Contracts and Negotiation: The Fundamentals for Interventional Radiologists

Laura Findeiss, MD^{1,2}

¹ Department of Imaging and Radiological Sciences, Emory University School of Medicine, Atlanta, Georgia

² Department of Radiology, Grady Memorial Hospital, Atlanta, Georgia

Address for correspondence Laura Findeiss, MD, Department of Radiology, Grady Memorial Hospital, 80 Jesse Hill Jr. Drive SE, Atlanta, GA 30303 (e-mail: lfindei@emory.edu).

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Abstract

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- interventional radiology

There are numerous situations in which a physician may be in a position to negotiate a high-value contract. For an interventional radiologist, these may include personal employment contracts, vendor contracts for capital equipment, show-site agreements, research contracts, group partnerships, professional services agreements, and other types of relationships. Opportunities for physicians to learn about the nuances of contracts, themselves, are limited, and most will learn about negotiation and contracts through experience and sometimes through failure. This article will review contracting as it relates to physician employment relationships, with the goal of reviewing the fundamental principles of contracting and negotiation, exploring the prerogatives of hospitals, physician groups, and individual physicians as they relate to building mutually beneficial and productive relationships, and examining common pitfalls of contracting.

Work relationships for interventional radiologists have traditionally been limited to a few specific types, including employment or partnership with radiology group practices and academic faculty employment. As interventional radiology (IR) has become more broadly recognized and valued in the care of patients and IR procedures have been adopted as standard of care for many disease entities, opportunities for interventional radiologists have broadened and include alternative scenarios such as employment or partnership in multispecialty practices, freestanding outpatient practice arrangements, solo or IR-only practice arrangements, IR professional services agreements (PSAs), and direct hospital employment. As the market has changed and more scenarios present themselves as options, the need to understand the nuances of negotiating contractual relationships on one's own behalf has increased so that one may ensure that these arrangements best represent one's expectations.

Contracts

There are a limited number of types of contracts that an interventional radiologist may encounter in the quest for

employment. These include employment agreements, partnership agreements, and professional services or medical services agreements (PSA/MSA). Contracts may be entered into as an individual, or may be executed on a physician's behalf in a partnership scenario, with the individual physician being bound by the parameters of the agreement without being an explicit individual signatory. Each agreement that binds the individual physician should be read carefully in its entirety, including any appendices referenced, to ensure full understanding of the obligations and rights defined in the contract.

Employment agreements generally establish basic terms of engagement, outlining the obligations of each party. Defined obligations for the employee will typically include hours worked, job duties, and a set of expectations regarding ongoing competency, maintenance of licensure and certification, notice of resignation, assignment of certain rights to the corporation, loyalty to the company in terms of confidentiality of trade secrets, and employee standards of behavior. Codified obligations of the employer will include defined pay structure, allocated vacation time, benefits provided, details of liability insurance coverage, guidelines

for notice of termination, and practice support services provided by the corporation. These contracts may or may not include elements such as non-compete clauses, provision of tail insurance for claims made policies, predetermined severance agreements, recruitment stipends, or other details that should be reviewed carefully and understood clearly prior to signing. It is important to have some understanding of state employment laws as they relate to some typical boilerplate language, since some of the included provisions may not be supportable dependent on state and local statutes.

Partnership agreements become more complex, and an exhaustive discussion of such agreements is beyond the scope of this chapter. An important variable in establishment of partnerships is that of corporate structure, as this determines important features of individual liability and tax obligations. Before initiating detailed discussions related to practice partnership, a basic understanding of the structural differences between C-corporations, S-corporations, limited liability corporations, etc., is helpful to inform a basic understanding of one's risks and the benefits of partnership. A second variable is the accounting model used by the practice to manage its finances. There are important differences between cost accounting and accrual accounting approaches in terms of how the corporation may be positioned to respond to changes in the environment, versus the ongoing liquidity of assets available to the partners. The choice made by the corporation is a clue to the philosophy of the practice, as a cost accounting methodology may indicate more emphasis on short-term gains than on long-term strategic management of the practice. Finally, the corporate governance structure is very important to determining the capacity to influence the direction of the practice. Understanding the degree to which partners participate in leadership, the method of assigning leadership roles, and how the leadership roles are defined is imperative in assessing whether one's vision of the future can be accomplished within the structure of the partnership.

Professional services agreements are most typically entered into by a physician corporation and a hospital or health care organization. These codify the relationship of the physician practice with the hospital, establishing how services will be provided, the structure for payment of the physician practice, if any, and certain boundaries related to competition. These contracts may include exclusivity and non-compete agreements, and often create stipend or incentive arrangements to align the activities of the practice and the hospital.

Negotiation

For purposes of this discussion, negotiation will be reviewed from two standpoints: first, from that of negotiating on one's own behalf and, second, from the point of view of negotiating on behalf of a group or entity. There are similarities and differences in the approach, most importantly with respect to who the beneficiary is and who is held responsible for the terms of the ultimate agreement.

Consider three potential parties for simplicity: (1) individual physician, (2) physician practice, and (3) hospital or facility. Negotiated agreements may be created between any of these three entities, and the fundamentals of the process are very similar regardless of which combinations of parties are involved in the process. These parties typically have some interests and values in common and may have other non-aligned interests. All these interests and values represent the landscape surrounding the negotiation. These imperatives need to be identified upfront in the process of establishing an agreement. The more aligned are the fundamental interests of the parties, the more likely the parties will be successful in fashioning a mutually satisfactory agreement. It is critical to identify whether a negotiator is the ultimate decision maker early in the discussions, as there may be different motivations for the decision makers than for the negotiators. It is also critical to recognize outside forces that may work in support of or in opposition to the negotiated agreement once executed and, in so doing, mitigate in the agreement against this risk.

Personal Employment Negotiations

Setting the Table

Before embarking on the exercise and preferably early in the process of vetting an opportunity, it is valuable to take an inventory of one's own core values and interests and assess the core values and interests of the group or entity with which a potential arrangement exists. Once the fundamental interest in establishing a relationship is confirmed, exploring the areas of alignment and difference will form the basis for a vision of the future for which the negotiated agreement will provide a template for engagement.

Self-Assessment

1. Personal/lifestyle needs.
2. Short-term and long-term professional goals.
3. Practice philosophy.
4. Favored environment (prefer predictability/stability or change/innovation?).
5. Financial needs versus desires.

For example, an interventional radiologist graduating from fellowship has prospectively confirmed personal major work-related values including the desire to perform more than 80% IR, do only catheter-based interventions, have at least one senior partner as a back-up and mentor, and have the ability to see patients in a clinic setting, rounding on patients and documenting inpatient consults, and wishes to do no breast imaging. Salary is a moderate-level value as having a satisfying practice is more important for this individual than is compensation above the mean. Having recently married and considering starting a family, a family-oriented group and community is considered a high value, but total time off is relatively less important. The IR documented these values in a table prior to starting the process of looking for a professional opportunity (►Table 1).

Table 1 Work-related values of the physician

Factor	High value	Moderate value	Low value
% IR > 80	X		
Catheter-only IR	X		
Senior IR in practice	X		
Clinic	X		
Time to round/consult	X		
No breast imaging	X		
Salary		X	
Family friendly	X		
Time off			X

After multiple interviews around the region, five practices appear to be viable options and a spreadsheet has been started, reviewing the various scenarios (►Table 2). On review of the table of practices, the physician should decide with which entities to actively negotiate and which to reject. It becomes clear that there will be numerous trade-offs to be made in securing the right practice fit.

First, are there nonnegotiable elements? It is advantageous to identify these upfront, prior to embarking on the search, to maintain clarity of purpose. These should be few and clearly need to be truly unacceptable. For instance, if one needs to directly care for an elderly parent, living 1,500 miles away may be a nonstarter. In the representative scenario, if breast imaging is absolutely unacceptable, then a negotiation with Group E would depend on establishing upfront, whether this is a negotiable element. Once one's own priorities are established, identifying what is a must have versus a nice to have will be easier, and will help set a clear boundary around what represents a clear walkaway point. When the negotiating position is clear, the negotiation can be approached with confidence.

In assessing the employer/group practice, certain elements should be reviewed, including the group philosophy, mission, and vision. The satisfaction of individual physicians in the practice should be assessed, and the priorities of these individuals compared with one's own. Knowledge of the practice structure and governance is important, and it is important to inquire as to the reasons for departures of physicians from the practice in the past. Is partnership the usual outcome of joining the group? If not, what is the viability and likelihood of long-term employee status versus capacity for partnership/ownership? The later questions of salary, bonus structure, and time off are ultimately less important than these other core elements.

Taking the broader landscape into consideration will help guide the negotiation. It is helpful to understand the context of a potential employer's relationship to the broader medical community and the character of existing hospital partnerships. This knowledge can help establish in what ways one's own strengths may represent benefits to the employer.

Hospital/Partnerships Assessment

1. Community needs.
2. Payor mix.
3. Case mix.
4. Position in the health care ecosystem.
5. Economic position.
6. Governance structure and for profit/nonprofit status.
7. Perspectives of hospital board members.
8. Institutional history.
9. Medical staff culture.
10. Engagement with educational programs.
11. Strategic plan.
12. State and local politics.
13. Regulatory environment.
14. Culture.
15. Relationships.

Creating Strategic Alignment

A sense of a shared vision and a common understanding of the future state are advantageous in moving through the specific elements of building a contractual relationship. Without an upfront understanding of the philosophical position, challenges, and long-term strategic vision of the potential partner, it is hard to work from unifying principles. ►Table 3 outlines some common axes for alignment between physicians, practices, and healthcare organizations, and enumerates common themes for consideration. From the standpoint of establishing the areas of alignment, these topics can be helpful in establishing points of commonality for discussion. For example, if a hospital is highly focused on driving down costs and decreasing length of stay, and is not looking to expand service lines or create new revenue streams, a conversation about how the IR laboratory can be a revenue generator through growth of complex elective procedures will likely not garner enthusiasm. However, discussing a commitment to generate a high level of physician engagement in improving operations to create better efficiencies and optimize use of staff and facilities will resonate with the hospital partner and create value for the physician practice.

Whether negotiating on behalf of oneself or for a practice or group, once a clear picture of one's own (or one's party's) goals, imperatives, and long-term interests has been formulated and the major strategic interests of the other entity are understood, opportunities for alignment in achieving common goals can be outlined. It is this step that creates the most upside in the ultimate agreement, as it creates a spirit of common understanding and allows mutual commitment to a vision of the future. Some typical prerogatives of group practices, healthcare organizations, and physicians are outlined in ►Table 4. Constructing such a grid for one's own circumstances allows identification of areas of alignment that can form the basis for establishing directionality in a contract.

For example, a radiology practice is primarily focused on satisfying the needs of the hospital partner to secure its relationship going forward. An interventional radiologist is negotiating a contract with the radiology group and wants to

Table 2 Practice analysis spreadsheet

Practice	% IR	Case mix	No. of IRs	Clinic	Rounding	Salary	Time off	Family
IR/DR Group A	50% but can grow	All interventional procedures including trauma and other ED	1 existing	No but hospital wants	Occasionally after hours	80th percentile as partner after 2 y plus buy in	12 wk	Small community seems like strong family values
All IR Group B	100% (no dx)	Anything that comes in. High-level and minor	3 existing	Yes. 3 clinical associates support. 5 d/wk	Expected. 3 hospital contracts. Strong E/M billing	Start as employee at 40th percentile plus productivity bonus. Scale up over time. Opportunity to buy in to practice and real estate	6 wk as employee	Low focus on family in conversations with group
Multispecialty Group C	80% (vascular laboratory 1 d/wk)	High-level catheter work. PAD and oncology	No other IRs. 1 IC, 2 VS, one surgical oncologist	Yes. 5 clinical associates and vascular laboratory	Expected	60th percentile for IR expected based on projections. Opportunity to grow. Productivity based on collections	8 wk	Great schools. Most in practice with older children in college
Hospital employee D	100%	All image-guided interventions not done by radiology group	1	Yes. Shared with IC and VS. Hospital employs clinical associates and bills for them	Yes. Supported by clinical associate team	Base at 50th percentile for IR based on FMV* analysis, plus RVU incentive over a threshold, call stipend for > q4 calls	5 wk	Urban community. Public schools marginal. Good private schools. Good professional opportunities for spouse
IR/DR Group E	80% 1 d/wk mammo	Catheter-only intervention, high level. Biopsies, paracentesis, thoracentesis, and drains performed by abdominal radiologists, LPs by neuroradiology	3 existing, 1 senior, 2 in midcareer	Established. Looking at creating outpatient procedural center with clinic on site. 3 buildings under consideration	Yes—daily with dedicated clinical associate support for notes and timely consultation	Start at 60th percentile plus productivity bonus, 1 y to partner, low buy in. Rumor is 90th percentile partner income	14 wk as partner	Large group with variable interests. Several partners' families regularly spend time together socializing. Multiple young and school-age children

Abbreviations: FMV, fair market value; IC, interventional cardiology; IR, interventional radiology; LP, lumbar puncture; PAD, peripheral arterial disease; RVU, relative value unit; VS, vascular surgery.

Table 3 Common axes of alignment

Axis	Themes
Mission	Focus on underserved; religious mission; improvement in healthcare delivery; community resource
Economics	Jointly drive revenue; jointly lower cost; jointly create efficiencies; address payor relationships; address revenue cycle challenges
Lifestyle	Focus on patient, staff, physician wellness; “old-school” physician focus; resort community; holistic healthcare approach
Practice models	Innovation in practice structure; innovation in contractual relationships to support goals
Growth	Where is organization on growth/stability curve; opportunities for physicians to influence direction of organization; does growth plan align with practice/MD success?
Stability vs. innovation	Physician as influencers? Does tolerance for change align?

Table 4 Key prerogatives of negotiating parties

Hospital prerogatives	Radiology practice prerogatives	IR physician prerogatives
<ul style="list-style-type: none"> ❖ Uninterrupted service ❖ Market share ❖ Service line growth ❖ Capital resource utilization ❖ Cost of care delivery ❖ Appropriate utilization ❖ Patient satisfaction/patient experience ❖ Timeliness of care ❖ Consistency of care ❖ Quality ❖ Safety ❖ Critical results management ❖ Ease of scheduling ❖ Access to physician expertise 	<ul style="list-style-type: none"> ❖ Secure relationship with hospital ❖ High-end service line growth ❖ Mitigate financial risk (poorly reimbursed care) ❖ Guard against competition ❖ Minimize practice overhead ❖ Efficient workflows ❖ Seamless data access ❖ Customer satisfaction ❖ Safety ❖ Quality ❖ Secure community loyalty 	<ul style="list-style-type: none"> ❖ Consultative and longitudinal care paradigm ❖ Growth of service lines ❖ Secure relationship with hospital and medical staff ❖ Compete effectively ❖ Market share ❖ Efficient workflows ❖ Customer satisfaction ❖ Safety ❖ Quality ❖ Access to technology

understand what the group may be able to provide as support for the practice of IR going forward. Knowing that there are IR dependent service lines (hepatobiliary surgery, trauma, etc.) that the hospital values maintaining as part of securing market share would allow for a meaningful discussion with the practice about how IR can help the physician group contribute to the hospital's goals and, therefore, how the group can facilitate success for IR in advancing those service lines (advance practice provider recruitment, dedicated clinic time, etc.).

This exercise has value as an intermittent assessment tool, as well, after an employment relationship is established and will become more meaningful each time it is performed. Such an exercise is facilitated by a high level of engagement in medical staff committees and other “citizenship” activities, as these provide a broader perspective on the landscape of the medical community. For intermittently negotiating resources for the IR practice, this approach can be useful in understanding the perspectives and interests of the hospital and of your practice leadership.

Hospital Negotiations

When approaching negotiations on behalf of a corporation, there are boundaries related to fiduciary responsibility that

must be considered. The obligation of the negotiator in these instances is to the success and benefit of the corporation, and conflicts between personal and corporate benefit must be recognized. Personal benefit and corporate benefit may not always be aligned, and these conflicts of interest must be clearly articulated to be avoided.

The process for establishing the structure of a PSA should start with identifying, as with any negotiation, the ultimate goals and objectives of each entity. As with the exercise for employment contract negotiation, identifying the mission, vision, and values and the strategic direction of both parties is the first step in developing a shared vision of the relationship. If these fundamentals can be articulated and agreed upon early in the process, they establish a framework for building a mutually beneficial negotiated agreement.

The physician practice will commonly enter into a PSA to secure certain assurances from a hospital, to create financial stability and ensure access to patient referrals and hospital facilities. Hospitals also benefit from obtaining a commitment from physicians to cover certain services, and are in many cases mandated to provide continuous coverage for certain patient care activities to meet requirements under EMTALA (Emergency Medical Treatment and Labor Act). Common arrangements relate to call coverage, with hospitals

compensating a practice or individual physicians for guaranteeing coverage of emergency services. Contractual compensation is often structured to either offset potential practice losses due to uncompensated care or due to the unavailability of a physician to cover other services. These compensation rates are typically tied to published data for fair market value (FMV) provided by a third-party entity to inform the negotiation.

Hospital-based practices, such as radiology, pathology, anesthesiology, and increasingly emergency medicine, commonly hold exclusive contracts to ensure continuity and uninterrupted care in these specialties that are integral to the functioning of the hospital around the clock. These exclusivities are often tied to performance metrics, with upside incentives for any number of activities by the physician group. These upside incentives are often where the opportunities for effective negotiation lie. The list of hospital prerogatives in ►Table 4 can readily form a basis for negotiation of such incentives. The financial upside for a hospital can be directly tied to unit performance on many of these items, and this creates a powerful opportunity for groups to apply physician effort to improve these measures. Although radiologists often feel they are powerless to impact such metrics, the alignment value of introducing the commitment of physicians to partner with a hospital around performance improvement is high.

Taking “cost of care delivery” as an example, there are numerous discrete activities in which the physician practice can engage to improve the bottom line. A commonly promoted activity in many hospitals currently relates to inventory standardization, and this represents a chance for physicians to make a big impact on cost of care, an easy first step in building aligned metrics into a contract. Second and third round opportunities include creating dyad leadership structures and compensated medical directorships through which the physicians can impact room turnaround or staffing structure, followed by less common, formal comanagement agreements through which the physician group may have an upside, but also shared risk with a hospital related to certain performance measures. From the standpoint of an interventional radiologist in a radiology practice, or an IR looking to build an independent relationship with a hospital, identifying the places where physician engagement can have a true financial benefit for the hospital allows metrics to be built into a contract, tying financial benefit for the physician to that of the hospital. Interestingly, there is often more than a financial benefit of pursuing these measures, and the physician and group-level imperatives in ►Table 4 often line up with the hospital imperatives: increasing efficiency in the IR suite reduces staffing costs while increasing technical procedural revenue for the hospital and simultaneously increases physician productivity and enhances referring physician satisfaction with the services provided. These are commonly win-win initiatives.

There are strict limits on the ways that hospitals can support physician practices, and legal protections need to be in place to ensure that there is no appearance that either party is inappropriately incentivizing the other within the

relationship. Hospitals are not permitted to provide space or personnel to support the physician practice without compensation for these resources and, similarly, there are certain services that physicians cannot provide without compensation. This is why nonmedical services, such as management responsibilities, performed by physicians must be compensated according to FMV determinations, and why office space in a hospital must be leased by physicians at a fair rate. Again, these rules create opportunities for building structures for collaboration through compensation models that are outlined in contracts, and when incentives are aligned, the collaboration can create better outcomes for both parties.

A Few Final Comments

It is important to understand the direction in which discussions are likely to go in advance of initiating a negotiation, and to have clear parameters for what is and is not acceptable as a final result. Literature on negotiation refers to the best alternative to a negotiated agreement (BATNA)¹ and the concept is critical to ensuring that the final result of a negotiation is better than what one started with, and better than the alternative. Having a clear understanding of the landscape, and a clear understanding of one's own goals prior to engaging, is mandatory for success.

Finally, for positive relationships coming out of a successful negotiation, avoid the temptation to try to add benefits for oneself or one's party once one's stated goals have been achieved. Many successful negotiations have soured because of the “and also...” request at the end. If you have not stated your terms clearly from the beginning, it is a failure that should be kept to oneself. Believing that a successful negotiation should be a platform for adding extras appears disingenuous and puts the future relationship at risk.

Conclusion

Successful negotiations are the result of establishing clarity about one's own goals, recognition of the vision and direction of a future partner, and an understanding of the culture and landscape in which the relationship will exist. Seeking to establish areas of aligned interests, and building an agreement that reflects common goals, is the most successful strategy for creating a positive long-term relationship. Understanding the legal boundaries surrounding physician and hospital contracts will help in navigating regulatory challenges inherent in these relationships. Finally, learning about corporate structures and the implications of different types of partnerships will help a physician avoid frustrations and misunderstandings once a practice relationship has been established.

Conflict of Interest

None.

Reference

- 1 Fisher R, Ury WL. *Getting to Yes: Negotiating Agreement without Giving In*. United Kingdom: Penguin Group; 1981