



ADVISORY LAW GROUP

2011 Anesthesia Business Update

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Introduction: 2011 – Year to Take Control...Or to Be Controlled

Obamacare. Accountable Care Organizations. ASC owners seeking to capture anesthesia billings. The pace of the battle over control of your future is quickening.

Some ignore it, as if it will go away. Many talk about it, but take no action. Only a few take the time to strategize, or even merely to plan, for their group's future, and therein lies your opportunity.

The great majority of anesthesia groups merely “are;” they consider themselves at the mercy of a hospital, of the government, and of commercial payors. Few groups plan even six months to a year into their future, planning being an incremental process, building on the present situation.

But the top echelon of groups take the time and make the effort to strategize for their long term success, strategy being the creation an envisioned, long term future which then serves as a magnet for transformational growth and success.

This year's Anesthesia Business Update centers on the battle for control over your future. It explores six major themes related to developing and refining your group's strategy in 2011. On the pages that follow:

- We'll take a look at the latest seismic attempt to effect a change in overall control, the Accountable Care Organization, and discuss how the process can be hijacked.
- On the group level, we'll discuss some of the secrets to hospital contract negotiation success.
- Also on the group level, we'll take a look at how a “simple” provision in an exclusive contract, the indemnification clause, can bankrupt your group by making you liable for damages you had no hand in causing.
- We'll discuss how creating an experience monopoly is an essential part of your group's long term success.
- And, last but by no means least, we'll discuss the planned replacement, yes, replacement, of physicians by paraprofessionals – and what you can do about it.

Long ago, physicians ceded control of the healthcare market only to have a healthcare “system” rise, a system controlled by bean counters and policy wonks.

Don't simply become a bit character in their play, strategize for your own future.





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ACO: A New Acronym for Control — and How to Hijack the Process



The talking heads of healthcare are at it again: A new acronym to save healthcare has arrived, the ACO, an “accountable care organization.”

Disraeli commented that there are lies, damned lies and statistics. It’s time to add acronyms to the list.

Words do matter. They are a chief element in propaganda. After all, who would argue with “accountable” – we all want accountability, right? We all want “care,” don’t we? After all, isn’t that what healthcare is all about?

But *accountability* to whom? And for what *care*, exactly? Lastly, and most importantly, who runs the *organization*?

Back to the Future

The fact is that we’ve been here before; we just used a different acronym: The “PHO,” physician hospital organization.

In the mid-1980’s into the early 1990’s, hospitals needed a way to assure that they, and not their competitors, other hospitals and the then nascent ambulatory surgery centers, would capture referrals from primary care doctors both directly to their facility and to the specialists within the hospital’s “world.”

Remember, too, that in many parts of the country, the other significant healthcare trend was the growing penetration of managed care. As a result, these same hospitals needed to assure their position in managed care networks.

One solution that proved popular was the creation of PHOs – “physician hospital organizations” – a type of integrated delivery system. In the PHO model, the hospital sponsored the creation of a linkage between primary care, as well as limited specialty, physician practices and the hospital. In some instances, this included the acquisition of physician practices, either directly by the hospital or indirectly via related tax-exempt foundations. In other instances, it included MSO-like arrangements in which the PHO provided a broad range of space, equipment and personnel support. In all instances, it included a participating provider structure such that the PHO could bind the physicians to the terms of managed care deals.

In other words, the PHO became a one stop shop under the *de facto*, if not *de jure*, control of the hospital, for managed care contracting with the physicians and the hospital.

Many of the PHOs formed during the heyday of the growth of managed care failed, especially those that embraced an employed physician model. The formerly independent practitioners who had built successful practices through focused work and entrepreneurial skill were frustrated by the hospital's multiple levels of bureaucracy and mind-numbing internal politics; they quickly understood how to game that system: just enough work, not more.

Enter the ACO

Over the past decade, significant focus has been given to the notion of paying for quality care as opposed to simply the volume of care. Think pay-for-performance, for example.

Of course, quality in terms of overall patient outcome, as opposed to the few measurable instances within a hospital-based physician group practice, is linked to treatment across many providers: multiple physician practice specialties, ancillary care providers, and the hospital, to name but a few. This, of course, has led to the pundits suggesting that organizations linking hospitals, physicians and other providers can be used to contract together, take risk based in part on achieving quality (however quality is defined), and distribute the income. *Ah, distribute the income.*

Although policy makers love to toss the idea around, and have broad definitions for an ACO (according to the Robert Wood Johnson Foundation, an ACO is a "local health care organization and a related set of providers - at a minimum, primary care physicians, specialists, and hospitals - that can be held accountable for the cost and quality of care delivered to a defined population"), absolutely no one knows what exactly, in terms of its definite structure, an ACO will be in operation.

Of course, that didn't stop Congress from including in the newly enacted Patient Protection and Affordable Care Act (AKA "Obamacare") authority for the *Secretary of Health and Human Services* to establish an ACO program.

In deliberately loophole filed fashion that only a politician could love, the statute says very little of what an ACO is, conditioning almost all requirements on regulations to be issued by “the Secretary” who is supposed to establish, by January 1, 2012, a shared savings program “that promotes accountability for a patient population and coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” As this goes to press, those regulations have not been issued.

Groups of providers *that meet criteria specified by the Secretary* may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO. If that ACO meets quality performance standards *established by the Secretary*, it is eligible to receive payments for shared savings.

As determined by the Secretary, certain groups are eligible to participate as ACOs:

- ACO professionals 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.
- *Such other groups of providers of services and suppliers as the Secretary determines appropriate.*

The statute states that an ACO must meet 8 basic requirements. It must:

1. Be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
2. Agree to participate in the program for not less than 3 years.
3. Have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers.
4. Include a sufficient number of primary care ACO professionals for the number of Medicare fee-for-service beneficiaries assigned to the ACO (at a minimum 5,000 beneficiaries).
5. Provide the Secretary with such information as *the Secretary* determines regarding its ACO professionals, concerning utilization, outcomes, quality of care, patient experiences and other factors.
6. Have a leadership and management structure that includes clinical and administrative systems.

7. Define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
8. Demonstrate that it meets patient-centeredness criteria *specified by the Secretary*, such as the use of patient and caregiver assessments or the use of individualized care plans.

But, again, the act contains no set definition of an ACO. To the extent that a hospital will participate in an ACO, it is a PHO with a few bells and whistles. On its face, it's about quality, combining physicians and facilities, patient-flow, contracting and payment. But at its heart, it's about contracting and payment, the same notion as a PHO.

The Golden Rule

The reality is that there is only one acronym at play here: PCN — Power, Control and Naiveté. Issues of power and control underscore all levels of healthcare. As to the “N” for naiveté, it's yours that they are counting on.

On the macro level, the moving force behind ACOs is outside of the healthcare delivery system itself: Rather, it is large employers, commercial payors and big government. The central issue of concern in respect of our nation's healthcare has not been lack of quality — it has been the cost for that quality, and cost is what ACOs are all about. The notion is that by coordinating care and standardizing treatment money will be saved.

Note that the large employers pushing for ACOs aren't administering Medicare dollars — for them, the notion of an ACO extends to saving on their employees' coverage, the same goal sought by the commercial payors lobbying for “quality” based reform. For them, the game plan is to extend the “benefit” of ACOs to commercially insured individuals.

On the micro level, that of hospitals and your practice, an ACO is about power and control over physician services rendered and, importantly, power and control over physicians' incomes. ACOs are the intended funnel of payor funds — they serve as a mechanism to distribute those funds and, as such, invoke the Golden Rule: He who

has the gold makes the rules. Medicare, large employers and commercial payors have the gold – thus the ACO. Hospitals represent a larger concentration of capital than do disparate physician practices and are therefore more able to shoulder the cost of forming ACO structures and bearing the cost of the sophisticated data systems required; in this context they have the gold and they will seek to make the rules.

As an anesthesiologist, if you think that it's difficult to negotiate with third party payors or to obtain stipend support from the hospital to shore up declining reimbursement, think what it will be like when there is one real payor in town, the hospital-controlled ACO.

In both the distant and recent past, physicians abdicated the power of controlling the future of healthcare in favor of other tradeoffs. Historically, the welcoming of Medicare presented a tradeoff of short term benefits for long term woes. And, most recently, the AMA's sponsorship of Obamacare and even the ASA's incredibly naïve support of the House version of the healthcare reform bill, led physicians down the path of even less control than before.

Hospitals and their associations are counting on this same degree of physician naïveté, as well as disinterest, as they scramble to build ACO networks. Don't for a minute think they have your interest at heart. They view ACOs as a way to "align physician incentives" to those of the hospital.

This is akin to the way in which auto manufacturers "aligned" their suppliers through processes such as GM's Program for the Improvement and Cost Optimization of Suppliers ("PICOS"). The publicly announced purpose of those programs was to work more closely with the company's suppliers to reduce costs and to improve product quality and on-time delivery – a better product at a lower cost. Through "partnership" and "relationship" and "cooperation" that involved sharing the suppliers' cost and production, the manufacturers promised a new world in which they and their suppliers would produce a better product at a lower cost, jointly profiting from their long term, higher volume arrangement.

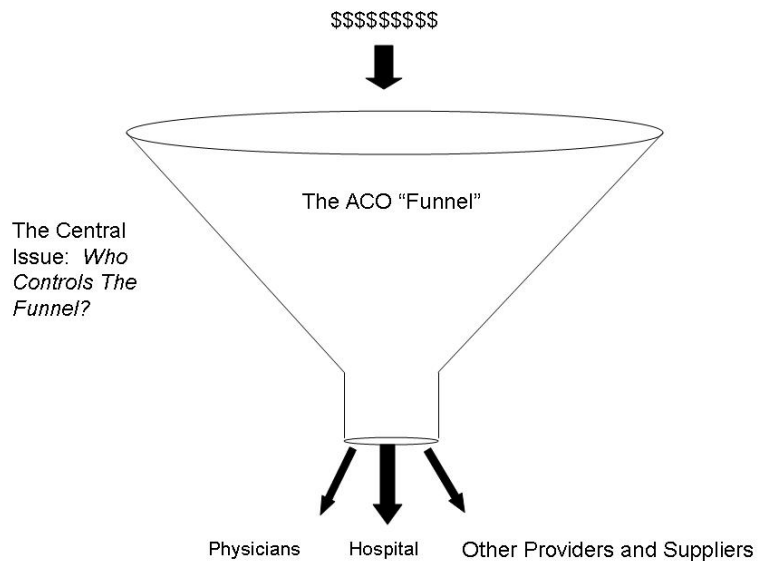
Compare the stated purpose of the PICOS-type programs with the purpose of an ACO as set forth in the Patient Protection and Affordable Care Act: A program “that promotes accountability for a patient population and coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and re-designed care processes for high quality and efficient service delivery.”

The reality of the automobile manufacturers’ programs was, of course, very different. A wolf in sheep’s clothing, the real goals were to gain control over suppliers as they played one against the other, pushing for lower and lower prices guaranteed over longer and longer periods. Through the guise of assisting with the supplier’s production processes, the manufacturer was able to gather more data on the supplier’s true costs; once in possession of that data, they were able to demand even greater price breaks based on cost, not value.

Again, look to ACO structure, specifically to its data reporting elements. Medicare makes an initial payment to the ACO, which reports back in respect of cost and quality issues. Medicare will then determine if cost and quality goals were met; if so, a bonus payment is made to the ACO. But over time, Medicare (and you can substitute the private insurers who will clone this system for themselves) will be in the position to cram down lower and lower initial payments based on more and more data of what it actually costs to provide the services – a downward spiral leading to the same place PICOS pushed the auto suppliers – insolvency.

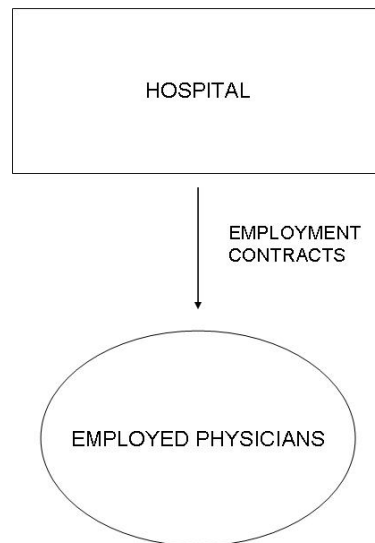
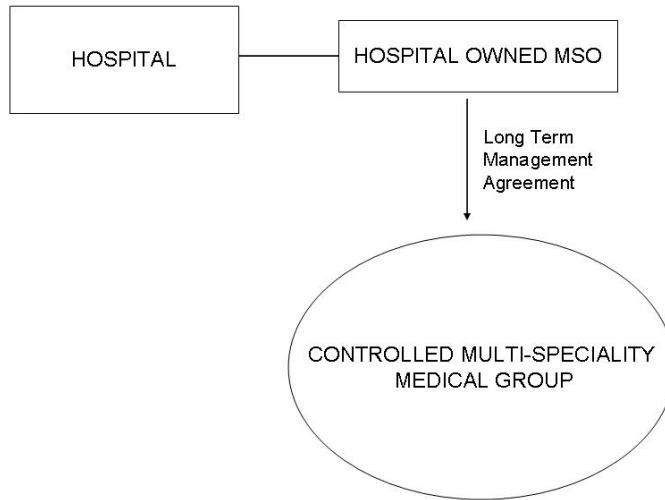
The Financial Structure

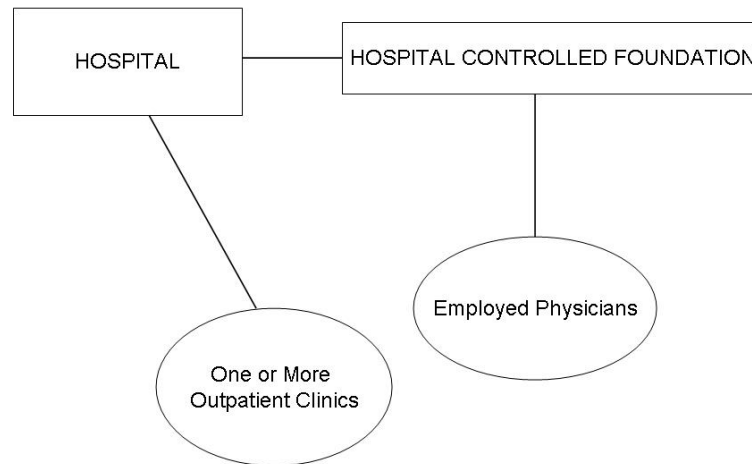
The easiest way to conceptualize the financial structure of an ACO is to imagine a funnel with dollars coming in the top and being distributed out the bottom:



As the illustration indicates, the central issue is who controls the funnel of ACO dollars – if you think for a moment that hospitals believe that it's you, you're in for a shock.

For example, several of the ACO structures that hospitals and their counsel are touting as favored designs for the healthcare system of the future are as follows:





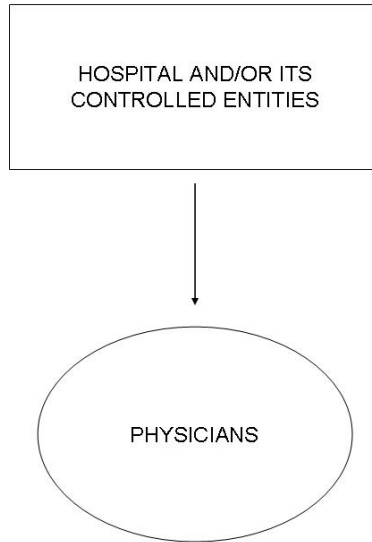
The Hijack Opportunity

Over the twenty years or so, there's been a move on the part of physicians, notably surgeons, to break away from what has become the hospital-centric control of healthcare dollars. The move started with the development of ambulatory surgery centers and, with time, blossomed into the development of specialty hospitals.

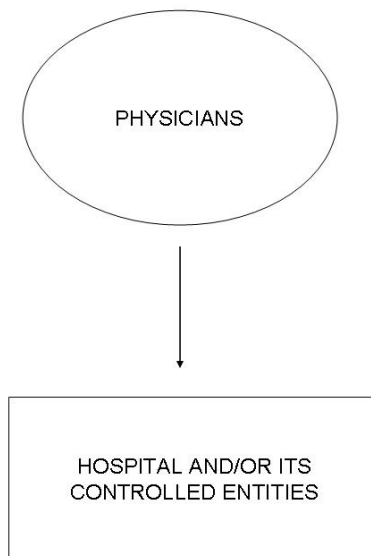
The general acute care hospitals, the larger players, lobbied against the “unfairness” of allowing smaller competitors into the market (the humor of this is that it's as if Walmart were lobbying against allowing competition from independent merchants). In addition to its many other system-changing provisions, the Patient Protection and Affordable Care Act caps existing physician investment, and prohibits future physician investment, in hospitals participating in federally funded healthcare programs — a blow to specialty hospitals.

However, ownership of the facility itself is generally not the driving force: control of the cash is. In that sense, the ACO model can actually be flipped to serve as an even better model than the specialty hospital for gaining control of the hospital-side of the healthcare system.

In other words, the hospital view of an ACO involves control and power moving from the hospital over the physicians:



But there's no rule that requires that control run one way – why not take the structure and shift it to run from the physicians over the hospital?



One of the impediments to establishing an ACO is the cost, not just of the structure, but of the data systems required to coordinate care and to report. The cost structure is one of the key reasons why hospitals have an advantage in the ACO formation process.

Instead, then, of starting from scratch, why not simply hijack the hospital's process?

Difficult, yes. But what's the real alternative?

Secrets to Exclusive Contract Negotiation Success



Books such as *Getting to Yes*, *Secrets of Power Negotiating*, and *The Art of Negotiation*, and the hundreds more like them, spout the conventional wisdom on negotiation — and almost all of it is useless in respect of negotiating an exclusive anesthesia contract. This conventional wisdom is infected with three grave errors:

- It confuses negotiation with bargaining.
- It prescribes strategies applicable to transactions, such as buying a car or even a company, which terminate on closing (Transactional Contracts™), not to ongoing relationships like an exclusive contract which are created on closing and continue past it, hopefully for as long as you wish it to continue – these are Relationship Contracts™.
- Perhaps worst of all, it portrays negotiation as the series of back and forth proposals and counterproposals culminating in the deal, or in no deal, which is akin to describing an around the world cruise as consisting of the docking procedure at the final port.

As you'll learn, negotiation of an exclusive contract or of other relationships with a hospital is an extensive process that is wedded to, and cannot be separated from, a larger strategic vision and a wide set of tactical tools.

This article touches on several of the concepts of a larger process for exclusive contract and hospital negotiation that I refer to as The Contracting Continuum™.

Negotiation Strategy and the Relationship to Overall Strategy

Negotiation is valuable only if its goals are aligned with your practice's greater strategic goals.



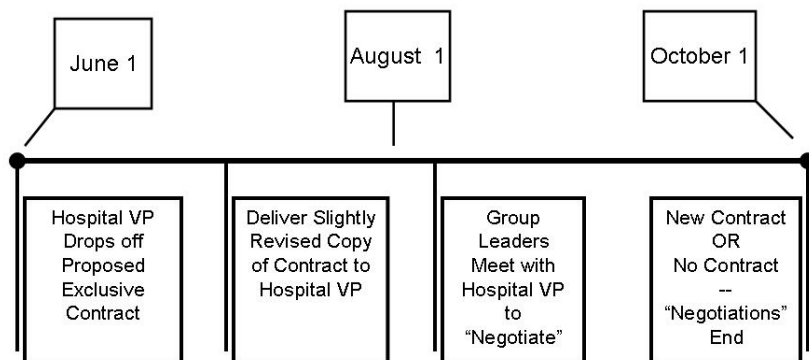
Take for instance a group in a rural setting. The group's overall business strategy is to focus on providing all-M.D. anesthesiology services at facilities within 100 miles of its primary location. It learns of an opportunity to provide services at a hospital two hundred miles distant, a hospital that requires an M.D./CRNA care team approach. Should it negotiate for that opportunity? Clearly, this opportunity is an outlier in respect of overall strategy, both in terms of geographic scope and the professional staffing model.

Overall group strategy is not irrevocably fixed. However, for it to serve as a true strategic vision, it must be strong enough to constrain nonconforming goals. So, either an outlying potential negotiation, like the one discussed above, must be considered undesirable, or the group must carefully consider revising its overall strategy in all regards, not simply make an exception in this one instance.

The method for determining overall strategy, and for aligning negotiating strategy with it, is a process that I refer to as Focus on the Future™. Although that process intersects with The Contracting Continuum, its complexity is beyond the scope of this article and more information can be obtained at www.advisorylawgroup.com/2011/focus.html.

Toss out the Timeline Paradigm

Contrary to the usual, but naïve, advice, you should not conceive of hospital contract negotiation as involving a time line. The following image is not the visual that you should hold in mind:



Yes, I know that that’s the common paradigm, but we’re trying to pull you out of the primordial soup of common, commodity based groups.

Note that I’m not saying timing is unimportant. Timing is very important.

But the time to “start” negotiations on an exclusive contract is not when the RFP hits your desk, it’s not when the CEO delivers a draft of the proposed document, and it’s not some magic three, or even six, months prior to the end of your current contract’s term.

Rather, and perhaps this is the most important point, the time to being negotiating is... well, in the paradigm I urge you adopt, it’s actually already begun.

Welcome to the Real World

I'd like to pause for a moment before I continue to make an important disclosure and to then allow you to make a decision as to whether or not you want to continue to read.

There is simply no such thing in the real world as “win-win” negotiating. Most of the provisions at issue in an exclusive contract are viewed by the hospital in the context of a zero-sum game: “What the anesthesia group gets, the hospital loses.”

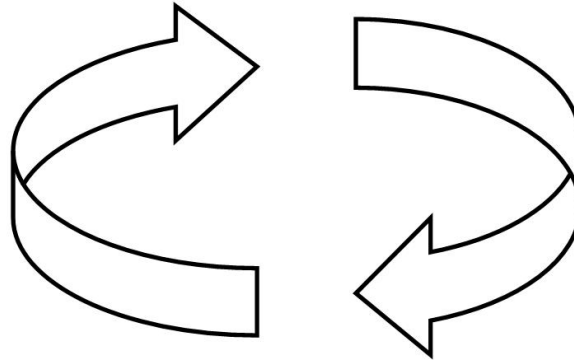
I've heard far too many times hospital CEOs state that they are looking forward to a long and mutually beneficial relationship with a group; yet a week or two later, with no adverse events having occurred in between, they announce an RFP for the anesthesia contract. I've heard far too many times, in defiance of the obvious kickback implications, a CEO demand concession after concession because, after all, “I'm giving you the anesthesia franchise.”

The elements of The Continuum are on the proper side of the ethical “line.” However, these are not strategies and tactics for the weak of heart or mind, for the penny wise and pound foolish, or for those wanting to “do the right thing.” These are strategies and tactics for those who want to increase the likelihood of their long term success, those with a proper sense of self-worth, and those who want to turn offers of \$120,000 in stipend support into \$4 million.

So, in our preferred paradigm there is no distinct beginning and there is no distinct end. Instead, there's an always continuing process: The Contracting Continuum paradigm.

The Continuum

Here's a simple way of viewing The Contracting Continuum paradigm:



This cycle demonstrates that negotiation, in the larger sense of The Contracting Continuum, is a continuing process.

This concept is most easily grasped in the context of the renegotiation of an existing exclusive contract: My clients understand that the day to “begin” negotiating their next exclusive contract is as soon as the ink is dry upon signing their present exclusive contract.

This concept is based on the fact, hidden in the open, that seemingly discrete events in the life of running an anesthesia group are interrelated. Each event, each instance, each interaction, whether within your group, between your group and the hospital, or between group members and other physicians, reverberates far beyond the scope of the immediate issue.

The nexus is that they are all elements upon which the success, or failure, of the group hinges, and, as such, with the proper approach, they can be managed and manipulated to your benefit.

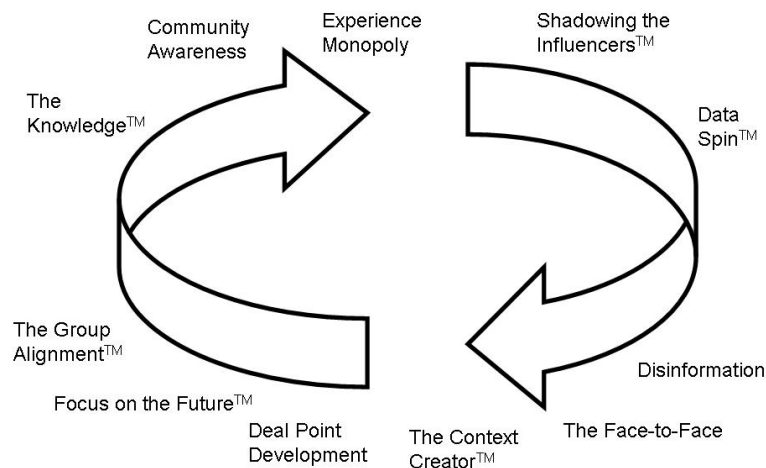
Yet the average anesthesia group, even one “benchmarked” to best practices¹, fails to comprehend the interconnectivity inherent in respect of hospital-based groups.

¹ I'm a strong *disbeliever* in “benchmarking” as I find that in practice it encourages a cap on innovation. Successful groups don't benchmark, they aim to exceed all current standards. After all, if man had been content to benchmark to the best dragging sled, the wheel would never have been invented. Why should you limit your success by benchmarking?

Its leaders may address some of the events facing them, perhaps, in any given month, a contract dispute with an independent contractor physician and an increasing lag between the date of cases and the submission of claims for payment, and attempt to manage them as discrete instances. Other events are viewed as inconsequential in the scope of the group’s overall relationship with the hospital, for example, a minor argument between one of the group’s physicians and a hospital tech, and are allowed to “fade away,” *as if that is actually possible*.

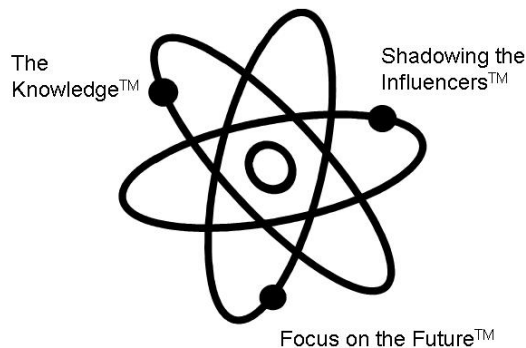
However, if you understand how to identify these elements, create a proper strategy and then coordinate implementation of tactics, you will create a transformationally better future for your group and for yourself.

The concept of The Continuum demonstrates that once the process is started it does not stop. The following, somewhat less simple, visual highlights some of The Continuum’s many subprocesses:



Think for a moment of the process’ cycle as an escalator – the cycle is always progressing, but for each of us there’s a point at which we get on. Once on the cycle, groups should never get off.

But to be more complete, at the same time, each of the subprocesses themselves is really an individual cycle that once started, continues to move. In fact, although the visual of the full process is far more complicated, the image of an atom, with its multiple electrons in constant motion, provides a clearer mental image of The Contracting Continuum.



Several of the elements of The Contracting Continuum are described below. Please keep in mind that although there is a certain order to the commencement of some of the elements in the initial adoption of The Continuum, once begun, they operate continuously.

The Group Alignment™

The longest journey may indeed start with the first step, but if you're not wearing shoes you certainly won't get very far.

Similarly, even if your group has the exclusive contract at a hospital, if its members, owners and employees/subcontractors alike, aren't aligned with the group, all of its other efforts expended in The Continuum process may be for naught.

The Group Alignment process impacts at multiple levels. On a very basic level it involves an analysis, and potential realignment, of:

- The group's personnel;
- The incentives and restrictions set forth in the group's organizational documents, its employment agreements and subcontracts, and its compensation plan; and
- The group's non-monetary, personnel-binding initiatives.

Take, for example, a group which has, among its subcontractors, a physician who is constantly at odds with the group. He recently refused to sign a newly revised subcontract that the group offered to all of its subcontractors. He claims that support from a group of cardiac surgeons immunizes him from the need to agree to the revised terms. The Group Alignment issue is pretty clear: Does the group want this issue to fester and potentially impact upon the group's relationships with its other subcontractors and the hospital?

Or for example, consider a group of 25 physicians, fifteen of whom are shareholders and all fifteen of whom are on the board. Although the group has the necessary officers required of a corporate organization and its president is nominally the leader of the group, its culture is that all business decisions are generated by consensus among the board members/shareholders. The group has had an exclusive contract with Hospital X for close to 20 years, but income is moderate at best and the agreement is harshly favorable to the hospital. The president is unable to overcome the fact that a subset of 6 shareholders, all of whom are close to retirement, do not want to press the hospital for the changes necessary. Is the group willing to continue to be mired in mediocrity?

Framing the Issues

Exclusive contract deal points do not exist in a vacuum – they exist within a framework. Without our intervention, the framework is destined to be the hospital's or "how it's always done" (which is just another way of saying "the hospital's"). Here's an example: "Charity hospitals exist to serve the community's patients, not to provide remuneration to physicians."

We must devote significant efforts to framing the issues well in advance; many of the elements of The Continuum provide the tools to disseminate the message. For example, a simple re-frame of the above might be, “In order to provide the highest level of care to the community, we need to recruit and retain the best physicians.”

The framing is constantly reinforced though the group’s actions during the course of the negotiation process.

An example of this is the way in which financial and performance data is transmitted to a hospital’s valuation expert in connection with a fair market value analysis of proposed hospital support: As mentioned, the group must frame the issue of support as something other than simply money for the group’s physicians, thus the above example of framing to patient care, recruitment and “retention.” Simply delivering raw data to the valuation expert does nothing to reinforce the frame. Rather, all data would be managed and presented in a way that enhances the “story” – the presentation wraps the data in an argument based upon the group’s frame.

The Knowledge™

The process to which I refer as The Knowledge is really an intelligence gathering operation. It’s aimed at gathering information on the facility you are targeting and on the individuals who are in a position to influence the facility’s decision.

The process first involves identifying the players, including:

- Hospital administrators
- Hospital board members
- Medical staff leaders
- Hospital counsel, both in-house and “outside”
- Other potential key influencers

The next step in the process is to develop as much in depth information on each of them as is possible. For example in connection with the hospital’s COO, a short list of the dozens of sources would include drawing on the group’s members’ prior interactions with the COO, researching the experiences of other hospital based groups that have negotiated with the COO, discovering the community and professional groups to which the COO belongs, and conducting internet and public records searches.

The Knowledge process also gathers information on the facility and on the external and internal issues affecting it. Although individuals, not entities, make the actual decisions, focusing solely on the individuals would not reveal the pressures that may be bearing on the facility itself or the facility's track record of dealings, both of which are highly valuable.

This process is also deployed at potential competitors for the exclusive contract.

All of the information gathered in the course of The Knowledge process is preserved in a deal book for use in the course of the overall negotiation, as discussed in detail below.

Contracting Force Multiplier

The ultimate purposes of The Knowledge effort are to influence the behavior of third parties in favor of the group, and to alter their perceptions of it.

This is accomplished through a series of subprocesses deployed in combination and which together act as a force multiplier. This combination is an application of what is known militarily as "psychological operations."

Profiling

The information gleaned from The Knowledge process is used for several purposes.

Profiling is one of those purposes. It's conducted with the goal of deducing how the subject will think, behave and act in similar circumstances.

This is by no means exact, but it can be highly predicative of future behavior.

The results of this process can be used as a guide for tactics deployed against the profiled individuals in the course of later face to face negotiations. For example, does she get upset easily? Does he seem to be overly concerned about being viewed as "fair?"

The results of this process can also be used in deploying created circumstances, both real and verisimilitudinous, likely to drive the subject's behavior in the manner most favorable to achieving our goals. This is not necessarily driving behavior to induce the

subject to take specific action – it can be driving behavior that results in that individual becoming a positive influencer or, conversely, in becoming marginalized and therefore neutralized. Also note that the created circumstances might be deployed in respect of a third party with the aim of marginalizing the true target. Think of questions such as: What pressure is the target under to deliver the contract? Who hired her and who might want her to fail?

Finally, profiling results are valuable in planning situations in which the predicted behavior itself can be used to create a pitfall.

For example, in an exclusive contracting renewal negotiation, we developed intelligence that the hospital VP charged with negotiating the agreement often played a game of deadline brinksmanship on contract renewal. We developed a strategy to stretch out negotiations, all the while embarking on a program of establishing one on one ties with the members of the hospital's community-based board to keep them apprised, from our perspective, of the deal's progress. Those conversations included planting the picture of the VP as an unfair bargainer. As expected, the VP delivered what he thought was a deathblow: a final, "best" offer a day before the board-designated contracting deadline. That offer imposed new, highly burdensome call and coverage obligations and slashed hospital financial support. We refused to bend to the demands, and using our now open lines of communication with the board, argued that the VP had, as we feared, sullied the name of the hospital by engaging in disreputable tactics. We succeeded in having the VP removed as the hospital's contracting point person. The hospital's president, whom we had learned from the Knowledge process viewed the VP with distrust as he appeared to be aiming for the president's job, stepped in to finalize the agreement in place of the now marginalized VP.

Community Awareness

The creation of community awareness, at the level of both the hospital community and the community at large, employs the results of various other Continuum sub-processes.

Developing community awareness is aimed at accomplishing two objectives: The first is to create direct benefit from their performance – in other words, to do good while you are doing well. The second is to manufacture situations that can be publicized in

order to sway broader opinion. Based on The Knowledge process and the resulting profiling, manufactured situations can be tailored to impact upon the targeted individuals, as can participation in existing community organizations and events.

An obvious example of creating awareness at the hospital community level is participation on medical staff committees. In connection with both the medical staff and the hospital board, it's extremely important to lay a plan of participation and of long term lobbying. At many facilities, medical staff support, and certainly board member support, is the difference between the group being viewed as "just another service" or as a valuable "partner."

An example of creating wider community awareness is participation in the city's annual health fair.

An example of a manufactured situation is the creation of a lecture series and scholarship program at area high schools for students with an interest in becoming doctors.

Finally, an example of a tailored situation is the offering of that type of program at the private school that the hospital CEO's daughter attends and on whose board the CEO sits.

Publicity Push

In order to publicize the group's activities, there is a coordinated push for publicity. The process involves the use of press releases, newsletters, websites, blogs and other activities designed to obtain favorable publicity.

Of course, the push seeks publicity for the group's community awareness efforts. It also includes generating publicity for group initiatives, personnel changes and the other events.

Putting the publicity push into context, participation in events such as those discussed in connection with developing community awareness brings a limited, but highly focused, community consciousness. The purpose of the publicity push is to leverage off of the group's community and other activities to include a larger audience, one that will directly or indirectly be of benefit to the group.

Disinformation

In general terms, psychological operations involve transmitting information and using indicators in order to influence the intended target's emotions, attitudes, and ultimately, their behavior in support of our intended goals.

Just as the creation of community awareness and the related publicity push seek to transmit truthful, yet spun, information that is attuned to its intended audience as a result of profiling, a similar process using disinformation can be employed.

The term “disinformation” in this context is used to mean misinformation that is deliberately disseminated in order to influence or confuse. Disinformation aimed at the hospital's or a key administrator's weaknesses and vulnerabilities can be highly valuable in swaying their negotiating behavior.

An example would be the use of false indicators that the group is giving greater weight to other practice location alternatives, thus suggesting that the group might walk away from the deal.

Conclusion

Negotiation is a continual process, not a 1-2-3 series of steps arranged upon a timeline.

Proper preparation for the “face to face” stage of negotiation requires a long term commitment to developing information and to employing it. This effort is best viewed as a series of interlocking processes designed to maximize your outcome.

The processes presented above are among the many processes that comprise a complete contracting strategy. For more information visit www.advisorylawgroup.com/strategicgroupprocess.html

Indemnification in Exclusive Contracts: Benefit or Bankruptcy



Why do so many anesthesia groups agree to become liable for someone else's misconduct? How can you avoid rushing into a similar fate?

Since taking on the outsourcing of the service, each day shortly before noon, the St. Mary's School courtyard is filled with the marvelous scent of charbroiled food as you, a Registered Dietitian and Cordon Bleu trained chef/owner of Champagne Catering, are hard at work delivering a delicious meal in a safe environment.

Then one Wednesday, Sally Johnson, the most senior teacher on staff, and Betsy Anderson, a first year teacher, enter the lunch line together shortly before 1:00 p.m. By the time they arrive at the service counter and Sally says "Two burgers, please," there's only one burger left. You hand the burger to Betsy and tell Sally that that was the last one.

Despite her years of balanced temper, Sally completely loses it, shouting "That's it! I'm tired of St. Mary's trying to force me to retire!"

A week later, Sally sues St. Mary's School, alleging, among other things, violations of the Age Discrimination in Employment Act. One day after being served with the lawsuit, Saint Mary's chief administrator sends you a letter demanding indemnification by Champagne in respect of all losses, costs, damages and attorneys' fees relating to Sally's age discrimination claim.

Like David McLean, the boy in the 1953 sci-fi classic, *Invaders From Mars*, you wake up, realizing that the demand for indemnification, like the Martian invasion, was only a dream. Keep reading because, like little David, you'll soon realize that the dream was simply a premonition of things to come.

Shifting Risk

Just as beauty depends on the eye of the beholder, perspective governs the purposes of an exclusive contract. Certainly, from the group's perspective, exclusivity and financial support are among the key elements. But there are other elements at play, provisions that govern the allocation of risk. Indemnification provisions are a dangerous example of risk allocation within an exclusive contract.

The basic concept of indemnification is simple: It's a requirement that one party must be responsible for the loss suffered by the other party, the indemnified party. Stated from the perspective of legal risk, the party with the legal responsibility for damages, the indemnified party, shifts the financial responsibility to another party.

The problem is that this simple concept is extremely malleable when applied to an exclusive contract. Consider it as a sort of "indemnification putty."

In some cases, this indemnification putty can be shaped into provisions beneficial to anesthesia groups and *relatively* benign to hospitals. An example is a provision indemnifying the group and its leaders from damages resulting from their performance of hospital-related administrative duties imposed by the exclusive contract.

In other cases, the putty can be shaped into provisions that might cut against you but which incorporate some degree of fairness. An example would be requiring the group to indemnify the hospital in the event that the group's decision to terminate a physician results in a lawsuit against the hospital. Please note that I am not endorsing this type of provision as it leaves many issues open but, rather, simply using it as a prototype for one of the stops on the indemnification continuum.

And in egregious cases, indemnification putty can be shaped into something far more dangerous, a sort of contractual C-4 explosive as opposed to non-toxic Play-Doh. Here's an example of actual indemnification language sought by a hospital:

Group shall indemnify Hospital for any costs, expenses, losses and attorneys fees arising out of or incident to any harassing, abusive or otherwise inappropriate behavior or conduct by Group or any of Group's employees, agents or subcontractors, including without limitation behavior or conduct that results in the assertion of claims (including derivative claims or other claims asserted against Hospital) arising under Title VII of the Civil Rights Act of 1964, as amended, the Americans with Disabilities Act, the Civil Rights Act of 1991, the Age Discrimination in Employment Act, the Older Workers Benefit Protection Act and any analogous local, state or federal law or statute.

The danger in a provision like this one is that it goes well beyond the sort of “you break it, you buy it” notion underlying the previous example: The claims that the hospital seeks protection against are all employment-related claims, claims that would most likely be brought against the hospital *by its employees*, not by the employees of the group. How much, if any, causative responsibility would your group have for the events that you would, pursuant to such an indemnification provision, be held financially responsible for?

Dreams of Things to Come

Let’s apply a little dream therapy. Now that you’re awake, you’re not longer a caterer, you’re an anesthesiologist, Champagne Catering is Champaign Area Anesthesia Medical Specialists, and St. Mary’s is the hospital not a school.

Sally Johnson, R.N., a twenty year veteran employee of St. Mary’s is working with you in O.R. number 5. About five minutes into the case, she realizes that she mis-oriented the patient warming unit and begins to move into the area between you, your monitors and the patient’s head to check and adjust the temperature. To prevent Nurse Johnson from moving into your work field, a potentially dangerous situation, you motion to her to stop and then you quip, “You’ve been here for 20 years, you should know better than come up here.”

Despite her years of balanced temper, Nurse Johnson completely loses it, shouting “That’s it! I’m tired of St. Mary’s trying to force me to retire!”

A week later, Nurse Johnson sues St. Mary’s Medical Center, alleging, among other things, violations of the Age Discrimination in Employment Act. One day after being served with the lawsuit, Saint Mary’s chief administrator sends you a letter demanding indemnification by Champaign Area Anesthesia Medical Specialists in respect of all losses, costs, damages and attorneys’ fees relating to Nurse Johnson’s age discrimination claim.

The basis of the claim? The exclusive contract between St. Mary’s and your group contains the very provision described above, indemnification against employment-related claims.

Sure you have defenses and you have arguments over how to construe the meaning and scope of the indemnification provision and you have arguments concerning allocation of responsibility. But do you want to be put in a position in which you are left holding the bag and grasping for defenses?

“Hey, What’s the Risk?”

As we’ve discussed above, there’s a significant difference between being called to indemnify based on something that you are in control of and something for which you have only tangential, or perhaps no, actual responsibility. In the latter case (in fact, the Nurse Johnson case) you are being put in the position of an insurer, without the luxury of having collected a premium.

One of the important concerns you must consider before entering into an indemnification provision is this issue of causation. Another is to understand that properly estimating the risk that you are assuming requires more than simply determining the probability of an occurrence – it also requires an understanding of the magnitude of the damages that might occur: The risk of pulling the one “loser” out of 6 total choices (that is, 5 good results and 1 bad) is only 16.67%, seemingly low. But the analysis changes as we apply that probability (a) to spinning the roulette wheel at a holiday celebration for your party favor – five great gifts and one whoopee cushion, or (b) to the chambers of a revolver in a game of Russian Roulette. The downside of door prize roulette – a joke item; the downside of Russian Roulette – death.

The risk of having to cough up real dollars in respect of an indemnification provision might be low, say the same 1 in 6, or 16.67% used in the above example, but if the total losses to be indemnified could be \$7,000,000, then the “expectation” (16.67% of \$7,000,000) is really \$1,166,900. What is your group receiving in return for this \$1,166,990? But what if you’re wrong and the \$7,000,000 is really \$10,000,000 and what if you’re even more wrong about the odds? And, in any event, a \$7 million or a \$10 million obligation would probably be your anesthesia group’s equivalent of losing at Russian Roulette.

The Key Points

Unlike a gift, it's truly better to receive indemnification than to give it.

On the other hand, if you are feeling generous, at least understand the extent of the disconnect between causation and the duty to indemnify, the probability of an occurrence, and the scope of the potential loss. Then remember to question what you are receiving in return.

Bear in mind that if you fail to take these elements into account, it will be as if you've made a potentially group-destroying "gift" without ever having had the intent to do so – we usually call that being taken.

The Company Model of Anesthesia Services:

Is Making Less Money to Work at the ASC
Worth Jail Time to You?



When asked why he robbed banks, Willie Sutton responded, “Because that’s where the money is.”

Ambulatory surgery center (“ASC”) owners, often surgeons, seek to obtain a share of anesthesia fees for the same reason. But instead of a gun, many are turning to a new model of money extraction, the so-called “company model.”

The abrupt, bank robber approach to demanding a kickback is clearly illegal: “Bob, if you want to provide anesthesia at Greenacres ASC, you’ve got to pay us thirty cents on the referred dollar”.

Although there are far more ASC owners willing to take the bank robber approach than the industry likely will admit, some ASCs are choosing a slightly softer approach — forcing the anesthesiologists working independently at the ASC to instead work for an ASC affiliated entity that distributes a share of the anesthesia fees back to the ASC owners.

“Bob, if you want to provide anesthesia at Greenacres ASC, you’ve got to become an employee of our entity, Greenacres Anesthesia Services. We’ll even pay you commensurate with your production. In fact, we’ll pay you the lion’s share, seventy cents on the dollar!”

These entities are the “companies” of the so-called company model.

Of course, demanding 30% as a direct kickback (the bank robber approach) leads to the same economic effect as does forcing the anesthesiologists into an entity that “rewards” them with a 70% share (the company model).

But is the company model structure legal? That’s the \$25,000 fine *plus* five years in jail *plus* exclusion from Medicare and Medicaid question. Of course, there are also Civil Monetary Penalties to consider, but you get the point.

Business Models

In order to better understand the issues of the company model, it's helpful to consider the evolution of anesthesiologist-ASC business models.

Conventional Model

The conventional, fee for service relationship between anesthesiologists and ASCs mirrors the conventional relationship between anesthesiologists and hospitals – the anesthesiologists, directly or through an anesthesiologist-owned entity, provide services to the patients of the ASC for their own account, in the manner of the surgeons performing their cases at the facility. In this relationship, the facility charges a facility fee and the physicians, both the surgeons and the anesthesiologists alike, charge their own, independent professional fees.

In many cases, the relationship between the anesthesiologists and the ASC takes on an additional factor or factors.

One or several of the anesthesiologists providing patient care services might assume other duties such as serving as the facility's medical director. In compensation for those services, and to avoid a kickback (the provision of those services for free being an inducement to receive the referral of anesthesia cases), the ASC pays a fee, for example, a medical director stipend, in an amount equal to the duties' fair market value.

In some relationships, the volume of cases or total reimbursement to be earned from providing coverage of the ASC's anesthesia needs is not sufficient to attract or retain anesthesiologists. To obtain anesthesia coverage, the ASC pays a coverage stipend to the anesthesiologists or their professional entity in order to supplement their billings.

Over time, some ASC owners began to question the conventional model of their facility's relationship with anesthesiologists.

For some, it was an issue of economics. Many ASCs were located in markets that were already saturated. Many were located in areas that became economically depressed. Many, even in otherwise good locations, had cost structures that reduced, or even eliminated profitability.

For others it was a question of greed. Surgeon owners saw that anesthesiologists' earnings from the surgery center could be greater than their own. Others viewed the right to provide anesthesia at their ASC as a "franchise" that had value and they wanted a share of it.

Captive Model

No matter the motivation, a second ASC-anesthesia business model took form, one that I refer to as the captive model. This model has the anesthesiologists working for the ASC as employees or as independent subcontractors – the defining characteristic being that, through one method or another, the ASC pays the anesthesiologists a fixed or production based sum. In some variants, the ASC bills the anesthesia fees under its own name; in others, it bills and collects under the name of the anesthesiologists – in any event, the anesthesia fees eventually find their way into the ASC's bank account.

Company Model

For one or more reasons in any particular situation, the captive model began to morph into the company model. Some ASCs found that payors rejected their claims for anesthesia fees when billed under the ASC's name. In states with prohibitions on the corporate practice of medicine, lay entity ASCs cannot provide medical services and therefore cannot employ the anesthesiologists or even subcontract with them under a financial structure in which the ASC participates. Some ASC's had neither of these problems but simply wanted to separate out, perhaps for management purposes or perhaps to disguise their real intent, the anesthesia coverage arrangement into a separate entity.

In some instances, it was not even the ASC itself that sought to change the relationship with their anesthesia providers by forming an anesthesia company owned by the ASC itself or by all of the ASC's owners. Instead, it was a subset of the ASC's owners, usually one or more surgeon-owners with referral clout, who sought to skim a bit of the profit cream off of the top of anesthesia services.

Key Compliance Issues

Stated in simplified terms, the federal antikickback statute (the "AKS") prohibits remuneration, that is, the transfer of anything of value, for referrals.

State laws, which differ in their treatment, scope and interpretation, generally contain similar provisions barring remuneration for referrals, sometimes expressed as anti-kickback or fee splitting prohibitions. Because of the variations in state laws, our focus will be on the federal concepts applicable to Medicare and Medicaid patients.

Courts have interpreted the AKS to apply notwithstanding the fact that there are many purposes for the arrangement that may be legitimate – the fact that one of the purposes is to obtain money for the referral of services or to induce further referrals is sufficient to trigger a violation of the law.

There are certain statutory and regulatory exceptions, known as “safe harbors,” that define permissible practices not subject to the antikickback statute because, in the opinion of the regulators, they would be unlikely to result in fraud or abuse. The failure to fit within a safe harbor does not mean that the arrangement violates the law, there’s just no free pass.

The question, then, for the company model is whether the arrangement violates the AKS.

Of course, the facts and circumstances of the structures vary and each potential deal must be analyzed carefully before it is structured. But it is possible to highlight the significant likelihood that many company model deals are illegal.

The Department of Health and Human Services’ Office of Inspector General (“OIG”) has issued two fraud alerts applicable to the analysis of company model deals, its 1989 Special Fraud Alert on Joint Venture Arrangements, which was republished in 1994 (the “Fraud Alert”), and its 2003 Special Advisory Bulletin on Contractual Joint Ventures (the “Advisory Bulletin”). The OIG uses the term “joint venture” to mean any arrangement, whether contractual or involving a new legal entity, between those in a position to refer business and those providing items or services for which Medicare or Medicaid pays.

Although the OIG withdrew its once proposed sham transactions rule, it made clear in issuing the safe harbor regulations and in other documents that compliance with both the form and the substance of a safe harbor is required in order for it to provide

protection. In other words, even though planners generally work to fit a company model deal into the confines of a safe harbor, the OIG's position is that if one underlying intent is to obtain a benefit for the referral of patients, the safe harbor would be unavailable and the AKS would be violated.

The Fraud Alert and the Advisory Bulletin

The Fraud Alert states:

“Under these suspect joint ventures, physicians may become investors in a newly formed joint venture entity. The investors refer their patients to this new entity, and are paid by the entity in the form of “profit distributions.” These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary program expenditures.”

In describing examples of questionable features of suspect joint ventures, the Fraud Alert mentions, among others:

- Investors are chosen because they are in a position to make referrals (e.g., the surgeon owners of the ASC who become the owners of the company model entity);
- one of the parties may be an ongoing entity already engaged in a particular line of business (e.g., the anesthesiologists); and
- the referring physician's investment may be disproportionately small and the returns on investment may be disproportionately large when compared to a typical investment in a new business enterprise (e.g., the company model, which requires only nominal start up capital).

It's obvious that the features of a company model include many of those stated by the OIG in the Fraud Alert to be questionable.

The Advisory Bulletin issued by the OIG in 2003 sheds even more light on the analysis of company model structures. It focuses on questionable contractual arrangements in which a healthcare provider in an initial line of business, termed the “Owner” expands into a related healthcare business by contracting with an existing provider of the related item or service, the “Manager/Supplier,” to provide the new item or service to the Owner’s existing patient population. Note that the term “existing provider” as used in the Advisory Bulletin is not limited to situations in which the specific anesthesiologists have an existing relationship with the ASC at the time the company model joint venture is formed.

The Advisory Bulletin describes some of the typical common elements of these problematic structures. (See the sidebar.) They appear almost as if meant to describe a company model structure in which the ASC or some or all of its surgeon owners form the company solely for the purpose of providing anesthesia services to the ASC: Little capital is required. The anesthesiologists, not the owners, provide the actual services and, absent their engagement by the company, they would be providing anesthesia services for their own account. The company’s owners capture a share of the anesthesia revenue. And, importantly, the more cases the ASC or its surgeons refer to the company, the more those company owners make.

The Advisory Bulletin states that despite attempting to fit the contracts creating these joint venture relationships into one or more safe harbors,

The 2003 Advisory Bulletin states that problematic joint ventures typically exhibit the following elements:

- The owner expands into a related line of business that is dependent on direct or indirect referrals from, or on other business generated by, the owner’s existing business.
- The owner does not operate the new business, the manager/supplier does, and does not commit substantial funds or human resources to it.
- Absent participation in the joint venture, the manager/supplier would be a competitor in the new line of business, providing services, billing and collecting

such protection might not be available. The OIG views the discount given within the joint venture's common business enterprise (e.g., the anesthesiologists agree to be paid less by the "company" than they would receive if they billed independent of the joint venture) as not qualifying for the safe harbor applicable to discounts.

Even if the contracts could fit within one or more safe harbors, the Advisory Bulletin states that they would protect only the payments from the Owner to *the Manager/Supplier* for actual services rendered, not the "payment" from the Manager/Supplier back to *the Owner* in the form its agreement to provide services to the joint venture for less than the available reimbursement, that is, the "discount" given within the joint venture.

Again, the failure to qualify for safe harbor protection does not mean that a venture is illegal. It does mean that it might receive additional scrutiny that could lead to prosecution.

In 2009, the ASA requested that the OIG issue a Special Advisory Bulletin on the company model. The ASA renewed that request in June 2010. Although the OIG has acknowledged the initial ASA request, as of this writing it has yet to act.

The Bottom Line

The bottom line is that company model ventures are fraught with kickback danger for all parties involved. Although it may be possible that a particular instance qualifies for safe harbor protection, the OIG's position as expressed in both the Fraud Alert and the Advisory Bulletin demonstrates that these arrangements are subject to special scrutiny.

As the government's focus on weeding out healthcare fraud intensifies, the need to fully understand the risks grows. Each situation must be analyzed carefully as there is a high chance of an AKS violation leading to criminal fines, civil penalties, exclusion as a provider and even imprisonment.

... And An Important Post Script

The Fraud Alert and the Advisory Bulletin make clear that there is no requirement that a fraudulent joint venture be operated through a new legal entity. Captive model structures in which anesthesiologists work directly for the ASC itself, whether as employees or as independent subcontractors, are joint ventures.

The financial relationships within those captive model joint ventures are as equally suspect as those within company model joint ventures, a fact most often glossed over.

In fact, the company model format may simply be a slightly slicker variation of the captive model – slicker because it provides the ASC with alternative way, the company, to bill for anesthesia professional fees and, in a state with a strong prohibition on the corporate practice of medicine, creates a medical entity to hold the anesthesia business. Lastly, in other instances, the company model is just a captive model with stickier fingers – instead of the ASC itself, or all of the ASC's owners, sharing in the anesthesiologists' pie, a subset of the surgeon owners take that slice for themselves.

Viewed in the light, the captive model and the company model are two sides of the same coin, one that the surgeon owners of ASCs are attempting to put into their pocket. Both models pose significant AKS dangers.



ADVISORY LAW GROUP

Creating an Experience Monopoly



Mediocrity, *n.* – med-i-oc-ri-ty. The quality of being average or lacking in exceptional quality or ability.

I'm consistently amazed how often, when speaking with potential new client groups, that the response to my question, "What sets your group apart from other anesthesia groups?" is something akin to, "Nothing really. We do what most other groups do. We're all board certified or board eligible." With some additional prodding, the response might be kicked up a notch to something like, "Well, we *are* benchmarked to best practices."

But what does "benchmark" really mean? It means that we, too, follow the leaders – that we, too, are . . . mediocre. In fact, if everyone benchmarked to best practices, there'd be no modern medicine, no anesthesiology – we'd just be *really* good at praying for divine intervention.

In order to achieve a transformationally better future, it's anathema for your group to simply do what every other group does, even if it's doing what the best of everyone else does. Instead, your group should be devoting significant effort to creating a monopoly in terms of the experience that the group provides to its "customers:" hospitals, referring surgeons and patients. The term I use to describe this experience monopoly is a Unique Hospital/Referral Source/Patient Experience™.

The reason why this is so important goes far beyond the immediate, and highly valuable, impact on the individuals your group's service affects, from patients to referral sources to hospital administrators. The importance goes all the way to the relationship between your group and the facilities at which it provides services, especially to the relationship preserved by way of an exclusive contract.

In order for you to get a better understanding of what I mean, and why it's important to you, I need to share some of the secrets of exclusive contracting and stipend support negotiation.

If you were to pick up any one of the popular books on negotiation they'd be crammed full of advice, almost all of which is totally useless in connection with negotiating agreements between anesthesiology groups and healthcare facilities.

That's because traditional negotiating strategy applies to a contractual relationship that concludes upon the transaction. I refer to those kinds of deals as "Transactional Contracts™." Examples would be buying a car, agreeing on a price for real estate, or coming to terms on the price of a year's supply of widgets. Each of those negotiations builds up and then culminates – it culminates in a deal in which the parties exchange, say, widgets for dollars and then part ways.

But exclusive contract relationships between anesthesiology groups and facilities are entirely different. They fall into a category that I've termed "Relationship Contracts™" – instead of culminating in a "closing," at which point there is an exchange of money for goods or services, and at which point the parties part ways, this second set of contracting culminates in the creation of a relationship which then, as of the "closing," continues forward in time.

Because of this, anesthesiology groups need to take a different approach, both in terms of the process of obtaining an exclusive contract relationship with a facility and especially in terms of the process of getting that contract renewed or extended or expanded.

In my practice, I've given this process a name, The Strategic Group Process™, but no matter what you call it, it recognizes the fact that the complexity of Relationship Contracts is such that instead of there being a time line . . . steps 1 through 4 carried out in sequence over time toward completion (like in the manner of a Transactional Contract) . . . Relationship Contracts require a process based approach that implements a number of substrategies, and their ensuing tactics, concurrently.

Among the substrategies that groups must implement are those aimed at positioning your group so that it is viewed by the hospital administration and by the medical staff as the only conceivable provider of anesthesia services. Creating an experience monopoly is one of those positioning strategies.

We know that humans tend actually to make most decisions on the basis of emotions, not intellect, and that they then "back fill," in a manner of speaking, their preliminary emotional decision with "facts" that they can use to justify their emotional decision to third parties.

I'm not suggesting that facts are not important. What I am suggesting, is that anesthesia group leaders must understand that negotiation is not simply about hard facts — just *who* tells the better story, your group or a another anesthesia group, or your group or the hospital, might mean who wins the economic battle.

The unique experiences of which I write are valuable both because of the real benefit they bring to their intended audience and because they tell the broader story that only your group can provide that package of experiences, experiences which other groups would never consider delivering even if they could understand their importance.

What your set of unique experiences consists of will depend completely on your circumstances.

For example, how does your group interact with surgeons, individually as well as with their medical staff department? What educational and training experiences are you providing for O.R. staff? How can you package and present data to increase O.R. efficiency? What deliverables are provided to patients that increase their satisfaction and therefore their entire surgical experience? What follow up exists? How can the experience you provide become so deep that it cannot easily be separated from the hospital?

Asking these and other questions in respect of the group's relationship with surgeons, hospital administration and patients will help you design a truly unique set of experiences, an experience monopoly that will distinguish your group from all would-be competitors.

Embedding the benefit of that monopoly into the operation of the hospital leads to a situation in which the hospital becomes dependent upon the continuation of the experience your group provides and in fear of the cost of its potential loss.

The Healthcare Con-Vergence



Healthcare definition: The Long Con – a meticulously planned, long term confidence scam designed to obtain a large return from the “mark.” The opposite of the Short Con designed to instantly fleece the mark of the money or property on his person.

Nobel Prize winner Nels Bohr commented that prediction is very difficult, especially about the future. What did he know? After all, they’re handing out Nobel Prizes to almost anyone these days, apparently for what they might do in the future.

Certainly, some things are easier to predict. For example, the very different role of physicians in the healthcare system of the future.

I’ve always believed that we don’t have a healthcare system – we have a healthcare *market*. Or, at least we had one. As words matter in persuasion, propaganda and politics, the public at large, and many within the market itself, became sold on the “system” approach – voila, there was a “system” to fix. Of course, the fix was in: Obamacare.

So just how will physicians fit within the system? A prominent role in return for the AMA’s support of Obamacare? Maybe not.

Consider these trends that appear to be converging on your medical degree:

The Struggle over Money and Control

As Obamacare has promised more care for less money, the battle for control of limited healthcare dollars and of the delivery system itself is intensifying. Obtaining the power to allocate funding and delivery means that those in control of allocation will have the ability to shift funding, and cost savings, to themselves or their favored participants.

Accountable care organizations (“ACOs”) are an example of this struggle over money and control. Although not specifically defined, these hospital plus provider organizations are to act as funnels for federal healthcare dollars. Picture every case as being

subject to a super global fee: \$X dollars to be paid for all related services, both facility and physician sides. With the hospital in charge of allocating your fee, how fair will it act? Of course, this begs the question of whether it should be acting at all.

The Shift to the Lowest Cost Alternative

With fewer healthcare dollars per patient to spend, those doing the allocating will be tempted to select the provider who offers the service at the lowest price. There will be a predisposition toward acceptance of substitute classes of providers. There will also be the adoption of lower standards as to what constitutes an acceptable substitute service.

For example, let's look at the current state of the nurse vs. physician debate. Nurses, and those that hire them, that is, hospitals, seek to greatly expand their roles. They see existing limitations placed on the scope of nursing practice as anachronistic and view a healthcare future that is largely nursing-led.

The battle is on for public perception, but nurses consistently come in first in the annual Gallup Poll on the public's opinion on honesty and ethical standards. Even the English language has the odds stacked in favor of nurses. (I wrote this short story to demonstrate: "Sally *nursed* the escaped convict back to health. Afraid he'd be identified, the convict *doctored* Sally's drink.")

Looking even deeper at the nursing issue, consider the CRNA vs. anesthesiologist war for more clues.

Political and economic pressure have forced regulatory change: Fifteen states have opted out of Medicare's CRNA supervision rule, and CMS guidelines already permit CRNAs to administer labor epidurals for the purpose of analgesia without physician supervision.

In 2010, the Lewin Group released a study funded by the CRNAs' national organization, the American Association of Nurse Anesthetists, concluding that CRNAs acting independently provide anesthesia services at the lowest economic cost, with no difference in the level of care.

A second AANA funded study was released in the August 2010 issue of *Health Affairs*, concluding that there are no differences in patient outcomes when anesthesia services are provided by CRNAs, anesthesiologists, or CRNAs supervised by physicians. The study's recommendation? That the Centers for Medicare & Medicaid Services allow CRNAs in every state to work without the supervision of a surgeon or anesthesiologist.

Hospital administrators are already more willing than ever to accept CRNA delivered anesthesia from their contracted providers.

Doctorates for All

Just as it has become in pharmacy and physical therapy, the new gold standard in registered nurse education is a doctoral program awarding a PhD, DrNP, or similar degree.

Of course, nurses with doctorates want recognition of their status: "Hello Mr. Smith, I'm Dr. Jones." No, not exactly.

If there are less dollars to go around and if nurses and other paraprofessionals can, at least in terms of public perception, deliver the same service (or, at least, a level of service benchmarked to the mediocrity of "national healthcare"), and if those paraprofessionals are "doctors," can we then expect a major reboot of the "system" in which M.D.s are removed from the flow chart, or relegated to a less prominent role, the role of technician, not of front line provider with control over patient care and, importantly over the flow of patients to and through a system, and replaced with cheaper "doctors?"

À la *Invasion of the Body Snatchers*, once nurses are "doctors," the transition will be complete.

No Magic Pill

There's no magic pill to resolve this dilemma.

On the political front, there's the ballot box.

On the medical society front, there's tremendous P.R. work to be done to convince the public of the deceptive substitution of providers.

And, on the levels that can more easily be impacted by your personal involvement, there's the fight, at the medical staff level, to protect patients by making certain that physicians control medical care and that paraprofessionals are supervised by the appropriate physician specialist in implementing that physician's orders. On the medical group level, it's avoiding establishing business practice that foster acceptance, on the part of your patients and referring physicians, of employed or subcontracted paraprofessionals as *substitutes* for your physicians themselves: Physician extenders are one thing; physician executioners are quite another.

Whether by plan or coincidence, the substitution of paraprofessionals for physicians is a major element of the long con of national healthcare. As they say in the confidence game, if you don't know who the mark is, it's you.



ADVISORY LAW GROUP

About The Strategic Group Process™



The Strategic Group Process™ was developed from Mark F. Weiss's work with anesthesia groups over the past three decades. The Process provides a road map for you to explore your practice's alternatives and to strategize for its future. It also serves as an overlay to the relationship between us in which work on specific initiatives and projects is coordinated with your practice's overall goals.

The simple fact of the matter, misunderstood or ignored by nearly all of your competitors, is that almost all of the events, occurrences and relationships in the "life" of an anesthesiology group are not separate instances; rather, they are interrelated and, as such, all combine to lead to your success...or to your failure. For example, the terms of an exclusive contract, the provisions of a subcontract or employment agreement with a provider, and manner in which your billing and collection service operates are interrelated: Each impacts upon the other and, therefore, each can be coordinated in a manner that geometrically increases the advantage to you.

The Strategic Group Process™ also avoids the major complicating factors of traditional legal work: Traditional legal work is engaged on a "piecemeal" basis, without coordination with your overall goals; it is generally focused reactively on problems, not proactively on the mitigation of dangers, exploitation of opportunities, and the multiplication of your strengths. Traditional legal work does nothing to control the level of complexity — to the contrary, it often increases it.

The Strategic Group Process™ unfolds over quarterly sessions centered on one or more elements of the process. The initial strategy of the process is The Focused Future Advantage™ — it empowers you through developing your understanding of your own best future and the need to strategize to achieve it. The second strategy is The Unique Experience Planner™ — it results in an understanding of what it is that will remove you from being viewed as a commodity provider.

Each quarterly module, in addition to focusing on a key strategic area, will introduce coordinated subprocesses and present tactics. Each module involves written materials and tools. As the Process, and your work in connection with it, both independently and in concert with us, continues, the materials will become your “play book” for the success of your practice.

Access to The Strategic Group Process™ and its subprocesses greatly accelerates the timeline for resolving legal and business issues. Although each element of the Process is a structure, the implementation is specific to your exposures, opportunities and abilities. This is by no means the usual consulting approach of forcing a client into a predetermined box — rather, it embodies our desire to assist you in assessing your situation, establishing clear goals, developing a strategy to achieve those goals, and then accomplishing that transformational future.

Contact Advisory Law Group today to discuss starting the Process.

Email: request@advisorylawgroup.com

Call: 310-843-2800



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Additional Readings

The following selected articles by Mark F. Weiss are among those available at www.advisorylawgroup.com.



Turning a Mandatory Compliance Program Into a Strategic Advantage.

Obamacare mandates that physicians participating in Medicare or Medicaid have operating compliance programs. Turn the mandate into a strategic advantage.

Will You Pay the Price for an ASC Deal Gone Wrong?

Anesthesiologists should think twice, or even thrice, about ASC deals.

Countering Pressure in Face to Face Negotiation.

Learn how to increase your chances of a favorable negotiation by gaining leverage in countering, or harnessing, the effects of group pressure.

Managing Risk: Required For Success.

Medical Groups and entrepreneurial physicians must learn to manage business risk as a part of their overall strategy.

Are You Headed to the Anesthesia Factory?

Are you headed to the Anesthesia Factory to deliver more commodity service, or are you creating an experience monopoly?

Like Your Exclusive Anesthesia Pact? Learn To Defend It.

If you like your exclusive anesthesia agreement, you'd better learn how to defend it from political, yes, political, attack.

To Control the Contract, Control the Context.

Negotiation doesn't take place in a vacuum, it takes place within a context. So why not control the context?

Thriving Despite (so-called) Healthcare Reform.

No matter what "healthcare reform" law is imposed, the steps that you need to take, right now, to thrive in the face of this looming future are the same.

Securing Customer Satisfaction.

Stop kidding yourself that the delivery of expert, even world-class, medical care is sufficient to guarantee your group's future. Understand how to identify and incentivize high level customer service.

Deploy the Power of Persuasion.

Maximize your group's negotiating power by carefully choosing the message.

Opportunities Knocking In Market Flux.

Let other anesthesiologists worry about surviving the down economy:
Take these steps now in order to thrive.

Increase Negotiating Power.

Physician groups can greatly increase their negotiating power by controlling context.

Anesthesiologists Should Heed Stark Law Ruling.

Anesthesiologists and other hospital based physicians can learn a valuable lesson from a False Claims Act case involving Stark law violations.

Response Letter to the Editor.

See my response to Letter to the Editor in connection with my article, Establish Surgeon Support Without the Monkey Business.

Crafting Effective Employment Contracts.

Learn some of the not so obvious purposes of employment agreements.

Establish Surgeon Support Without the Monkey Business.

Anesthesiologists need to understand that the way to garner surgeon support is by tying to the surgeons' goals.

Boosting Collections, A Group Effort.

What action might an anesthesia group take, both pre- and post-operatively, to boost collections?

Creative Destruction.

The dominant business and financial paradigm for many physicians, especially hospital-based specialists, is that they are a commodity, a valuable one, perhaps, but a commodity nonetheless. If you are ever to break out of the current paradigm, it will not be by benchmarking to the best practices of other groups headed downward in the same maelstrom.

Anesthesia Group (un)Governance.

Democracy is fine for government; it just doesn't work for anesthesia groups of more than a few members, at least not on any level past the election of a leader.

Anesthesia Groups Must Confront the Four Fs.

Too many practices operate as a collection of individuals whose purpose is to provide services at a hospital. From a business and psychological perspective, they have not evolved much during the past 20 years.

Gain Your Fair Share: Gainsharing Makes a Comeback.

Gainsharing is a pay for performance model particularly suited to surgeons and to hospital-based groups.

2011 Anesthesia Business Update

About Mark F. Weiss and Advisory Law Group, A Professional Corporation



Mark F. Weiss is a nationally recognized expert on the legal and business issues affecting medical groups, with a particular emphasis on anesthesia and other hospital based-groups.

Through his firm, Advisory Law Group, Mr. Weiss advises clients nationally on achieving their goals, maximizing their profits and managing their risk of loss.

He has obtained transformational results for his clients. He has turned tenuous relationships between groups and hospitals into strong, long term exclusive contracts with multi-million dollar annual stipend support.

Other law firms view the world through a microscope trained to see the minutia of the “legal” issue and, as a result, ignore virtually everything else. As a result, they preach a purely “legal solution” that, quite often, is worthless in terms of any practical benefit for you.

Mr. Weiss views the world differently: He and Advisory Law Group operate on the same entrepreneurial level as do you. We understand that the legal issues involved are intertwined with your business issues and cannot be separated. We understand that psychological and political issues often transcend the obvious issues. We understand that advising you involves evaluating the issues, fashioning our advice, and implementing a solution, all on multiple levels.

In addition to more traditional approaches, Mr. Weiss has developed specific, propriety processes, including The Strategic Group Process™ for anesthesia group success.

Mr. Weiss is a frequent speaker, the author of more than 100 articles on issues affecting healthcare providers, and a regular columnist for Anesthesiology News.

He holds an appointment as clinical assistant professor of anesthesiology at USC's Keck School of Medicine.

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