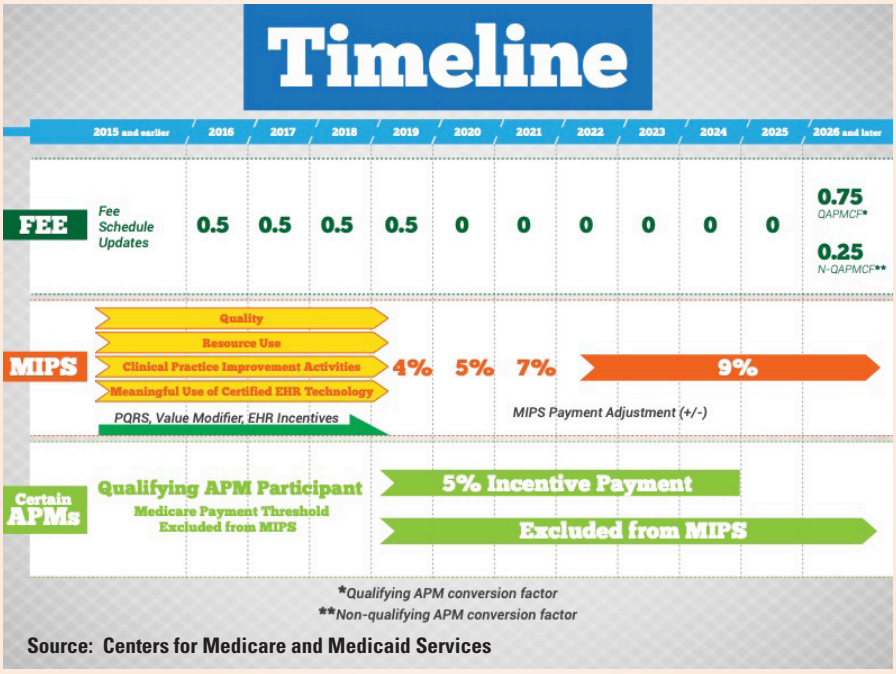
FIGURE 1

Fees, Bonuses and Incentives Under the Quality Payment Program



Source: Centers for Medicare and Medicaid Services

What CMS Will Tell You

In the memorandum, "Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act" (April 4, 2015), CMS estimated that from fiscal years 2015 through 2025, MACRA would increase combined federal spending for Medicare, Medicaid and the health insurance marketplace by $102.8 billion.

This represents a considerable investment from a budgetary perspective, and CMS further explained how the investment would be distributed through its yearly final rules. Thankfully, they summarized the schedule in which fees, bonuses and incentives are made available.

The key points of the timeline (Figure 1) showcase the steady incentive available for those providers participating in an APM and the graduated nature of MIPS over the years. From a high-level perspective, this would suggest that MIPS participation represents the highest level of bonuses available under MACRA. We know now that this isn't true.

Budget Neutral

One of the central requirements of the MACRA legislation is that it must remain budget neutral. This may seem out of alignment with the memorandum above, but keep in mind that the memorandum was talking about overall spending and not just how MACRA distributes funds. MACRA was designed to save the government an estimated $47.7 billion on overall spending in the same period versus the Sustainable Growth Rate (SGR) formula, which was one of the main reasons for its adoption.

The budget neutral requirement has placed CMS in an interesting position over the past couple of reporting years. With the initial "pick your pace" option, far more practices were able to avoid a penalty, and thus, not fund the bonus side of the program. Of course, CMS could have decided to bypass a flexible onboarding process with the initial years of MACRA to fund the initial bonuses of four percent, but as it was, the lack of funding on the penalty side deeply depressed the bonus for exceptional performers. Regardless of how the bonus side is balanced, the maximum penalty will be four percent in 2019, five percent in 2020, seven percent in 2021, and nine percent in 2022 and beyond.

While the requirement for budget neutrality persists for MIPS, no such requirement exists for the APM. Eligible providers receive a fixed five percent bonus for each of the first six years and a higher base payment rate. Bonuses in the APM program, as well as contractually specified bonuses or penalties, have no budget neutrality requirement.

The 2018 CMS final rule included projections that speak volumes regarding what they consider for the anesthesia specialty.

By reviewing the data in Tables 1 and 2, you can see that the number of providers expected to be neutral or to receive a positive adjustment constitute *about 97 percent of all eligible anesthesia clinicians*. This does not provide much room for an upside for providers, given MACRA's budget neutral nature.

Due to this adjustment, providers saw far less than the expected four percent bonus. Recently adjusted from above two percent, CMS has published that the maximum bonus anesthesia will receive will be 1.88 percent on Medicare Part B charges in calendar year 2019 for reporting year 2017. On average, if a provider collects $65,000 in Medicare Part B charges for a given year, the bonus will be $1,222 for exceptional performers. The number of hours spent on

TABLES 1 & 2

MIPS Financials by Specialty and Practice Size

MIPS Estimated Payment Year 2020 Impact on Paid Amount by Specialty, Standard Participation Assumptions *

Provider Type, Specialty	Number of MIPS Eligible Clinicians	Paid Amount (mil)**	Percent Eligible Clinicians Engaging with Quality Reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
Overall	**604,006**	**$55,444**	**96.8%**	**97.1%**	**74.4%**	**2.9%**	**618.2**	**-118.2**	**0.9%**
Addiction Medicine	82	$3	97.6%	97.6%	75.6%	2.4%	0.0	0.0	0.4%
Allergy/Immunology	1,743	$153	95.1%	95.9%	71.9%	4.1%	1.6	-0.8	0.6%
Anesthesiology	17,105	$837	97.6%	97.2%	73.3%	2/8%	8.4	-2.6	0.7%

MIPS Estimated Payment Year 2020 Impact on Total Estimated Paid Amount by Practice Size, Standard Participation Assumptions *

Practice Size	Number of MIPS Eligible Clinicians	Paid Amount (mil)**	Percent Eligible Clinicians Engaging with Quality Reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
ALL PRACTICE SIZES	**604,006**	**$55,444**	**96.8%**	**97.1%**	**74.4%**	**2.9%**	**618.2**	**-118.2**	**0.9%**
1-15 clinicians	116,626	$24,219	90.0%	90.9%	61.3%	9.1%	265.5	-82.4	0.8%
16-24 clinicians	25,488	$3,700	92.6%	93.0%	53.6%	7.0%	30.7	-10.4	0.5%
25-99 clinicians	118,786	$9,702	97.0%	97.1%	65.8%	2.9%	92.6	-17.6	0.8%
100 or more clinicians	343,106	$17,824	99.4%	99.5%	83.4%	0.5%	229.4	-7.8	1.2%

Practice size is the total number of TIN/NPIs in a TIN.
*Standard scoring model assumes that a minimum of 90 percent of clinicians within each practice size category would participate in quality data submission.
** 2014, 2015 and 2016 data used to estimate 2018 payment adjustments. Payments estimated using 2015 and 2016 dollars.

Source: Centers for Medicare and Medicaid Services

supporting MIPS annually can help identify the return on investment, but from a purely financial perspective, a few extra cases yearly would clearly supplant any bonus experienced.

Exclusion for Anesthesia

The final piece of the financial puzzle from CMS is the exclusions that are available to allow a group to opt out of MACRA altogether. If a provider were to look up their requirement to report through the Quality Payment Program page (https://qpp.cms.gov/participation-lookup), most anesthesia providers would see what is shown in Table 3.

This determination allows a group to skip the reporting requirement in a given year. This is re-evaluated every year, but it shows the provider can be excluded from reporting simply by reporting as an individual. As groups exit the MIPS program, further depression will be experienced on the bonus side of the payment.

TABLE 3

MIPS Participation

MIPS Exempt as an Individual	
Eligible provider type	Yes
Enrolled in Medicare before January1, 2018	Yes
Medicare patients for this clinician	Exceeds 200
Allowed charges for this clinician	Does not exceed $90,000

MIPS Included as a Group	
At least one eligible provider type at this practice	Yes
Medicare patients at this practice	Exceeds 200
Allowed charges at this practice	Does not exceed $90,000

Inflation Effect

Unfortunately for all those participating under MACRA, the program is designed to be a program of attrition. Not unlike other entitlement programs, inflation will continually have an effect on those providing services that will benefit those receiving care. Inflation applied to the long-term operation of MACRA elicits some startling results (see Figure 2).

Under MIPS, when adjusted for inflation, top-performing providers will be operating below today's earnings. Under Advanced APMs, in addition to the five percent bonus and the gain share option,

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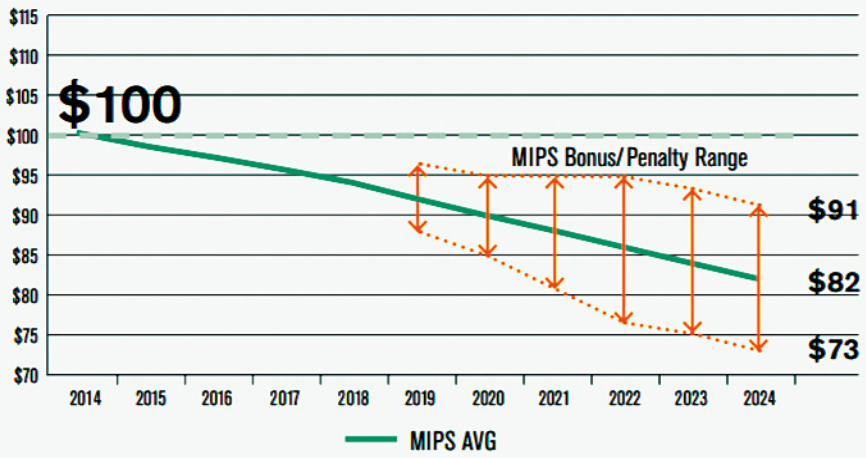
FIGURE 2

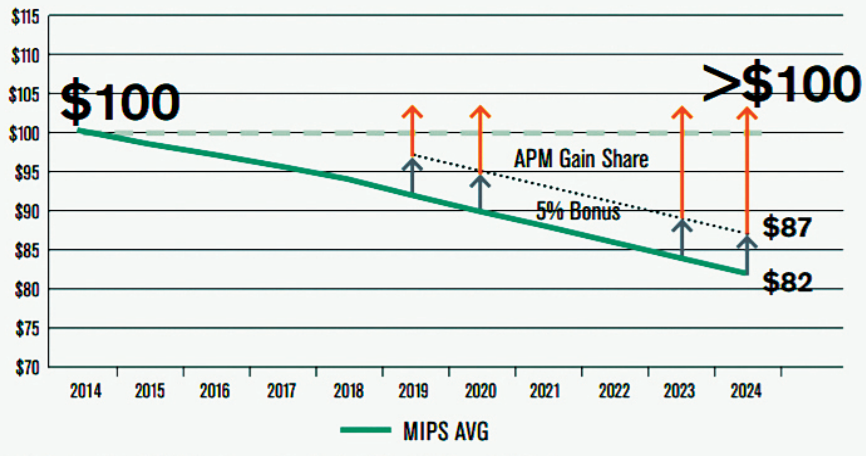
Inflation Effect

INFLATION-ADJUSTED 10-YEAR CHANGE IN PHYSICIAN PAYMENT UNDER MIPS



Note: Inflation is projected CPI-U from Congressional Budget Office 2016 Economic Outlook

INFLATION-ADJUSTED 10-YEAR CHANGE IN PHYSICIAN PAYMENT UNDER APMs



Note: Inflation is projected CPI-U from Congressional Budget Office 2016 Economic Outlook

Source: Derived from presentation, Value-Based Payment Systems: How Will They Change the Delivery of Care? Robert Mechanic, MBA, Brandeis University.

providers can earn a true bonus. APM participation introduces a new aspect to the group's model if it is not already participating in an APM. It represents the only way to earn future dollars that are worth more than today's.

What Now?

Groups have made decisions to continue with MIPS for three primary reasons: requirements by insurance carriers, requirements by hospital contracts and public reporting. Even if a practice is not required to report to CMS and no current contracts with their facilities or payers necessitate reporting, longitudinal data for such an influential program may contribute to future value as it showcases a commitment to quality in light of degrading financial benefit. In light of this, we recommend taking a balanced approach when making a decision on future MACRA participation.

The reality of the shift to value-based care under MACRA fell short of the initial hope. Budget neutrality, exclusions for anesthesia and inflation have forced groups to re-evaluate their role with MACRA. From a purely financial perspective, it is hard to justify continued participation for no other reason than to protect a portion of future earnings. However, many groups will continue to report in spite of the negative financial picture, as participation provides the most flexibility in negotiations with payers and facilities and serves as a continual performance metric.

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HR Essentials for Anesthesia Groups: Keys to Finding and Keeping the Best

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surprisingly, medical residents were more likely (78 percent) than working physicians (55 percent) to not confront the perpetrator when harassment occurred. Medscape's report of sexual harassment among other clinicians, including nurses, nurse practitioners and physician assistants, found that 10 percent of respondents were sexually harassed within the past three years.

To address this issue as part of an overall effort to create a supportive work environment, we recommend that anesthesia groups consider sponsoring training led by an employment attorney or other specialist. However, regardless of whether training is an option, anesthesia groups should, at a minimum, develop policies for their employee handbooks covering a definition of harassment, reporting mechanisms and the consequences in order to eliminate ambiguity about expectations for employee behavior.

Drug testing and substance abuse: Deaths from accidental drug overdoses are on the rise, and more states are legalizing marijuana. Practices must be particularly sensitive to ensuring a drug-free environment in which the use and abuse of legal and illegal drugs is not tolerated.

As professionals who hold responsibility for patients' lives perioperatively, it is critical for anesthesiologists struggling with substance abuse problems to receive prompt treatment. Well-defined policies and procedures related to workplace drug testing and substance abuse can help anesthesia practices clarify the ambiguity and uncertainty that often surrounds this issue.

Although the overall incidence of drug abuse is not consistently higher among anesthesia practitioners than other specialties, anesthesiologists are consistently over-represented in drug treatment centers, according to the International Anesthesia Research Society. Anesthesiologists account for 12 to 14 percent of physicians treated in three well-known treatment programs, but they constitute only four percent of U.S. physicians.

As the current opioid epidemic continues to rage and marijuana becomes legalized in a growing number of states, it's more important than ever for anesthesia practices to have steps in place for addressing suspected substance abuse among staff and to be prepared to act as a referral resource.

As with sexual harassment, policies and procedures communicating expectations and consequences for all employees as part of a comprehensive employee handbook can go a long way in addressing a situation of that is often fraught with indecision. Policies and procedures should include off-site treatment resources.

Employee handbooks: Running a smooth practice requires consistent communication and messaging about the group's mission statement, goals, job classifications, policies, procedures and benefits. Well-written, up-to-date handbooks aligned with current legislation are an essential component of effective workforce management. Their value to an anesthesia practice can't be overstated. Signing on to become part of a practice is a major commitment. The employee handbook is the playbook that helps individuals function effectively within the group.

In addition, the handbook must accurately reflect the wide range of federal, state and local laws related to various aspects of the work environment, such as sick leave. HR must revise the handbook as these laws change. Some policies are driven by practice size. The Family Medical Leave Act (FMLA), for example, pertains to organizations with 50 or more employees within a 75-mile radius. For anesthesia practices with fewer practitioners, an FMLA policy would not be required. It's important for groups to know all of the applicable laws.

Employee wellness: A valuable way to keep productivity high and absenteeism low is to include employee wellness programs in benefits offerings. According to Glassdoor, 88 percent of employees who report a high level of overall well-being also report feeling engaged at work.

As clinicians with enormous responsibilities and demanding schedules who deal with complex and often critical situations, anesthesiologists and CRNAs experience a great deal of stress. Employee wellness programs can play a crucial role in this regard.

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One type of employee benefit that fits under this category is the Employee Assistance Program (EAP), through which employees can receive confidential guidance, support and information via an external source through a toll-free number for the full range of issues that can affect job performance, health, and mental and emotional well-being, including disruptive behavior and marriage and financial problems.

The design of an employee wellness program is highly subjective and can vary widely from group to group in the range and types of benefits offered. One group may allocate resources for a fitness center, while another may decide that focusing more on mental health services should take priority.

Benefits: Although benefits are only part of the picture when it comes to attracting qualified clinicians, the more comprehensive the package, the better. In addition to medical, dental, life and disability benefits, candidates will want to know the perks they will receive on top of these essentials, such as sign-on bonuses, relocation stipends, tuition reimbursement and continuing medical education stipends. Again, there is no one-size-fits-all solution to benefits package design, but the benefits package can tip a candidate's decision in favor of your group. A robust benefits offering can make or break the attractiveness of an employment offer and strengthen your ability to recruit and retain superior talent.

In a highly competitive marketplace, simply making basic benefits available is hardly enough, as there is always a need to assess and compare what other practices are offering. Having knowledge of benefit coverage levels across the industry can help your practice design a benefits program that stands out.

Employee leave: Issues around leave have become incredibly complex. Never before have practices had to track, document and manage as many layers and types of employee leave as in the current environment, including sick leave, family leave, medical leave, military leave, jury duty, domestic violence leave and many others.

Group managers and supervisors need training and education to ensure the group applies leave laws in a fair and nondiscriminatory manner. Decisions regarding the various types of leave a group offers will depend to some extent on its demographic makeup. For example, a relatively younger clinician population might be more likely to expect leave benefits pertaining to childbirth.

Technology: Today's highly technology-connected employees want and expect the convenience of quick access to benefits and other HR-related information. Practices should consider investing in the development of technology-based solutions that fulfill these needs, such as a website or portal that allows employees to manage their benefits online or browse the handbook for policy information, or a mobile phone app for reporting time and attendance.

At the same time, practices must take steps to protect their information, equipment and proprietary intelligence, and must be especially careful to employ HIPAA-compliant policies and strategies to protect their employees' private health information.

Compliance: An effective HR function must stay abreast of when and how to incorporate federal, state and local employment mandates into employee policies and procedures in order to comply with the law. Key factors in this ongoing process include the size of the workforce and the state in which the group operates. HR can help train managers and supervisors on emerging trends in federal, state and local laws and help keep documentation current.

For example, the FMLA, which provides up to 12 weeks of unpaid, job-protected leave to eligible employees, doesn't apply to organizations with fewer than 50 workers. If your group is smaller, what benefit will it provide when an employee requests maternity leave?

Finding and keeping top clinical and professional talent is a key to building competitive advantage in an unpredictable market. Though a solid HR program is central to that, some anesthesia groups tend to push HR concerns to the side as issues of contract negotiation, business development and financial planning take precedence. Anesthesia group leaders must be HR savvy and recognize that HR isn't a separate silo; it permeates and influences every aspect of practice management.

Lorraine A. Morandi, MA, is Director of Human Resources for Plexus Management Group, LLC (Plexus MG). She brings more than 25 years of HR experience to the leadership team. Ms. Morandi graduated with a Master's Degree in Counseling Psychology from Boston College. Prior to joining Plexus MG, she worked for nearly 15 years at MarketOne International LLP, where she was Vice President of Human Resources, overseeing staff growth and development in the organization's domestic and international offices. Ms. Morandi has also held a variety of senior human resources and recruiting positions with the Human Resources Organization (HRO) and the Norfolk District Attorney's Office, Mount Ida College and New Pond Village, all in Massachusetts. Ms. Morandi welcomes inquiries regarding Plexus MG's HR services for anesthesia groups and can be reached at LMorandi@PlexusMG.com.

Imagining Uberism in Anesthesia

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Uber has dramatically transformed the taxi business. We no longer talk of grabbing a cab; we "Uber" from point A to B. Airports now send us to ride-sharing pickup points where we see dozens of people staring at their phones trying to find their rides. For many of us, the Uber and Lyft apps are the most used on our phones. Some of us have even given up our cars because it is so much easier to pay for the ride than to incur the costs of ownership.

What started as a clever internet application has not only transformed how we get around, but also how we think about the services we want and use. The genius of the application is that it matches up people who want to earn money with those who want to avoid the hassles of driving, parking or running the risk of a DUI. Uber is now a world-wide phenomenon and a company worth more than $60 billion. The app works just as well in Prague or Chennai as it does in Fort Lauderdale. Uber is the most cost-effective solution to personal freedom and mobility. It has redefined the concept of customer service by simply matching demand with supply.

So what does this have to do with anesthesia? Everything and nothing. Hospital administrators have started to adopt an Uber mentality regarding their requirements for anesthesia services. Yes, they want 24/7 coverage, but they don't want to pay for providers during the time they are not caring for patients. Administrators would like to add to the three A's of anesthesia to include a fourth, along with availability, ability and affability: affordability. Like Uber, they only want to pay for actual service.

Their focus is the overall cost of anesthesia, which keeps going up. We all know why anesthesia coverage is so expensive:

administrators are selling availability to surgeons, and that requires providers who are ready to go when the surgeons want to operate. Anesthesia practices have a different priority: making sure they have enough staff to meet the variable demand.

On the surface, very large anesthesia practices appear to have a significant strategic advantage. Having more providers gives them more flexibility to meet the demands of the operating room and obstetrics suite. But the basic challenge is universal. Every time an anesthesia practice has to schedule a provider, there is a cost, irrespective of whether the provider is productive or not. In scheduling, we talk of 7:30 am starts because each location requires dedicated staff.

While some practices may use locum tenens on peak days to meet demands, this is not a very cost-effective option. The preferred mode has been to employ sufficient staff for peak utilization, which means the payroll meter is still running when surgical volume is down. However, this is changing as practices are creatively challenged to meet these demands more cost efficiently. Nowhere is this new pressure more evident than in obstetrics, where providers may wait hours for a patient to present.

The Conundrum of OR Efficiency

The scheduling of ORs can be likened to the scheduling of plane flights: the goal is to ensure that every flight goes out full. Thanks to sophisticated computer algorithms, airlines seem to accomplish this much of the time. In fact, they are allowed to overbook, which is something an OR would never be allowed to do, as it would jeopardize patient safety.

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Imagining Uberism in Anesthesia

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So why is it so hard to achieve consistently optimum OR efficiency? While the variability of surgeons' needs and demands plays a role, it isn't the entire picture, and few hospitals have found a good solution. Evidence also suggests the problem is getting worse, which explains why 75 percent of American anesthesia practices require financial support from their facilities.

Another major factor driving the need for financial support is the payer mix in hospitals that persists as other surgical settings have emerged over the past few decades. Cases that were once done in the hospital are being done in freestanding surgical centers. These surgery centers may have siphoned off the better payer mix, leaving governmental payers concentrated in the hospital setting.

Many riders still prefer to take a taxi versus an Uber. Taxi drivers are licensed for transport. They are accountable by virtue of their employment by a specific company. Uber drivers, by contrast, are just regular people, some of whom want to make a few extra dollars in their spare time. When you order an Uber, you never know who will show up or what kind of vehicle they will be driving. This is a source of concern to some potential riders, but an advantage to most. With few exceptions, all of my Uber drivers have been courteous people driving nice cars. They are virtually always eager to earn a five-star rating for the trip.

What distinguishes anesthesia from transportation is the challenge of ensuring that every provider is appropriately qualified for the case. This difference may be where the application of the Uber concept to anesthesia breaks down, except that individual practitioners working independently actually is the anesthesia model of the past. Most of today's anesthesia groups started as loose confederations of individual anesthesia practices. The model worked until managed care changed the landscape and providers needed to negotiate as a unified entity.

A Focus on Cost

Three things have led me to use Uber and Lyft for all my transportation needs: 1) the price is always right. My average fare from my house to the airport is never more than half of what I used to pay for a cab. 2) I love the app. I always know when the driver will arrive, whereas I used to wait impatiently for the local cab service. 3) I find the drivers to be interesting people, which makes the trip especially pleasant. Isn't this what hospitals really want: to pay only for the level of service they need; to have responsiveness and availability; and to have providers eager to impress patients with their high level of customer service?

Let's be clear about the context for this discussion. In healthcare within the United States, the focus has shifted from quality to cost. Quality care is a given and a threshold that must always be met. Now, cost is where everyone believes the focus must be. According to many analysts, healthcare in the U.S. is too expensive considering the results. There are theories about why this is true, but few viable solutions. The Affordable Care Act addressed many aspects of access to care but did nothing to make it more affordable. This problem affects all areas of healthcare.

In anesthesia, one might argue that the real problem is OR productivity. Inefficient OR utilization costs anesthesia practices a fortune and is one of the main reasons for the need for financial support from the facility. If every OR generated sufficient billable units at a reasonable yield per unit, the problem would be solved. Unfortunately, poor OR utilization limits the number of billable units and eroding payer mix drives down potential yield per billed units. While hospitals spend fortunes on business plans intended to improve utilization and payer mix, rarely do they effect any meaningful change. Most practices are doing well if they can maintain the status quo.

Why is efficiency such a challenge? For one, a hospital contract is a lot like the New York City cab medallion. It gives a group of providers an exclusive franchise. Like the taxi medallion, this means that the facility knows the providers and their qualifications. The arrangement provides a level of accountability that would not oth-

erwise be possible. Ideally, it means the hospital deals with one entity that can ensure consistent customer service. A professional services agreement gives the administration considerable leverage over the practice. The irony is that while the specialty has evolved to a point where virtually all anesthesia practices now have exclusive contracts, this may actually be contributing to the increasing costs of care.

Finding Middle Ground

Anesthesia practices must deal with two types of venues: traditional hospital surgical suites and outpatient ambulatory venues (which is where we are starting to see more creative scheduling and staffing models). Practices that are starting to deploy providers to a variety of ambulatory venues are starting to build scheduling teams that take the bookings and assign the providers, which is not that different from what the Uber app does. So what is different in the ambulatory environment? There is no guarantee of work or any call.

Uber has generated billions of dollars in profit while reducing the cost of transportation. As a business, it is still running at a loss, although this does not appear to discredit the basic model. All we hear about in hospital contract negotiations is that the administration wants to find ways to reduce subsidies. Given the current paradigm, in which anesthesia practices must employ enough providers to meet the facility's potential needs, that is a tall order. The providers' payroll and benefits expectations make anesthesia a fixed cost in the equation, while the revenue potential of surgical and obstetric cases is variable and often somewhat unpredictable. The challenge is to align the two, or at least to align the incentives of both the anesthesia providers and the administration. Since the providers want fair and reasonable compensation and the hospital continuously strives to reduce its costs, there is little middle ground. And there won't be until there is an Uber app for anesthesia. Crazy you say? Who would have anticipated the success of Uber before it happened?

So what is missing? First of all, there is no equivalent software application. However, such an app should not be all that complicated to create. Second, there is not a large enough pool of independent providers in any given geography to make their flexible deployment feasible. But even more important, the provider mindset is more focused on security and predictability than flexibility and availability. Imagine if every anesthesiologist and CRNA had the potential to generate a target number of ASA units per clinical day and get paid a reasonable amount per unit billed. There would be no need for subsidies, and most providers would probably make more. It would clearly be a paradigm shift, but it might prove to be a necessary one.

Applying the concept of Uber to anesthesia would clearly be a paradigm shift, and we all know that change tends to come slowly in medicine and even slower to anesthesia. From a stakeholder perspective, there would be more players opposed to such a change than for it.

There are obstacles. Like Federal Express, it wouldn't work on a small scale. There are over 1,000 Uber drivers in Fort Lauderdale alone. How could one create a comparable pool of qualified anesthesia providers?

The German word "uber" means over. *Deutschland uber alles* means Germany over everything. The *Ubermensch* strives to be more and better than their competitors. It is a very appropriate name for the company and an interesting concept. Thus far, we have mega groups but no uber groups, except in cities such as San Antonio, Phoenix and Las Vegas, which have a surgeon-request market.

The best solution to any problem is the one all the stakeholders hate least. Hospital contracting pits the anesthesia providers against the administration. Contracts do get resolved and implemented, but one side always loses. Imagine if it were different. Imagine if it were truly a win/win. How can we make it work? Imagine if someone figures it out.

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An Update on the 'Company Model' and Other Anesthesia Kickback Schemes

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Kickbacks in healthcare are rarely (but *not* never) as blatant as an envelope of cash passed under the table. But they do exist in many forms and settings.

When asked why he robbed banks, the notorious criminal Willie Sutton reputedly responded, "Because that's where the money is." Referring physicians, quite often but not always the owners of facilities, and facilities themselves, might seek a share of anesthesia fees for the same reason. But instead of using a gun, they turn to less violent but still violative devices, one of which is the so-called "company model" of anesthesia services. Others include questionable management services deals and expense-shifting arrangements.

Warning: unlike a bank robbery, the compliance issues cut both ways. The intentional submission to kickback demands is a crime. So, too, are schemes in which anesthesia providers propose kickbacks to obtain referrals.

The Key Compliance Issue

The federal anti-kickback statute (AKS) prohibits the offer of, demand for, payment of, or acceptance of any remuneration for referrals of patients whose care is covered by federal healthcare programs such as Medicare, Medicaid and Tricare (among many others).

There are exceptions, known as "safe harbors," that describe certain arrangements not subject to the AKS because they are unlikely to result in fraud or abuse. The ability to fit within a safe harbor is voluntary. In other words, the failure to qualify for a safe harbor is not fatal for the parties to the arrangement; rather, a detailed analysis of the statute itself and of the facts of the deal is then required.

Company Model Arrangements

Let's begin with a quick primer on the company model. In its most direct form, the company model involves the formation, by the surgeon-owners of an ambulatory surgery center (ASC), of an anesthesia services company to provide all of the anesthesia services for the center.

In the typical scenario, prior to the formation of the company, all anesthesia services were provided by anesthesiologists, alone or in concert with CRNAs, either for their separate accounts or for the account of their anesthesia group. After the formation of the company, the anesthesiologists and CRNAs are employed or subcontracted by the company, with a significant share of the anesthesia fee being redirected to the company model's owners, the surgeons.

There are other variants of the model, such as that in which the facility itself directly employs the anesthesia providers or controls the company that, in turn, employs them. However, for purposes of this discussion, the issues are relatively the same. For that reason, we'll use the surgeon-owned "anesthesia company" as the avatar for a company model scheme.

Broad OIG Guidance

Two fraud alerts issued by the Office of Inspector General (OIG) of the Department of Health and Human Services, the agency charged with regulating and enforcing the AKS, are applicable to the analysis of company model deals: its 1989 Special Fraud Alert on Joint Venture Arrangements, which was republished in 1994, and a 2003 Special Advisory Bulletin on Contractual Joint Ventures.

Note that the term "joint venture," as used by the OIG in the alerts, is not limited to the creation of a legal entity; rather, it covers any arrangement, whether contractual or involving a new legal entity, between parties in a position to refer business and those providing items or services for which Medicare or Medicaid pays.

The OIG has made clear that compliance with both the form and the substance of a safe harbor is required in order for it to provide protection. The OIG demands that if one underlying intention is to obtain a benefit for the referral of patients, the safe harbor would be unavailable and the AKS would be violated.

Although each alert illustrates the OIG's regulatory posture, the 2003 Special Advisory Bulletin is particularly on point in connection with analyzing company model structures. In it, the OIG focuses on arrangements in which a healthcare provider in an initial line of

business (for example, a surgeon) expands into a related business (such as anesthesiology) by contracting with an existing provider of the item or service (anesthesiologists or CRNAs) to provide the new item or service to the owner's existing patient population.

The 2003 Special Bulletin lists some of the common elements of these problematic structures in general. Neither of the alerts are anesthesia-specific (or, for that matter, specific to any medical specialty). In the points that follow, I have substituted words such as "surgeon" and "anesthesiologist," all in brackets, for the broader terms used by the OIG.

- The surgeon expands into [an anesthesia business] that is dependent on direct or indirect referrals from, or on other business generated by, the owner's existing business [such as the surgeon's practice or ASC].
- The surgeon does not operate the [anesthesia] business—the [anesthesiologist] does—and does not commit substantial funds or human resources to it.
- Absent participation in the joint venture, the [anesthesiologist] would be a competitor [of the surgeon's anesthesia company], providing services, billing and collecting [for the anesthesiologist's own benefit].
- The [surgeon] and the [anesthesiologist] share in the economic benefit of the [surgeon's] new [anesthesia] business.
- The aggregate payments to the [surgeon] vary based on the [surgeon's] referrals to the new [anesthesia] business.

Advisory Opinion 12-06

The OIG's first direct pronouncement on the propriety of the company model came in June 2012, when it issued Advisory Opinion 12-06. The anesthesia group requesting the opinion presented two alternative proposed scenarios, one a management fee deal and the other a company model structure. We'll discuss the company model structure first and then, in the section below, relating to other types of kickback schemes, explore the proposed management fee arrangement.

In the proposed company model structure, the surgeons, or their ASC, would set up an anesthesia company to hold the exclusive anesthesia contract at the ASC. The anesthesia company would engage the anesthesia group at a negotiated rate as an independent contractor to provide the actual anesthesia care and certain related services. The anesthesia company would retain any profit.

In its Opinion 12-06, the OIG stated that no safe harbor was available in respect of the distributions that the surgeons would receive from their anesthesia company. The ASC investment safe harbor does not apply to protect distributions of anesthesia profits. Even if the safe harbor for payment to employees applied, or if the safe harbor for personal services contracts applied, those safe harbors would protect payments to the anesthesiologists. But they would not apply to the company model profits that would be distributed to the surgeons, and such remuneration would be prohibited under the AKS if one purpose of the remuneration is to generate or reward referrals for anesthesia services.

Because, as mentioned above, the failure to qualify for a safe harbor does not automatically render an arrangement a violation of the AKS, the OIG then turned to an analysis pursuant to the 2003 Special Advisory Bulletin and found that the physician-owners of the proposed company model entity would be in almost the exact same position as the suspect joint venture described in the bulletin: that is, in a position to receive indirectly what they cannot legally receive directly—a share of the anesthesiologists' fees in return for referrals.

Therefore, the OIG stated that the proposed company model venture could potentially generate prohibited remuneration under the AKS, and the OIG potentially could impose administrative sanctions on the requestor. In other words, the OIG declined to approve the arrangement.

Advisory Opinion 13-15

On November 12, 2013, the OIG released Advisory Opinion 13-15 dealing with a situation closely akin to a "company model" deal. *[Note to reader: In full disclosure, the author was counsel to the anesthesia group in its request for Advisory Opinion 13-15.]*

Underlying 13-15 was a proposed arrangement whereby a psychiatry group performing electroconvulsive therapy (ECT) procedures at a hospital would capture the difference between the amount it collected for anesthesia for ECT patients and the per diem rate it would pay to the anesthesia provider.

Initially, an anesthesia group held the exclusive contact to provide all anesthesia services at a hospital (Hospital). Then, in late 2010, a psychiatry group with a practice centering on performing ECT

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procedures relocated to the Hospital. "Dr. X," board certified in both psychiatry and anesthesiology, is one of the psychiatry group's owners.

In 2011, the anesthesia group began negotiating with the Hospital for the renewal of its exclusive contract. The Hospital demanded an initial carve out: Dr. X would be allowed to independently provide anesthesia services to ECT patients.

The following year, when negotiating the 2012 renewal, the hospital demanded amendments to the carve-out provision:

- Dr. X would be allowed to provide anesthesia services to ECT patients and the anesthesia group would be required to provide coverage for Dr. X.
- Pursuant to what was called the "Additional Anesthesiologist Provision," the psychiatry group would determine if an additional anesthesiologist was needed for ECT anesthesia. If so, the anesthesia group would negotiate to provide those services. If the anesthesia group and the psychiatry group did not come to terms, then the psychiatry group or Dr. X could contract with an additional anesthesiologist.

Subsequently, the psychiatry group informed the anesthesia group that an additional anesthesiologist was needed. The parties began negotiating. Under the proposed arrangement presented to the OIG, the anesthesia group and the psychiatry group would enter into a contract pursuant to which the anesthesia group would provide the additional ECT anesthesia services. The anesthesia group would reassign to the psychiatry group its right to bill and collect for the services. The psychiatry group would pay the anesthesia group a per diem rate. The psychiatry group would retain the difference between the amount collected and the per diem rate.

OIG's Analysis

The OIG has stated on numerous occasions that the opportunity to generate a fee could constitute illegal remuneration under the AKS even if no payment is made for a referral. Under the proposed arrangement, the psychiatry group would have the opportunity to generate a fee equal to the difference between the amount it would bill and collect and the per diem rate paid to the anesthesiologists.

The OIG found that the proposed arrangement would not qualify for protection under the AKS's safe harbor for personal services and management contracts. That safe harbor protects only payments made by a principal (here, the psychiatry group) to an agent (here, the anesthesia group); *no safe harbor would protect the remuneration the anesthesia group would provide to the psychiatry group by way of the discount between the per diem rate their group would receive and the amount that the psychiatry group would actually collect.*

Because failure to comply with a safe harbor does not render an arrangement per se illegal, the OIG then analyzed whether, given the facts, the proposed arrangement would pose no more than a minimal risk under the AKS.

The OIG flatly stated that *"the proposed arrangement appears to be designed to permit the psychiatry group to do indirectly what it cannot do directly; that is, to receive compensation, in the form of a portion of the anesthesia group's revenues, in return for the psychiatry group's referrals of patients to the anesthesia group for anesthesia services."*

The OIG concluded that the proposed arrangement could potentially generate prohibited remuneration under the AKS and that the OIG could impose administrative sanctions in connection with the proposed arrangement. In other words, the OIG declined to approve the arrangement.

Advisory Opinion 13-15 demonstrates a fact lost to many when discussing company model deals: they generally do not fit into an available safe harbor—either the personal services and management contract safe harbor or the employee safe harbor. Not only is this because payment is not set in advance and will vary with the value or volume of referrals, but even more fundamentally, because those safe harbors apply only to payments from the principal to the agent, *not to payments, that is, remuneration, from the agent to the principal.* In 13-15, the discount that permits the referral source to profit from the arrangement is *remuneration to the principal.*

Second, although failure to fit within a safe harbor is not ipso facto fatal, the OIG has again illustrated that being put in a position to profit from one's referrals raises significant concerns of prohibited remuneration—that is, of violation of the AKS. Note that payment of so-called "fair market value," the supposed holy grail of anti-kickback analysis, is not a panacea. Deals that place the referral maker in the position of profiting from its referrals are

highly suspicious even in the face of valuation studies and valuation opinions.

The Bottom Line on the Company Model

The term "company model" is an industry descriptor of certain types of arrangements. It's not the case that any specific law or regulation makes, in blanket fashion, company model deals illegal.

In similar fashion, although they give great insight into the minds of the federal enforcers of the AKS, that is, of the OIG, advisory opinions themselves are binding only on the specific requestor. As such, courts do not defer to the opinions as creating any sort of precedent. The AKS is a criminal statute, and, as such, intent to provide/accept remuneration to induce referrals must be proven. That means that the analysis is highly fact-specific.

In similar fashion, when an alleged company model scheme underlies a federal False Claims Act (i.e., whistleblower) lawsuit, specific facts relating to the kickback-tainted claims for payment must be pleaded with particularity, although there is some variance among the federal court circuits as to the required degree.

For example, in 2017, the False Claims action brought by the Florida Society of Anesthesiologists against a number of surgeons and facilities based on allegations of company model arrangements (*U.S.* ex rel. *Florida Society of Anesthesiologists v. Choudhry*) was dismissed after the Florida Society failed three times to plead sufficient facts to withstand the defendants' attack on its pleadings.

The bottom line is that each arrangement within the rubric of the company model must be scrutinized extremely carefully. The "chance" of criminal conviction, or of civil judgment on the False Claims front, may be low, but the criminal penalties (jail time, civil monetary penalties, exclusion from participation in federal healthcare programs) and trebled civil damages judgments are high. Low odds times high penalties equal high risk.

Management Services/Expense-Shifting Arrangements

Let's turn to another category of often-seen, highly questionable arrangements: the imposition of management fees or other expenses on the anesthesia providers, or, as illustrated by the return, below, to Advisory Opinion 12-06, to the proposed *offer* to pay such fees.

Back to Advisory Opinion 12-06

As you'll recall from the discussion above, the anesthesia group requesting Advisory Opinion 12-06 presented a second scenario, one involving a management fee arrangement. In that arrangement, the anesthesiologists would not meld into a company model structure. Instead, the existing anesthesia group would continue to serve as the ASC's exclusive provider of anesthesia services. And accordingly, the group would continue to bill and collect for its own account.

However, the group would begin paying the ASCs for "management services," including preoperative nursing assessments; adequate space for all of the group's physicians, including their personal effects; adequate space for the group's physicians' materials, including documentation and records; and assistance with transferring billing documentation to the group's billing office.

Although both Medicare and private payers set their reimbursement to the ASCs taking into account the expenses of the type included within the management fee, the ASCs would continue to bill Medicare and private payers in the same amount as currently billed. The management fee would be at fair market value and determined on a per patient basis. No management fee would be charged in connection with federal healthcare program patients.

Consistent with its longstanding viewpoint, the OIG found that carving out federally-funded patients was ineffective to remove the proposed arrangement from within the purview of the AKS, because the payment of the fee in connection with private payers would influence the decision to refer all cases, thereby not reducing the risk that their payment is made to induce the referral of the federally-funded ones.

The OIG stated that the AKS seeks to ensure that referrals will be based on sound medical judgment, and competition for business based on quality and convenience, instead of paying for referrals. But under the management fee proposal, the ASCs would be paid twice for the same services: by Medicare or by the private payer via the facility fee, and then also by the anesthesiologists via the management fee. That double payment could unduly influence the ASCs to select the requestor as the ASCs' exclusive provider of anesthesia services. Therefore, the OIG concluded that the management fee arrangement could potentially generate prohibited remuneration under the AKS, and that the OIG potentially could impose administrative sanctions on the requestor.

Sweet Dreams

In August 2016, the U.S. Attorney for the Middle District of Georgia, joined by Georgia's Attorney General, announced a civil settlement with a series of anesthesia businesses collectively known as Sweet Dreams Nurse Anesthesia (Sweet Dreams).

In that settlement, Sweet Dreams agreed to pay $1,034,416 to the U.S. government and $12,078.79 to the State of Georgia to resolve allegations that it violated (*due to underlying AKS violations*) the False Claims Act and the Georgia False Medicaid Claims Act.

Sweet Dreams was alleged to have entered into arrangements with ASCs to provide the facilities with free anesthesia drugs in exchange for exclusive anesthesia agreements. Like the elements of the "management services" that the requestor

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anesthesia group proposed to provide to the surgery center in Advisory Opinion 12-06, anesthesia drugs are a part of the expenses covered by the facility fees paid by Medicare, Medicaid and other payers.

By either providing the drugs itself, or reimbursing the ASCs for the cost of drugs, an anesthesia group puts itself in the position of providing what is essentially double payment to the ASC: once from the anesthesia group and once from Medicare or the other payer. That double payment could unduly influence the ASC to select the group as the ASC's provider.

The allegations announced in connection with the Sweet Dreams settlement were, for the most part, similar to commonly observed kickback demand/offer situations: the demand or offer to provide personnel to work in the ASC, the provision of drugs, the provision of supplies, the provision of anesthesia machines and so on. However, another allegation may be one of a kind: That they agreed, through an affiliate, to fund the construction of an ASC in exchange for contracts as the exclusive anesthesia provider at that and a number of other ASCs.

Southern Crescent Anesthesiology

We've all probably seen them: unpaid medical directorships. Yes, sometimes they're demanded by a facility, from ASCs to hospitals, as a part of the "deal" for an exclusive contract. And sometimes they're offered by the anesthesia group to induce the facility to choose it as the exclusive provider.

But free isn't always free. Sometimes it costs millions, as in the 2018 settlement of allegations that CRNA David LaGuardia (LaGuardia) and his anesthesia entities Southern Crescent Anesthesiology, PC (SCA) and Sentry Anesthesia Management, LLC (Sentry) provided a free medical director to an ASC.

The portion of the settlement allocated to the free directorship wasn't specifically disclosed, because it was part of an overall $3.2 million settlement paid to the federal government by a medical practice (Georgia Bone & Joint), an ASC (Southern Bone & Joint, aka Summit Orthopaedic Surgery Center) and La Guardia, SCA and Sentry that also resolved allegations that Georgia Bone & Joint and LaGuardia submitted false claims to Medicare for non-FDA approved prescription drugs purchased outside the U.S.

The Bottom Line on Management Services/Expense-Shifting Arrangements

Although on the first level, they might appear to be commercially reasonable, arrangements by which anesthesia groups provide anything of value to or for a facility in connection with the right to provide services to patients is fraught with AKS danger. This is true whether the items or services are demanded by the facility or a surgeon . . . or offered by the anesthesia group. Same issue. Same bottom line. Same potential crime.

Just as in connection with the company model arrangements discussed above, the legal issues are highly complex and involve compliance with a *criminal* law statute, the AKS. Anyone confronted by, or designing, an arrangement that potentially violates the AKS must obtain counsel well versed in the issues.

Last, but not least, in answer to the question I suspect lurks in the minds of readers ("But Mark, how will I ever get caught?"), it pays to know that many cases come to light as the result of whistleblowers, whether actual whistleblowers under the FCA or just those who "drop the dime" by contacting the OIG or other federal or state authorities to report what they think might be a crime. You have to pay attention to the fact that many whistleblowers are insiders, including physicians and medical group or facility employees. Whistleblower Adam Nauss, who worked with Sweet Dreams for several years, received a portion of the settlement. So, too, did whistleblower Sharon Kopko, the former practice administrator at Georgia Bone & Joint and Summit Surgery Center.

Picture each of your employees and colleagues with a whistle around their neck.

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Motivating Your Group to Deliver Value: Incentives That Work

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There is a lot of talk in anesthesia and all of medicine and healthcare today about providing value.

These discussions primarily focus on providing value to important constituents (such as a hospital) so that the anesthesia group can continue to work with the institution. But anesthesia groups work with a variety of stakeholders, and each of these stakeholders has different needs and, therefore, a different measure of value.

Patients are looking for:

- Excellent quality care
- Effective communication

Hospitals want:

- Excellent quality care
- No problems
- Physician participation on hospital committees, programs and initiatives
- Cost savings

Payers want:

- Excellent quality care (at least they say they do)
- Low cost

And the anesthesia group itself wants value from group members to support efforts to meet the needs of the stakeholders above and the needs of the group itself.

Motivating Group Members

One would think that anesthesiologists would have a natural motivation to continually look for ways to provide value

to these stakeholders. However, many anesthesiologists believe that as long as they provide excellent quality care, all the other considerations are irrelevant.

In fact, becoming an owner in a private anesthesia practice requires the following:

- Show up and do the work for several years (pay your dues).
- Don't hurt anyone (provide good clinical care).
- Don't tick off any of the shareholders (make them like you).

In most anesthesia groups, once a shareholder track group does these things, they become owners/shareholders with no further expectations. This stands in stark contrast to other professions, in which those given a vote must show, in advance, that they:

- Bring something special to the organization, beyond technical ability (such as special expertise, being a "rainmaker," strong leadership skills, or other special skills).
- Do work beyond the professional/technical work to grow and develop the organization.
- Are willing to adopt and adhere to the group's normative behaviors, primarily regarding governance. Normative behaviors are the traditions, behavioral standards and unwritten (or written) rules that govern how a group functions.

Given the fact that, in many cases, anesthesia group shareholders have limited expectations to do anything (other than provide clinical care), anesthesia group leaders need to look at various ways to motivate group members to focus on and provide the value that stakeholders demand.

So how do you motivate physicians? What incentives have a better chance of working?

Studies have shown that there is probably no such thing as a universal motivator. Some are motivated by money, whereas others are motivated by time off, recognition or other factors.

In his excellent book, *Leading Leaders,* Jeswald Salacuse points out that physicians are what he calls "elites." Elites are individuals who have brains, talent, wealth, power and many options. He notes that "motivating them [the elites] is a lot like shopping for the person who has everything." In fact, he points out that different people have different motivations,

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and therefore, group leaders need to figure out what those motivations are. This means that group leaders have to get to know their members very well, a process that usually requires one-on-one interaction, in order to target the right incentives for the individual. It's not a one-size-fits-all proposition.

Incentives

So what incentives should be considered to help motivate anesthesiologists to provide value?

Many people start with money, thinking that it is the only way to motivate people. There are two key problems with believing that money is the end-all-be-all:

1. If money is the only incentive you use, people will only do the things that generate money. Anesthesiologists often see this in their compensation system. We have seen many situations where the physicians only do the things that directly generate dollars for themselves, whether that means covering their assigned shifts so that they receive their portion of the equal share compensation, or only doing the things that generate "points" under their productivity system. In these circumstances, other extremely important tasks (such as governance activities) are left to those who understand that the stakeholders want more value than just the clinical services.
2. We are living in a world where economic pressures are such that everyone has to do more with less. Often, a pool of money can't be drawn up to motivate every type of desired behavior.

Engage Group Members

So what are some options to incentivize anesthesiologists? Here are a few ideas.

An unstated thought of many physicians is "How good can an idea be if I haven't been a part of developing it?"

If physicians don't have input into how the practice is governed or the plans for the future, they don't have much of an incentive to follow the leadership or implement the plans. This is why group leaders need to find ways to include group members in practice governance activities.

One way is to bring group members together for strategic planning sessions where the membership discusses and debates the group's mission (what we are about as an organization), values (what is important to us) and vision (where we are heading as a group).

Another way to engage group members is with the effective use of committees. The group should identify the needed committees and then give them important work to do. This "shares the load" and helps the group members feel more involved and informed. But to be successful, the board should:

1. Create a charter that outlines the committee's job and work plan for the coming year.
2. Have the committee work on an issue before the board considers it in detail.
3. Make every effort to accept the committee's recommendation. Why? If the board always rejects the committee's recommendations or re-does the work, the committee will reach the conclusion that their thoughts are not being considered and stop doing the work.

Support Group Leaders

Every group needs individuals who will step up and perform important leadership tasks for the organization. This work can include:

- Directing group governance activities
- Dealing with external third parties, such as the hospital and payers
- Operational activities, such as recruitment and scheduling
- Dealing with disruptive physician behavior

These leaders definitely need administrative time to perform these functions. It is unreasonable to expect them to sacrifice their personal time year after year for the group's benefit.

Further, it is unlikely that all the work required of these individuals can be done during the work day. Much of it must be done after hours. Therefore, many groups do carve out monies to be used as stipends for this leadership work.

Over the years, we have heard all the arguments against the practice of paying leaders. These arguments include:

- "We should all share the administrative work equally."
- "This administrative work is not needed. The only important work is the clinical care. The rest of the world will take care of us."
- "The leaders will do it for free. See, they already are."
- "The leaders also benefit from the work they do."
- "We don't want to pay very much or people will do it only for the money."

- "If we pay for one thing, we will have to pay for all things."

These are all smokescreens that individuals use to get the milk for free.

Establish Normative Behaviors

What do normative behaviors have to do with incentives and motivation? If disruptive behavior in a group is not addressed, it can demoralize group members and create a disincentive for improving the practice and providing value.

Normative behaviors should not be overlooked. In 2012, Google embarked on an initiative, code-named Project Aristotle, to study Google's teams and figure out why some worked well and others did not. They looked at 180 teams across the company. The researchers found that what distinguished good teams from dysfunctional groups was how the teammates treated each other. They found that the right normative behaviors raised a group's collective intelligence, whereas the wrong normative behaviors impeded a team, even if the individual members were exceptionally bright.

This is why more groups are developing a written Code of Conduct and a system to deal with those who do not meet group standards of behavior.

As noted in an earlier *Communiqué* article ("Disrupting the Disruptive Physician," winter 2018), a Code of Conduct is the agreed upon standards of behavior among group members. It sets out, in general terms, the reasonable standards and duties for the group's professionals. It is a sort of "rules of the game" for the organization.

Anesthesia groups create a Code of Conduct for the following reasons:

- As a vehicle to communicate what the group considers important about physician behavior and conduct.
- To improve the group's chances of continuing to have the freedom to govern itself.
- As a method to hold errant physicians in check without making them feel they are under personal attack.
- As a vehicle to remove personalities and private opinions if it becomes necessary to intervene.

What should be considered in a Code of Conduct? Medical groups tend to focus on answering the following questions:

1. What behaviors do we expect of each other? What is acceptable to us? What is inappropriate?
2. What are some of the unwritten rules that guide our behavior that that we should write down so they are universally understood?
3. What are each physician's rights and responsibilities?

Recognition

Group leaders must act in an intentional manner to recognize individuals in the group who have provided important service, especially those who have made significant sacrifices. This means that recognition should be included periodically in board meetings.

But the leadership should not forget those who sacrifice by doing extra clinical work so that group leaders can attend meetings with external third parties during the clinical day. A formal thank you (at a group meeting or with a note) for such service goes a long way. Some groups send thank you notes with a small gift certificate. This doesn't fully compensate for the time, but it does show appreciation for the sacrifice.

Other Incentives

Many other incentives can be used to motivate individuals. Examples include:

- Using time off/vacation as a reward for exceptional performance or exceptional sacrifice.
- Supporting additional, specialized training with time and expense reimbursement. Several groups we know of provide time and expense reimbursement for future group leaders to attend a Master of Business Administration program.

Summary

To sum up:

1. Anesthesia group stakeholders require value, and the value expected goes beyond providing excellent clinical care.
2. Group members will often need to be motivated to provide value. Providing this motivation requires using targeted incentives.
3. While economic incentives can be part of the plan, over-reliance on money can create problems.
4. Other incentives should be a part of the leader's toolbox.
5. Leaders must do the tough work of understanding which incentives will motivate an individual member.

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.

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Professional Events

Date	Event	Location	Contact Info
January 7-10, 2019	J.P. Morgan 37th Annual Healthcare Conference 2019	Westin St. Francis Hotel San Francisco, CA	https://www.jpmorgan.com/global/healthcareconference
January 18-20, 2019	American Society of Anesthesiologists PRACTICE MANAGEMENT™ 2019	Paris Las Vegas Hotel & Casino Las Vegas, NV	http://asahq.org/practicemanagement
January 27- February 1, 2019	California Society of Anesthesiologists 2019 Winter Anesthesia Conference	The Westin Maui Resort & Spa, Ka'anapali Maui, HI	https://www.csahq.org/continuing-medical-education/events/details/2019/01/28/cme-events/csa-2019-winter-meeting
February 9-10, 2019	Arizona Society of Anesthesiologists 45th Annual Scientific Meeting	Hilton Scottsdale Resort & Villas Scottsdale, AZ	http://www.az-anes.org/annualmeeting/2019/annualmeeting.html
February 11-15, 2019	Healthcare Information and Management Systems Society 2019 Conference and Exhibition	Orange County Convention Center Orlando, FL	http://www.himssconference.org/
February 15-16, 2019	Georgia Society of Anesthesiologists 2019 Winter Forum	Crowne Plaza Atlanta Perimeter at Ravinia Atlanta, GA	https://gesa.memberclicks.net/winter-2019-meeting
March 7-10, 2019	California Society of Anesthesiologists 2019 Annual Meeting and Workshops	JW Marriott Desert Springs Resort & Spa Palm Desert, CA	https://www.csahq.org/continuing-medical-education/events/details/2019/03/07/cme-events/csa-2019-annual-meeting
March 9, 2019	Michigan Society of Anesthesiologists 64th Annual Scientific Session	The Henry Hotel Dearborn, MI	https://www.mymsahq.org/Events/AnnualScientificSession.aspx
April 1-4, 2019	Becker's Hospital Review 9th Annual Meeting	Hyatt Regency Chicago Chicago, IL	http://www.beckershospitalreview.com/conference/

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