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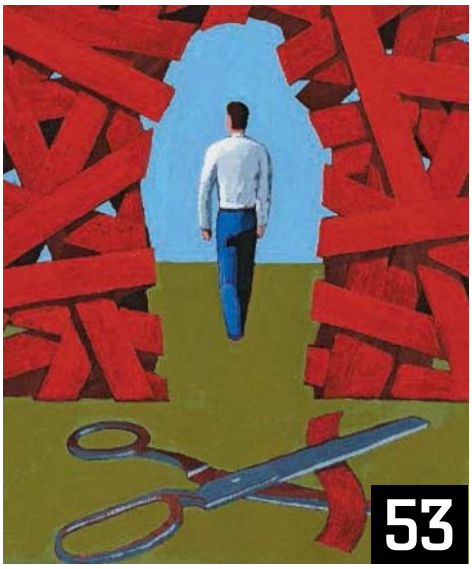

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MISSION STATEMENT *Medical Economics* is the leading business resource for office-based physicians, providing the expert advice and shared experiences doctors need to successfully meet today's challenges in practice management, patient relations, malpractice, electronic health records, career, and personal finance. *Medical Economics* provides the nonclinical education doctors didn't get in medical school.

Physicians who want to be part of accountable care organizations may be best compensated over the long run by controlling their ownership and operation.

VIEWPOINT PART 1 OF 2

Keeping your practice INDEPENDENT in the age of big medicine

IF YOU'RE DECIDING WHETHER TO JOIN A HOSPITAL SYSTEM OR LARGE MULTISPECIALTY PRACTICE, HERE ARE SOME POINTS TO CONSIDER

[By **ALAN S. GASSMAN**, *JD, LLM, and* **FREDERIC R. SIMMONS JR.**, *CPME, CPA*]

The healthcare world has seen major changes in the past 30 years that have led Wall Street and hospital systems to impose paradigm shifts on medical practices willing to accept their premises and terms. These shifts often result from changes in the economic climate or new legislation and have been based largely on the assumption that big business can profit from controlling doctors' methods, referrals, and oversight of patient treatment.

Part of business's strategy has been to persuade doctors that joining the large healthcare system model is inevitable. As a result, droves of doctors who believed they were acting with prudent foresight switched from smaller physician-owned practices to large corporate health systems, often motivated by misleading representations and a modest amount of cash upfront. When the system has failed, doctors have suffered greatly, often returning to private practice a few years later with battle scars and significantly reduced net worth.

Recall (or ask your older colleagues about) when hospitals were buying practices in the 1980s, or when the practice management companies were buying medical groups in the 1990s, or when the hospital physician organizations and state-sponsored medical plan purchasing groups were going to control healthcare, and "800-pound gorilla medical groups" were going to survive. The vast

GETTY IMAGES; PHOTODISC / STEVE COLE

"IN PAST TRANSITIONAL TIMES, THE DOCTORS WHO PROSPERED WERE EITHER THOSE WHO REMAINED UNAFFILIATED OR THOSE WHO HAMMERED OUT CASH-RICH DEALS WITH LIVABLE ESCAPE CLAUSES."

majority of the structures built around the above "accepted conclusions" are gone now.

Nevertheless, in the age of the microchip and World Wide Web, there may be systems that doctors, hospitals, insurance carriers, and even government agencies can plug into together to coordinate and improve healthcare. We believe such coordination will work best if independent physician groups in multiple specialties participate as venture partners rather than as employees of large groups. In this first of a two-part article, we focus on information and strategies to consider in planning for this next round of changes.

GOVERNMENT INCENTIVES FAVOR BIG MEDICINE

Numerous signs point to a major shift toward big medicine. The government's move toward large, cooperative health system models is clear in the 2010 Patient Protection and Affordable Care Act. In this context, Mayo- and Cleveland Clinic-type arrangements are seen as key to providing quality, efficient patient care through sharing information and working "in–house" to provide the full scope of coordinated medical services.

POWER POINTS

Current government financial incentives favor hospital systems and large medical groups.

Profitable practices with low overheads stand the best chance of staying independent.

It's not too soon to begin planning for ways to participate in one or more ACOs.

Any offer to purchase your practice should be considered negotiable.

Consequently, hospitals, insurance plans, and HMO systems are under pressure to acquire or partner with medical practices in certain specialties, such as cardiology, gastroenterology, and psychiatry. Recent changes in Medicare reimbursement for inpatient services such as cardiac catheter labs and nuclear scanner tests add to the momentum. At the same time, the "anti-referral laws" basically make outright employment the sole means by which a healthcare system can control the decision-making and referrals of its physicians. Thus, executives and administrators are seeking ways to increase collaboration in all aspects of patient care and treatment.

As a further incentive, the new accountable care organization (ACO) regulations scheduled to go into effect in 2013 will provide Medicare bonus monies to integrated organizations composed of medical groups, hospitals, and outpatient facilities that treat 5,000 or more patients with favorable outcomes. Essentially, the entire medical system may enjoy the same risk-sharing profits and rewards for efficient care as primary care physicians in managed care organizations have been earning for many years.

We believe that physicians who want to be a part of these ACO systems generally will be best compensated over the long run by controlling their ownership and operation—provided the organizations are based on sound models and professionally designed management systems that are loyal to the physicians while being accountable to all players in the system. We expect that many private carriers and HMOs will need to plug into these ACO systems, which will include outpatient testing, treatment, hospital services, and home healthcare and will be controlled by physician groups, hospital systems, or healthcare plans.

As the healthcare world moves toward big medicine, it is crucial for physicians to plan ahead, understand their options, and take steps to strengthen their bargaining positions. In past transitional times, the doctors who prospered were either those who remained unaffiliated or those who hammered out cash-rich deals with livable escape clauses. We have every reason to believe history will repeat itself.

PROFITABILITY: THE KEY TO SUCCESS

In each transition we have witnessed, a medical practice's profitability has been the primary factor in determining its success, so maintaining strong revenues and controlling overhead should be top priority for practices. We have never seen a physician group experience stellar success because it bought the most beautiful building, had the most expensive testing or treatment equipment, or took the most time off.

On the other hand, working effectively with referral sources, meeting patients' needs, taking advantage of service and reimbursement opportunities, and responding to market demand, while honing a good reputation for intellectual achievement and inventiveness, make a significant difference. It's also crucial to have qualified, trustworthy employee(s) who understand medical practice finance and management to ensure appropriate billing and coding and to monitor the staff's overall effectiveness.

In our experience, smaller practices tend to be more profitable per owning physician (with the possible excep-

tion of multi-office, single-specialty practices) as long as they are managed well and overhead and revenues are controlled by each office.

BE CAUTIOUS ABOUT INVESTMENTS

Physicians and physician groups should be very cautious about investments that require significant overhead or long-term commitment. When opportunities do arise, it's advisable to pursue available joint venture options or structure an arrangement with a quick and inexpensive exit that will allow others to bear most of the risk.

Outward signs of practice success don't always indicate a healthy bottom line. Consulting with experienced certified public accountants and practice consultants and benchmarking with other groups or practitioners are beneficial in monitoring and maintaining control of a practice's finances.

If you have carefully considered the previous advice and have decided that a hospital network best suits you, it's important to understand the situation you are entering to maximize your position within the larger network. The advice that follows focuses on what you need to know.

WORKING WITH OTHER MEDICAL GROUPS

Participation in large medical group organizations has advantages and drawbacks. Advantages include better market access and bargaining power with health plans, resulting in better reimbursement, unified computer networks, electronic medical systems, and sometimes a reasonable balance of power within the group.

Larger groups also may attract more sophisticated management personnel and often enjoy economies of scale in the cost of ancillary operations and facilities. Experience shows that this model can work well with single-specialty groups. Size also can provide negotiating leverage, particularly when the group can move patients to competing hospitals.

On the other hand, we've seen clients join large group practices and encounter much higher per-physician overhead, along with expensive and sometimes ineffective management. Also, a "large-herd mentality" can result

ACCOUNTABLE CARE ORGANIZATIONS

Below are answers to some common questions and answers regarding accountable care organizations (ACOs). The information was gleaned from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (HHS). Additional information is available on the CMS Web site at cms.gov/OfficeofLegislation/.

The Affordable Care Act aims to improve the healthcare delivery system through incentives to enhance quality, improve beneficiary outcomes, and increase the value of care. One of the key delivery system reforms is the encouragement of ACOs. ACOs have a goal of facilitating coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs.

Q: What is an ACO?

A: An ACO is an organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.

For ACO purposes, "assigned" means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of his or her choice, regardless of whether the physician or provider is a part of an ACO.

Q: What forms of organizations may become an ACO?

A: The statute specifies the following:

- physicians and other professionals in group practices;
- physicians and other professionals in networks of practices;
- partnerships or joint venture arrangements between hospitals and physicians/professionals;
- hospitals employing physicians/professionals; and
- other forms that the HHS secretary may determine appropriate.

Q: What are the types of requirements that such an organization will have to meet to participate?

A: The statute specifies the following:

- have a formal legal structure to receive and distribute shared savings;
- have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum);
- agree to participate in the program for not less than a 3-year period;
- have sufficient information regarding participating ACO healthcare professionals as the HHS secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings;
- have a leadership and management structure that includes clinical and administrative systems;
- have defined processes to a) promote evidenced-based medicine, b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative, electronic prescribing, and electronic health records, and c) coordinate care; and
- demonstrate it meets patient-centeredness criteria, as determined by the HHS secretary.

in a less competitive position than some smaller groups enjoy. Additionally, the success of single specialty groups generally does not extend to multispecialty groups unless one specialty is clearly in charge.

HAVE AN EXIT STRATEGY

Doctors who join large groups should be mindful of the "divorce clause." If a large group medical practice breaks up, those members who are able to move to an independent or more profitable practice will be in a much better position to keep their patient bases (and independence) if they have negotiated the right to continue practicing in their geographic areas without significant interruption.

Oftentimes, noncompete covenants can be negotiated to provide the doctor with a buyout right or the right to consider the clause noneffective under certain circumstances.

We've seen significant differences in the treatment of physicians leaving hospitals or corporate systems, depending on the nature of the noncompete covenant and other contractual leverages that were negotiated.

IMPACT OF ACOs

As mentioned previously, 2013 is the goal date for implementing the benefits of ACOs with 5,000 or more patients. Physicians participating in these plans likely will see higher compensation and access to additional marketing and referral patterns. It appears that hospitals, insurance carriers, and other healthcare systems are open to networking into these systems to unify healthcare administration and control costs.

The guidelines will not require that all 5,000 patients be handled under one medical group or entity, so medical groups should not have to legally integrate into "super groups" or hospital or healthcare plan ownership to participate.

There will, however, be expensive and time-consuming changes to computerization, common protocols, and electronic health record coordination that practices will need to undertake to participate in these organizations. This is where the large companies may have the upper hand, because these systems will be costly and likely will require large information technology teams to monitor and maintain them. Computer system businesses make quantum leaps each year, however, so these systems should be available to all ACOs, whether the controlling organizations are hospital systems, insurance companies, or large physician practices.

Although the ACO system rules may cost doctors and potential sponsoring organizations significant lost time and effort in meetings and other coordination efforts, it is important to prepare for them and begin seeking parties with whom to share management system organizations sooner rather than later. It's likely that some entrepreneurial and astute medical groups in each specialty will work to bring physician groups into networks to fulfill the ACO requirements without having to be a part owner or an employee of a hospital, health plan, and/or HMO system.

Also, some software and consulting platform companies will prosper by providing systems services to hospitals, healthcare plans, and medical practices. It is not too early to be in discussions with other practice groups and institutions about future planning, but with a view toward working from a position of strength and opportunity rather than one of fear or uncertainty.

DON'T SIGN UP RIGHT AWAY—NEGOTIATE!

The first offer provided to a physician by the hospital, healthcare plan, HMO system, or group practice almost always will be negotiable. Many physicians don't realize the benefits they can gain through appropriate negotiations and proper communications, including more thoughtful provisions, better financial concessions, contingency escape clauses, and long-term, more balanced relationships. (An excellent book on this topic is *Getting to Yes* by Roger Fisher and William Ury.)

When negotiating, beware of false deadlines, misrepresentations, and unfounded assumptions. Arguing politely over what works best and over legal and business terms is a common business practice that can lead to a much better structure for all involved parties. Don't ever believe that "this is our contract and it is nonnegotiable." Don't do business with anyone who tries to foist that type of arrangement on you.

In the next part of this two-part article, we'll look at the various methods for calculating the monetary value of a medical practice, the potential impact of anti-trust laws on ACOs, why it's important for physicians employed by hospitals and other medical systems to have a say in management, and how to resist the lure of what may seem like a large purchase price for a medical practice. MB

Gassman is a partner in the law firm Gassman, Bates and Associates in Clearwater, Florida. Simmons is chief executive officer of Clearwater Cardiovascular and Interventional Consultants in Clearwater. They acknowledge the assistance of Kristen Sweeney, a professional writer for Gassman, Bates and Associates, with this article. The opinions expressed are those of the authors and are not intended to represent the views of Medical Economics. *Send your feedback to medec@advanstar.com.*

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It's (somewhat) about the money (Part 2)

By Alan S Gassman, JD, LLM,Frederic R. Simmons Jr., CPME, CPA

New healthcare delivery systems: Arm yourself with negotiating power if you sell your practice

Alan S Gassman, JD, LLM

In the first part of this two-part article exploring options for independent practices in a world increasingly dominated by big medicine, we examined how government incentives often favor hospital-owned systems and large, multispecialty practices, the link between practice profitability and maintaining independence, the impact of Accountable Care Organizations (ACOs) on healthcare delivery, and the value of negotiating any purchase offer from a larger organization.

Frederic R Simmons, Jr., CPME, CPA

In this second part, we'll look at the methods used to value medical practices, the impact of antitrust laws on the pricing of doctors' services, how a hospital or managed care company exerts influence over practices in which they invest, and how doctors in independent practices can best evaluate a purchase offer.

MEDICAL PRACTICE VALUATION

Typically, businesses are valued based upon a mathematical ratio common to their industry. For example, for many years medical practices were valued at approximately 1 times gross revenues, meaning a doctor who had $1 million annually in gross revenues could expect to sell the practice for $1 million, payable over time. Then it became common to value a practice based on 1 times net income, so a doctor netting $400,000 in earnings could expect to sell the practice for $400,000.

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In recent years, medical practice valuations have been low and uncertain, and we expect this trend to continue. Many doctors feel that rather than buying an existing practice, they can earn equivalent income by establishing a competing practice. Therefore, a prospective buyer may only be willing to pay a "convenience and acceleration" fee for purchasing a going concern with patient charts, personnel, an established location, and protocols. The benefits associated with an existing medical practice typically are nowhere near 1 times gross revenues or net profits.

By contrast, Wall Street's price/earnings ratio in the Standard & Poor's 500 Index is 15 to 1, meaning that a company earning $1 per share would sell for $15 per share on average. If a corporation could buy the practice described above and replace the doctor with one who would work for $300,000 a year, and have strategies in place to enhance profitability, then the value of that practice on Wall Street could be $15 million.

Stock prices are often based upon anticipated earnings—and executive bonuses are often based on stock prices. Thus, if a company such as HCA can tell Wall Street that it anticipates increased earnings because of physician practice acquisitions costing less than one times earnings, and that the resulting earnings increases may be on a 10 times earnings model, then executives at the company may receive bonuses as stock prices increase, based upon projected earnings and not the actual success of the model.

Another example would be a 20-physician group where each physician makes $300,000 per year ($6 million worth of income) being acquired for $6 million with each physician then accepting a salary reduction to $250,000 in exchange for an upfront payment and a share in any future income growth.

Expected increases in profits from ancillary and in-patient hospital functions might be $1 million per year. If the profit from the $50,000 per doctor payroll reduction is $1 million, and the expected increases in profits from ancillaries are $1 million per year, then projected future profits will be $2 million. If HCA stock is trading at 10 times earnings, the result is a $20 million value from a $6 million investment. This makes it more than worthwhile for HCA or another corporation to come calling with enough cash to make the transaction a reality.

This is how some practice management companies had huge increases in their stock prices, followed by abysmal losses and eventual financial failure during the 1990s. They failed once Wall Street realized that they could not enhance income, and that the medical groups they purchased actually performed much worse due to lower pay and poor management. Many doctors had to fight their

way out of these contracts by litigation or negotiation. It was an unpleasant experience for many participating doctors.

THE FUTURE OF MEDICARE HMOS

The practice of allowing Medicare to pay HMOs 115% of the average cost of treating a managed care patient will certainly be revisited. If HMOs can effectively manage care, shouldn't they bill less than 100% of what is spent per patient per month on average? And the level of reimbursement to many of the specialists servicing HMO patients is less than the Medicare rate. It would be interesting, therefore, to know where the extra money is going.

ANTITRUST LAW

Antitrust laws designed to prohibit doctors in a specialty and region from joining together for the purpose of negotiations help assure continuing opportunities for independent practitioners and small practices. Furthermore, small practices often operate on lower per-doctor overheads than the big groups. With "any willing provider" legislation, which requires any qualified doctor who agrees to a health plan's payment terms to be allowed on its panel, the doctors who do not join the large groups may be the ones who do best.

Additionally, these antitrust laws prohibit separate doctor groups from fixing prices or even discussing what they charge managed care plans. However, an "IPA safety zone" in the antitrust regulations allows competing medical groups to join independent practice associations (IPAs). These may, under certain circumstances, take on managed care plan contracts and pay the physician groups to work the contracts.

Under this "messenger model IPA" an independent company is set up that may be owned by any number of the involved physician groups and/or investors or managers. The physicians who join the IPA give its management a fee schedule or conversion factor indicating what he or she is willing to accept from a payer.

An IPA manager (the "messenger") then develops and shares a spreadsheet that hides each doctor's and practice's identity, while showing how the participating doctors are reimbursed. Using this "sterilized" data, the IPA members can negotiate with the manager as to what levels of compensation they would be willing to take from various managed care plans.

The IPA manager then tells managed care plans the general level of compensation that is likely to attract many of the IPA members. The manager

also has the authority to contract on the IPA's behalf with payers offering at least their minimum price.

Once the managed care plan provides its terms to the IPA, each IPA member has the right to accept or reject those terms. The IPA cannot require every doctor to accept the terms of any particular contract. Furthermore, the IPA allows the managed care plan or HMO to have most, if not all, of the IPA members on its panel, saving time and coordination expenses and efforts.

Overall, IPAs have worked best where the doctors' groups joining them have had good relationships and commonality of decision-making, while still functioning legally and independently as described above. Medical practices using common software, electronic medical records systems, and other common IT infrastructure will probably be ahead of other groups if and when it comes time to negotiate for participation in an ACOs.

THE IMPORTANCE OF CONTROLLING THE MONEY

Typically, about 15% of the money flowing through the healthcare system is spent on insurance carriers and their administrative tasks, including credentialing, 35% is spent on physicians and physician office ancillaries, and 50% is spent on hospital and inpatient expenses. The physicians control most of their own spending, and the physicians control many hospital decisions that affect how the hospital bills and spends its money.

If physicians control a greater percentage of the pie, then they can assure that office services, testing, and treatment are maximized based on cost-effectiveness and the needs of the patients. However, if the hospitals control the 85% of the remaining expenses, then it's likely that more patient testing and treatment will occur at the hospital, leaving less money for physicians and outpatient treatments, and stifling the development of alternatives that might compete with hospitals.

It stands to reason that over time the physicians who control and derive their profit from the medical practices will have more income, while the physicians who are controlled by hospital systems will have less income, but the initial economic incentives that the hospital provides induce physicians to join them rather than staying independent.

There has been some concern that physicians and hospitals partnering would violate laws prohibiting physician self-referrals. However, there's a strong possibility that these laws will be modified to allow enhanced influence over

doctor decision-making by hospital and other medical system organizations. This may permit ACOs to exist without outright employment of physicians by systems that need to control physician referrals.

HOW CONTROL IS EXERTED

Typically, a hospital or managed care company investing in a physician structure will ask for the greatest operational and management control possible. By controlling the ACO they can control referral rules, when and how procedures and treatments will be permitted, supplies and equipment used and prescribed, and many other aspects of medical treatment.

Where administrators are required to respond directly to physicians who hold positions of equal or greater authority, medical practice companies are often more balanced, more responsive, and much more physician-friendly, even when disputes must be resolved by a third-party arbitrator or a hospital chief executive officer.

Medical groups with multiple locations may be in a better position to negotiate favorable terms with a purchaser if they have a proven track record of multiple office coordination, information system usage, and coverage of a broader marketplace.

Where physicians own their buildings and significant equipment, a long-term lease arrangement can be negotiated. But the arrangement must specify that upon termination of employment, the physicians should be able to also terminate the lease and resume their independent medical practices. This is particularly important if and when the sponsoring organization does not comply with applicable agreements, including prudent billing and collection processes.

HOW WILL PHYSICIANS BE PAID?

Devising compensation plans for physicians in integrated medical systems is often extremely difficult. Hospitals are not permitted to pay more than fair market value for a physician's practice, or to pay a physician more than fair market value compensation. Otherwise, the hospital could be accused of paying for ancillary service referrals.

Most hospital/physician employment models call for compensation arrangements to be renegotiated every two to five years. If the doctor has the

right to terminate the arrangement without significant financial cost, then renegotiations can benefit both sides.

On the other hand, if the buyer of a practice requires doctors to sign a long-term, noncancellable agreement, then the physician is in danger of being taken advantage of if the compensation formula proves to be less than what the doctor could earn on his or her own.

At that point the doctor and hospital have to renegotiate or the doctor will need to leave the area to realize his or her earnings potential. Of course, the hospital will have the upper hand in such negotiations, since the cost of relocating and starting over, both professionally and personally, can be tremendous.

WEIGHING THE PROS AND CONS OF A PRACTICE SALE

A medical practice's sale price is often an important motivator for the physician, but when the price is divided by the number of years of commitment, there may not be as much financial incentive as the physician initially thought. The exceptions are usually cases where funds from the sale represent the final step in an impending retirement, or are invested wisely, or used to repay debt.

Too often, unfortunately, physicians who sell their practice don't invest the proceeds of the sale wisely. The safest course is almost always to place at least a portion of the funds in certificates of deposit, money market funds, or short-term bonds so it is available to buy back the practice or establish another one if the new arrangements don't work out.

Developing a spreadsheet can be helpful for anticipating the financial results of a practice sale. While there are certainly tax advantages to receiving capital gains dollars now, as opposed to dollars later that will be subject to ordinary income tax rates, the loss of the ability to fully fund a 401(k) plan, travel and entertainment expenses, and more to invest in future years may make a practice sale seem less appealing than before.

On the other hand, the hospital system may provide a guaranteed income, and assume responsibility for practice amenities and management oversight, tradeoffs that will appeal to physicians who do not want to manage the business aspects of their practices.

PREPARING FOR CHANGING DELIVERY SYSTEMS

Every physician in private practice should be evaluating how to prepare for the opportunities, dangers, and organizational changes that will occur as the result of the fast-paced structural changes in healthcare delivery systems. This may not always require making significant changes or joining a large organization. There have been instances of physicians joining hospital systems or multispecialty practices, only to have their practices and financial situations damaged to the point where they felt they had to leave and start over.

The "any willing provider" rules, Medicare and other open panel provider plans, and market demand may well give every physician the opportunity to make a reasonable living, and to possibly beat the larger and more administratively top-heavy provider organizations. Almost every specialty has profitable niches and developing areas doctors should watch for and participate in when feasible.

The largest asset most physicians possess is the ability to make a living. From a professional satisfaction standpoint, it can be vitally important for physicians to have a good working environment and control over their practice. Many doctors who have stayed in small groups have enjoyed financial, professional, and interpersonal success.

Should you decide to join a large provider organization, don't feel compelled to sign its contract as presented to you, even if it seems as though all your colleagues are doing so. While negotiation is often a detailed and time-consuming process, it can yield great results for parties who do it well.

By appropriate negotiation, realistic action, and controlling overhead costs, physicians will improve their chances of staying independent if they so choose, and strengthen their bargaining position if they decide to be acquired by a provider organization.

Information + Preparation = Astute Decision-Making. There is still plenty of time to prepare if the well-informed physician begins weighing the options now. Think carefully before you leap, and if you do, make sure you take along a parachute—just in case.

Gassman is a partner in the law firm Gassman, Bates & Associates in Clearwater, Florida. Simmons is chief executive officer of Clearwater Cardiovascular and Interventional Consultants in Clearwater. Theyacknowledge the editorial assistance of Kristen Sweeney of Gassman, Bates & Associates. Send your feedback to medec@advanstar.com [medec@advanstar.com]

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Alan S Gassman, JD, LLM
Frederic R Simmons, Jr., CPME, CPA

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