

Money

Avoiding landmines when signing a hospital contract

Look closely at compensation, impacts of new payment models, termination clauses, and restrictive covenants

by **ALICE G. GOSFIELD, JD** *Contributing author*

HIGHLIGHTS

01 Many hospital employment agreements include restrictive covenants prohibiting three types of behavior: working for a competitor, soliciting employees to leave, or soliciting patients to leave their practice.

02 Many hospitals base their employed physician compensation on work relative value units (wRVUs), which is the essence of a volume driven payment.

Physician employment contracts with hospitals or healthcare systems can be unpredictable. Mergers and layoffs are all often overlooked realities for employed physicians, especially during a time when so much emphasis is on reducing healthcare costs. If you are negotiating an employment contract, take a close look at the compensation arrangement, termination clauses, and non-compete agreements.

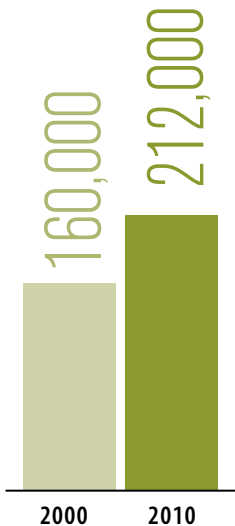
► **BECAUSE THINGS** may not work out as anticipated for either the physician or the employing hospital or health system, it is important to address at the outset some of the potential issues that may arise upon termination of the relationship. This article examines typical issues that should be addressed in a hospital employment contract

and suggests post-termination matters that should be brought up before signing.

THE BASIC RELATIONSHIP

Many health systems have practice entities that are separate corporations through which they employ physicians. In other

PHYSICIANS EMPLOYED BY HOSPITALS



Source: American Hospital Association

While the physician ranks in hospitals have been growing, some systems have adopted compensation ceiling policies that won't go above the 75th percentile.

circumstances, the physician is employed directly by the same entity that holds the hospital license and hospital tax identification number.

Where the employment is directly by the hospital or the same entity holding the hospital license, there are some additional restrictions that apply under Medicare rules, such as the prohibition under the Stark statute against compensating physicians for "incident to" services provided by hospital personnel. In a separate practice of the hospital, "incident to" revenues could be allocated to the employed physicians within the hospital group, as part of their productivity.

No matter which entity is the employer, the relationship is a one-to-one proposition. Under common law, the employment relationship is that of master-servant, which means the employer has the right to tell the employee how, when, and where to perform services. Many hospital employment contracts contain these strong control features.

If you were previously in a group, and even if all the members of your group become employees of the hospital, unless you are in a separate corporate structure (which can happen but is unusual), you should understand that you are an individual in relationship to your employer. Your group cohesion will mean very little.

Familiarize yourself with the policies and rules you are expected to comply with as of the start date, and that the hospital will notify you regularly of changes during the term.

COMPENSATION

Many physicians seek hospital employment for financial security. The sustainability of many apparently lucrative employment relationships is eroding. However, this makes the compensation clauses extremely important.

Many hospitals base their employed physician compensation on work relative value units (wRVUs), which is the essence of a volume-driven payment. Some have adopted policies that they will not compensate a physician above the 75th percentile of relevant compensation surveys so as to be certain they are paying fair market value, even if the physician is significantly more productive than his or her peers.

Being clear on the expectations of productivity and that wRVU targets are realistic is important. The opportunity to earn a bonus above a base salary will often be an issue.

Often these contracts do not address the fact that over the three years of the contract, for example, new payment models including case rates, bundled payment, and global capitation may be introduced, so that wRVUs are no longer an appropriate sole measure of performance for compensation.

How these changes will be accommodated going forward, and the extent to which the employed physician has any say in their construction is also important. Being certain on what basis the compensation can change over time will be critical, especially because hospitals have begun to be assessed Stark and false claims settlements, where excessive compensation was paid.

Many hospital employment contracts assign to the hospital Meaningful Use and Physician Quality Reporting System (PQRS) bonuses and do not pass those payments through to physicians. Few have yet addressed what will happen when penalties kick in for PQRS reporting failures.

In addition, beginning in 2015 the value-based payment modifier for the Medicare physician fee schedule will apply to groups of 100 or more physicians reporting through the same tax identification number based on 2013 performance. How will that be handled?

In the last analysis, the question to ask when entering an employment situation with a hospital that is facing its own challenges from fewer readmissions, the effects of their value based payment modifier, and lower volumes of admissions, is what happens when the hospital believes it cannot financially sustain what it agreed to. Sometimes you can negotiate that if the hospital proposes a compensation change that is more than a certain percentage lower than the original compensation, you can walk away with no restrictive covenant.

This raises the issue of bases for termination.

TERMINATION

One of the first issues is whether the loss of productivity, which may not be in the physician's control, is grounds for outright termination or for renegotiating the compensation. Parsing out the distinctions between lower performance from lack of effort versus loss of productivity from a shift in utilization can be thorny, but it can be addressed in contract language.

The hospital employer will → 27

→ 26 typically document a litany of bases for immediate termination (e.g., loss of license, loss of insurability, violation of alcohol or drug policies) with no opportunity to save employment.

There are typically other grounds for termination for cause (e.g., violation of a policy) with a cure period. For termination without cause, there are pros and cons to the length of time for notice. If termination without cause is only available on 180 days notice, this gives both parties the opportunity to make other arrangements, but if the physician is unhappy he or she is stuck for six months. If the hospital is unhappy with the physician, they have six months of service from a disgruntled employee.

If, however, the notice period is only 60 or 90 days, then there is little security in the arrangement. In addition, if the hospital can terminate the physician without cause, it is fair to ask that any restrictive covenants not apply, but not all hospitals will concur.

Another issue is whether the physician has the right to terminate for breach of contract. Surprisingly to many physicians, many employment agreements do not allow this. If the physician terminates for breach, the restrictive covenants should not apply, but not all hospitals will agree to that. In the last analysis, these decisions are sometimes made on the front end with little appreciation of what they will mean on the back end.

The parties can always agree later to something not in the contract. The likelihood of that depends entirely on context.

RESTRICTIVE COVENANTS

Many hospital employment agreements include restrictive covenants prohibiting behavior of three types: working for a competitor, soliciting employees to leave, or soliciting patients to leave their practice.

These are almost always in place during the term of the employment, but often are also in place post-termination, sometimes for longer than a year. The enforceability of these clauses and their reasonableness in terms of geographic scope and length of time is determined by state law. As systems increasingly consolidate, hospitals are often more concerned about their employees fleeing to a competitor than going back into private practice.

As a result, it is sometimes possible to negotiate permission to be in independent

PHYSICIANS AND HOSPITAL ADMINISTRATORS

Breaking down cultural differences

Physicians and hospitals must co-exist for the success of the U.S. healthcare system, but both physicians and the executives who run hospitals have very different philosophies, and this dichotomy can lead to conflict.

Physician culture

- Values autonomy, trained to work independently

- The need for quick decision-making

- Resistant to hierarchy

- Trained in biomedical sciences, clinical expertise

- Seeks consensus in group decisions

Hospital administration culture

- Trained to delegate and work in groups, embraces the collective mission

- Deliberate decision-making

- Hierarchy is key to success

- Trained in management, social sciences

- Respects top-down hierarchy when making decisions

Source: Nathan Laufer, MD, "The employment of doctors by hospitals—indentured servitude or practice salvation?"

practice—even with a group—as long as the practice is not managed, affiliated with or owned by a competitor.

Non-solicitation clauses sometimes prohibit a terminating physician from taking hospital employees with him or her. Usually the prohibition is on active solicitation, but if someone leaves voluntarily, the provision is not triggered. Careful drafting can be important.

Solicitation of patients post-termination

Many hospital employment contracts assign to the hospital the Meaningful Use and Physician Quality Reporting System (PQRS) bonuses that have been available and do not pass those payments through to physicians. Others do. Few have yet addressed what will happen when penalties kick in for PQRS reporting failures.

is often prohibited, but depending on how the relationship unfolds, if employment is terminated by either party after a short time, it is sometimes possible to bargain for the ability to take back the patients that you brought. When employment situations fall apart early, usually both parties are unhappy.

In anticipation of potential termination, some hospital employers are willing to specify in the agreement what steps they will take to notify patients of the physician's whereabouts when he or she leaves. Some state laws have requirements regarding notices and whether the patients belong to the hospital or the physician.

These issues also relate to patient records and what happens with them.

MEDICAL RECORDS

Physicians typically bring medical records with them when they become employed. Hospitals usually integrate the records into the system's electronic health record (EHR).

While physicians have the right of access to records of patients they are treating, in some states, such as South Carolina, the law says the records themselves belong to the physicians. The hospital is then the custodian of the records.

Upon termination, the issue is whether the physician can take back what he or she brought. Patients can always direct that a copy of a record be made available to their physician post-termination, but with EHRs it can be important to specify in the contract the format in which the records will be provided, the process for that to happen, and who pays the expense, if any.

In addition, the question of how access to records will be made available to the physician for legitimate reasons post termination should be addressed.

BILLING RECORDS AND POST-PAYMENT AUDITS

In virtually all hospital employment contracts, the hospital handles the billing and

collection for the physicians.

Medicare law requires that during the term of employment, the physician have access to all claims submitted on his or her behalf, but it is important to include that in the contract. And the right should extend to post-termination access, as well for audits and other reasons.

In addition, since the hospital will control the claims submission process, it should indemnify the physician for negligence in claims submission, including post-termination. The hospital often will have a provision that says that the physician indemnifies them for negligence in documentation.

If the hospital will not agree to indemnify, an alternative approach is to have it warrant that it will submit claims in accordance with the standards of the industry. In turn, the physician can agree to submit claims in accordance with legal and payor requirements.

Increasingly hospital employers use contract provisions that provide for financial responsibility, including post-termination, for the physician whose documentation has led to audits, investigations, settlements, or penalties which the hospital must pay.

If these clauses are presented, it is important for the physician to have access to the basic data on which the determination has been made; that the hospital be obligated to pursue the defense of such claims and involve the physician, and even that they jointly select the lawyers to manage the case, if any.

The physician will need legal representation in these circumstances; and the hospital should be obligated to respond to that need and any issues the attorney raises during the resolution of the matter. It is important to provide the foundation for these concerns in the employment agreement.

CONCLUSION

The healthcare landscape is changing rapidly, and hospital employment is a pathway

physicians are increasingly pursuing. But it is fraught with pitfalls. The contract is where those issues can first be confronted. The ability to do so, however, will depend entirely on context.

The more important the potential employee is to the hospital or system, the greater the likelihood these issues can be negotiated. On the other hand, some systems have their requirements and will not change them.

Indications of potential problem areas

can be gleaned in the negotiation process. These issues should inform the decision about whether to sign at all. ■



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MUST WATCH

KEY POINTS OF AN EMPLOYMENT CONTRACT

by Scott Baltic

Physicians considering an employment agreement with a hospital have many decisions to make. Hospitals have learned from previous cycles of buying practices and hiring large numbers of physicians, says H. Christopher Zaenger, president of Z Management Group in Elgin, Illinois. Here is what physicians need to know to succeed in the current climate:

Next contract is key

"The hammer that hasn't fallen yet" for many physicians who've sold their practices, Zaenger warns, is that a typical hospital employment contract runs for two or three years, after which the hospital has the unilateral right to adjust the physician's compensation.

Read the contract

Whether contracts are for partnerships, hospital employment, or insurance, "physicians don't read contracts, they just sign them," Zaenger says. "Some doctors just hate paying lawyers."

When joining a hospital or a larger practice, "Go in with your eyes wide open," he says, and if you don't talk to a lawyer, at least talk to your accountant.

Magnifying contract details

- Realize that employment contracts typically specify that the hospital's interest is assignable in the event of a merger, says Alice G. Gosfield, JD, of Alice G. Gosfield and Associates, Philadelphia, Pennsylvania.
- Be sure to read the survivorship provision to see if it gives you an out in the event of a hospital merger, agrees William J. DeMarco, MA, CMC, president/ chief executive officer of Pendulum HealthCare Development Corp. And if the hospital's expectations change following a merger, "You need to reopen negotiations," he advises.
- Bear in mind that non-competition provisions are highly variable, says DeMarco, so they warrant substantial attention. (Zaenger knows one family practitioner who wound up having to move from the Chicago area to Wisconsin because of a non-compete.)
- Recognize that non-competition provisions can be renegotiated if the hospital wants to keep the physician as a source of admissions, Zaenger says. "It is all about money," he says.
- Examine whether the physician has the right to contract directly with a managed-care organization or other third parties, advises DeMarco.
- Specify in the contract that if the physician is terminated without cause, the restrictive covenants do not apply, Gosfield says.