

## “Pearls” in Negotiating with Your Hospital or Your Group

Judith Jurin Semo, J.D.  
Judith Jurin Semo, PLLC  
Washington, D.C.  
(202) 331-7366  
[jsemo@jsemo.com](mailto:jsemo@jsemo.com)

### Objectives.

1. Understand major legal issues relating to negotiating anesthesiology services agreements with hospitals and employment agreements with anesthesiology practices.
2. Appreciate strategies to protect anesthesiologists when negotiating anesthesiology services agreements and employment agreements.

This lecture will provide an overview of problem areas in negotiating exclusive contracts for anesthesiology services with hospitals and ambulatory surgical centers (“ASCs”), including problematic provisions frequently proposed by hospitals, and will suggest strategies to deal with those problem areas. It also will review important issues in negotiating employment agreements with anesthesiology practices. For ease of reference, the “Group” refers to the anesthesiology group that is negotiating or considering entering into an anesthesiology services agreement with a Hospital or an employment agreement with an anesthesiologist; the “Agreement” means the draft services contract (either with the Hospital or a Group) under consideration; the “Hospital” is the hospital with which the Group is negotiating; and the term “ORs” refers both to operating rooms and other anesthetizing locations.<sup>1</sup>

### I. Negotiating Anesthesiology Services Agreements with Hospitals

**A. Do You Need an Agreement?** A Group should consider carefully whether or not it needs a written agreement with the Hospital. If the Group requires compensation from the Hospital for certain services that the Hospital wants, but which are not self-supporting, an agreement is likely to be required, both for regulatory compliance purposes, in order to document the basis for the compensation and, if the Hospital is a nonprofit entity, to comply with nonprofit tax restrictions against inurement and private benefit.

But if the Group is not negotiating compensation, and if the Group has been providing services at the Hospital, what benefits will an agreement provide? Will the potential advantages be worth the cost, in terms of adverse provisions, that the Hospital may require? It is important for the Group to consider whether it has an option *not* to contract before it begins negotiating an agreement. Often, it is the Hospital that initiates discussions for an agreement. The Group should determine the Hospital’s goal in seeking an agreement and whether the Group can address the Hospital’s concerns (e.g., faster turnover of ORs) without an agreement. If the Hospital insists upon an agreement, the Group may have little choice. The important point is for the Group to assess why it is negotiating before simply agreeing to a contract.

As discussed in greater detail below, most Hospital-Group agreements are terminable on fairly short notice. Even those that are not terminable on short notice often provide the benefit of the agreement for a very limited time period, often not more than two years. Depending upon whether or not the Agreement contains any of the protections outlined in Sections I.D, E, and F, below, and any of the problematic provisions discussed in Section I.E, below, the Group may well be better off *without* an agreement.

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<sup>1</sup> The section on negotiating anesthesiology services agreements with hospitals is based upon an ASA 2006 Refresher Course Lecture prepared by this author, which was titled *Key Issues in Negotiating Hospital Contract*. The section on negotiating employment agreements with Groups is based upon material written by this author and included in a 2001 ASA practice management publication titled *Starting Out: A Practice Management Guide for Anesthesiology Residents*.

Hospitals often use exclusive contracts to control hospital-based physicians. In many instances, a Group will be best served by practicing without an agreement and having its physicians' rights and obligations defined by the Medical Staff Bylaws, rather than by an agreement drafted by a Hospital attorney to protect the Hospital's interests.

**B. Goals.** A Group-Hospital agreement represents a written outline of an evolving relationship. A Group-Hospital relationship is akin to a professional marriage, in which change is certain to occur. The best of agreements are ones that are sufficiently flexible to address the new and changing needs that both parties will have during the course of the relationship, and that identify how decisions will be made. A rigid agreement that simply states what the Group will do, with failure to perform resulting in breach, is unlikely to be in either party's interest.

**C. Exclusivity.** An exclusive agreement generally grants the Group the exclusive right to provide all anesthesiology services at the Hospital during the time that the Agreement is in effect, which will preclude other anesthesiologists from providing such services at the Hospital. It also will preclude payors from bringing in their own employed or contracted anesthesiologists to provide services to their members. Absent exclusivity, a Group may have a difficult time making financial projections, as it cannot be certain which cases it will have the opportunity to perform.

Whether or not an exclusive agreement works against a Group's interest depends upon the specific provisions of the Agreement. In general, Hospitals insert many protective provisions in exclusive agreements that are burdensome and restrictive for Groups. These provisions include covenants not to compete, which restrict the Group's ability to provide services at other facilities, including private physician offices; agreements to contract with any and all managed care plans; indemnification or "hold harmless" provisions; and provisions tying the privileges of Group members to the Agreement and waiving due process rights under the Medical Staff Bylaws.

It is important to read an Agreement carefully, as the Agreement may be characterized as an exclusive agreement, and it may have the adverse provisions that are common to an exclusive agreement, but it may have carve-outs to exclusivity. The carve-outs may apply to certain categories of services (e.g., anesthesia for cardiac cases and any thoracic cases performed by cardiac surgeons); new services, if the Group and the Hospital cannot agree upon compensation; services for patients covered by a particular payor, if the Group cannot agree on contract terms with the payor; or other situations outlined in the Agreement.

Ultimately, the question is whether the problematic provisions in the Agreement outweigh the benefits the exclusive Agreement offers. In making this assessment, it is essential to look at how long the exclusivity protection applies, which in turn depends upon the termination provisions of the Agreement and how quickly it can be terminated, and whether or not privileges are tied to the Agreement. An exclusive agreement that can be terminated without cause by the Hospital on sixty or ninety days' notice affords limited protection to the Group, as the contract can end at any time on fairly short notice. If the clinical privileges of Group members survive termination of the Agreement, so that Group anesthesiologists may continue to practice at the Hospital even after termination of the Agreement, the Hospital's ability to terminate the Agreement represents less of a threat to the Group, so that the Group may decide that the benefits of the exclusive Agreement are worthwhile, despite the Hospital's ability to terminate on fairly short notice.

**D. Protecting Against Unqualified Coverage Obligations.** In the early days of exclusive contracts, anesthesiology groups frequently welcomed exclusivity and the ability to provide all of the anesthesiology services a hospital wanted. With the implementation of the Medicare physician fee schedule, which undervalues anesthesiology services; the increased penetration of managed care; the shortage of anesthesiologists and nonphysician anesthetists, with the resulting increases in salaries; and rising costs for professional liability insurance, the financial pressures on anesthesiology practices have forced careful assessment of the financial implications of the coverage requirements of an anesthesiology services agreement.

**1. Protection against underutilized or inefficient ORs.** The central part of the Agreement is the discussion of the Group's coverage obligation. An open-ended statement of coverage (e.g., "The Group will provide all anesthesiology services the Hospital requires") can tie the Group to an open-ended obligation to provide whatever coverage the Hospital directs, including for new or low-volume services, without regard to whether or not the services are self-supporting. It is best for the Agreement to outline with specificity the number of locations the Group is to cover at what times, and then to protect the Group against the cost of covering underutilized or inefficiently scheduled locations. Such protection can be in the form of language providing that the Group is not obligated to cover ORs that have less than a target level of utilization (e.g., 70-75%) as measured over a designated time period (e.g., two months) or, alternatively, that the Hospital either will consolidate cases in fewer numbers of ORs or will compensate the Group for the difference between the target and actual levels of utilization. The compensation can be based upon an hourly rate reflecting the Group's cost to cover the room, a target per-unit or per-case fee, or some other methodology that results in fair market compensation for the Group.

**2. Time period to measure utilization.** If the contract addresses utilization, it is important to identify the hours during which utilization will be measured and the time period for measurement. If ORs are inefficiently utilized, with gaps in the OR schedule, the Group will want OR utilization to be measured during OR "prime time" (e.g., 0700 to 1500), rather than during the late afternoon/early evening, when the Group may be incurring additional costs, either in the form of overtime or additional compensation for nonphysician anesthetists, or for a fresh crew of anesthesiologists to cover the late afternoon to midnight time frame. The time period for measuring utilization should be sufficiently long to even out scheduling fluctuations (e.g., 30, 60, and perhaps 90 days), but not overly long (e.g., six months). The longer the time period, the greater the risk that the Group may lose substantial funds trying to cover poorly utilized, or inefficiently utilized, locations.

**3. Measuring utilization.** It also is important to specify in the Agreement how OR utilization will be measured. Utilization can be measured in terms of quantitative terms (time that an OR is used) or financial terms. Quantitative measures of OR utilization such as the time an OR is utilized or the number of ASA units generated do not address problematic payor issues, but they can protect a Group against being required to provide personnel who stand around unoccupied for much of the day. On the other hand, anesthesiology practices often do not want to open their books to hospitals, and they frequently will avoid measuring OR utilization in terms of precise dollars generated. As a compromise, even if a Group does not want to open its financial records to the Hospital, the Group may want to consider disclosing the revenue generated from one particular OR, if there is a question as to the need for the additional location. Other ways to measure OR utilization are in terms of billable anesthesia minutes or the number of units an OR generates during the designated time period (e.g., an OR generating five hours and fifty-seven minutes of billable anesthesia time during the eight and one-half-hour period from 7:00 a.m. to 3:30 p.m. would be considered at a 70% utilization level).

The *Cost Survey for Anesthesia and Pain Management Practices*, which now is published on a biannual basis by the Medical Group Management Association in collaboration with ASA, offers additional benchmarks that a Group may wish to consider, such as the total revenue per ASA unit or the total revenue per anesthetizing location. The objective nature of the *Cost Survey* information can be useful in a negotiation.

**4. Call coverage.** Another important part of the Group's coverage obligation is the nature and extent of call coverage. Is call coverage in-house or by beeper? How many anesthesiologists or nonphysician anesthetists must be available? What level of coverage is required for obstetrics, and must separate coverage be provided? If call coverage is self-supporting, it tends to be less of an issue than when the revenues generated do not cover the cost of coverage. It can be useful to specify the number of anesthesiologists or nonphysician anesthetists the Group is obligated to provide during call times, in order to avoid open-ended staffing obligations during times that are especially expensive to cover.

**5. Hospital-employed staff.** If the Hospital employs nonphysician anesthetists, what is the extent of the Hospital's staffing obligation? Must it provide one nonphysician anesthetist per

anesthetizing location, or will the Group provide anesthesiologists to perform cases personally in some rooms? To the extent that the Hospital employs the anesthetists and provides one anesthetist per OR, the Hospital is sharing the risk of OR underutilization or inefficiency.

**6. Changes in coverage requirements.** It is in the Group's interest for the Agreement to identify with as much specificity as possible how the parties will handle changes in coverage demands. Critical changes include the Hospital's desire to open new ORs, to expand the hours of coverage for existing ORs, or to have the Group cover new services. Other situations that a Group may want to include as a "changed circumstance" requiring renegotiation of the coverage and compensation provisions include a change of a designated amount (e.g., 10%) in the Group's revenues (if the Group is willing to open its books), or in either the number of patients covered by any one payor (governmental or private) or the total number of patients treated at the Hospital. Other categories of "changed circumstances" that will affect coverage and the cost to the Group of providing coverage include the following situations: establishment or offering of any new clinical service; expansion/elevation of the level of service provided by an existing clinical program (e.g., expanding a high-risk neonatal service); a decision by one or more payors to cease paying, or to reduce payment, for certain categories of anesthesia services (e.g., anesthesia for GI procedures); establishment of a residency program involving residents who rotate through the Department; use of residents (e.g., surgical residents or residents in other specialties) to provide services; recruitment or hiring of a physician specializing in high-risk patients; or cultivation of the Hospital as a referral or transfer center.

It is in the Group's interest to provide that coverage for such changed circumstances is to be the subject of negotiation between the parties, rather than a contractual obligation on the Group's part. In addition, the Group will want the Agreement to provide a minimum amount of advance notice of any new location or service that may be the subject of negotiation, in order to allow sufficient time for recruiting. Ideally, the Agreement will contain a fallback mechanism identifying precisely how the new services will be handled in the absence of another agreement (e.g., the Hospital paying the Group for the cost of providing the service, to the extent the service is not self-supporting).

As noted above, OR utilization is an important criterion to be considered in defining the scope of the Group's coverage obligation. OR utilization also can serve as a valuable control on opening new ORs. For example, an Agreement may specify that the Hospital will not open any additional ORs, whether on a short-term or permanent basis, unless all existing ORs have been at the target level of utilization outlined in the Agreement for a designated (e.g., no less than a 60-day) time period.

**7. Working with the Hospital to increase services.** Despite the very protective tone of this discussion, it is important for the Group to recognize the Hospital's very legitimate interest in trying to make the Hospital a place of choice for surgeons. These contracting pointers are offered to try to deal with one of the most contentious issues that arise between hospitals and anesthesiology practices. But these suggestions are not intended to suggest that it is in the Group's interest to block requests for new services or new coverage. In fact, it may help a Group to have protective language included in an Agreement if the Group also includes language to the effect that the Group will exercise best efforts to accommodate requests to open or close ORs or to provide new services on shorter notice than required by the Agreement. The primary point is that the Group should do everything it can to assist the Hospital to grow volume at the Hospital, but the Group should not be required to incur unreasonable financial risk in providing new services, or to be in breach of the Agreement, if it cannot accommodate requests on shorter notice than the Agreement requires.

## **E. Problematic Provisions.**

**1. Unqualified coverage obligations.** As discussed in Section I.D, above, a broad, unqualified obligation to provide all services the Hospital may require is an open-ended obligation that could be very costly for the Group, and could lead to breach if there is not an understanding as to the level of coverage required. Similarly, language providing that the Group will "accommodate Medical Staff requests for additional procedures on a short-notice basis and remain on site at the Hospital to perform requested procedures" also could be very burdensome for a Group to honor.

**2. Noncompetition restrictions.** Hospitals often include broad language in an agreement that restricts the Group from owning or providing services of any nature for any entity that provides anesthesiology services in the Hospital's service area. Some agreements even restrict all outside activities of a Group, with no geographic limit. Typically, the noncompete applies while the Agreement is in effect although, in some cases, the restriction applies after the Agreement terminates. In addition, some Hospitals include provisions that restrict the ability of individual anesthesiologists who leave the Group from practicing at "competing" facilities in the Hospital's service area for a designated period of time after they leave the Group, if the Group's exclusive contract with the Hospital remains in effect.

This type of restriction is extremely problematic for a Group, as it precludes the Group from following cases that migrate to other, less costly settings. Although one could argue that the presence of qualified anesthesiologists in a non-hospital setting would facilitate taking cases outside a hospital, the truth is that surgeons who have ownership interests in an ASC, or who want to perform procedures in their own offices, will do so, whether or not the Group agrees to provide services. A surgeon will find someone to provide anesthesia services, and a Group subject to a noncompete will be unable to diversify its payor mix by providing services at locations other than the Hospital. In the long run, as more cases, often with a better payor mix, move to hospitals with a better location, ASCs and surgeons' offices, a Group subject to a noncompete will have no way to improve its financial position by providing services outside the Hospital, and likely will be financially dependent upon the Hospital. Even if a Hospital agrees at a later date to lift the noncompetition provision, it often is too late, as other anesthesiology practices have already established a foothold in the attractive hospital, ASC, and office settings.

In addition to limiting the Group's financial options, a noncompetition provision also restricts the Group from adding more anesthesiologists and nonphysician anesthesiologists, which results in fewer anesthesiologists and anesthesiologists taking call. A noncompetition provision also can make the Group less unattractive to new recruits, as the practice is not diversified when the Group only provides services at an inpatient facility.

Some anesthesiology practices think that such a provision is not a problem, as there are few outside locations in their communities. This view fails to take into account the potential for change in their practice and the likelihood that, at some point, alternative facilities will be developed, and that the Group will want to have the ability to compete to provide services at those new locations.

### **3. Managed care.**

**a. Obligation to contract with payors.** If a Group is required to participate with every payor the Hospital designates, without regard to the payment rates and contract terms offered, the Group will have no leverage to negotiate. It is critical for the Group to have the ability to walk away from a negotiation if the payor is offering below-market rates or unreasonable contract terms. Many practices have found that they are unable to get a payor's attention to discuss increases in payment rates unless they serve notice of termination of a participation agreement. A Group is best protected if its contractual obligation is limited to a good-faith effort to reach agreement with payors, and if it is not obligated to participate with payors that are not offering at least median commercial rates in the market and reasonable contract terms. Note that median commercial rates will not protect a Group if rates in that state or market are below national averages. The ASA survey of payor rates ([http://www.asahq.org/Newsletters/2007/07-07/pracMgmt07\\_07.html](http://www.asahq.org/Newsletters/2007/07-07/pracMgmt07_07.html)) provides an objective basis for assessing whether rates in a market are above or below national averages. Alternatively, if a Group has negotiated favorable rates with other payors, it may want to use the rates it has negotiated with other payors (ideally, the highest rate; if necessary, the median or mean rate) as the reference point for new payor agreements.

**b. Time frame for entering into an agreement.** Hospitals often include unrealistically short time frames (e.g., thirty or sixty days following the Hospital's notification that it wants the Group to contract with a payor) for a Group to enter into an agreement with a payor. It is in the

Group's interest to provide adequate time for it to reach terms with a payor. In addition, the Group will want to provide that it is not in breach of its obligation under the Agreement so long as it is actively engaged in ongoing, good-faith negotiations with a payor, has promptly responded to each communication from the payor, and/or is awaiting a response from the payor.

**c. Consequences of not reaching agreement with a payor.** If a Hospital agrees to limit a Group's obligation to a good-faith effort to reach agreement with payors, it may insist upon including "what if" language: provisions outlining the consequences if the Group does not reach agreement with a payor. These consequences may include termination of the Agreement or a Hospital's ability to contract with other anesthesiologists to provide services. In the latter instance, the Group will want such other anesthesiologists to be limited to providing services to the specific payor's members, rather than any and all patients in the Hospital. This type of provision can be particularly problematic for a Group, if the Hospital can bring in other anesthesiologists and the Group remains subject to a noncompete.

**d. Other strategies.** Other options to deal with managed care contracting requirements mandating that the Group enter into payor contracts include setting a floor (a designated conversion factor) below which the Group is not obligated to enter into an agreement. To be effective, the conversion factor needs to be adjusted by some measure (e.g., a set percentage each year or the Consumer Price Index for Medical Care Services) during the term of the Agreement. Another strategy, which may be harder to achieve, is to have the Hospital supplement the amount a payor is offering, so that the payment rate is not less than a target level (e.g., median commercial rates or the other measures noted in Section I.E.3.a, above).

#### **4. Term and termination.**

**a. Termination without cause.** Termination without cause can be a protection or a threat, depending upon other provisions in the Agreement and the length of the notice of termination. If the Agreement is balanced and contains appropriate protections, the Group probably will not want the contract to be terminable without cause and, at a minimum, will want the notice period to be at least 180 days. To minimize the potential for this provision to be exercised, the Group may want to require that the Hospital agree to a "no-hire" clause (see Section I.F.2, below), or to provide that privileges are not tied if the Hospital terminates without cause.

**b. Termination for cause.** Termination for cause often is immediate, so it is important to consider the nature of the grounds for termination for cause, whether they are unduly subjective, and whether the Agreement provides for "notice and cure." Notice and cure is a common provision under which the Hospital must notify the Group of a problem and afford the Group a reasonable opportunity to remedy it. A question that often arises is whether or not the Group has effectively remedied the problem. It often is useful to have independent review of a Group's effort to cure, either by a committee composed of physicians (e.g., Medical Executive Committee), or by an *ad hoc* panel of three or five non-Hospital employed physicians, with one (or two) each selected by the Hospital and the Group, and the third (or fifth) selected by the other two (or four) members.

**5. Indemnification.** An indemnification clause is a contractual undertaking to absolve another party of all liability in a defined set of circumstances. It typically appears as language in an Agreement providing that the Group will hold the Hospital "harmless" from any and all liability – *i.e.*, will be responsible for paying for all costs and expenses – in connection with a particular set of circumstances. Absent this type of undertaking, the Group would not have an absolute obligation to pay the Hospital. Instead, the extent of the Group's liability in a dispute, both to the injured party and to the Hospital, would be determined by the judge or the jury.

Frequently, an indemnification provision applies to all costs the Hospital incurs in connection with the services the Group provides. The Group's obligation would apply even if the Group did nothing wrong, but a frivolous claim was made. This type of liability is *not* covered by most

professional liability policies and it represents an unlimited and unacceptable risk for a Group. A Group is best protected by deleting such a clause. Alternatively, although less desirably, the provision should be substantially modified to limit it to (a) actions that are determined to be negligent or intentionally wrongful by a court of last resort (*i.e.*, no appeals are pending), (b) such amounts, if any, as actually are paid by the Group's professional liability carrier, and (c) liability that is not due in part to actions of the Hospital or its employees or contractors, and to provide that it (d) does not apply to settlements by the Hospital that are not approved in advance in writing by the Group, and (e) does not apply if the indemnification obligation would have the effect of limiting or nullifying the Group's professional liability coverage.

Separately, an indemnification clause also may apply to costs the Hospital incurs as a result of the Group's failure to perform in accordance with the Agreement. This type of indemnification is very broad and would allow the Hospital to require the Group to pay all costs and damages in connection with services the Group was contractually obligated to, but did not, perform (*e.g.*, the cost of *locums* coverage and even lost revenue for cases the Hospital shows it lost due to the Group's inability to provide services).

Finally, if the Group has no option but to agree to some form of indemnification, in addition to the protections suggested above, it is in the Group's interest for the provision to be reciprocal and for the Hospital to indemnify the Group.

**6. Removal of a Group physician.** Hospitals frequently want the ability to require a Group to remove any physician or nonphysician anesthetist for very subjective reasons, such as the person's "performance or cooperation is deemed unsatisfactory." Typically, the Hospital makes the decision whether the unsatisfactory performance or cooperation has been cured, without any of the protections afforded by the Medical Staff Bylaws. At a minimum, some process needs to be inserted, in order to limit the potential for arbitrary or subjective application of the provision. If the Hospital insists upon the ability to require the Group to remove a physician, the Agreement should allow the Group sufficient time to recruit a replacement, so that it need not engage a costly *locums* physician.

**7. Tying of privileges to the contract.** It is common for Hospitals to require, as part of an exclusive contract, that the privileges of all Group members be tied to any expiration or termination of the Agreement. Such a provision can have an extremely damaging effect, as it makes it hard for a Group to exercise independent judgment about different issues if it is threatened by termination of the clinical privileges of Group members. Moreover, if the Hospital can terminate the Group without cause, and if the clinical privileges of Group members are tied to the Agreement, the balance of power shifts to the Hospital, as it controls the Group's reactions on all important matters. The Group should try to limit the circumstances in which privileges are tied, so that the provision applies only if the Agreement is terminated for cause, and not if the Agreement expires or is terminated without cause. If the Hospital insists upon tying privileges to the Agreement, the Group should consider including a "no-hire" provision (see Section I.F.2, below).

**8. Confidentiality.** Beware of confidentiality clauses that bar the Group from discussing the Agreement with third parties. It certainly is appropriate for a Group not to discuss confidential financial provisions with outsiders (but see below in this paragraph), but the Group will want to be able to discuss general aspects of the contract (*e.g.*, coverage, managed care, or noncompetition) with medical staff members, particularly in the event of a dispute with the Hospital. The ability to "lobby" medical staff members regarding a particular issue may be important to the Group in order to build support for its position. In the event of a confidentiality provision that limits disclosure of the financial terms of an Agreement, the Group should make sure that the provision allows the Group to discuss the financial terms with its attorneys, accountants, and business consultants, and that the Group is allowed to reveal the fact of the compensation (although not necessarily the amount) to candidates the Group is recruiting.

It also is in a Group's interest for a confidentiality provision to require the Hospital to protect the Group's confidential information against unauthorized use or disclosure. This provision is

especially important in the event the Group is disclosing financial information to the Hospital in connection with a compensation mechanism. See the discussion in Section I.F.6, below.

**F. Contractual Protections.** Many protections are discussed in the overview of problematic provisions in Sections I.D and E, above. In addition, a Group should consider negotiating to include the following protections:

**1. Utilization controls on coverage obligation.** Although this protection is discussed in detail in Section I.D, above, it is worth noting here to ensure that the Group's coverage obligation is limited to reasonably well-utilized and efficiently scheduled ORs.

**2. "No-hire": restricting the Hospital from contracting with Group members following termination.** If a Group is unable to include protections against termination without cause and tying of privileges to the Agreement, the Group will want some counterbalance in the Agreement in order to make the Hospital think carefully about terminating the Agreement. A provision that gives the Group more control over its workforce, and makes it harder for the Hospital to replace the Group, can provide some measure of protection. Although a Group may have restrictive covenants with its employees (depending upon their enforceability in the state in which the Group practices), a Group may not want to have to enforce each covenant separately, if tension with the Hospital becomes pronounced and one or more Group anesthesiologists (or nonphysician anesthetists) want to sign with the Hospital. To achieve this goal, the Group may want to consider a provision that limits the Hospital's ability to contract, directly or indirectly, with one or more Group anesthesiologists or nonphysician anesthetists, or with any entity with which such former Group anesthesiologists or nonphysician anesthetists are associated, for a designated time period (e.g., one or two years) following expiration or termination of the Agreement. This type of provision also has the beneficial effect of minimizing the potential for a subset of Group physicians to try to secure the Agreement for themselves, to the disadvantage of other Group members, in the event of a disagreement among Group members on strategy.

**3. Termination for cause: independent review of an effort to remedy a claimed breach.** This point is discussed in Section I.E.4.b, above. If the Agreement is terminable without cause on very short notice, this provision will be of somewhat less significance.

**4. Insurance for administrative activities.** Depending upon the scope of the administrative duties the Group is to perform, the Group may well want the Hospital either to provide liability protection or to indemnify the Group against liability incurred in connection with the administrative services the Group must perform under the Agreement, such as evaluating the performance of Hospital personnel.

**5. Limiting the scope of an indemnification clause.** See Section I.E.5, above.

**6. Confidentiality and nondisclosure.** As noted in Section I.E.8, above, it is in a Group's interest for an Agreement to include a confidentiality provision that requires the Hospital to protect the Group's confidential information against unauthorized use or disclosure. If the Group is disclosing any of its financial information to the Hospital in connection with a compensation provision, the Group will want to include a confidentiality and nondisclosure provision that limits the Hospital's use of the Group's confidential information to administration of the Agreement. The Group will not want its confidential information used at a later time in connection with efforts aimed at replacing the Group (e.g., preparation and issuance of a Request for Proposal). On a related note, if the Group is disclosing information to a consultant, whether retained by the Hospital or by the Group, the Group should consider requiring the consultant to execute a confidentiality agreement (and possibly a noncompetition agreement, depending upon the nature of the consultant's business).

**7. Successors and assigns.** Although it is in the Group's interest for the Agreement with the Hospital not to be assignable by the Hospital without the Group's advance written permission, if the Group wants the Agreement to remain in effect, it will want the Agreement to be binding on any and all successors in interest to, and assignees of, the Hospital.

**8. Specifying provisions that survive termination.** If there are provisions in the Agreement that the Group will want to be effective even after the Agreement terminates (e.g., a “no-hire” undertaking, confidentiality, right of access to records, and/or a Hospital’s agreement to indemnify the Group for administrative services), the Group should make sure that the provisions survive expiration or termination of the Agreement.

**G. Negotiating Strategy.**

**1. Overall approach to negotiating and revising a Hospital’s draft agreement.** A Group must understand the Hospital’s goals in order to negotiate a successful agreement. What challenges does the Hospital face and how can the Group assist the Hospital to meet these challenges? As the Group tries to advance its agenda during the negotiation, each point should be reviewed in the context of how the Group’s position will help the Hospital meet its needs.

In most cases, a Group is trying to ensure that coverage requirements are realistic, and that the Group can afford the level of coverage and services required. These goals serve to promote stability in the provision of anesthesiology services, which ultimately is in a Hospital’s interest. A Group that is financially stable is better able to provide coverage and to meet new staffing needs, which can help a Hospital to attract additional volume.

In revising a Hospital’s draft agreement, it is important to try to maintain the spirit of the goals the Hospital is trying to promote. Simply deleting objectionable provisions is unlikely to assist the Group in reaching agreement with the Hospital. If the Group wants to add significant new concepts to the Agreement, it is best to discuss those ideas in advance, to avoid surprise, and to increase understanding of the reason for including the provisions, which may minimize the potential for rejection of the ideas.

**2. Negotiating key terms.** It often can be helpful for a Group and a Hospital to negotiate the basic terms of the Agreement, before turning to the actual language of the Agreement. If the Group and Hospital are able to address in advance how they will deal with specific issues, it can be easier to draft the Agreement, which may result in a more efficient use of attorneys’ time, and resulting savings in legal fees.

**H. Conclusion.** A Group may not be able to incorporate all of the suggestions referenced in this summary, as most agreements involve compromise on the part of both the Group and the Hospital. Nonetheless, the suggestions in this summary will provide a framework for reviewing and drafting agreements that are workable for both a Group and a Hospital and for minimizing the Group’s exposure to undue risk.

**II. Negotiating Employment Agreements with Anesthesiology Groups**

**A. Do You Need an Agreement?** A written employment agreement serves the useful purpose of focusing the parties on whether they actually have reached agreement on the terms of employment. It can minimize the potential for misunderstandings by establishing the details of the relationship – time commitment, call responsibility, compensation, outside employment, termination, and restrictions after employment. The Agreement serves as a written record of the deal, which can be important down the road as time passes, memories fade, and leadership in the Group changes.

Employment agreements can provide important protection both for you and for the Group. This lecture will concentrate on the issues that the resident anesthesiologist who is negotiating an employment agreement will want to bear in mind. On a day-to-day basis, the employment agreement generally has little effect, as scheduling and case demands dictate the duties and responsibilities of the parties. The employment agreement becomes critical when problems arise in the employment relationship or when it becomes necessary to terminate the relationship, because the agreement contains the blueprint for such matters as how fast the Group can terminate you, your rights upon termination, and the relationship

between the parties after termination and, in particular, the limitations on your practice following termination of employment relationship.

**B. Is the Agreement Consistent with Prior Discussions?** Does the Agreement reflect what was discussed during the interview? What types of restrictions does the Agreement impose? How quickly can the Group terminate the Agreement? And what happens when the relationship is over? Does the Agreement bar you from practicing at the Hospital (or other facilities) at which the Group practices, or does it broadly limit you from practicing in a designated geographic area? Depending upon the baggage in the Agreement, you may be better off without an Agreement.

**C. Negotiating Strategy.** As a resident, you may feel that you have relatively little bargaining power and that the chances of accomplishing what you want through negotiation are slim. Although a Group may be unwilling to modify many of the provisions in the Agreement, it may be willing to modify some provisions that are of importance to you. Your success will depend upon several factors, many of which are out of your control, but some of which are within your control.

You should try to determine through a discussion with the Group how much is truly negotiable and how much of the Agreement is based upon the Group's agreement with the Hospital. If the Group's agreement with the Hospital has adverse provisions (e.g., termination without cause on short notice or a restrictive covenant), those provisions will be reflected in the Group's employment agreements with its physicians and the Group will not have the ability to change those provisions. Although the provisions may be of concern, if the Group has no flexibility on those points, it is not worth trying to negotiate changes to those provisions. The Group is unlikely to share a copy of the Hospital Agreement with you, but the Group can identify which provisions are based upon the Hospital Agreement.

After reading through the Agreement, identify the provisions that are of greatest concern. Although most employment agreements are subject to some degree of negotiation, be selective in identifying your priorities. It is important to appreciate that, if your concern pertains to a policy that broadly affects all Group employees (e.g., moonlighting or the amount of vacation provided), the Group is far less likely to agree to modifications. In general, focus on the issues that you have the greatest chance to change, unless the point is of overriding importance to you. If an issue is important to you, ask for what you want before signing the Agreement, as you may have less bargaining power as an employee than as a prospective employee. Finally, be mindful of the manner in which you make your requests. Be careful of the tone of your communication, whether in conversation with a Group liaison or in e-mail correspondence, so that your requests for changes do not appear to be overly aggressive.

Make certain you understand how the Agreement will work before you sign. Even if the Group does not agree to all of your requested revisions, you may feel more comfortable that you have explored the extent to which your concerns can be accommodated.

**D. Duties.** How clearly are your responsibilities outlined? Will you have exposure to the full range of cases? If the Group provides services at more than one location, where will you be assigned? If the Group covers an ambulatory surgical center, you will want to be certain that you rotate through the main ORs to maintain your skills. Does the Group practice in a care team setting? What is the general physician to anesthetist ratio, and are you comfortable practicing in that setting?

How are scheduling and call coverage addressed? Will you be required to take more call than other Group physicians? Will you have lower priority in scheduling? If you have lowest priority in the schedule and compensation is based in whole or in part on productivity, you are likely to be disadvantaged. Does the Agreement allow you to swap call with someone else? If you are interested in earning additional income, can you pick up additional call? What is the response time when you are on call? Does the employment Agreement contain a residency requirement related to the call requirement? If the position is part-time, how is part-time status defined? Are weekends and evenings handled in proportion to the part-time status?

## **E. Compensation and Related Issues.**

**1. Compensation.** Compensation certainly is important, but it is only one of the important areas in negotiating an employment Agreement. Is the level of your compensation clear? If the Agreement is for more than one year, is the compensation for following years specified? Will you receive a bonus and on what basis, or is the award of a bonus entirely within the Group's discretion? Is the amount of a bonus based upon a formula or is it also within the Group's discretion? Who keeps any outside income you earn (e.g., honoraria, expert witness fees)? Beyond your own compensation, it also is important to understand how the "partners" (who more likely are shareholders, rather than true partners) are compensated – not the level of compensation, but the methodology. Do they receive equal compensation or is compensation productivity-based? How is productivity measured and is nonclinical time included in the mix? Is the risk of the payor mix blended (*i.e.*, do the physicians receive the actual collections from the cases they perform or is the money pooled and then the average unit value calculated)? This last point is important, because if the funds are not pooled, it can lead to competition for cases and tension within the Group.

Understand when your compensation is payable. If compensation is expressed as an annual lump-sum amount, the contract should state that amount is payable in equal installments. If your income will be based upon a percentage of the Group's net income, make sure you understand how "net" is defined. What expenses are deducted from the Group's gross income to arrive at net income? In general, you should be wary of complicated formulae used to determine your income. The Group will be in control of the calculations and it will be difficult for you to predict your level of income. If you have no choice, consider two protections: provide a base level below which your income cannot go ("provided that in no case shall Employee's annual salary be less than \$\_\_\_\_\_"), and consider retaining the ability to require an accounting to determine accuracy of calculations.

**2. Benefits.** The type and scope of fringe benefits can be a significant component of compensation and deserve attention. Groups frequently describe benefits in general terms (e.g., "such benefits as Employer provides to all employees"), in order to retain the flexibility to change benefits without having to change all of their employment agreements. Although it is in your interest for the benefits, and your financial contribution to those benefits, to be fixed and not subject to change, it is more difficult to negotiate revisions to contractual provisions that broadly affect all Group physicians. Make sure you understand the extent of employee contribution to benefits. Although disability may initially appear to be a distant potential need, disability coverage is important, and you should understand how "disability" is defined, when benefits are payable (is there a waiting period?), how long they are payable, and whether the benefits will be taxable. (In general, if you pay for disability insurance with your after-tax dollars, payments you receive under the disability insurance policy will be tax-free. But if the Group pays the premiums, then payments under the policy will be taxable.) What type of pension plan is offered? What is the vesting period and what are the eligibility rules for contribution?

## **F. Term and Termination.**

**1. Term.** The term of the Agreement is only as long as the period for notice of termination. Even if the Agreement states that it is to continue for one or two years, if it is subject to termination on ninety days' notice, it is only a ninety-day agreement. Is the Agreement automatically renewable? Automatic renewal means that the Agreement continues in force without any action by either party. As noted in Section II.E.1, above, if the Agreement renews and your compensation for subsequent years is not stated and is not subject to a formula, you probably will want an escalation clause to adjust your compensation in subsequent years.

**2. Termination without cause.** Termination without cause can be a protection or a threat, depending upon other provisions in the Agreement and the length of the notice of termination. In the context of an employment agreement, you, as an employee physician, will not want the Group to be able to terminate your employment without adequate advance notice. At the same time, however, if you decide that you do not like the position and want to get out of the Agreement, you will not want a long notice period. A ninety-day notice period often is a reasonable compromise. In most Agreements, notice

periods are mutual – the same for both parties. Sometimes, a Group may have a shorter notice period than the employee physician, and it is most uncommon for an employee physician to have a shorter notice period than the Group.

**3. Termination for cause.** Termination for cause often is immediate, so it is important to consider the nature of the grounds for termination for cause, whether they are unduly subjective, and whether the Agreement provides for “notice and cure.” Notice and cure is a common provision under which the Group must notify you of a problem and afford you a reasonable opportunity to remedy it. A question that often arises is whether or not the employee has effectively remedied the problem. In the context of an employment agreement, that decision is made by the employer Group and would only be subject to challenge in an action for wrongful termination.

**G. Opportunity for Advancement.** The future often is not addressed in an employment agreement and for good reason. From the Group’s perspective, it does not want to be tied down to a commitment of advancement to a relative stranger. Even if an Agreement purports to address shareholder status or the time frame to consideration, it is important to recognize the limitations of the Group’s commitment. Its promise to advance you terminates along with the Agreement. The Group’s historical practice and the experience of other physicians in the Group may be the best practical predictor of how the Group will deal with you.

#### **H. Post-Termination Issues.**

**1. Noncompetition restrictions.** A covenant, or agreement, not to compete with the Group (also known as a restrictive covenant or noncompete) is an agreement on your part not to practice in a designated geographic area for a specified period of time. A noncompete clause can severely restrict your options if your employment terminates and is likely to be a key negotiating priority. The enforceability of restrictive covenants depends upon state law, but in most states, they are enforceable if they are reasonable in geographic scope (a wider area may be more enforceable in a rural area, whereas a narrower geographic area probably will be required to be enforceable in an urban community) and time (eighteen months probably is enforceable; five years may not be). This type of provision is likely to be one that you will want to eliminate or narrow, particularly if you will be providing surgical anesthesiology services rather than pain management services, and thus will not be in a position to “divert business” away from the Group. Again, if all Group physicians are subject to the same restrictive covenant, the Group is unlikely to change it for one physician.

It also is important to understand whether or not the restrictive covenant is based upon a requirement in the Group’s agreement with the Hospital, as hospitals frequently restrict the ability of contracted anesthesiologists from providing clinical anesthesiology services at other facilities. The anesthesiology groups, in turn, must obtain parallel agreements from their employee or contracted physicians. If the Group has this type of restriction in its agreement with the Hospital, it will not have the ability to modify this restriction in its employment agreements.

**2. Insurance and payment for tail coverage.** In most employment situations, the employer purchases the malpractice coverage for the employee physician. Check whether the cost of the coverage is deducted from your compensation or is otherwise charged to you. What type of coverage will be purchased – “claims-made” or “occurrence”? An “occurrence” policy provides coverage for the clinical services you provide during the time that the insurance coverage is in effect, no matter when a claim relating to those services is asserted. In contrast, a “claims-made” policy provides coverage for claims asserted during the time period that the liability policy is in effect. Once the policy expires or coverage terminates, you have no insurance protection for clinical services provided under that policy, unless you purchase what is known as “tail” coverage from the company that issued the policy that is about to expire or terminate, or “nose” coverage from the new carrier that will be writing your next professional liability policy.

If the coverage is “claims-made,” are you required to purchase tail coverage? How much will that tail coverage cost? Is the Group reserving the right to deduct the cost of tail coverage from your

final pay check? If you are required to purchase tail coverage, you may want to limit the circumstances in which that obligation applies by providing that the Group must purchase tail coverage if it exercises its option to terminate the Agreement without cause or if it elects not to renew the Agreement. That provision may serve as a practical limitation on the otherwise unlimited ability of the Group to terminate you without cause (if such a provision is included in the Agreement) or not to renew the Agreement.

**3. Tying of privileges to the contract.** Tying the continuation of your clinical privileges to the contract (*i.e.*, requiring you to resign your clinical privileges at the Hospital or other facilities upon termination of your employment Agreement with the Group) means that you no longer can practice at the Hospital once your employment terminates. This restriction is significant, but if the Group has an exclusive contract with the Hospital (or other facilities), you will be shut out of the Hospital, without regard to what your employment Agreement provides. You also will want to determine whether or not the Group's agreement with the Hospital mandates inclusion of this language in your employment Agreement. Many hospitals require that physician groups include this type of provision in their employment agreements in order to minimize the possibility that competing groups of anesthesiologists will try to provide services in the Hospital.

Because of these practical considerations, a tying provision, while important, may drop in relative importance in comparison with other negotiating priorities.

**I. Other Information Regarding the Group.** An employment relationship is one of the most important relationships you will have. It is important to understand the Group's history and the nature of its relationships with the facilities at which it provides services, in order to assess the stability of the Group and of a position with the Group. The following list of points to explore is not exhaustive, but it should provide some important information to guide you in making a decision regarding different employment opportunities.

➤ Does the Group have an Agreement with the Hospital or other facilities at which it practices, and what is the nature of those Agreements? How long is the Group's Agreement with the Hospital, and will it be terminating within the first year of your employment?

➤ As a reality check, you also will want to know the general history of the Group's relationship with the Hospital, including how long the Group has been providing services at the Hospital, with or without an Agreement, and whether there been tension between the Group and the Hospital administration or Medical Staff? Another useful source of information is the Hospital's relationship with other hospital-based physicians. Have there been issues with other departments and how have those issues been resolved?

➤ Can the Group's Agreement with the Hospital be terminated without cause and are the clinical privileges of Group members tied to the Agreement? (You can explore this point when you ask about a provision tying your privileges to the employment Agreement.)

➤ Does the Group have a history of making most of the physicians who join the practice equity owners of the practice, or does the Group have very few equity owners? Does the Group have a reputation for hiring physicians and turning them over after a short period of time?

➤ What is the relationship among Group members? Is the Group collegial or are there factions within the Group?

➤ If the Group practices in a care team mode, what is the typical medical direction ratio? Does the Group employ the anesthesiologists and has it always done so, or did the Hospital previously employ them? Were there any issues or problems when the Group assumed responsibility for employing the anesthesiologists? If the Group previously employed the anesthesiologists and the Hospital now employs them, were there any issues or problems when the Hospital assumed responsibility for employing the anesthesiologists? Are the anesthesiologists part of an independent group that contracts with the Hospital?

➤ Does the Group have a knowledgeable practice manager and sophisticated information management system?

➤ Has the Group focused on billing compliance issues?

➤ Has the income of Group members gone down in recent years and, if so, why?

**J. Conclusion.** Although you may not be able to incorporate all of the protections mentioned in this monograph, the points referenced in this summary will provide a framework for reviewing a proposed employment Agreement and to reach a more balanced Agreement that is workable for both the Group and you as an employee.

### **Additional Sources for Information on Negotiating Exclusive Contracts**

1. ASA Practice Management Monograph, *Contracting Issues: A Primer for Anesthesiologists* (1999), available at <http://www2.asahq.org/publications/pc-170-2-contracting-issues-a-primer-for-anesthesiologists-1999.aspx>.
2. American Society of Anesthesiologists, *Starting Out: A Practice Management Guide for Anesthesiology Residents* (2001), available at <http://www2.asahq.org/publications/pc-221-2-starting-out-a-practice-management-guide-for-anesthesiology-residents.aspx>.
3. David A. Cross, M.D., *Evaluating Contracts for Anesthesiology Services: Considerations and Pitfalls From the Clinician's Perspective*, ASA Newsletter, February 2008 ([http://www.asahq.org/Newsletters/2008/02-08/pracMgmt02\\_08.html](http://www.asahq.org/Newsletters/2008/02-08/pracMgmt02_08.html)).
4. Karin Bierstein, *Pros and Cons of Exclusive Contracts*, ASA Newsletter, August 2006 ([http://www.asahq.org/Newsletters/2006/08-06/pracMgmt08\\_06.html](http://www.asahq.org/Newsletters/2006/08-06/pracMgmt08_06.html)).
5. Karin Bierstein, *Hospital Contracts Survey: 2004 Data*, ASA Newsletter, April 2005 ([http://www.asahq.org/Newsletters/2005/04-05/pracMgmt04\\_05.html](http://www.asahq.org/Newsletters/2005/04-05/pracMgmt04_05.html)).
6. Karin Bierstein, *Exclusive Contracts Not Always Lawful After All?*, ASA Newsletter, July 2004 ([http://www.asahq.org/Newsletters/2004/07\\_04/pracMgmt07\\_04.html](http://www.asahq.org/Newsletters/2004/07_04/pracMgmt07_04.html)).
7. Karin Bierstein, *Negotiating With Hospital Administrators Part II: Conducting an Effective Negotiation*, ASA Newsletter, March 2004 ([http://www.asahq.org/Newsletters/2004/03\\_04/pracMgmt03\\_04.html](http://www.asahq.org/Newsletters/2004/03_04/pracMgmt03_04.html)).
8. Karin Bierstein, *Negotiating with Hospital Administrators*, ASA Newsletter, January 2004 ([http://www.asahq.org/Newsletters/2004/01\\_04/pracMgmt01\\_04.html](http://www.asahq.org/Newsletters/2004/01_04/pracMgmt01_04.html)).

### **Additional Sources for Information on Employment Agreements**

1. American Society of Anesthesiologists, *Contracting Issues: A Primer for Anesthesiologists* (1999), available at <http://www2.asahq.org/publications/p-170-contracting-issues-a-primer-for-anesthesiologists-1999.aspx>.
2. American Society of Anesthesiologists, *Starting Out: A Practice Management Guide for Anesthesiology Residents* (2001), available at <http://www2.asahq.org/publications/pc-221-2-starting-out-a-practice-management-guide-for-anesthesiology-residents.aspx>.