

PROTECTING YOUR EXCLUSIVE CONTRACT, YOUR PRACTICE AND YOUR PROFITS

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In these turbulent times for the business of anesthesia groups, in which the pace of, to use Joseph Schumpeter's term, "creative destruction," is quickening, it is more important than ever to take a strategic approach to the way in which exclusive contracting and group structure and group functions are intertwined. To simply keep on keeping on with a pure focus on patient care, thinking business success, or even business survival, will follow, is folly.

Consider this very instructive example:

In the late 1920s, Walt Disney had his first big commercial success with a cartoon character named Oswald the Lucky Rabbit.

Disney had an exclusive contract with Universal Pictures for the distribution of



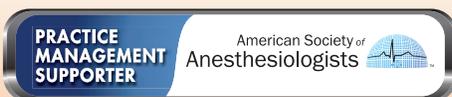
Oswald cartoons. It paid Disney a tidy cut, but not nearly enough. So Disney, based in Burbank, set off on the train for Universal's headquarters in New York City to renegotiate the terms of the deal.

Continued on page 4

► INSIDE THIS ISSUE:

- Protecting Your Exclusive Contract, Your Practice and Your Profits 1
- 2012: There Is Much To Do 2
- The Benefits Of Strategy 3
- CMS Finally Speaks (Again): The Medicare Shared Savings Program Final Rule and its Relevance to Anesthesiologists 8
- What Is Your Value Proposition? Is Your Practice the Steak or the Sizzle? . . 12
- Federal Insurance Legislation - Can It Help Me? 17
- Compliance Corner: Practices Should Prepare for More Audit Activity . . 20
- Event Calendar 24

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2012: THERE IS MUCH TO DO

From day to day, the great majority of anesthesiologists, nurse anesthetists, anesthesiologist assistants and their group practices provide excellent patient care. Most enjoy comfortable relationships with their hospitals and surgery centers, too.

The world of health care is changing all around us, though. Every anesthesia practice needs to understand the more important changes and to adapt, or plan to adapt. In this issue of the Communiqué, you will find a number of articles that will help you prepare for the short-term and long-term future.

We start with Mark Weiss, Esq.'s *Protecting Your Exclusive Contract, Your Practice and Your Profits*. Mr. Weiss aptly shows that the process of negotiating your next hospital contract starts the moment you have signed this one. The anecdote about Walt Disney's arrival at Universal Pictures' headquarters in New York to renegotiate the terms of their deal, only to find that Universal, not he, held the copyright in his cartoon character and that Universal had hired away Disney's cartoonists is aptly chosen. Preparing to negotiate your next hospital contract also requires a complete understanding of the present agreement and solid relationships not just between the hospital and the group, but also between the group and its anesthesiologists.

ABC's Arne Pedersen takes the issue of planning farther out in time in his article *The Benefits of Strategy*. Mr. Pedersen reviews four major benefits of a strategic plan – providing a format or venue for a group to address issues; elucidating strategic objectives; allowing the group to coalesce around the strategic objectives, and accountability – and concludes that taking advantage of the benefits of strategy will permit the group to dictate its own future.

The strategic planning process, especially for larger groups with high aggregate expenses, might include an objective of obtaining better value in its insurance contracts. Sara Carpenter, CPA, CFO of Doctors & Surgeons National Risk Retention Group, explains the origins of the

risk retention group alternative to traditional malpractice insurance in *Federal Insurance Legislation – Can It Help Me?* With a 25-year history, the risk retention industry has established a solid track record and a risk retention product should be on the radar of any group interested in changing its professional liability coverage.

A regular subject of planning in anesthesia practice is compliance. Abby Pendleton, Esq. and Jessica Gustafson, Esq. provide an overview of enhanced governmental and private sector activity in monitoring claims for physicians' services in *Anesthesia Practices Should Prepare for More Audit Activity*. The attorneys suggest three strategies: (1) focus on documentation improvement, (2) stay on top of payer policies and guidelines and (3) engage in educational activities.

In his article *What Is Your Value Proposition? Is Your Practice the Steak or the Sizzle?*, ABC Vice President Jody Locke describes different strategies that groups wishing to secure their future should consider. First, identify the stakeholders: group members, surgeons, patients, administration and operating room staff, typically, as well as the objective of each. Then build solid lines of communication to each and determine how to provide the service that will make your group more valuable than competitors queuing up to take your place. Understand, for instance, that patient satisfaction to a hospital administrator means many things beyond a successful patient outcome.

What is the "sizzle?" It includes exceeding "customers'" expectations – not just explicit expectations, but even those that the customers themselves have yet to articulate. The hospital does not necessarily expect the anesthesiology group to initiate programs to improve drug and technology management, for example, but these are among several areas where anesthesiologists might prove their unique value. The group that takes risk while defining new opportunities to create value is a committed and valued partner.

The final regulations on Accountable Care Organizations (ACOs) appeared on

November 2, 2011. Greater flexibility in eligibility and in governance of ACOs, simpler quality performance standards and especially the creation of a "track" that does not involve financial risk sharing make it easier to launch ACOs, as explained by Neda Mirafzali, Esq. and Kathryn Hickner-Cruz, Esq. in *CMS Finally Speak (Again): The Medicare Shared Savings Program Final Rule and Its Relevance to Anesthesiologists*. ACOs and other new healthcare delivery system models that tie payments to quality and efficiency achievements are very much part of anesthesiologists' future.

The ability to participate fully in ACOs and more generally in shared savings programs with other providers and with payers is central, we believe, to anesthesia groups' longer term survival. Many readers supported that view in their responses to a survey that we conducted in October, 2011. That is why we are launching the Zenith Anesthesia Practice Network, which will allow client anesthesiologists to engage collectively in clinical quality data gathering and benchmarking, among other activities including group purchasing. We will keep you aware of its development in future issues of the Communiqué. We will also willingly consider your ideas for other topics that we might address – and of course welcome proposals for articles that you may be interested in writing.

With all good wishes for continuing success in 2012,



Tony Mira
President and CEO



THE BENEFITS OF STRATEGY

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There are many forces affecting anesthesia groups today such as the pending Supreme Court ruling on the Patient Protection and Affordable Care Act, high unemployment, pending cuts in Medicare, and a very slow economy. Regardless of what one believes, strategically addressing these issues is paramount in providing the necessary road map for the future. Otherwise, a group may find itself in an unfavorable position. This article seeks to explore the benefits of strategy for anesthesia groups.

By definition, strategy¹ is “a plan, method, or series of maneuvers or stratagems for obtaining a specific goal or result: a strategy for getting ahead in the world.” Clearly, developing strategy positions a group for success. Furthermore, Sun Tzu describes the importance of thinking through strategy as such, “the general who wins a battle makes many calculations in his temple where the battle is fought. The general who loses a battle makes but few calculations beforehand. Thus do many calculations lead to victory, and few calculations to defeat: how much more no calculation at all! It is by attention to this point that I can foresee who is likely to win or lose.”² Again, in order to get ahead in the world, it is clearly better to take the proactive steps than not.

With that said, a strategic plan provides various benefits for anesthesia groups including:

1. Appropriate venue to address issues
2. A set of strategic objectives as part of the road map



3. An avenue to coalesce a group around the strategic objectives
4. An accountability tool for a group to see how the leadership is guiding for the future

It is important to note that a strategic plan is just that, a strategic plan. It is not set in stone. It is also not a detailed business plan. Business plans, however, are borne out of strategic objectives from a strategic plan.

APPROPRIATE VENUE

The strategic planning process is an appropriate venue to address issues for three specific reasons. The group will have open and honest discussions about the strategic direction given a variety of issues. The group will also begin to form strategic objectives during this process. Finally, the group will focus on the development of the strategic objectives.

Since this is the venue for open and honest discussions, appropriate rules and etiquette are in order for the duration of the conversations. An informal use

of Roberts Rules of Order is always applicable. Depending upon how a group interacts, it may be necessary to have an experienced facilitator who can help guide a group through these discussions. This leads to the next point of developing strategic objectives.

STRATEGIC OBJECTIVES

The discussions will need to converge on a set of strategic objectives for the group. Whether a group does it on its own or through a facilitator is not the point. The point is that the outcome from the discussions needs to be a set of strategic objectives. Strategic objectives are not specific business plans. They are objectives that a group will use to focus their practice toward in the future. These objectives may be offensive or defensive in nature. The objectives will have some parameters around them, which includes various factors. For example, a group may develop a strategic objective to address the issue of a very slow economy by taking both defensive and offensive approaches. The defensive approach may include a hiring freeze as an example. The offensive approach may include aggressively growing the practice through additional practice opportunities at other hospitals and ambulatory surgery centers. There certainly would be several factors involved, including cash flow, to take into consideration.

COALESCE A GROUP

Another benefit is that strategic planning will help a group to coalesce around the strategic objectives. The strategic planning process sharpens the vision for the group; clearly delineates the

¹ strategy. Dictionary.com. Dictionary.com Unabridged. Random House, Inc. <http://dictionary.reference.com/browse/strategy> (accessed: December 06, 2011).

² Sun Tzu, The Art of War

PROTECTING YOUR EXCLUSIVE CONTRACT, YOUR PRACTICE AND YOUR PROFITS

Continued from page 1

But Universal knew he was coming. And they knew what he wanted. They had signaled clearly that they were looking out for their own interests and that they controlled the power in the relationship—in fact they had made overtures, which had been rebuffed, to buy Disney out and employ him.

So while Disney was on his way to New York, Universal's agents hired away his staff of cartoonists. And when Walt arrived, he was surprised to learn that his company's original agreement with Universal had signed over to Universal all of his intellectual property rights to the Oswald character.

Walt's problems were that he thought that he had a team and that he thought that he had value in the underlying business assets: the rights to Oswald. But his team was loosely organized and not at all bound to his business so they were free to leave. And, he didn't understand the intricacies of his exclusive contract with Universal which gave the distributor ownership of the Oswald character.

Of course, although not exact, the analogy between the Disney-Universal

situation and many anesthesia group-hospital relationships is tight.

Many anesthesia group leaders operate under the mistaken assumption that their group's business will simply continue on and on, even if they have not paid proper attention to protecting it, either in respect of the relationship with the hospital or the relationship between the group and its physicians.

Many anesthesia groups fail when disgruntled members or employed or subcontracted physicians break away, undercutting the group, its business operations, and sometimes its very existence.

Hospitals often have the same motivation as Universal did, but in respect of anesthesiologists, not cartoonists. They want to gut the group of its leadership, directly employ the anesthesiologists or put them into an ACO vehicle and, voilà, the business of the former group will be theirs. The analogy holds true for the staffing agencies masquerading as so-called national groups as well, as they often gain their foothold by luring away a group's providers.

PROTECTING YOUR PRACTICE

In this article, we'll focus on a few of the many elements of a larger process that I call The Practice Protector Process™ that serves as a series of guideposts for preserving and continuing your group's exclusive contract relationship with the hospital. More information on the Process is available at www.advisorylawgroup.com/thepracticeprotector.html.

Many of the same elements apply in obtaining an initial contract and, importantly, in expanding the business of your group to provide services at multiple facilities.

Additionally, and even though for

simplicity's sake we will break preserving your exclusive contract relationship into three temporal categories, the reality of the situation is that nearly everything your group does and nearly every interaction your group and its physicians, other providers and employees have, whether with regard to patients, referral sources, the hospital or any other influencers, have a bearing on your group's ability to extend and renew its exclusive contract. Many of those elements are not themselves time specific.

The Before Stage

For purposes of this discussion, let's draw a distinction between the time before and the time after the commencement of *traditional* negotiation of an exclusive contract.

In other words, if you were to ask nearly everyone to explain when the negotiation over the renewal of an exclusive contract begins, they would say when we first have a discussion with the hospital concerning the renewal, whether that's an oral conversation or the exchange of something in writing.

And, of course, they would be one hundred percent wrong.

As I mention above, because what you're doing many months, and even years, before you get to that point—that point being what I call the “face-to-face” stage—influences what happens during the face-to-face stage, those actions and events must be considered negotiation if you are to stand any chance of achieving a transformational result.

So, let's refer to what happens before the face-to-face stage as the “Beginning Stage.”

Among other things, during the Beginning Stage you want to make sure that you do not allow yourself to be put





into the same situation that Disney found himself in when his entire team was poached by Universal. The relationship between the group and its owners, and between the group and its subcontractors/employees must be examined, strengthened and documented.

Additionally, the governance structure within the group must be questioned and, if need be, revamped in order to permit it to quickly make the necessary strategic and tactical decisions that successful contracting entails.

Optimally, the group should engage in a Publicity Push™ strategy which includes, but is in no way limited to, a preemptive strike against competitors' claimed features and benefits.

Although these items give you the flavor of what should be occurring during the Beginning Stage, they're simply a few of the many elements of the larger process.

So, for example, if we take a typical group practicing at the fictitious Community Memorial St. Mark's Hospital, with a three-year contract that renews in a year and a half, if they're just beginning the process, they are already a year and a half late.

Let's assume they get moving fast, realizing that their 17 member, rule-by-

consensus management committee has never been, and never will be, able to make quick strategic, or even tactical, determinations. They move to correct that.

They examine each of the group's organization-physician relationships and the way they are documented and take steps to preserve the ties that bind members to the group, even though covenants not to compete are not enforceable in their state.

Based on information developed through the Practice Protector Process, they create multiple initiatives to build support and engage in an active push for publicity and to create foreshadowing, both public and private.

The During Stage

For purposes of our discussion, we'll use the term of the "During Stage" to describe the goings on during the face-to-face stage of the negotiation—the part of the negotiation that most groups mistakenly believe is the entire negotiation.

Of course, the During Stage is far more complex than the actual across-the-table discussions. Think of it as consisting of multiple subcategories, a few of which are discussed below.

Although it may appear as if the negotiation is being conducted between two parties—your group and the hospital, the reality is often very different. There are often significant influencers, for example, medical staff leadership, influential surgeons, and, in some cases, the community at large, that can have, if used properly, a tremendous impact on the outcome.

Thus, for example, in recent negotiations my clients and I have deployed various forms of recommendations and endorsements both from within and outside the medical staff. In appropriate situations, we've also intertwined the process with the use of media relations.

You must develop a strategy and deploy tactics to exert control over the negotiation process itself. The group's negotiating team, led by experienced counsel and comprised of group members empowered to make decisions, must follow a negotiating strategy consistent with the group's overall business strategy. At all costs, your group must avoid "negotiation by ambush" in which hospital administrators seek to pull group leaders—often those most easily influenced—into impromptu meetings, or even into a hallway chats which, to a hospital administrator, *are* meetings, to "discuss" deal points.

As to the deal points themselves, and, obviously there are deal points in common in almost every exclusive anesthesia contract negotiation, most groups and their advisors make the mistake of focusing simply on the issues as they impact the group's performance obligations in favor of the hospital and the hospital's obligations to the group.

But what's often missed is that exclusive contracts also generally contain provisions that have an impact, sometimes a severe impact, on the relationship between the group and group members—both owners and employees.

PROTECTING YOUR EXCLUSIVE CONTRACT, YOUR PRACTICE AND YOUR PROFITS

Continued from page 7



An obvious example would be a provision permitting the hospital to remove a physician from the roster of providers pursuant to an exclusive contract. For a group that provides services at only one hospital, what's the impact of any particular physician no longer having the ability to provide services on behalf of the group? Obviously, and for purposes of this discussion I'm not addressing whether or not a provision like that is appropriate, if your group can no longer use the services of that doctor, then that relationship is going to end—but what does the agreement between the group and that physician, for example, the shareholders agreement or employment agreement, provide in that regard?

That's just a very simple circumstance—the real impact is much more complex—how can actions permissible under an employment agreement trigger breaches pursuant to the exclusive contract? How can performance under the exclusive contract trigger breaches under the employment

agreement? How can action permissible under an employment agreement result in the loss of your exclusive contract in favor of a new contract in the name of the former employee?

The After Stage

Lastly, we'll use the term of "After Stage" to describe the events following the execution of the agreement.

Ah, but wait! If you've been reading carefully, you know that there really is no After Stage.

Just as August Kekulé said that his vision of a snake eating its own tail (an Ouroboros) inspired his discovery of the structure of the benzene ring, that image should inspire your realization that the "After Stage" is the same as the start of the Beginning Stage: as soon as the ink is dry on this year's renewal agreement, your group's actions and interactions begin to influence the renewal, or nonrenewal, of the agreement two or three years hence.

BACK TO OSWALD

As we come to a close, there is a second aspect to the Oswald story that's instructive for anesthesia group leaders.

Oswald the Lucky Rabbit didn't turn out to be so lucky for Universal after all. That's because it made a rather elementary error: it believed that the value in the Disney enterprise resided in its copyrights and its cartoonists—after all, Walt wasn't the one who actually drew the cartoons—which it, Universal, could capitalize on through its movie distribution system.

But under Universal, Oswald failed, because the real value was in the intellectual capital, the spark, residing in Disney himself. Soon after the Oswald debacle, Disney regrouped, Oswald the Lucky Rabbit morphed into Mickey Mouse and the rest became history.

If your group already has that spark, develop it and use it to your advantage in the full range of negotiation. If it doesn't have it, then you either have to develop it, which is possible with the right approach, or start practicing the words, "excuse me, when can I pick up my paycheck?" ▲

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THE BENEFITS OF STRATEGY

Continued from page 3



benefits of each strategic objective; and prioritizes those same objectives. Instead of looking at a landscape filled with issues and no clear direction, the process helps to sharpen the vision for the group. The group identifies its vision through the discussions. An example of the vision may be to remain an economically viable and independent group. Using this example, the group will develop a set of strategic objectives that support that vision. An example of a strategic objective for this vision might be to mitigate a hostile takeover by the hospital. A group might perceive the benefits of this strategic objective as greater autonomy and control as an example. Finally, the group then would decide what priority to assign this strategic objective. Is this strategic objective the top priority, or in the top five, or even the top ten? The group decides this as part of the process.

ACCOUNTABILITY

Ultimately, the group holds the leadership accountable for implementing the strategy, guiding the group, and developing more concrete business plans from the strategic objectives. Depending upon the governance structure of the group, the leadership will execute this work in the board and various committee meetings. The leadership is responsible to communicate with the group regarding the ongoing progress of the strategy implementation.

APPROACH

One final point to make is the approach to completing the strategic planning process. With these benefits of strategy come several approaches to developing strategic plans. The two approaches for the purpose of this article are the McKinsey strategic problem-solving model and the decision-making model found in the book, *Lead with Intent*, by Arne Pedersen. Both models help in decision-making but also guide the user through strategic decision making for the purposes of strategic plans.

The McKinsey model begins with the business need that must be solved and moves through data analysis and interpreting the results to the final plan and implementation.³ This is a time-tested model with thousands of clients.

The decision-making model is similar with its seven steps: identify the problem, gather the information, develop courses of action, analyze and compare, make a decision, make a plan, and implement.⁴ This is also time-tested by military, civilian, and business leaders alike for multiple decades.

In both models, the focus on strategic objectives is a key to success as alluded to earlier. For a group doing this exercise, it is important to know who the group is, what the underlying culture of the group is, how and where the group fits in and what you see as the strengths, weaknesses, opportunities, and threats of the group. Additional data from the billing system and the hospital system(s) will aid in the analysis.

The strategic objectives that are developed from this process are the objectives a group will focus on. Each objective will address a specific strategic issue such as the pending Supreme Court ruling on the Patient Protection and Affordable Care Act. The objectives form the base for the plan, which the group will approve and then look to their respective leadership to implement.

In conclusion, a group can decide to do nothing with its future dictated. Conversely, a group can decide to take advantage of the benefits of strategy and dictate its own future. The group's future rests upon this important and deliberate decision. ▲

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³Rasiel, Ethan M. and Paul N. Friga, *The McKinsey Mind*, McGraw-Hill 2001, pp. xv-xvii

⁴Pedersen, Arne, *Lead with Intent*, IBJ 2007, pp. 73-74

CMS FINALLY SPEAKS (AGAIN): THE MEDICARE SHARED SAVINGS PROGRAM FINAL RULE AND ITS RELEVANCE TO ANESTHESIOLOGISTS

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In the Summer 2011 issue of the Communique, we analyzed the then-new Medicare Shared Savings Program (“MSSP”) accountable care organization (“ACO”) proposed rule (“Proposed Rule”) (issued by the Centers for Medicare and Medicaid Services (“CMS”) on April 7, 2011) as it related to anesthesiologists.

At that time, physicians’ desire for involvement in the MSSP (which was born as part of President Obama’s healthcare reform law) was bleak, at best. The Proposed Rule introduced barrier after barrier after barrier that left the medical community disappointed and angry. Anesthesiologists were left with no clear understanding of the role they would play in the new push for better care for individuals, better health for populations, and lower growth in expenditures—CMS’ three-part aim for ACOs. Anesthesiologists were dubious as to whether they would actually enjoy a piece of the Medicare shared savings pie. But they were also confident that the anesthesia community would certainly not reap such benefits if the MSSP final rule (“Final Rule”) mirrored the Proposed Rule.

Fortunately, CMS received 1,320 comments on the Proposed Rule from various physician advocates, including the American Society of Anesthesiologists (“ASA”). As noted above, the Proposed Rule was not received well by the



healthcare community and, accordingly, a large percentage of these comments were laden with criticisms. In response to the feedback it received, CMS made some “significant” modifications to the MSSP in the Final Rule published on November 2, 2011, including the following:

- Greater flexibility in participation eligibility;
- Multiple start dates in 2012 and longer agreement period for those starting in 2012;
- Greater flexibility in the governance and legal structure of an ACO;
- Simpler quality performance standards;
- Adjustments to the financial model

to increase financial incentives (and decrease in disincentives) for participation; and

- Greater flexibility in timing for the evaluation of sharing savings and the repayment of losses.

This article will examine each of these significant modifications in more depth, comparing the provisions of the Final Rule to the provisions of the Proposed Rule and setting forth the impact this will have on the anesthesia community, as a whole.

GREATER FLEXIBILITY IN ELIGIBILITY

Consistent with the Proposed Rule, CMS determined that the following entities (or combinations of entities) may form ACOs:

- ACO Professionals (physicians or practitioners) in group practice arrangements;
- Networks of individual practices of ACO Professionals;
- Partnerships or joint venture arrangements between hospitals and ACO Professionals;
- Hospitals employing ACO Professionals;
- Certain critical access hospitals;
- Rural health centers; and

- Federally qualified health centers.

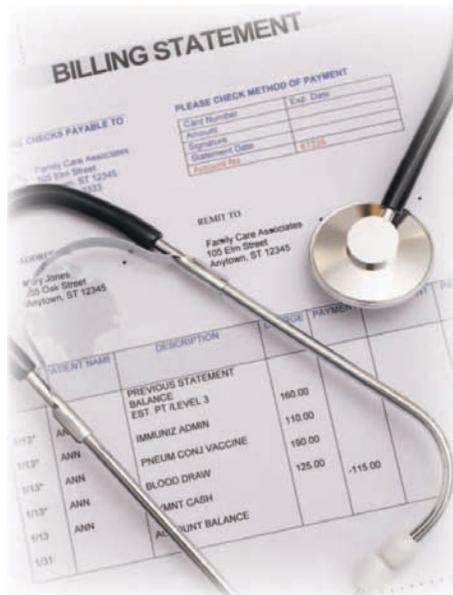
Moreover, CMS maintained that Medicare enrolled entities not specified in the list above may participate in the MSSP by joining an ACO formed by one or more of the organizations listed above.

MULTIPLE START DATES AND A LONGER AGREEMENT PERIOD IN 2012

According to Section 3022 of the Patient Protection and Affordable Care Act (“PPACA”), the MSSP is to be established no later than January 1, 2012, and ACOs in such program must participate for a period of not less than three years (i.e., three performance years). However, CMS, recognizing its short timeframe in implementing the MSSP, will accept ACO applications in early 2012 and established two start dates for this first year. The first start date, April 1, 2012, will have a 21-month long first performance year, while the second start date, July 1, 2012, will have an 18-month long first performance year. Irrespective of the start date, the first performance year will end on December 31, 2013 and all ACO participation agreements will terminate on December 31, 2015.

GREATER FLEXIBILITY IN GOVERNANCE AND LEGAL STRUCTURE

CMS proposed that ACOs exhibit shared governance (in which the ACO participants would have appropriate control over the decision-making process) in the form of governing boards (e.g., a board of directors, board of managers, etc.) (“Board”). The Board would be tasked with executing the functions of the ACO, including promoting evidenced-based medicine, coordinated care and patient engagement. Seventy-five percent of the Board would be comprised of ACO participants (with this 75% being comprised of a representative from each ACO participant organization) and



25% of the Board would consist of the Medicare beneficiaries served by the ACO, non-providers, etc. This proposal was met with both criticism and praise.

Proponents of the proposal supported the 75% Board composition resting with the ACO participants as they believe the ACOs should be provider driven. Opponents of the proposal, however, contended the 75% threshold “is overly prescriptive, will prevent many existing integrated systems from applying, fails to acknowledge that governing bodies will balance representation across all the populations it covers for multiple payers that may, for instance, encourage participation of local business on the governing body, and will be unnecessarily disruptive to many organizations, especially those with consumer-governed boards.” Opponents believed that there should not be a one-size-fits-all approach to governance and that each governing body would need to be structured differently depending on its historical makeup, the interest in participation and other market dynamics.

In its Final Rule, CMS solidified the 75% ACO-participant representation and the 25% “other” representation on the Board. However, in order to provide the Board and the ACO with

greater flexibility, CMS eliminated its requirement that a representative from each ACO participant be included on the Board. CMS stated, “we believe that ACOs should have flexibility to construct their governing bodies in a way that allows them to achieve the three-part aim in the way they see fit.” Consequently, CMS has also allowed for a degree of innovation for ACOs unable to meet the 75% threshold or the beneficiary representation on the Board. Boards seeking varying Board representations (due to their inability to meet the requirements) must describe how the proposed-ACO governance will involve ACO participants in innovative ways and/or why the different governance structure will provide for meaningful participation by Medicare beneficiaries. In this respect, CMS has made participation in the ACO more capable of meeting the needs of both those who participate in the ACO, as well as those beneficiaries receiving care from the ACO.

Anesthesiologists interested in joining an ACO should be attentive to the ACO’s governance structure, the opportunities for anesthesiologists to become actively involved in ACO leadership and the mechanisms in place for distributing shared savings to anesthesiologists and others. The shared savings available to anesthesiologists under the MSSP through their respective ACO will be dependent upon the collective performance of the ACO and not the anesthesiologists alone. Because participants will be *sharing* in cost savings, all providers and suppliers will be dependent upon each other to maximize savings and, in turn, maximize their individual return on their efforts to promote efficiency and integration of medical care. As such, anesthesiologists should be aggressive in their representation in the ACO and on its Board to ensure their interests are adequately represented.

CMS FINALLY SPEAKS (AGAIN): THE MEDICARE SHARED SAVINGS PROGRAM FINAL RULE AND ITS RELEVANCE TO ANESTHESIOLOGISTS

Continued from page 9

SIMPLER QUALITY PERFORMANCE STANDARDS

In its Proposed Rule, CMS called for 65 quality performance standards, spanning five quality domains (patient experience of care, care coordination, patient safety, preventive health, and at-risk population/frail elderly health) that, if achieved, would result in greater savings to the ACO and, thus, greater return in the shared savings. After reviewing the comments received, CMS removed what it called “redundant, operationally complex or burdensome measures,” reducing the number of quality performance standards to a more-manageable 33 quality performance standards, spanning four quality domains that are very similar to the proposed domains (patient/caregiver experience, care coordination/patient safety, preventive health and at-risk populations). Of these 33 measures being finalized, 22 will be collected using the Group Practice Reporting Option interface, seven will be collected using

patient surveys, three will be collected using claims, and one will be calculated from electronic health record (“EHR”) incentive program data.

CMS recognized that requiring ACOs to achieve all 33 measures may not be feasible and may result in unreasonable burdens upon ACOs. As such, in the Final Rule, CMS requires that ACOs need only achieve the prescribed quality performance standard on 70% of the measures in each of the four domains. Those ACOs that do not reach the 70% mark will trigger a corrective action plan and re-evaluation. Continuing to fall short of the 70% performance standard will result in being terminated from the MSSP.

It is important to note that even if a particular quality performance standard does not target anesthesiology, the quality of anesthesiology services provided to patients will directly impact performance on standards relating to patient experience and will indirectly impact performance in other areas. Irrespective

of whether the standards specifically address anesthesiology services, anesthesiologists will play an important role in the performance of their ACOs.

BENEFICIAL ADJUSTMENTS TO THE FINANCIAL MODEL

Under the Proposed Rule, CMS outlined two financial models. ACOs would choose one of these two models and then participate in the MSSP under such model during its *first* three-year participation agreement.

The first model—the one-sided risk model (“Track 1”)—allowed for limited downside risk; the ACO would share in the savings (sharing beginning at a savings of 2%, with some exceptions) in the first two years of the agreement without being responsible for the losses above the expenditure target. During the third year, the ACO would have been required to share in any losses and savings. CMS designed Track 1 to be most appropriate for and desirable to less experienced ACOs.

The second model—the two-sided risk model (“Track 2”)—provided that the ACO would share in both the losses and the savings for all three years, with sharing beginning at the first dollar. After an ACO’s first three-year-term agreement to participate in the MSSP has terminated, CMS proposed all ACOs participate in Track 2. Track 2 is a viable option for more-experienced ACOs that are prepared to share in both losses and savings.

Many in the healthcare community expressed concern regarding the shared risk in the third year of Track 1. Under the Final Rule, CMS finalized its two-model approach to ACOs participating in the MSSP. However, notably, those ACOs electing to participate in Track 1 will not share in any risk. Track 2 remains a risk-



sharing model for all three years of the initial participation agreement. For both Track 1 and Track 2, savings would begin on the first dollar once a Minimum Savings Rate (“MSR”) has been achieved; however, the MSR will vary based on size for ACOs choosing to participate in Track 1 and will be a flat 2% for ACOs choosing Track 2.

Other important changes made by CMS to the MSSP financial model under the Final Rule include the elimination of the performance payment withhold as a mechanism to offset future losses of each ACO. Under the Proposed Rule, CMS would apply a mandatory flat 25 percent withhold each year to any shared savings payment earned by an ACO. In response to concerns expressed by many commentators, CMS elected not to adopt the proposed withhold of shared savings. CMS determined that such withhold was unnecessarily burdensome to ACOs and that CMS had other sufficient mechanisms available to ensure that ACOs who assume risk will be accountable for the shared losses they may incur.

Before participating in an ACO, anesthesiologists should gather information regarding the experience of the ACO and its ACO participants, the track selected by the ACO and its MSR, if applicable, the individual obligations that anesthesiologists will be required to fulfill and the collective benchmarks that the ACO participants as a group will need to achieve. Anesthesiologists should take the time and expend the effort necessary to understand their individual down-side risk to ACO participation before committing.

GREATER FLEXIBILITY WITH RESPECT TO TIMING CONSTRAINTS

PPACA provides that ACOs that participate in the MSSP shall be eligible to receive shared savings payments on an annual basis if the ACO has met the quality performance standards and has achieved the required percentage of cost savings. Such calculation is made based upon claims submitted by providers

and suppliers for services and supplies furnished to ACO beneficiaries. However, PPACA does not provide a period during which CMS must make such shared savings determination. In the Proposed Rule, CMS suggested a six-month claims run-out period to calculate shared savings payments but acknowledged that the length of such run-out period must be determined after weighing CMS’s interests in gathering more accurate and complete claims data (which factor favors a longer period) with its interest in providing timely feedback to ACOs (which factor favors a shorter period). After deliberation, CMS elected to use a three-month claims run-out period.

The Final Rule also offers ACOs who assume risk flexibility in the repayment of shared losses. The Proposed Rule provided that ACOs would be required to repay CMS in full for any shared losses within 30 days of receipt of notification of the shared losses. However, under the Final Rule, CMS extended such period to 90 days.

CONCLUSION

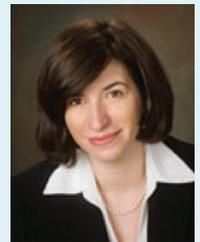
As a result of the MSSP and similar programs adopted by Medicare and other third party payors, anesthesiologists today find themselves facing a new health care payment regime, which increasingly pays them for value (i.e., the quality and efficiency of medical services provided) as opposed to volume alone. Affiliating with an ACO that participates in the MSSP is one means for anesthesiologists to work with other health care providers and suppliers to improve the quality and efficiency of care and share in the resulting savings.

That being said, certainly not all anesthesiologists will participate in the MSSP through an ACO. However, in light of the changing reimbursement environment (evidenced by the MSSP and similar initiatives), all anesthesiologists, irrespective of whether they participate in an ACO or not, should continue

and strengthen efforts to ensure that patients receive the highest quality of care practicable and collaborate with other health care providers and suppliers to promote patient-centered care. Whether through an ACO or otherwise, anesthesiologists will be better positioned in the future if they play an active role in the changes that are occurring within their hospitals and their healthcare communities more generally. Anesthesiologists must ensure that their voices are heard and their value to the healthcare delivery system continues to be appreciated and acknowledged. ▲



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WHAT IS YOUR VALUE PROPOSITION? IS YOUR PRACTICE THE STEAK OR THE SIZZLE?

Jody Locke, CPC

Vice President of Anesthesia and Pain Management Services, ABC

Anesthesia is the quintessential service specialty. Establishing and maintaining a consistently strong relationship with a hospital, a clinic or an ASC is no easier for an anesthesia group practice than for any other type of service provider, be it car mechanic, internet provider or hair stylist; today's medical consumers know they have options that give them leverage in demanding services and loyalty. For too many anesthesia practices this is a relatively new and somewhat disconcerting state of affairs. Anesthesia vulnerability to replacement has grown in direct proportion to the amount of financial support provided by the facility; practices that receive no subsidy support clearly have the strongest

position, at least to the extent that they provide quality care. Competition for anesthesia contracts has ushered in a new era of service expectations and changed the perception of the role of the specialty in the facility. Quite simply, consistently good outcomes are simply no longer enough to sway the thinking of an administration considering the need to provide significant levels of financial support. As the scope of customer expectations changes, every practice must redefine its role and commitment to the medical staff, or have it redefined by the market. There is a growing number of practice managers who have learned this lesson the hard way. Their experience should teach us a basic truth about today's

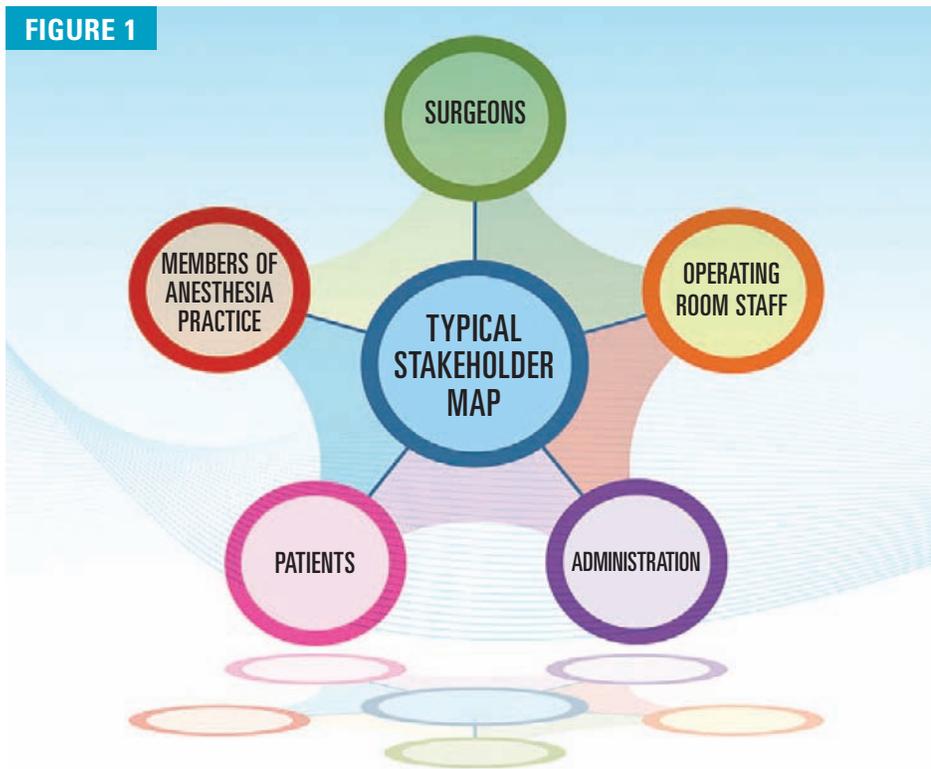
market: hope is not an option. Today's successful practices are survivors because they made themselves indispensable by clearly demonstrating that their best option is the administration's best option.

SECURING YOUR FUTURE

Effective strategic positioning must begin with a clear identification of each of the group's categories of customer. Stakeholder analysis has become a critical discipline and an invaluable tool to help define the communication plans necessary to make anesthesia an essential and critical player in the management of operating room and obstetric operations. It is not enough to just focus on the idiosyncrasies of surgeons or to assume that nothing can be done to change the status quo. Sometimes the surgeons are, themselves, pawns in a larger strategic game. All too often it is those with the most direct line of communication to administration that can have the most impact on the perception of the anesthesia team. The identification of anesthesia's true customers must focus on the entire scope and focus of surgical and obstetric operations from scheduling to profitability. A clear understanding and appreciation of the goals and objectives of each of the various classes of stakeholders can provide invaluable insight into potential opportunities for value creation. The more interaction, the better. There is no substitute for clear and open lines of communication.



FIGURE 1



The typical stakeholder map includes five categories: surgeons, operating room staff (including nurses), administration, patients and the members of the anesthesia practice itself (See Figure 1). Understanding the strategic role of each involves an assessment of each stakeholder's specific goals and objectives in the relationship as well as a determination of the ways in which anesthesia can best support those objectives. The ultimate challenge often lies in the fact that the goals and objectives of one stakeholder may be at odds with those of another; this is where the art of diplomacy and finesse become most important. More often than not, the satisfaction of all stakeholder objectives requires the resetting of some of the stakeholder's objectives. An analogy is often made to Southwest Airlines' entry into the competitive market for professional travelers: by defining its own objectives as frequency of flight options, reliability of service and low fares, the airline forced its customers to re-

evaluate their own priorities with regard to air travel. In the end Southwest not only secured its place in the market but changed the industry.

ANESTHESIA'S RELATIONSHIPS WITHIN THE HOSPITAL: CUSTOMER SERVICE EVERYWHERE

Conventional wisdom holds that all surgeons care about is availability of anesthesia staff so that they can operate instantly when there are patients requiring surgery. It is also typically assumed that hospital administrations have bought into this notion and that they are committed to providing availability of operating room time to lure profitable specialists away from competing medical centers. There is always some truth in such assumptions, but the question that must be asked is whether these are assumptions based on history and custom or an optimum state of affairs. In a growing number of institutions anesthesia is being called upon to help moderate the idiosyncratic

requirements of surgery in an effort to improve operating room efficiency and profitability.

Too often the role of the operating room staff is either misunderstood or taken for granted. Anesthesia practices have a tendency to forget just what a direct line of communication nurses and operating room support staff have to administration. More often than not it is input and feedback from these front-line staff that forms the basis of an administration's perception of an anesthesia practice. Inconsistencies in communication and outlier providers often do more to damage the reputation of the department as a whole than any objective statistical measure of quality or outcomes. As one recovery nurse once expressed it, "Every time those doors swing open our hearts skip a beat wondering who will be bringing in the next patient; because depending which member of the department it is, we may have our work cut out for us to stabilize the patient."

Volumes could be written about the socio-pathology of relations between anesthesia groups and their hospital administration. There is no better example of the lack of a tradition of customer service, per se, in medicine than the way so many practices interact with the people who actually hold their purse strings. Not only is there typically a lack of regular interaction, but the intercourse that does take place is often more confrontational than collaborative. There are so many lessons that anesthesia providers could afford to learn from business about customer loyalty cultivation. A case in point is a basic understanding of medical economics. Steven Covey's admonition to seek first to understand is a good starting point. Contract reviews and subsidy calculations have created a growth business for highly paid consultants who do little more than act as intermediaries

Continued on page 14

WHAT IS YOUR VALUE PROPOSITION? IS YOUR PRACTICE THE STEAK OR THE SIZZLE?

Continued from page 13

between the anesthesia practice and administration. There is little in their analysis and PowerPoint presentations that most intelligent people could not have figured out on their own. When a hospital administrator resorts to formal Requests for Proposal (RFP) for anesthesia services it is tantamount to a vote of no confidence in the ability of a practice to define its value proposition and deliver it consistently. More important than the specific areas of misunderstanding, however, is the fundamental difference in approach to problem-solving. An anesthesia provider who prides himself on his or her ability to resolve complex clinical problems in a matter of seconds may lack appreciation for the art of administrative decision-making, which can require hours of patient negotiation and education.

The role of patient satisfaction is not always clear or logical. One might argue that an individual patient's level of satisfaction with surgical or obstetric services is not as important as might be supposed given the scope of services provided by even a small facility. One might also argue that quality of care and professionalism are a given. Here is where the metrics differ. A successful anesthetic outcome for the department of anesthesia can still be a customer service disaster for the hospital. Understanding and appreciating this distinction is the key to understanding the role of patient satisfaction in a hospital. Only when anesthesia groups start to appreciate their role in ensuring a consistently positive surgical or obstetric experience and the importance of that patient's potential to refer other patients will the interests of anesthesia and administration have been truly aligned.



Ideally, a medical group should provide a service that far surpasses the individual contributions of its members. Professionals have a tendency to assume the competency and professionalism of other professionals. There is no greater challenge than the need to monitor or discipline another professional. Drug diversion is just one of many problems that can haunt even the best of departments, but the most common and difficult problems are attitudinal. Professionals are expected to maintain a consistent attitude and demeanor. When they decompensate under stress, the repercussions are significant and can completely undermine the credibility of the management of the practice. By the same token, unhappy providers or those whose expectations cannot be met can also have an adverse impact on the overall perception of the department. No department can afford to have team members who are not 100 percent committed to the success of the team.

Anesthesia groups with the best reputations and most secure futures are

those that have dedicated themselves to anticipating the specific customer service expectations of all their customers. Such groups make it a point to monitor satisfaction at every level of the institution. Sometimes the process takes the form of surveys and statistical analysis, but more often it is the result of regular communication and inquiry. The groups appreciate the value of any and all feedback and know that there is no substitute for a consistently aggressive approach to customer satisfaction. They place great value in committee participation. All feedback is taken seriously and discussed at the highest levels of the organization. It goes without saying that the strength of a group's reputation is only as good as its least strong provider or the latest unresolved customer service issue.

But this is only the beginning; environmental scanning and the triaging of customer input defines the baseline. True value creation requires a knowledge and understanding of customer desires

and expectations that exceeds that of the customers themselves. This is what defines the sizzle to the solution. Today's customers are looking for the wow factor that takes them to the next level. Americans in general are impatient for the latest technology or the best strategy. Hospital administrators are no exception. To appreciate the importance of this concept is to understand the success of a Google or an Apple. In both cases the companies distinguished themselves by providing services or technology that allowed their customers to do new and additional things, do them faster and be more productive. This is the essential and underlying expectation of all hospitals in today's competitive healthcare environment.

NEW ROLES FOR ANESTHESIA

Any anesthesia provider or group practice that does not believe it can significantly contribute to the growth and success of the facilities it serves has already lost the battle and probably the war. The opportunities are virtually limitless for those committed to defining and executing them, but five are worth specific consideration as starting points for a serious value added strategy. They are:

1. operating room management,
2. drug management,
3. technology management,
4. risk management, and
5. surgical patient satisfaction.

When asked what opportunities there are for an expansion of services to a given facility, most anesthesiologists will suggest some aspect of operating room management. Few anesthesia practices actually play a major role in O.R. management but this is probably more a function of lack of experience and the perception that assuming responsibility for the running of the operating rooms would involve considerable political risk for very little financial reward. The



exceptions, however, are quite notable. Years ago when Dr. Mark Rogers assumed the chair at Johns Hopkins he negotiated for Dr. Robert Donham to take over the management of the operating rooms using a scheduling program that had been designed by and paid for with department funds. Drs. Julian Gold and Ronald Wender also made a proposal to the management of Cedars-Sinai hospital in Beverly Hills that also gave the department considerable management oversight for all operating room staff and operations. There are numerous other examples, starting with the work done by Dr. Franklin Dexter and colleagues at the University of Iowa. Dr. Michael Roizen also has written about the potential role of anesthesia in this area.

The point is that a department of anesthesia should have more and better data about what actually happens in the operating rooms than even the hospital.

The fact is that most private groups simply use this information to enhance collections and not to improve operating room efficiency or effectiveness. While this is starting to change, the role

of anesthesia in the management of operating rooms is still in its infancy. The irony is that by ceding responsibility for the management of the ORs to others, anesthesia is foregoing an invaluable opportunity to directly manage the factors that determine provider income and lifestyle. A commitment to playing a more active role can clearly prove to be a win-win situation for groups with the tools and commitment at avail themselves of the opportunity.

But there are other possibilities as well. Why should the hospital pharmacy play such a significant role in drug management, for example? Is this not also an area where anesthesia brings significant expertise and experience to the table? It is probably true that few anesthesia providers have a good handle on the true economics of drug costs and usage, but this is information that should be readily available given a nominal investment in time and the formulation of some simple budget templates. It is not uncommon for hospitals to be open to cost-sharing arrangement for savings in drug costs. An active role in this area would be consistent with the current interest in co-management options.

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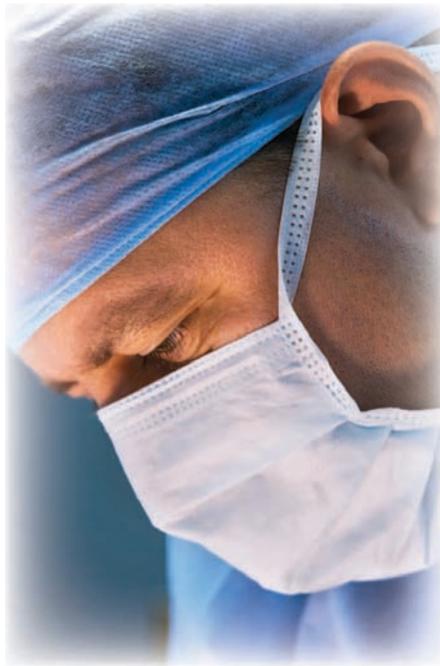
WHAT IS YOUR VALUE PROPOSITION? IS YOUR PRACTICE THE STEAK OR THE SIZZLE?

Continued from page 15

Anesthesia also brings considerable expertise to the hospital in the area of technology management. The current focus on ultrasound is just one of many examples of a new technology that has been carefully evaluated and ultimately implemented by the anesthesia department, but there are so many others. Why should anesthesia not play an active and aggressive role in helping a facility define state of the art operating room technology? It is true that some will ask what is the financial benefit to the department or group, but often the potential value should be measured not strictly in terms of short-term return on investment, but long-term interdependence and partnership. In other words, most businesses make certain investments intended to secure or maintain good customer relations, and to emphasize their value to the institution.

Risk management is another area of increasing interest to anesthesia practices as the specialty asserts its role in defining pay for performance measure (P4P). It is safe to say that with all the new programs being developed and implemented to capture clinical data throughout the entire continuum of anesthesia care, that anesthesia has a significant armamentarium to offer. Why should those who have been so well trained to assess individual patient risk factors not step up to the plate to share their experience and insights?

Ultimately, anesthesia plays the definitive role in creating a positive surgical experience. The sad truth is that all the hard work and discipline that goes into managing patients safely through the trauma and abuse of surgery with such consistent outcomes goes unnoticed. Rare is the hospital with a strong reputation



for advanced surgery that does not rely on sub-specialty trained anesthesiologists and, in many cases, nurse anesthetists to achieve the results they do. Again the role of anesthesia is just starting to be defined, but the potential would appear to be nearly unlimited. Perhaps it is time for anesthesia to step out from behind the curtain and take some of the credit for material improvements in surgical morbidity and mortality.

This short list of opportunities will no doubt inspire consideration of others. The core issue is not what services anesthesia groups are qualified to offer, but rather the commitment to redefine the role of anesthesia in the hospital. As in so many businesses outside medicine the market for medical care is impatient for new solutions to long-standing historical problems. The tide is clearly starting to turn with the aggressive role of so many large anesthesia groups across the country.

It has been said that there are three ways to play any game. One can choose not to play; one can play not to lose, or one can play to win. In today's competitive market there is no room for anesthesia practices playing not to lose; they are destined to be replaced by more professional and active practices with better and more creative insights into the challenges of practice management. There is a reason anesthesia is seeing a resurgence of practice aggregation: the market is insisting that anesthesia step up to the plate in partnership with the facilities it serves. Leverage is the name of the game. Small practices will find themselves challenged to provide the kind of value added services that their larger competitors are offering. Some might be skeptical of the ability of a larger entity to provide a better and more customized service; and they might be right, but being right is no longer good enough. Today's decision-makers are an impatient lot. They are less concerned with being right than being better. The impact on anesthesia is already clear. Everyone wants to partner with a team that is willing to take risks, create value and distinguish itself in the market. ▲

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FEDERAL INSURANCE LEGISLATION - CAN IT HELP ME?

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WHY FEDERAL INSURANCE REGULATION?

Normally, insurance companies are regulated by the states. As a result, there are hundreds of statutes and rules affecting companies that operate in multiple states. The National Association of Insurance Commissioners (NAIC) issues guidance to standardize insurance laws, but states are not required to follow its recommendations. As might be expected, this results in increased costs as companies design multiple products to comply with diverse and sometimes conflicting state regulations and formalities.

For the most part the Federal Government has not interfered in state insurance laws, leaving the regulation of the industry to state regulators. Non-interference has worked adequately during soft markets in which insurance is easy to find.

IMPACT OF A “HARD MARKET”

During “hard” markets in which insurance coverage is difficult to obtain, the federal government has stepped in to allow an insurance company to operate in many states as long as one state agrees to license the company and be its primary regulator. The last time this occurred was in the mid 1980s when Congress was besieged by requests from industry and local governments who were unable to find affordable liability insurance. When Independent truckers circled Congress to demonstrate their discontent, Congress finally took action that changed the



liability insurance industry irrevocably.

The last hard market in medical malpractice insurance happened in 2001 when St. Paul suddenly decided to stop offering insurance to doctors. The company found that premiums were not covering claim costs and they were losing money. Thus thousands of doctors insured with St. Paul found themselves without liability insurance.

Here are some examples of Federal insurance legislation passed during hard markets:

1981 Product Liability Risk Retention Act.

This Act was passed to expand the market for product liability insurance, which is issued to manufacturers to protect against product defects.

1986 Liability Risk Retention Act. (LRRRA)

The 1981 Act was amended to expand the market for professional liability insurance, but it excluded workers' compensation, homeowners and auto

insurance. Under the Act, risk retention groups that met certain licensing requirements of one state could operate nationwide, exempt from any other states' requirements. The Act allowed groups with similar risks to form risk retention and risk purchasing groups.

The risk retention group must also be owned by its insureds. Membership in the risk retention group is limited to persons engaged in similar businesses or activities with similar liabilities. The Act requires a risk retention group to prepare a feasibility study or plan of operation detailing coverage, deductibles, limits, rates, and rating classification systems for each line of insurance the group intends to offer. The feasibility study or plan of operation must be filed with the group's licensing state and with every state in which the group intends to operate.

Likewise, the Act requires risk retention groups to file annual financial statements with their licensing states and all other states in which they operate. Financial data submitted by a risk retention group must be certified by an independent public accountant and must include a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist.

In summary, the Act requires the insured members to be in a similar industry (examples are doctors, attorneys and other professionals) and to be the owners of the risk retention group either through direct stock purchases in the

Continued on page 18

FEDERAL INSURANCE LEGISLATION - CAN IT HELP ME?

Continued from page 17

group, or membership/ownership in an association or corporation that owns the risk retention group and whose sole purpose is to provide insurance to its owner members exclusively.

1983 Multiple Employer Welfare Arrangements (MEWA) under the Employee Retirement Income Security Act (ERISA)

A MEWA provides employee health insurance and other benefits to members of an association that are linked by a common thread like employment or profession.

Resolving federal versus state conflicts

Federal laws have not been welcomed by state insurance regulators, who are understandably uneasy about companies over which they have no regulatory power. Over the years the companies that are formed under federal statutes have found operating in multiple states requires cooperation with state regulators. Companies that take this route have, for the most part, been successful. These companies follow sound insurance principles approved by the NAIC. These sound principles include partnering with "A" rated reinsurers, selecting well known actuarial firms with experience in their line of business, and hiring experienced and respected management teams. Companies regarded favorably by rating agencies like Demotech (the primary rating agency for Risk Retention Groups) are also well received.

How can these federally regulated companies help doctors?

The Federal Risk Retention Act and its amendments have dramatically increased the availability of insurance. As a result, doctors have lots of choices when deciding from whom to buy their insurance.

The problem with more choices, of



course, is more potential for confusion. The choices include:

- Publicly traded insurance companies, such as *Medical Protective* and *The Doctors Company*.
- Doctor-owned insurance companies usually run by the State Medical Associations, these includes companies like *MAG Mutual* in Georgia and *PMSLIC* in Pennsylvania. Some of the doctor owned companies are being acquired by publicly traded companies like *The Doctors Company*.
- Risk retention groups owned by the insureds, such as *Doctors & Surgeons National Risk Retention Group*
- JUAs - joint underwriting associations formed by states to provide insurance coverage as a last resort.

Risk retention sponsors

A risk retention group is usually formed by a sponsoring organization for a specific purpose. For example, a hospital may offer insurance to its doctors through its own risk retention group. The hospital may pay for or offer the insurance at reduced rates to attract doctors and their

patients. Some examples of hospital owned risk retention groups include:

- *Controlled Risk Insurance Company of Vermont, A Risk Retention Group*, owned by the Risk Management Foundation of the Harvard Medical Institution
- *Mountain Laurel Risk Retention Group*, owned by Jefferson Hospital System in Pennsylvania

Risk retention groups have also been formed for particular medical specialties. Some examples of companies, which are rated "A" and "A-" by A.M. Best include:

- *Ophthalmic Mutual Insurance Company, A Risk Retention Group*
- *Preferred Physicians Medical Risk Retention Group* (for Anesthesiologists)

Other risk retention groups are broader in scope and offer coverage to many specialties to capitalize on the insurance principles of large numbers and spread of risk. Examples of Demotech "A" rated companies include:

- *Oceanus Risk Retention Group*
- *Doctors & Surgeons National Risk Retention Group*

Why is a rating important?

Rating by an independent third party gives assurance that the company is in a stable financial condition.

What is the difference between all these companies?

Companies vary widely and doctors need to look at more than price.

Here are some examples of issues to watch for:

- If a hospital offers cheap coverage it may be looking to push liability on to the doctors avoiding their responsibility to provide an independent defense.
- An insurance carrier may settle a claim without policy holder consent and then report the results to the NPDB (National Practitioner Data Bank). Doctors do not like receiving letters in the mail informing them of a claim settlement to which they did not agree. These unapproved settlements have damaged many skilled doctors' reputations.
- The insurance company may offer risk management so insubstantial that it has little impact on the practice and provides less protection.
- The insurance company may not offer additional services like asset preservation plans, which can be of great value in providing a litigation proof defensive shield.

What are the strengths of risk retention groups?

Risk retention groups have practicing physicians on their boards who are uniquely positioned to understand the problems doctors face. Some risk retention groups have risk management programs that make real differences in preventing and containing lawsuits. A select few offer a "white glove" service that includes free wide ranging legal advice and CMEs.

Some risk retention groups



aggressively defend their doctors to discourage predatory litigation. A medical malpractice lawsuit is usually filed by a plaintiff attorney hired on contingency. This means the plaintiff lawyer only gets paid when he has a favorable settlement (favorable to the attorney and his client). Plaintiff attorneys may take from 25 to 50% of the settlement. Thus plaintiff attorneys are eager to file lawsuits when insurance is involved because they know the company represents the "deep pocket" that will pay the claim.

Some companies manuscript policies for unique circumstances. (e.g. multiple locations, non-clinical staff, etc.)

Doctors insured by risk retention groups can benefit through distributions and/or lower premiums when the group is profitable.

What are the weaknesses of risk retention groups?

Risk retention groups may be smaller than conventional insurance companies, which may have stronger balance sheets. Risk retention groups partner with "A" rated reinsurers to address this issue.

Risk retention groups are not covered by state guarantee funds in the event of insolvency. "A" rated reinsurance addresses this problem.

How can risk retention groups protect doctors from litigation?

Risk retention groups work to make sure that doctors are protected from the major causes of lawsuits, which may typically arise from lack of informed

consent and failure to diagnose a condition.

For example, the patient may allege that the doctor did not fully disclose the risks of treatment. This issue may be overcome with a strong informed consent form and procedure designed by the risk retention group.

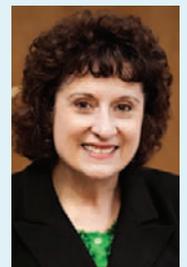
The failure-to-diagnose allegation may be overcome with strong documentation procedures designed by experienced risk retention group physicians in similar clinical fields.

Should you consider a risk retention group for your insurance?

Risk retention groups are no longer the new kids on the block. The industry has a twenty-five year history and merits consideration.

A risk retention group should meet your specific needs. Make sure you choose a company that understands your specialty and has strong risk management and asset preservation programs that protect you personally and professionally. Then you will be able concentrate on practicing medicine without fear of reprisal. 

Sara Carpenter, CPA, CFO, has been involved in physician and hospital owned medical malpractice and health insurance companies for over twenty-five years. Sara worked with Deloitte and Touche as a small business



consultant. She owns her own consulting company which advises doctors and hospitals on insurance matters. An expert in insurance company financial management, Sara works with the Finance and Audit Committees of various insurance companies to insure sound financial management, including the selection of appropriate investments and the analyzing and procuring of "A" rated reinsurance. Sara has a Masters in Professional Accountancy from Georgia State University and is a Certified Public Accountant licensed in Georgia and North Carolina. She can be reached at scarpenter@dsnrrg.com.

Compliance Corner

As part of our desire to keep both clients and readers up to date, the Communiq   has been printing compliance information since its inception.

ANESTHESIA PRACTICES SHOULD PREPARE FOR MORE AUDIT ACTIVITY

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The administrative burden and financial pressure on physicians and other healthcare providers, as a result of increased scrutiny of claims and audit activity by third party payors, is not expected to end anytime soon. Many physician practices around the country are already feeling the impact in the form of pre-payment audits and edits, voluminous record requests, and post-payment audit review activity.

By way of background, over one billion claims are submitted to Medicare each year. This means that Medicare processes over four million claims per work day (over 9,000 claims per minute). Because of this volume, Medicare contractors process most claims without investigation or even reviewing any clinical records. As a result, the Medicare Trust Funds are vulnerable to the submission of false and fraudulent claims as well the submission of claims failing to meet certain documentation and other requirements. Because of this vulnerability, the Department of Justice, the Department of Health and Human Services and the Centers for Medicare



and Medicaid Services (“CMS”) have taken steps to combat activities perceived to constitute Medicare fraud and to seek out overpayments paid to healthcare providers.

As we have previously reported, CMS’ Medicare Recovery Audit Contractor Program (“RAC”) is already underway in all 50 states. The main objective of the Medicare RAC Program is to identify and recoup overpayments to health care providers. The RAC contractors are compensated on a contingency fee basis for monies that they restore to the Medicare Trust Funds. In Addition, CMS recently issued final regulations governing the implementation of a Medicaid RAC Program. These regulations require

each state to implement a Medicaid RAC Program by January 1, 2012. Accordingly, practices may soon be recipients of record requests initiated by their respective state Medicaid RAC contractor in addition to requests from the Medicare RAC contractor. Although there are differences in the Medicare and Medicaid RAC Programs (e.g., appeals process), the main objective (i.e., to identify and recoup overpayments) for all practical purposes is the same.

Not only are the CMS RAC audit programs in motion, but Medicare Administrative Contractors (“MACs”) (or Medicare Carriers and Intermediaries) conduct their own audits, and Zone Program Integrity Auditors (“ZPICs”) (or Program Safeguard Contractors (“PSCs”)) are conducting nationwide benefit integrity audits. Similarly, Medicaid HMOs are busy with audit activities. In addition to these government audits, many private payors appear to be following in line with the government’s latest audit initiatives by contracting with outside vendors to conduct claims reviews and audits.

During the audit process, physicians are held to certain standards including, but not limited to:

- Having legal responsibility for all claims submitted under their billing numbers;
- Having legal responsibility for knowing Medicare policies regarding the services and procedures they perform, including policies on documentation. Pursuant to federal regulations, a physician will be deemed to have knowledge of a Medicare coverage policy if the Medicare Affiliated Contractor (“MAC”) (i.e., Medicare Carrier or Intermediary) provides actual notice to the physician regarding coverage; if CMS has provided notices related to the subject service (e.g., Manual issuances, bulletins or other written guides); and/or if a National Coverage Decision has been adopted with respect to the service.⁵; and
- Being subject to medical necessity and documentation requirements (including for anesthesia services). The Social Security Act confers to patients entitlements to a range of medical services defined by broad categories. The Social Security Act also describes exclusions from coverage, most notably including payment for expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Generally speaking, a service may be covered if it is reasonable and necessary under Section 1862 (a) (1) (A) of the Social Security Act.

Given the highly-regulated health



care environment and the ever-increasing audit landscape, it is extremely important for anesthesia and pain management practices to focus on compliance activities including deploying substantial effort towards improving medical record documentation. Although many physicians appear to believe that their documentation is sufficient to withstand audit scrutiny, the practical reality is that auditors traditionally take a very technical and conservative approach to documentation often times denying legitimately provided services based on reasons such as “lack of documentation to support services”. With this in mind, we offer the following straightforward tips for consideration:

1. FOCUS CONSIDERABLE EFFORT ON DOCUMENTATION IMPROVEMENT:

The most prevalent types of denials raised in the various audit processes include documentation deficiencies. For those practices deploying a medical direction practice model, a key issue should be to ensure appropriate documentation of compliance with the

medical direction requirements. As a refresher, according to 42 C.F.R. § 415.110 (b):

The physician alone inclusively documents in the patient’s medical record that the conditions set forth... have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

Although CMS has not provided specific national instruction regarding the manner in which this documentation must be accomplished, there are many ways that medical direction can be documented (e.g., individual attestation statements with a comment section; a combination of attestation statements and time line initialing; handwritten notations with no formal attestations, etc.). Whichever form of documentation is used by an anesthesia practice, the bottom line is that documentation should be present to clearly establish

⁵ 42 C.F.R. § 411.06 and Medicare Claims Processing Manual (CMS Pub. 100-04), Chapter 30, § 40.1.

⁶ 42 C.F.R. § 415.110.

ANESTHESIA PRACTICES SHOULD PREPARE FOR MORE AUDIT ACTIVITY

Continued from page 21

that the anesthesiologist fulfilled his/her regulatory obligations with respect to all of the following responsibilities:

- The anesthesiologist performed the pre-anesthetic exam and evaluation;
- The anesthesiologist prescribes an anesthesia plan;
- The anesthesiologist participates in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
- The anesthesiologist ensures that any procedures in the plan that he or she does not perform are performed by a qualifying individual;
- The anesthesiologist monitors the course of the anesthesia at frequent intervals;
- The anesthesiologist remains physically present and available for the immediate diagnosis and treatment of emergencies; and
- The anesthesiologist provides post-anesthesia care, as indicated.⁶

To the extent that an anesthesia practice is utilizing an electronic medical record, it is imperative to carefully review records to ensure that the appropriate documentation is captured and clearly displayed when printed to hard-copy form.

With regard to medical necessity, each note should establish the medical necessity for the service provided. Specifically, according to the OIG:

- The record should be complete and legible;
- Each encounter should include the reason, relevant history, exam findings, prior test results, assessment, clinical impression or diagnosis, plan of care, date and identity of the observer. Records should take into account any applicable National Coverage Decision or Local Coverage decision requirements; and
- If not documented, the rationale for ordering a test or service should be easily inferred and past and present diagnoses should be accessible.

By way of example, with respect to pain management physicians, documentation of visits should include the patient's diagnosis; the patient's pain history; a description of prior treatments and the patient's response to each treatment; the rationale for the encounter; documentation of the location and intensity of pain; any other information required by a Medicare Local Coverage Decision; and any other information that will help establish the medical necessity for the service or procedure performed. Moreover, anesthesiologists must be mindful that medical necessity does apply to anesthesia services. It is particularly important to document the medical necessity for the anesthesiologists' involvement in certain types of cases including, but not limited to, the provision of monitored anesthesia care; the provision of anesthesia services by qualified anesthesia providers in colonoscopy cases and other procedures where the surgeon may have handled the anesthetic for the procedure in the past; and the provision of anesthesia services by qualified anesthesia providers in chronic pain management cases. Merely relying upon hospital protocol or that the surgeon requested anesthesia involvement is not sufficient to establish medical necessity when challenged.

2. OBTAIN AND REVIEW PAYOR POLICIES AND GUIDELINES:

Whether dealing with contract requirements which typically require the anesthesia practice to follow the payor's guidelines and policies (which may be unilaterally changed and revised from time to time) or Medicare requirements, it is important that every physician in the practice understands the requirements applicable to the services being submitted for payment. In order to make sure the





practice is obtaining necessary billing and documentation rules and guidelines, the practice should designate an individual who is responsible for (1) determining which third party payors have published policies and guidelines (this can be accomplished by making telephone calls; researching websites; reviewing contracts; communicating with billing personnel or billing company representatives); (2) creating a list of the payors (with applicable websites) that have policies and guidelines and keeping the list updated; and (3) obtaining the available information. The Medicare Contractors all have websites and many have email services that are easy to register with to receive updates.

Once the practice is obtaining necessary billing and documentation information, the information must be appropriately disseminated to the physicians. As the policies may contain requirements regarding documentation and frequency limitations in addition to coding issues, the physicians and providers in the practice should be included in the distribution. Many physicians believe that they do not need to review the materials as long as their billing company/administrative staff is aware of the policies. Physicians must understand that they are personally

responsible for services billed under their numbers. Moreover, that the payor policies often contain information necessary for the physician such as specific documentation elements that must be contained in the record to support billing of a service. In addition to the potential audit and overpayment exposure that exists for failing to comply with payor policies and guidelines, physicians should be aware that certain patterns can lead to the physician being de-participated from a payor program.

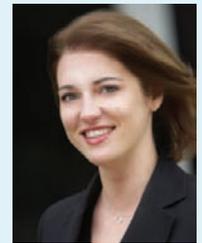
3. ENGAGE IN EDUCATIONAL ACTIVITIES:

Anesthesia practices should make compliance education a component in regularly scheduled board or other corporate meetings. For example, when a new policy is published by Medicare that impacts the practice (e.g., a policy on anesthesia for endoscopy cases, etc.), the policy should be discussed at the meeting to ensure that everyone has received the information and understands the information. If there are no new policies to discuss, the allotted time for education can be used to provide refresher education on other issues. For example, the definition of anesthesia time could be discussed to ensure everyone is tracking and documenting time appropriately.

We recommend that the practice document these educational efforts. This can be accomplished by drafting simple meeting minutes that reflect that compliance education on a particular topic took place. ▲



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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
January 27-29, 2012	American Society of Anesthesiologists ASA Conference on Practice Management	Buena Vista Palace Lake Resort Lake Buena Vista, FL	http://www.asahq.org/For-Members/Education-and-Events/Calendar-of-Events/2012/January/ASA-CONFERENCE-ON-PRACTICE-MANAGEMENT.aspx
February 25, 2012	Michigan Society of Anesthesiologists Annual Scientific Session	Troy Marriott Troy, MI	www.mianesthesiologist.org
March 17, 2012	Washington State Society of Anesthesiologists Spring Scientific Meeting	Bell Harbor International Conference Center Seattle, WA	http://www.wa-anesthesiology.org/
April 15-18, 2012	Medical Group Management Association 2012 Anesthesia Administration Assembly Conference	Westin Kierland Resort and Spa Scottsdale, AZ	www.mgma.com/aaa2012
April 19-22, 2012	California Society of Anesthesiologists 2012 Annual Meeting	Ritz-Carlton Hotel Laguna Niguel, CA	http://www.csahq.org/up-more.php?id=47
May 4-6, 2012	Anesthesia Billing & Practice Management Seminar 2012	Caesars Palace, Las Vegas, NV	http://www.certain.com/system/profile/web/index.cfm?PKwebID=0x28268324b1&varPage=hotel
May 4-6, 2012	Advance Techniques for Acute and Chronic Pain Management	Motor City Casino Hotel Detroit, MI	info@anesthesiallc.com
May 18-20, 2012	Arizona Society of Anesthesiologists Annual Meeting	Scottsdale Resort and Conference Center, Scottsdale, AZ	www.az-anes.org
June 8-10, 2012	Florida Society of Anesthesiologists Annual Meeting	The Breakers Resort and Spa Palm Beach, FL	http://fsahq.org/

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