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HOW TO NAVIGATE THE RISING TIDE OF AGGRESSIVE RFPs

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Hospitals increasingly are disrupting their relationships with their longstanding anesthesia groups as they seek to cut stipends and get more for nothing. The favored tool? The request for proposal, or RFP.

Consider the prototypical “Springdale Anesthesia” and its 20-odd anesthesiologists, which held the exclusive contract with Quad Cities Regional Medical Center for almost three decades. As the facility grew so did Springdale and its expertise, recruiting subspecialty-trained physicians to the practice despite the hospital’s less than desirable location and, in some subspecialty practice areas, lack of sufficient case volume.

The symbiosis between the group and the facility was enhanced by the coverage stipend Quad Cities paid, and by the fact that both the breadth and depth of coverage provided by the fully board-certified group had enabled the hospital to recruit surgeons to expand into profitable service lines.

As the years passed, contract term seemed to meld into contract term. To be true, there were simple negotiations around renewal time and, on occasion, a bump or two over demands for new coverage or more money. But as the years progressed the pats on the back for jobs well done became more and more hearty.

Until one day, as on the neck of a turkey fattened for months and months prior to Thanksgiving, the ax fell. Called to a meeting with Quad City's chief executive officer, Springdale's president was handed a notice with the three dreaded letters: RFP.

Later, Springdale's leader recalled having heard the CEO say, "We hope that Springdale submits a proposal." For the moment, he still had need of a shirt collar.

Unfortunately, this scene is playing out with increasing frequency, as if the tactic were viral, or at least the topic of a detailed briefing at a hospital association conference.

Of course, the concept of an RFP is not new; it has been used for decades across many industries and by governmental agencies. But as opposed to its traditional use—identifying vendors for discrete supply orders or for a one-time project—the current RFPs for anesthesia services are increasingly being used as clubs to beat down the expectations of the present provider group.

The Three RFPs

Having dealt with anesthesia RFPs over four decades, I've classified them into three distinct categories.

1. **True RFPs:** These are genuine searches for the best-quality provider with a favorable ratio of quality to cost. This type of RFP is the closest in relationship to the traditional form used in industry and government. It is commonly seen in situations in which the current, or sometimes very recently former group, has “blown up” and can no longer provide coverage. It’s also frequent in scenarios where the current group has completely lost the facility’s trust.

2. **Fictitious RFPs:** These RFPs belie the fact that hospital administrators are not interested in the merits of any response; they have already decided to whom they will award the contract. Yet, for one political reason or another, they’ve decided to issue a phony RFP to project a patina of “fairness” to the medical staff, to the hospital’s own board, to some third party—or perhaps to you.

3. **Fulcrum RFPs:** Consider this the weaponized RFP. As the name implies, the increasingly common fulcrum RFPs are designed to create leverage. The facility intends on renewing with the present group but uses the RFP as a tool to dictate terms by fiat and to pressure the group into negotiating against its own best interests out of fear of replacement. Nonetheless, the facility is open to competing proposals.

Category Dictates Strategy

It’s essential that a group understand in any particular situation what type of RFP it is dealing with to calculate its response, or, in some cases, to determine whether to respond at all. It also is necessary to develop very good intelligence to identify the other responding parties.

For example, why should a group incur the cost of responding to a fictitious RFP if it won't be the anointed one? After all, the fix is already in; don't become a bit player in someone else's show. The only reward will be significant expense at considerable effort.

Or, in connection with a true RFP, especially in situations in which so-called anesthesia staffing companies are "bidding," it's vital to weigh the possibility that the process will simply result in a race to the lowest bottom line. Will the former accountant turned staffing company executive care if his group's proposal does not make economic sense if holding the contract will increase the company's market share?

The strategy involved in a potential response and the tactics a group will employ depend on a proper assessment of the RFP's character and on the likely competitors for the contract.

Lastly, the fulcrum RFP situation requires the most advanced strategic thinking and tactical awareness on the part of the group. Groups must deploy both defensive and offensive tactics: On the defense, it's imperative to hold the group together under the strain of what is a violent attack. On the offense, in launching this type of RFP, the hospital has left itself vulnerable as its preference is not to replace the current group. This leaves open the possibility that the current group can transform the situation into an even stronger position, through a strategy executed both within and outside the RFP process to demonstrate the unique benefits provided by the group and the loss that would result to the facility if the relationship did not continue.

Of course, the best strategy for any group includes the creation of an experience monopoly for the hospital, surgeons and patients that results in a situation that the hospital would be foolish to disrupt. Even if the hospital does turn to the use of an RFP, it would be comparing a proven, successful package

to untested alternatives. But, just as some hospitals are run by fools who know price, but not value, the best strategy also includes never being wed to serve only one facility.

As financial pressures on hospitals increase and as commoditization of anesthesia services continues, the trend toward RFPs will intensify. Develop and implement a strategy now for dealing with them now, preferably years before you find yourself on the receiving end of an RFP designed to replace you, to force disadvantageous terms, or, even worse, to have you offer to cut your own economic throat in the mistaken belief that a slow bleed is better than a quick chop.

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