

An Endangered Species: Small to Medium-Sized Independent Anesthesiology Groups

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At this year's ASA Conference on Practice Management, one of the most talked about panels was the one examining the issue of large anesthesiology groups taking over practices. I think Mr. Adessa's comment about the after-presentation questions from attendees summarizes the reactions to the panel: "Shortly after I completed my presentation at

the recent ASA practice management meeting, I became engaged in conversations with physicians who 1) embraced the concepts I had put forth, 2) felt that the presentation failed to adequately promote available opportunities for the small, independent practice or 3) were well on their way to a second dose of Prozac."



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John L. Adessa

A ample evidence suggests that a material number of small to mid-sized independent anesthesia groups will merge, be acquired and or lose service contracts by the end of 2010. The reality is that throughout the nation on any

given day, there are multiple discussions and negotiations taking place between anesthesia groups. These discussions will lead to mergers of anesthesia groups, either by acquisition or joint venture initiatives. All these efforts are aimed at improving efficiencies, increasing economies of scale, reducing costs and gaining additional leverage.

I believe that the extent and pace of these activities will be fully realized in the next six to nine months and that the receptivity of hospitals and hospital systems (as these large anesthesia management companies [AMCs] evolve) will be much greater than anticipated by most anesthesia groups.

It is clear that merger and or acquisition activity has steadily increased over the last five years as large AMCs and dominant anesthesia groups (DAGs) have evolved or have been created through:

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Small to Medium-Sized Groups Are Endangered

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In a darkened office, late into the evening, the hospital administrator sits quietly and ponders a career question: "Should I or should I not replace this anesthesia group?"

To the surprise and dismay of anesthesiologists across the country, this question is being asked and answered. Anesthesiologists are losing their exclusive contracts to provide service. They are losing their independence as owners of multimillion dollar businesses. And they are becoming employees of hospitals, large mega-groups or publicly owned corporations.

This does not need to be your ultimate destiny. How might a small to medium-sized anesthesia group become so valuable to a hospital that the thought of replacing this independent group is unacceptable?

Here are a few brief suggestions drawn from the history and experience of small to mid-sized anesthesia groups that have successfully maintained both their independence as well as a strong working relationship with their hospital administrations. It should be noted that while this material is being directed to the smaller practices, we maintain that the outlined principles and suggestions apply equally to all practices, regardless of size.

The areas reviewed will include:

1. Providing Leadership in the O.R.
2. Competent Practice and Business Management
3. Developing the Entrepreneurial Spirit
4. Minimizing Support Requests

Providing Leadership in the O.R.

The anesthesiologist should be a leader in the O.R. and actively involved in the care of his or her patients. This would include, but certainly not be limited to, regularly checking on the status of the patient as well as being present for the critical portions of the anesthetic, including induction and emergence. The anesthesiologist should be the one communicating medical concerns with the surgeon, the patient (and his/her family) and hospital staff. These activities send a powerful message. It clearly tells the surgeons how important the anesthesiologist perceives the care of his/her patients to be.

By active involvement in the anesthetic care of the patient, the anesthesiologist is clearly stating that he/she is a physician, with years of training, is board certified and has the skills necessary for the intraoperative safety of the patient. This carries weight, especially when medical issues or matters involving O.R. management are being reviewed. The involved anesthesiologist, respected by his/her peers in the O.R., will be respected by the administration.

Active and ongoing training in the latest anesthetic and pain techniques is critical. The anesthesiologist should be prepared to answer "yes" when a surgeon inquires about a new way to make the patient comfortable postoperatively. Surgeons who clearly perceive that the anesthesiologist is working pro-actively to help and support his/her patients will generally be more willing to listen and cooperatively work on issues regarding scheduling and staffing.

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- Multiple mergers of smaller anesthesia practice groups.
- Acquisitions of anesthesia groups (groups purchased) by larger, well-funded AMCs or practice management companies.
- Non-cash acquisitions (of anesthesia groups) that occur when an AMC or DAG obtains an exclusive provider agreement through a bid process or through direct negotiations with a hospital or health system and in the process assumes or replaces the existing group.

Note: An AMC is generally characterized as having more than 100 anesthesia professionals and internal clinical and business management. A DAG may have many of the above but also include 30 percent or more of the practicing anesthesiologists within a specific geographic area of service.

When one examines the provision of anesthesia services in the highly populated 24 U.S. coastal and border states (drawing a “U” from the state of Maine down the eastern seaboard, across the southwest states and up the west coast to the state of Washington, and including the contiguous states of Pennsylvania, Tennessee and Vermont), 20 of these 24 states have operating AMCs and or DAGs, and many states have multiple AMCs or DAGs.

Most of these AMCs or DAGs exhibit many or all of the following characteristics that provide an economic advantage over small, independent anesthesiology practices:

- Substantial levels of cash flow, liquidity and or access to capital.
- Professional clinical and business management.
- Proprietary quality assurance (QA) programs, data warehouses and/or access to other data repositories that enable high levels of clinical analysis, outcomes management and, equally important, credible reporting.
- Scale that is concentrated (within a geographic region) and that leads to leverage when negotiating payer contracts that subsequently result in increased compensation, superior rates of success in the important area of recruitment and in retention rates of qualified physicians and nurse anesthetists.

Competing against these well-capitalized, highly leveraged and professionally managed groups will, to say the least, be difficult for the small to medium-sized group. In addition to the advantages already noted, AMCs and DAGs

avoid many of the problems smaller groups face or experience, including:

- Low reimbursement rates that lead to
- Reduced levels of compensation that
- Result in physician/nurse anesthetist acquisition and retention problems and
- Coverage and service issues and, most problematic,
- Substantial subsidies from the hospital required to meet coverage and service requirements.

Obviously, not every small or medium-sized group will disappear from the anesthesia community.

You may, for example, have the good fortune to practice at one of the unique hospitals that is not experiencing a negative shift in its payer mix, and you are easily able to recruit, provide competitive compensation and do not require a subsidy. In this case or scenario, your group is probably insulated from competitive threats.

However, most groups are not in this position, and if your group receives a subsidy and you are experiencing any of the challenges previously noted, then in my opinion, your practice is at an even higher level of risk — at risk from competitors negotiating significantly better rates of reimbursement, which (therefore) can reduce the hospitals’ subsidy payment while the competitor can generate margins or profits, operating within the reduced subsidy.

Your practice is further at risk due to the competitors’ financial ability to risk share with the hospital, potentially integrate other hospital-based specialty services, recruit on a national basis, provide both qualitative and quantitative reports for the anesthesia services provided, and develop and adhere to a set of performance metrics and standards.

Today’s reality for most hospitals is an economically challenging environment characterized by a deteriorating payer mix, an increase in bad debt, a shift of more of the insurance risk to the end user, a resulting need (for the hospital), and provision of subsidies to many of their hospital-based specialty groups.

Working in the hospital’s challenging environment requires that the anesthesia group contribute in a collaborative service-oriented manner and produce material service and clinical benefits to the hospital.

Previously noted benefits that an AMC or DAG provide to hospitals will be supplemented by benefits that accrue to

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They are also more likely to “go to bat” for the group when, despite all efforts to prevent it, an impasse with the administration develops.

When addressing issues associated with non-qualified or problem providers, the group should have a formal procedure for dealing with employees who are perceived to be problematic to hospital staff, surgeons and/or patients. If necessary, the physician leadership must be willing to terminate its relationship with a partner, physician employee or anesthetist if there is a failure to meet the professional standards expected of a medical group.

There must be zero tolerance of socially unacceptable behavior, including, but not limited to, issues of personal conduct. If the group cannot manage the behavior of its members, the hospital will manage it for them, either by employment or with the help of large anesthesiology corporations.

Quality: A quality management and improvement plan should be devised and initiated. Hospitals and practice management programs tout these programs and so should private anesthesiology practices. Some say it is the wave of the future and that reimbursement increases will be tied to quantified and measurable performance indicators.

Competent Practice and Business Management

The anesthesia group should be willing to retain and appropriately compensate the services of a competent practice manager. Having an individual dedicated to the business and non-medical administrative components of a practice can be extraordinarily critical to the success of a group. The expertise provided by a qualified business and practice administrator includes, but is certainly not limited to:

1. Leadership and knowledge during discussions with the hospital on critical financial issues;
2. A liaison between administration and the group to help address issues before they rise to the level of problems;
3. Reviewing and providing recommendations relevant to the selection of expensive, but needed, financial products such as malpractice and health insurance;
4. Negotiating reasonable reimbursement rates from third-party payers;
5. Overseeing the billing of services and verifying that collections are being legally maximized;

6. Providing guidance to the group’s leadership on critical issues such as governance;
7. Helping the anesthesiologists to more fully appreciate the risks and rewards of owning and running their own business;
8. Liaison between the group and local and national political leadership;
9. Other services.

Entrepreneurial Spirit

While we all generally want to make more money for our labor, it is usually only the employee who is guaranteed a salary that will not be impacted (at least for the term of the contract) by fluxes of the economy. Depending upon a variety of factors, income can increase or decrease from year to year, sometimes significantly. For an anesthesia practice, income can increase because of:

1. Increased O.R. utilization without equal or corresponding increases in the expense of providing the service;
2. Increased rates associated with payer contracts;
3. Drop in the cost of critical services such as malpractice or health insurance;
4. Or a combination of the above and others.

Income can decrease because of:

1. Loss of critical surgical volume due to the opening of regional surgery centers;
2. Increased compensation requests from ancillary providers such as nurse anesthetists;
3. Loss of providers who are temporarily replaced by locums;
4. Decrease in reimbursement by government and other payers or a deteriorating payer mix;
5. Or a combination of the above and others.

We have seen anesthesiologists willing to accept the rewards associated with business ownership, i.e., enhanced revenue, but unwilling to accept its corresponding risks. Because of this, some anesthesiologists have stated that they would rather have a guaranteed income not affected by market forces than take the risk that their income might fall below a certain level. This is an attitude usually associated with that of an employee rather than an owner.

It is our opinion that maintaining the entrepreneurial

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a hospital that utilizes a multispecialty management group, benefits that include: single-vendor accountability, responsiveness, financial integration with cross-subsidization among or between specialty groups and consistent reporting, to name only a few of the single-vendor advantages.

Single-vendor service, superior QA and reporting services, and financial integration (of results) with a subsequent reduction in subsidies will present hospitals and hospital systems with powerful incentives to consolidate their hospital-based services.

There are AMCs and physician practice management companies that have already initiated the process of implementing a single-vendor, multispecialty vision. When combined with the explosion of consolidation activities in anesthesia (e.g., three AMCs now provide anesthesia services at more than 150 Texas hospitals, with not one of the three even in existence prior to 1999), small- to medium-sized, at-risk anesthesia groups must be proactive in developing a strategic vision.

When developing a strategic vision, your group should make certain that the vision recognizes the demographics as well as the personality of your group.

Example A: If most of the members of the group are nearing retirement age, does the group wish to “cash out” and sell its practice (with the exclusive hospital contract) in exchange for an up-front cash payment and a secure employment agreement?

Example B: If the group has traditionally experienced concerns or problems with partnership arrangements or sharing control, does it make sense (for the group) to engage in merger or consolidation discussions with other anesthesia groups?

Once you have reached consensus on a common vision, there are options available to the group and/or strategic initiatives a group can employ to take advantage of and meet the challenges or threats present in today’s anesthesia practice environment. These options would include but are not be limited to:

- The aforementioned sale to a large regional or national management company.
- A merger or consolidation with other geographically aligned or contiguous anesthesia groups.
- A joint venture (JV) with a large AMC, DAG or other hospital-based specialty group.
- A decision to pursue expansion (by the group itself)

and to acquire that expertise necessary to effectuate a successful expansion plan.

- None of the above, but a refocus on the development of internal competencies, the consistent delivery of a high level of patient and surgeon service that can be **qualified and quantified**, and the use of external assistance to negotiate more equitable payer contracts, to the extent possible.

While I personally believe that a consolidation, merger or JV approach is more conducive to obtaining most of the operational and or economic advantages that an AMC or DAG has been able to develop, it is, after all, your practice. How you wish to practice and provide services to your patients should be the most important part of making your decision.

Pinnacle has recently announced consolidations with Greater San Antonio Anesthesia and Haverford Anesthesia Associates (New Jersey, Pennsylvania and Delaware anesthesia group), creating the largest anesthesia practice and management company in the country. Composed of almost 800 physicians/nurse anesthetists, nurses and an additional 300 management and support staff, Pinnacle provides services at more than 140 hospitals, ambulatory surgical centers, short-stay hospitals and advanced pain management centers.

Pinnacle is a 100-percent physician-owned and governed organization.

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spirit can be one of the greatest protections against takeover from either the hospital or a large conglomerate. It means, among other things, that sometimes it is necessary to work harder for the same amount of money, at least for as long as it takes for the natural ebb and flow of business to move the income back to a higher level. It can include a willingness to assume some reasonable measure of risk with the hospital when new business opportunities present themselves.

Minimizing Support Requests



One manager told his group that each dollar they received was a like a single string tied to the sticks of a puppeteer. Each string limits independence. Each dollar has its cost. Each penny received by the group that it did not directly earn limits its ability to make critical decisions free from interference from others.

If the group feels it is forced to request support, then the terms must be reasonable. Despite the inherent dangers of

accepting a stipend, at its most basic level, the financial support is ultimately utilized to provide the funds necessary for the retention of qualified providers. And ultimately, it is the retention of qualified providers that is critical to the well-being of both the hospital and the group.

And so, here is our most important recommendation relative to the issue of a financial support request:

To maintain qualified providers, and/or to compensate the group for certain requested services, only the *absolute minimum* should be negotiated.

At a certain point and at a certain dollar level, the hospital may perceive the demands of the anesthesiologists to be excessive for the services the group is providing or which it has been asked to provide. Some dismayed anesthesiologists discover, too late, that another group of anesthesiologists is willing and capable of providing quality service at less than what it might have been demanding. Or, even worse, the hospital may consider managing the group's coverage and expense via employment or by utilizing an outside practice management company.

Conclusion

In a darkened office, late into the evening, the hospital administrator sits quietly at his desk and ponders a career question: "Should I or should I not replace this anesthesia group?"

If the group is well managed, if it is run by a group of enthusiastic, well-trained anesthesiologists deeply involved in the care of its patients, working proactively with the surgeons and the O.R. staff — and if it has established a reputation of quality care and independence with a reluctance to ask for and receive funds from hospital operations — and if it has the support of the surgeons and medical staff, then the answer becomes quite obvious.