■ ospital contract negotiations are more difficult for anesthesiology groups than they were a few years ago. Financial pressures on medical centers have been climbing, as they have been for physician practices. Many hospital executives have become more sophisticated in their understanding of management issues in anesthesiology departments. The price for an exclusive contract appears to have increased. This is a good time to review the pros and cons of exclusives — as well as the ways that cons may be tempered and pros be made more meaningful.

The prevalence of exclusive contracts for anesthesia services has remained fairly constant over the last decade at about 50 percent of hospitals. (Although independent ambulatory surgery centers [ASCs] also employ exclusive contracts, their circumstances are different and much of the discussion below does not apply to them.) The most recent of the hospital contracting surveys commissioned by ASA showed that in 2004; however, the proportion of anesthesiologists working in nonexclusive settings had increased from 5 percent to 14 percent in the previous four years. Data from the survey also showed that the number of anesthesiologists employed by the facility had more than doubled. Competition, at least among the anesthesiologists who do not currently hold a contract with their hospital, is clearly growing.

Pros

- 1. **Stipends:** Stipends, or payment for various services provided to the hospital, accompany more than half of all exclusive contracts. They are even more common in nonexclusive arrangements, where the stipend is usually the only incentive for entering into the contract. Some 40 percent of stipends are intended to compensate the anesthesiology group for providing direct patient services that do not cover the cost to the group, including general call coverage, obstetrical anesthesia, trauma, acute pain management and cardiac services. Another third of stipends are paid for medical director services; these are typically smaller in amount. Income guarantees have been gaining popularity, as has provider salary support.
- 2. **Exclusivity:** The group that does not have to accommodate independent providers or anesthesiology services has a number of advantages. Managing the department and the relationship with the hospital is considerably simpler.
- 3. **Right of first refusal:** A good exclusive contract contains a provision requiring the hospital to offer the group the

Pros and Cons of Exclusive Contracts

Karin Bierstein, J.D., M.P.H. Associate Director of Professional Affairs exclusive opportunity to furnish anesthesia services at a new location such as a freestanding ASC.

This summary covers only the most obvious pros of exclusive contracts. The cons are worth greater consideration because of their potential to obliterate all of the pros and because it is the anesthesiologists' responsibility to identify possible compromises.

Cons

"Exclusive contracts are brutal clubs utilized to pound the anesthesiologists into submission." Thus wrote an anesthesiology

group administrator and consultant responding to a recent question about the pros and cons. While most hospital contracts are not quite that horrifying, there is no question that hospitals view them, and try to use them, as a means to control the anesthesiology group. As an example, a recent hospital consultation performed by members of the ASA Committee on Quality Management and Departmental Administration was occasioned by the administration's interest in using upcoming contract renewal negotiations to bring about greater collegiality on the part of the anesthesiology group.

A contract may be so onerous as to make the anesthesiologists the functional employees of the medical center. Judith Jurin Semo, Esq., a leading expert on hospital-anesthesiology group contracts, is advising that the realistic goals of negotiations are twofold: to retain sufficient flexibility to meet changing circumstances and to be no worse off when the contract terminates. The contract may terminate sooner than the date stipulated in the agreement; if the hospital may terminate it simply upon written notice, the contract should be considered a 60-, 180- or 360-day agreement, depending upon the notice period. The most daunting hospital demands fall into four categories identified by Ms. Semo:

1. **Coverage:** A contract clause that requires the group "to provide all needed coverage" has the potential to ruin the group. Services that hospitals typically ask the anesthesiology group to cover include those with very low volumes and/or very low margins, such as labor epidurals, lithotripsy, imaging, critical care, preoperative clinics and emergency intubations. One group recently reported that its hospital had proposed a contract clause under which the anesthesiologists would indemnify the hospital for fines and legal expenses associated with violations of the Emergency Medical Treatment and Labor Act (EMTALA) — a statute that imposes liability only on the institution, not the physi-

cian. The cost of every coverage obligation must be calculated in terms of the anesthesia providers' salaries and benefits. Broad indemnification terms simply create too much financial exposure.

The group's responsibility for providing basic surgical anesthesia may become untenable if its scope is not defined and circumscribed. Inefficient scheduling wastes the anesthesiologists' and nurse anesthetists' (if any) time — and magnifies other problems where there is a shortage of anesthesia providers. The costs of such requirements and practices can be mitigated if the hospital agrees to utilization controls such as relieving the anesthesiologists of the obligation to staff operating rooms if utilization falls below a target level or precluding the opening of an additional room for just one or two cases. If the hospital wishes to accommodate surgeons' preferences that cause inefficient scheduling, the hospital may choose to compensate a good anesthesiology group accordingly.

Coverage obligations and costs often change with new circumstances. The hospital may create a new clinical service or program or open new operating rooms. It may experience a change in trauma level, in case volume or in payer or case mix. Anesthesiologists and other hospital-based specialists must care for all the hospital's patients needing their services; they have no ability to refer patients who require inordinate resources although they are uninsured or underinsured. The group may be able to temper the effect of any of these developments by obtaining volume ramp-up concessions or at least a commitment to work in good faith to resolve differences arising upon the occurrence of a predefined change.

2. **Managed care contracting:** It is surprisingly common for hospitals to seek the authority to negotiate anesthesiology groups' third-party payment rates, or to accomplish the same thing through a contract clause that requires the group to participate with every health plan in the hospital's network. No one wishes to take the risk of letting another party determine their fees, of course. A stipend in the form of an income guarantee would attenuate the risk.

Anesthesiology groups faced with a hospital demand to surrender control of third-party payment levels should always try to limit their obligation to making a good faith attempt to arrive at an agreement with the payers. They may also reduce the risk of an obligation to participate with all health plans by excepting those that do not offer at least the median of prevailing commercial rates and those who are already in breach of an existing agreement.

For many practices, an unconditional requirement to accept whatever payment level the health plans offer is a deal-breaker.

3. **Termination and tying of privileges:** Most exclusive contracts provide that if they are terminated, the anesthesiologists will automatically lose their hospital privi-

leges. Unless the group covers multiple hospitals, this tying of privileges could be catastrophic. It is a long-established quid pro quo for exclusives, however, and experience has shown that it is often possible to mitigate the risk by limiting the circumstances under which privileges will be revoked to those where the group breaches the contract and receives a genuine opportunity to "cure" the breach. Also the hospital may agree to revoke privileges only when a subsequent exclusive contract with another anesthesiology group goes into effect.

4. Noncompetition: Increasingly, hospitals seek to commit their anesthesiology groups to practicing at their facility exclusively. Contract clauses that prohibit the group from providing services at any other facility during the term of the exclusive agreement prevent the anesthesiologists from following higher-paying cases out of the hospital, e.g., to surgeon-owned ASCs, even if the hospital case volume declines. Some new variations on these onerous restrictions are noncompetition agreements that are designed to survive the termination of the overall contract, and provisions that prevent the group from enforcing the noncompetition clauses in its own employment contracts with individual physicians. The latter enable the hospital to replace the incumbent group with relative ease since it can contract directly with the anesthesiologists.

In an extreme example, one hospital attempted — unsuccessfully — to commit the group to train their own replacements if the hospital determined the incumbent group's services to be "unacceptable" for any reason.

Suggestions for moderating the risks of standard noncompetition agreements with the hospital include, according to Ms. Semo, clauses that:

- Lift the restriction if the case volume declines;
- Limit the restriction to specific facilities; and
- Obtain the hospital's offsetting obligation to give the group the right of first refusal for new hospital facilities.

Conclusion

Despite the national shortage of anesthesiologists, in some markets hospitals hold the upper hand and use exclusive contracts to control the availability and affordability of their anesthesia coverage. Anesthesiology groups need to increase their own sophistication in recognizing potentially disastrous contract provisions and their creativity in negotiating counterproposals.

SOURCE MATERIAL

Blough G, Scott S. Hospital Contracting Survey Update. 2005
Practice Management Conference (available at <www.
ASAhq.org>).