ON THE LEARNING CURVE

Employment Contract Negotiation

The first 5-10 years after completing residency can be a time of significant transition. Fellowships may be started and completed, new jobs are accepted, and families grow and change.

If you are very lucky, you will find the perfect job as soon as you finish your residency or fellowship—one that perfectly matches your interests, meets your needs, and changes as you need it to change.

BY LEE SAVIO BEERS, M.D.

More likely, however, you may change jobs at least once during this time. Job changes can be necessary or desired for many reasons, including moves, changes in interest, family changes, or undesirable job characteristics. Considering that the young physician typically has very little "business" experience and may change jobs at least once in the early years, skillful contract negotiation is a very important thing to learn.

The difference between a good, mediocre, or bad contract can change the experience of a job. I have a colleague who works part time in a small private practice, who was able to successfully negotiate for a nanny to care for her children on site while they were still nursing. There were other benefits the practice routinely offered that were less important to her and that she was willing to give up in exchange. This arrangement allowed her to find the balance between returning to work and spending time with her children, which worked for her. She was happy, her practice partners were happy, and the patients loved seeing their doctor's baby around the office. As you might guess, the last I heard, she was still with the same practice and everyone was thriving.

Contract negotiation can be a complex and lengthy process, and you won't learn all you need to know from this column. So, the first place to start is with some research; there are many resources available for both physicians and nonphysicians.

As with anything, it is better to do your research *before* you are in the middle of negotiating a job. Many professional societies offer a variety of on-line resources designed to help physicians find and negotiate for the best job possible. The American Academy of Pediatrics Residents Section Web page (www.aap.org/sections/resident) has some good information to get started. The Practice Management section of the American Academy of Family Physicians' Web site (www.aafp.org) provides a great deal of detailed information as well as archived articles on many related topics. The American Medical Association Web site (www.ama-assn.org) has sample contracts available for members to reference.

Talking to other physicians you know or contacting local pediatric groups can be helpful to get a sense of what others' experiences in your area have been. If you have the opportunity, talking with others who work for practices or organizations you are considering may be helpful as well. This can be particularly true for larger organizations that may not offer as much (or any) flexibility in their contracts.

For example, when I was a military pediatrician in the U.S. Navy, contract negotiation as it is traditionally thought of was not even an option. That being said, while I was not able to negotiate salary or benefits, I often was able to negotiate professional development opportunities within my division at a local level. If the basic contract is not negotiable, sometimes things such as relocation bonuses, promotion or academic opportunities, nonclinical time, or call responsibilities will be.

The next step is to decide what you want. You need to know, before you go into negotiations, which things are critically important and which are expendable. Prioritize these things for yourself so that you know what you are willing to bargain with. Think about what you absolutely have to have, what you would really like to have, and what you don't care so much about. Again, it helps to have a sense of what is available locally so that you can develop realistic expectations.

Know your "BATNA" or "best alternative to a negotiated agreement"—in other words, what you would do if you were unable to come to an agreement and decided to walk away from negotiations. This can help you decide when to compromise and when to walk away. If you already have an appealing offer from somewhere else on the table, you might be less compromising than if you have had no other offers and there are few jobs available in your field or geographic area.

Also, remember that you come to negotiations with many valuable strengths and skills; think about what you can offer that might be unique and of benefit to the practice or organization. Perhaps you are very interested in adolescent medicine and others in the group would love to have someone to refer their older patients to; this is an asset you can emphasize to your advantage.

Lastly—and hopefully this goes without saying—but be sure to read your contract carefully *before* you sign it and make sure you have your questions answered. I have heard of more than one physician who ignored the "noncompete" clause in their contract (a clause stipulating, for example, that you cannot practice within a certain geographic distance of your current job within a certain time period) only to find themselves unable to practice elsewhere in the community when they decided to move on. If you are unsure, don't hesitate to consult a lawyer to review the contract before you sign it.

Overall, you may spend considerable time up front researching and participating in contract negotiation, but the reward of a fulfilling practice that meets your needs more than makes up for it. ■

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Gainsharing Arrangements Slowed by Hospitals' Legal Fears

BY MARY ELLEN SCHNEIDER
New York Bureau

Hospitals are reluctant to offer physicians a portion of the savings generated by reducing clinical costs—a concept known as gainsharing—because of legal fears, D. McCarty Thornton, said during an audioconference on gainsharing sponsored by the Integrated Healthcare Association.

"It's clear, I think, that gainsharing is not on the fast track," said Mr. Thornton, a partner with the law firm of Sonnenschein, Nath, and Rosenthal LLP, based in Washington.

In the long run, gainsharing approaches that can save money without impacting patient care are likely take hold, he said, but first hospitals need clarification from Congress, the Health and Human Services secretary, and the Office of Inspector General about what arrangements are allowed.

In 1999, the HHS Office of Inspector General issued a special advisory bulletin saying that the civil monetary penalty provision of the Social Security Act prohibits most gainsharing arrangements. Under that provision, hospitals are prohibited from making payments to physicians to reduce or limit services to Medicare and Medicaid beneficiaries. The bulletin said that these types of arrangements could also trigger the antikickback provisions of the Social Security Act, which prohibits arrangements used to influence the referral of patients in federal health care programs.

"Historically, the office has been somewhat leery of gainsharing arrangements," said Catherine A. Martin, OIG senior counsel.

Since the 1999 bulletin, the OIG has issued a number of advisory opinions which outline gainsharing arrangements that would be allowable. In general, in order to give the green light to a gainsharing arrangement, the OIG looks for transparency and accountability, quality of care controls, and safeguards against kickbacks, Ms. Martin said.

In order to be transparent, any actions taken to save costs need to be clearly and separately identified and fully disclosed to patients. Hospitals must also put in place controls to ensure that cost savings do not result in the inappropriate reduction of services. OIG officials also want to see ongoing monitoring of quality by the hospital and an independent outside reviewer, Ms. Martin said.

But OIG is not the only regulator that hospitals and physicians need to consider when embarking on gainsharing arrangements, Ms. Martin said. Hospitals and physicians must also keep from running afoul of the Stark self-referral prohibitions, which fall under the purview of the Centers for Medicare and Medicaid Services. Gainsharing arrangements must also meet Internal Revenue Service rules, and hospitals are at risk for private lawsuits, she said.

But the industry is keeping an eye on two demonstration projects that test the gainsharing concept in the Medicare fee-for-service program. Both projects are set to begin this year.

The first project, which is required under the Deficit Reduction Act of 2005, will involve six hospitals and will focus on quality and efficiency in inpatient episodes and during the 30-day postdischarge period. The DRA provision waives civil monetary penalty restrictions that would otherwise prohibit gainsharing.

The second project will focus on physician groups and integrated delivery systems and their affiliated hospitals. The demonstration will include inpatient episodes, as well as the pre- and posthospital care over the duration of the project. This demonstration was mandated the Medicare Modernization Act of 2003.

Participants in both demonstrations will be required to standardize quality and efficiency improvement initiatives, internal cost savings measurement, and physician payment methodology, said Lisa R. Waters, a project officer with the division of payment policy demonstrations at CMS.

But CMS officials are looking to test various gainsharing models so participants will have flexibility in how they choose to target savings from reducing the time to diagnosis and treatment to improving discharge planning and care coordination.

There are some alternatives and variations on gainsharing that are occurring in the marketplace, Mr. Thornton said. For example, hospitals can move forward with nonmonetary gainsharing, in which the savings are earmarked to improve physicians' work lives by upgrading surgical suites or through better scheduling. Another option is to proceed with standard gainsharing but to carve out Medicare and Medicaid patients, who fall under federal statutes. However, the OIG has been skeptical of carve-out scenarios, Mr. Thornton said. ■