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POLITICIAN CHALLENGES EXCLUSIVE CONTRACT AND STIPEND SUPPORT: IMPACT ON PAIN PRACTICE

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A recent attack on exclusive anesthesia agreements and on the payment of hospital stipends has sobering implications for pain medicine practitioners, whether or not they practice independently or in conjunction with an anesthesia group, and even if their medical specialty is outside of anesthesiology.

As reported in the *Dallas Morning News* on Jan. 25, 2010, a Texas state representative attacked the one-year-old exclusive agreement, and its provisions for stipend support, between Pinnacle Anesthesia Consultants and the Baylor Health Care System. The legislator's claim: Exclusive contracts are noncompetitive and are one of the main culprits in the high cost of health care.

It would be easy, and dangerous, to write off the attack as the populist pandering of a petty politician exploiting the fear of rising health care costs—re-elect me, something must be done! It would be equally easy and dangerous to believe that this sort of attack, left unchecked, would be limited to a hospital's relationships with its perioperative physicians.

As we know from the past year of national health care “reform” wrangling, physicians, hospitals, pharmaceutical manufacturers and insurers are commonly portrayed as “greedy,” when on rational grounds, the greed is properly attributable to those who want to take your services and redistribute them to others for the distributor’s political advantage.

But playing to fears and leveling charges of “greed” make for good sound bites. And hospital administrators might attempt to take advantage of the same arguments to gain leverage in any of their negotiations that involve either or both exclusivity or financial support. Obviously, for those practicing pain medicine as a member of an anesthesia group, the group’s loss of its exclusive agreement or the impact of the loss of coverage stipend support might have a disastrous impact on their practice. But even for those who practice independently and come to pain medicine from a surgical specialty, the arguments can impact their ability to negotiate a medical directorship, to obtain stipend support or to obtain any sort of favored relationship with a facility.

In order for practitioners to protect their interests, they must be prepared to address the arguments being made against exclusive contracts and stipend support—to do so requires that they understand the rationale supporting hospital contracting and financial assistance.

Just as in a martial arts maneuver in which the opponent’s force is turned against him, the practitioner must strive to expose these populist attacks as empty retorts to a highly beneficial arrangement for all parties involved—physicians, hospitals, patients and payers.

Understanding the Arguments

The argument made against exclusivity and stipend support can be summarized as follows:

- Competition is good and it reduces prices.
- Multiple physicians practicing independently at a hospital compete for cases, leading to lower prices.
- Allowing one or more physician to hold an exclusive right to perform cases, and, therefore, prevent other physicians from competing for that line of business allows the holder of the contract to control pricing. This leads to higher prices.
- Hospital stipends increase the hospital's cost of business, therefore leading to higher prices.
- Accordingly, exclusive contracts and hospital financial incentives should be prohibited.

The attackers ignore that a hospital's purpose in entering into an exclusive contract is not to perform an act of kindness toward one physician or group or to grant a monetary favor, but to assure coverage of the service line.

Prior to the era of exclusive contracting, medical staff departments were open staffed, with membership available to anyone who met credentialing requirements. Without a business structure among the independent physicians holding those privileges, there was no mechanism by which the hospital could obtain a binding commitment that services would always be available.

Prior to the existence of physician groups tied together by way of a business relationship who were therefore able to contract with a hospital, there was no way for a hospital to ensure that all patients would be treated equally, or even treated at all. There was simply no mechanism to enforce charity care, or, for

that matter, the availability of a physician for a case with reimbursement that was less desirable than other cases.

Without the existence of a financially integrated business entity, there was no way, absent violation of antitrust laws, for the physicians—each of whom was operating an independent practice—to jointly contract with a managed care payer or even to discuss among themselves coordinating their contracting at the same rate.

Of course, all of this led to the formation of groups and to exclusive contracts. The impetus was not that of entrepreneurial hospital-based physicians who desired to form groups; rather, it was pressure from the hospital to obtain the benefits of assured coverage at a price standardized by the payer that led to the formation of hospital-based physician groups.

The formation of groups in response to these business needs and, importantly, in response to the need to comply with antitrust laws, and the resulting exclusive arrangements between those groups and hospitals did not do away with competition: It shifted it from the individual provider level to the group level.

A regional, and often even more geographically specific, market exists for physicians' services—just ask anyone who is trying to recruit two providers, one to a large metropolitan area and the other to a small, agricultural community. Unless compensation is at or above the relevant market rate, it will be difficult or impossible to recruit or retain highly qualified physicians. If the income resulting from providing services is insufficient to pay providers at the market rate, the only solution for the practice, short of a financial death by a thousand cuts (actually, by a thousand cases) or leaving the market, is financial support from the hospital.

Finally, the attackers ignore that payment for physician services is almost always dictated by the payer, not by the group, and that hospital stipend payments have little to no impact on the scope of reimbursement received by the facility for the related facility-side services.

Every Which Way

Those making political attacks on exclusive contracts and coverage stipends can't have it every which way: They want charity care and they want physicians to work for low governmental program and managed care rates. Yet they also demand compliance with antitrust laws that in turn require the existence of a financially integrated group. They pass anti-kickback laws, prohibitions on "self-referral" (e.g., the Stark rule), and impose private remuneration restrictions on nonprofits, mandating that no more than fair market value be paid, therefore acknowledging that there is a market. Yet those making the attack ignore the fact that fair market value must often be paid by a hospital in order to ensure the coverage the hospital requires and politicians demand.

The Hospital Is on Fire

Imagine the Texas legislator's chagrin if he and his family checked into a small hotel and took two identical rooms for a five-night stay. The first room was cleaned every morning by Chris, one of the housekeepers. The second room was cleaned the first and second mornings only, because Pat, the other housekeeper, decided to take the rest of the week off and Chris did not want to work overtime.
Would the legislator make a stump speech calling for more independent competition among the staff of a hotel, or would he write a letter of complaint to the manager?

Imagine that the firefighters in the Texas legislator's hometown were paid only for their actual efforts in fighting fires, not for waiting around until a call arrives, and if, when they were paid, they would receive only what the owners or insurers of the burning houses would pay. Would the firefighters agree to be tethered to the station? Would they quickly look for better opportunities? Would the town be able to recruit new firefighters?

Would the legislator make a stump speech branding the firefighters as greedy—they want to be paid to assure their availability—or would he urge the town council to supplement the firefighters' income?

Well Mr. Legislator, the hotel is actually a hospital, and the hospital is on fire. The choice is *not* whether or not to grant exclusive rights or whether or not to pay a stipend; it's whether or not to have the services available.

For those pain medicine practitioners who function within contracted anesthesia groups, the potential impact of these attacks on practices is obvious.

For those who practice independently, the attack still poses troubling concerns. For example, the argument as to exclusivity can be applied, with very little revision, to the relationship between a hospital and any physician holding a medical directorship. It can be applied to any physician or group that holds a favored relationship compared with similarly credentialed physicians on the medical staff, such as having an ability to practice out of a hospital-affiliated pain clinic—an opportunity that is foreclosed to competitors. The argument as to the impact of stipends on hospital charges can further be extended beyond hospital-based coverage stipends to any stipend paid by a hospital to a physician.

More Than Knowledge Required

As stated previously, pain practitioners must be prepared to address the arguments being made against exclusive contracts and stipend support, but the reality is that the best practitioners will be proactively engaged in countering these mistaken assumptions well before the face-to-face stage of any negotiation they have with a hospital; this takes preparation, time and effort.

In other words, it's not enough to simply know what to argue in opposition to these attacks; practitioners must develop, as a part of their ongoing business strategy, the tactics required to co-opt the argument from the start.

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