The Physician's First Employment Contract

(Florida Edition)

A Guide to Understanding and Negotiating a Physician Employment Contract From the Employee Physician's Perspective

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FLORIDA MEDICAL ASSOCIATION

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Part I: Introduction and Overview

Purpose. I wrote this guide for you to read before signing your first employment contract, and I've packed it with practical information. When you finish reading it, you will be well equipped to negotiate the most favorable employment agreement possible.

Types of Employment Contracts. This guide covers the various employment contracts you will likely encounter. Part II discusses the "typical" employment contract. It will guide you through the provisions common to employment contracts and give you suggestions on terms that merit special attention and perhaps further negotiation. Part III will guide you on hospital income guaranty and recruiting agreements. These agreements are specialized, unique contracts that can have very dramatic consequences for you. Part IV will discuss other types of contracts that might be presented in lieu of or in addition to the typical employment contract.

Professional Advisors. While there can be no substitute for a careful reading of the contract, it will be immensely helpful to ask for professional advice from an attorney who specializes in physician employment contracts. In particular, each state has laws that affect physician employment. Remember, your employer's attorney wrote the contract. Have a professional on your side to level the playing field!

Overview. This guide discusses the most common provisions found in a physician contract. Of course you might encounter a provision that is not discussed here. If that happens, as suggested above, seek professional advice. Where possible, this guide suggests negotiating options to consider. In addition, important "cautions" will be highlighted to warn you about important contracting hazards. It has been fifteen years since the first edition of this guide. The third edition builds on the first and second editions and explores in greater detail compensation provisions and the accelerating phenomenon of hospital employment.

Before You Get Your Contract. Before the contract stage, carefully vet the group you plan to join. When you interview, learn as much as you can about the way the physicians interact. It is supremely important that you feel you will be a good fit in the practice and mesh with the various personalities and the overall practice culture. Try to talk separately with support staff and with the more recently hired physicians. If at all possible, talk to physicians who have left the group — they can provide valuable insight.

Ask a variety of questions. What is the workload of the physicians? How many daily patient encounters are expected on average? What mentoring does the group provide? How will you be expected to grow your individual practice? Will you be expected to develop your own referral sources? Will you work primarily in one office location or from several locations? How does the group make decisions? Which physician "manages" the group?

When considering hospital employment, take the time to understand the process of the practice. In other words, do the hospital administrators and their staff "run" the practice?

How is the schedule determined, and in particular, vacation and call? In any setting, try to understand important economic drivers, such as the payor mix of the employer.

Caution: *Be sensitive to information that might warrant steering clear of the practice. For example, we have received calls, thankfully only on rare occasions, from newly employed physicians who realize to their horror that the practice engages in unlawful "up coding" (consistently billing a higher level of service than rendered; level 4 instead of a level 3, as an example) or other fraudulent practices. It is rare, but it can occur, and when it does, your professional reputation, your livelihood, and your participation in Medicare and other government-sponsored programs can be at risk.*

Part II: The Employment Contract

The Parties to the Contract. At the outset, in the very first paragraph, the contract will identify the persons who are entering into the agreement. You will be one party, usually designated as the "employee" or the "physician." The employer will be the other party, to whom this guide refers as the "group," the "practice," or the "employer."

Employer. Traditionally, your employer would be a legal entity owned by physicians. Employers usually select one of two forms of legal entities: professional associations (PAs) or professional limited liability companies (PLLCs). Each entity is governed by the Florida business law statutes and will file basic formation information with the Florida Secretary of State. The entity also is required to provide annual information to the State, which you may review on line.

Start Date. When the employer and you sign the employment agreement, it will be a binding legal contract. Usually the contract contains a date in the first paragraph reflecting the date the contract is signed and becomes binding on the parties. The contract also will state another date that will be the date when your duties under the agreement will start, which will be the "commencement date." Be realistic about the commencement date, keeping in mind whether you need to obtain a medical license from the state where the employer is located, or equally important, how long it will take to become credentialed with the group's insurance plans and obtain active hospital medical staff privileges.

Caution: *The practice may not bill you under another's physician's name while your credentialing is being completed. That billing practice is illegal and sometimes occurs in a practice's zeal to bill for a new physician's services before the credentialing process is completed. Discuss with your employer the credentialing process. Be proactive and supply the employer's staff with the information necessary to add you as a provider to the employer's various insurance contracts. In addition, the employer will need to add you to its Medicare group provider number pursuant to a Form 855-R.*

Do not assume that the process will be automatic. Periodically check with the employer to make sure it is diligently pursuing the credentialing process. Periodic checking with the employer will ensure it will be able to bill for your services when you report for duty.

Duties. This section of the contract describes your responsibilities. You will be expected to work full time. The group must approve any exceptions. If you plan to have an outside professional activity, you should ask that the activity be added to the contract as an exception. If you want to practice only part-time, discuss your needs with the group. Fortunately, groups are becoming more sensitive to a physician's desire to balance work and family time. Usually, the contract will provide that passive activities, such as investments, will not violate the exclusivity provision if they do not interfere with your full-time duties.

As far as patients go, the group always reserves the right to assign patients to its employee physicians. This reservation can have a significant impact on your ability to grow your practice if the physicians with longer tenure are given the first opportunity to take on new patients. Discuss with your employer how new patients to the practice are assigned.

Your contract will obligate you to comply with various standards of care and medical ethics and with the employer's policies and procedures. The employer also will obligate you contractually to maintain thorough chart records and timely submit complete billing information for your services to patients. A hospital employment contract will be very detailed in listing the duties and responsibilities of the employed physician. In addition, the physician will be restricted to referring patients only to the hospital's facilities and its other employed physicians.

Caution: *The employer is entitled to expect that you will adhere to various policies and procedures, in addition to more generally applicable standards of care. However, it is equally reasonable for you to ask that the contract specify that the policies and procedures must be in writing.*

It is common that this section contains fairly one-sided statements to the effect that you will work diligently and use your best efforts in performing your duties. The employer may reserve the right to dictate to you how to perform your duties. Often these statements will be tempered with the expectation that you will always exercise your independent medical judgment. Generally these types of statements are acceptable and do not usually present difficulties in the employment relationship.

If the practice has more than one location, consider requesting that you be assigned to a particular location and hospitals in its vicinity. Some contracts, particularly for primary care physicians, will indicate the number of patients you are expected to see in a day or week, sometimes expressed as a weekly average of patient encounters.

Caution: *If your contract has a stated workload, ask the group if it has had problems with physicians not meeting its expectations of productivity. A statement of a minimum number of encounters is indicative that the group has had problems with new physicians previously. An open discussion with the group about its expectations could avoid future problems in your relationship.*

Ownership and Setting of Fees. When you are employed, the group owns all fees generated by you and all accounts receivable. Frequently, you will see language stating that you reassign your right to Medicare and insurance reimbursements to the group. The blanket reassignment is not objectionable and is required under permitted exceptions to Medicare's rules that generally prohibit the reassignment of claims for reimbursement. Employers also reserve the right to set the fee schedule for your services. There may be statements to the effect that if you should receive payment directly, you'll promptly tender the payment to the employer. In the contract you may authorize the employer to act on your behalf with respect to billing and collecting claims for patient services.

Honoraria. Many contracts require that any payments for your related medical services, such as speaking honoraria, medical director fees, chart reviews or expert witness fees, belong to the group. You may want to ask that some minimum amount, such as the first $5,000 of these activities, will be retained by you, and amounts above that threshold will belong to the group.

Keep in mind that the group is paying you a salary and is interested in capturing all related revenue from your services. On the other hand, many of these activities have no connection with the medical practice of your employer, particularly if you pursue them on your own time, and you should feel confident in asking the employer for a waiver of a limited and defined set of these activities.

Call Coverage. Your contract will likely say you will be assigned call as the employer dictates. You will want to clarify the contract to say that the employer will assign call on an equal basis with the other physician employees and on a mutually agreed rotation. Discuss call in your interviews, as call schedules vary widely among practices and specialties.

Make sure that your contract talks about call consistent with what was discussed with you in your interviews. If you are a subspecialist, discuss whether there will be sufficient resources to provide call relief. It's not unusual in smaller communities that there is only one subspecialist, making call coverage and vacation a challenge for the newly recruited physician.

Compensation. The compensation sections of the contract will be of prime interest to you. The contract should state specifically how much and how often you will be paid. Employers have begun using a variety of compensation methodologies, which are summarized below. No matter the compensation methodology, the amounts payable to you are always gross amounts, meaning that the employer will withhold from the gross amount income, Social Security, Medicare, and other employment taxes. Your actual "take home" payment will be net of the taxes.

Sign on Bonus. Employees will often pay a new employee physician a "sign on" bonus, as an incentive to join the practice. A typical sign on bonus is $10,000 and is usually paid when the physician reports for work. Contracts now require repayment of all or a prorated amount of the bonus if the physicians employment doesn't last for two years.

Stated Salary. Traditionally the employer will express a newly employed physician's compensation as an annual or monthly base salary (e.g., $125,000 per year or $10,416.66 per month). The base salary usually will be payable monthly, twice monthly (e.g., the 15th and the last day of the month), or bi-weekly. The fixed salary offers the physician certainty and the ability to incur future expenses, such as a new house. However, employers are faced with a great deal of uncertainty over the employed physician's productivity, due to the unknown level of commitment by the new physician and reimbursement pressures from the payors. As a result, employers are tending to offer formula compensation arrangements more frequently.

With a few phone calls you should be able to determine the starting salary for your specialty. A great source of salary information is the Medical Group Management Association (www.mgma.com); however, you will need to purchase the MGMA's survey results ($625 for non-members and $345 for members). Keep in mind that the survey results are based on responses collected in the preceding year and lag the most current developments. Other salary surveys available for free on the Internet are helpful for benchmarking your proposed compensation. Remember, your base salary is always negotiable.

Formula Compensation. Employers are looking to share the cost of bringing on a new physician employee. To share the risk, the employer will base your compensation on a formula. The formula will almost always begin with your net collections for the employer. Under the formula model, the employer will usually assure the newly recruited physician of a minimum periodic payment referred to as a draw. The draw means the employer will make an advance payment to the physician employee to be repaid from the physician's compensation from the formula.

A couple of simple examples can illustrate the most popular formula compensation models. In one example, the employer may agree to pay the physician a percentage of collections, such as 40 percent. Under this formula, the physician makes 40 percent times the employer's collections for his or her services. If the employer collects $400,000 during the employment year, the physician will be entitled to $160,000. If the employer pays the physician a $10,000 monthly draw, the physician will earn a $40,000 bonus.

In a second example, the employer may provide that the physician will earn a $10,000 monthly draw and will be paid 50 percent of amounts that the employer collects over a stated threshold. The threshold is a collection amount that the employer believes will allow it to pay the draw, cover overhead, and earn a profit. In primary care practices, overhead, that is the cost to run the practice, hovers around 50 percent of collections. Thus, the employer may set the threshold at $600,000. One half of that threshold will cover overhead and the balance will cover the physician's monthly draw and provide a profit to the employer. The employer is motivated to pay the physician a higher percentage of collections above the threshold in order to incentivize the physician to work harder for the financial benefit of both the physician and the employer.

A third example is more complicated and is commonly used as a compensation formula after the first year of employment. In this model, the employer pays the physician as his or her compensation a percentage, e.g., 70 percent, of the difference between the employer's collections for the physician's services and the sum of three "buckets" of expenses:

1. The employer's overhead divided equally among the employee physicians;
2. The employer's specific expenses for the employed physician, such as professional liability insurance premiums, dues and subscriptions, health insurance, retirement contributions, and expenses incurred directly by the physician such as injectables; and,
3. The physician's draw and directly related expenses, such as employment taxes on the physician's compensation, retirement contributions to the physician's account, the premiums for the physician's health and liability insurance, and the cost of the physician's continuing medical education (CME).

This formula very closely resembles how the employer compensates its owners, with the difference being that the employer retains a percentage of the employed physician's collections as profit for the owners.

Under the formula compensation, the employer will only count actual collections it has in hand from the employed physician's services. Thus, the gross collections will be reduced for overpayments, refunds, and amounts disputed by the payors. In addition, the formula is measured over defined periods on a cumulative basis. In other words, the formula is calculated either at the end of a year of employment or quarterly during the year of employment. If the formula is applied quarterly, the employer will true up the physician's final compensation at the end of the year. The true up allows the employer to recoup deficits in the formula that might occur if the physician takes an extended vacation or otherwise becomes briefly less productive.

Be sure to get information from the practice on how the formula works. Ask the practice to run a sample calculation making certain assumptions in applying the formula. A sample will help you better understand the allocation of the practice's expenses to you. Remember that the practice will not begin billing for your patient encounters until you have been credentialed with the various plans, and then the practice will not begin receiving payments until 60 to 90 days after the practice begins billing the insurance plans or government payors, such as Medicare.

The lag in payment could affect the amount paid to you under a compensation formula. After you establish a steady stream of collections, the lag will cease to have an effect on your compensation. Be sure to ask whether you will be given credit for ancillary services, such as labs or x-rays, billed by the practice. If your compensation is based on a formula, make sure you don't have to repay any draws (advance payments) caused by a shortage in your production.

A productivity formula can be a beneficial compensation model for the physician; however, it is usually better to start with a base salary during your first year, while you are establishing your practice. While you have received great training during your residency or fellowship, transition to private practice still can be daunting. Thus the compensation formula is best crafted as a bonus opportunity for the new physician. In this manner, the physician can count on an assured salary and have the opportunity for a bonus if the physician exceeds the employer's performance expectations.

Hospital Employment Contracts. Hospitals are rivaling private practices as physician employers. The financial motivations of the hospital employers are beyond the scope of this brochure, but suffice it to say that there are significant motivations for the hospital to employ physicians.

wRVUs. The hospital employer uses a very clever device to compensate physician employees. This device is a unit of measurement for the physician's work, called work resource value unit (wRVU). The wRVU is tied to the procedure codes used in billing payors with each code assigned a specific values by an agency of the federal government.

Generally, the more complicated the procedure or the longer a procedure takes, the higher the number of the wRVUs. Thus, the hospital employer will translate the encounters of the employed physician to a number of wRVUs. As was the case in the discussion of base salary, the MGMA and other survey organizations provide summaries of percentiles of wRVUs produced by specialty by region of the country.

In your employment contract, the hospital will state that you will earn a defined salary for a limited period of time. For example, the hospital will pay you $20,000 a month during the first year of employment. After the first year of employment, the hospital will pay you based on the number of wRVUs you actually generate. You will earn a fixed amount for each wRVU, for example, $45 for each wRVU. This amount is usually called the dollar conversion factor per wRVU. If you generate 5,555 wRVUs in the year, you will make $250,000 under this example. The dollar conversion amount is a negotiated amount with the hospital. Again, MGMA's surveys can be helpful in benchmarking dollar conversion amounts. The survey will indicate the amount, for example, at the mean and at the 90th percentile.

The wRVU model can be beneficial to the physician employee as the employee is compensated on actual work performed. The physician is not penalized if the work is not collected by the employer, as is the case in the private practice formula model. However, you should read the fine print at the end of the contract that spells out the wRVU definition.

Often the hospitals contractually exclude certain types of wRVUs, such as units attributable to indigent care, which will lower your compensation. The contract may exclude wRVUs for any procedures for which there are no assigned codes, which may be significant in certain subspecialties. You should also be aware that hospital employment contracts always exclude

wRVUs associated with any ancillary diagnostic activities not actually performed by the physician. Similarly, the physician may not receive credit for work performed by a midlevel provider supervised by the physician.

The hospitals favor the wRVU model because it holds the physician employee accountable in performing services. By using wRVUs, the hospital can adjust the physician's compensation to correlate with the physician's production. If the hospital chooses to pay the physician a stated draw, the draw can be adjusted up or down in subsequent reporting periods to account for the change in the physician's activity over prior periods.

For example, if the physician's total units in one quarter are 10 percent less than the prior quarter, the contract may provide that the physician's compensation will be reduced by 10 percent. The hospital may choose to set a "critical" level of wRVUs, and if the physician fails to achieve the critical level, the hospital may terminate the physician's employment "for cause," as described later in this guide.

Caution: *The hospital contract's assumptions on wRVUs and the dollar conversion amounts can have a dramatic effect on your actual compensation. Use the survey results to your advantage. Use the lower median or mean wRVU annual units to set your base compensation, thereby permitting you to earn a bonus for production above that threshold. Negotiate dollar conversion amounts for your wRVUs that are closer to the 90th percentile, thereby maximizing your total compensation.*

Caution: *The hospital determines your wRVU production based on the CPT codes used in your billing. Negotiate with the hospital a means by which you can "audit" your production. In other words, you'll need to know what you have coded for your procedures and how the hospital translated the coding into wRVUs. You'll want to make sure that you get a periodic statement showing your wRVU productivity, ideally monthly, and the correlation between those wRVUs and the various codes you used in your evaluation and treatment of your patients.*

Term of Contract. Most employment contracts are for a specified period, such as one or two years. Some contracts will be for an indefinite period; in other words, the contract runs until terminated by one of the parties. Frequently, a contract will contain an "evergreen" or automatic renewal provision. This provision states that the term will renew for a like period if neither party terminates the agreement within a stated time before the expiration of the contract, such as 90 days before the end of the contract.

If your contract has a stated term, note in your calendar the expiration date. It is not uncommon for the employer to forget that your contract has expired. Similarly, you may want to note the automatic renewal date, in case you have second thoughts about remaining with the practice. Notwithstanding a stated term of years, you'll see below in the discussion on termination without cause that the employer will reserve the ability to terminate your employment on fairly short notice.

Termination. One or more sections of the contract will discuss how the contract may be ended before its scheduled end date.

Death and Disability. Your contract will end upon your death or disability. Disability will require definition in the contract. Usually disability will be defined as your inability to perform the essential functions of your job for a set amount of time. The period will range from 60 to 180 days, sometimes referred to as the "qualifying period." At the end of that period, your contract will end. You will want to make sure that your salary will continue during the qualifying period. You may find that your salary only continues for a portion of the qualifying period. Sometimes, the employer adds the right to have you examined by a physician selected by the employer to determine your disability. Personal disability insurance, which is a must, is discussed later. If the employer only pays your salary for a portion of the qualifying period, make sure your disability insurance will begin paying benefits when your salary stops.

For Cause. "For cause" means that one of the parties has a reason to terminate the contract. Typically, the contract will contain an extensive list of 10 to 20 "for cause" items that allows the employer to terminate the contract with little or no notice. These items include loss or suspension of your medical license, loss of hospital privileges, exclusion from the Medicare program, uninsurable for malpractice, or conviction of a crime. Sometimes the laundry list will include a generic catch all, such as unbecoming conduct.

Try to limit the for-cause list to truly egregious acts, such as the loss of license, and delete the subjective items. Usually the right to terminate for cause is reserved exclusively to the employer. Rarely, it will be extended to the physician, and in that case, cause is limited to nonpayment of your salary.

Caution: *Most employment contracts do not require the employer to inform the physician that he or she is terminated for cause. In reality, the employer must give the physician notice, but if your contract does not require notice, ask that the contract require notice. This addition will avoid the employer holding for-cause events in reserve and notifying you of an occurrence that may be months old.*

Opportunity to Cure. Sometimes "for cause" includes events that may not be so catastrophic as to require immediate termination of employment, such as the failure to observe one of the employer's policies. In this instance, make sure you have the right to "cure." The right to cure means that the employer must notify you that you are violating the contract in some manner and give you a limited period, such as 10 or 30 days, to rectify the situation. If you cure the default, the contract cannot be terminated, and it will continue in effect.

Caution: *The laundry list of for-cause events often includes very subjective infractions, such as failing to meet the expectations of the employer in performing services. Ask that the employer move these subjective, for-cause items to the "notice and opportunity to cure" list of items for which the employer must first give you notice of infraction and an opportunity to remedy the infraction.*

Without Cause—or For Convenience. Almost all physician employment contracts have a provision that will allow either party to end the contract without having a formal reason. The notice period for a "without cause" termination will range from 30 to 120 days. You will want the notice period to be the same for the employer and you; infrequently, the contract will require less notice from the group than from you, which is unfair. Your contract may allow the employer to relieve you of your duties during the notice period, which is perfectly acceptable if the employer must continue your salary.

On rare occasions, the contract may allow the employer to end the contract without cause but deny, by omission, the reciprocal right for the physician employee. This omission is extremely unfair and if encountered, the physician should insist on the reciprocal right to terminate the contract without cause. Failure to do so could limit your ability to pursue other opportunities without financial risk.

Caution: *If you become unhappy and end the contract without cause, you must stay for the required notice period. First, it is only fair that you give the group that time to find your replacement. Second, if you don't give the minimum notice, the group may have a basis to hold you responsible for the costs of finding your replacement and for interim staffing costs, such as the difference between a locum tenens rate and what you were paid. If you need a shorter amount of time, talk to your employer; a shorter transition may be possible.*

Payments After Termination. Your contract should state what, if anything will be paid to you when it comes to an end. For example, will you be paid for unused vacation? If your compensation is based on your collections, will you continue to receive collection credit after the end of the contract and for how long? On rare occasions, some contracts will contain a provision requiring the physician to repay the group on a prorated basis for expenses for which the physician has previously been paid, such as continuing education or used vacation. For example, if you attended CME early in the year, you would have to reimburse the group for a prorata portion. If this provision appears, try to have it deleted.

Effect of Termination. When your employment ends, the contract will require you to assist the employer in the transition of patients to the employer's other employed physicians and the completion of patient charts and billing records. You will be required to return to the employer all of its property.

Section 456.057, Florida Statutes, sets forth the requirements that must be followed when a physician retires, closes his office or relocates his practice. The statute adopts the concept of a "records owner." A "records owner" may or may not be a physician. A "records owner" means any health care practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any health care practitioner to whom records are transferred by a previous records owner; or any health care practitioner's employer, including, but not limited to, group

practices and staff model health maintenance organizations, provided the employment contract or agreement between the employer and the health care practitioner designates the employer as the records owner. Section 456.057(2), Florida Statutes. The statute requires the "records owner" to notify patients of the retirement, closing or relocation of a physician. When the records owner retires, terminates a practice, or is no longer available to patients, Section 456.057(13), Florida Statutes, requires the records owner to notify the patients of the termination, relocation or unavailability in the following manner:

1. Publish in a local newspaper a notice containing the date of termination or relocation and include an address where the records may be obtained from the physician terminating practice or another licensed physician. This is now required by law (Florida Administrative Code 64B8-10.002(4).) A copy of this notice must also be submitted to the Florida Board of Medicine.
2. Physicians may also, but are not required to, notify patients in writing of the date of termination or relocation and include an address where the records may be obtained from the physician terminating practice or another licensed physician) or place a sign in a conspicuous location on the façade of the physician's office.
3. Both notices must advise patients of their opportunity to obtain a copy of their records.

In addition, Section 456.057(14), Florida Statutes, requires that the records owner notify the Florida Board of Medicine and advise the Board who the new record owner is, and where the physician's medical records can be found. The records owner should also review all managed care contracts to determine if any notification provisions must be complied with.

This change will primarily affect employed physicians whose employment agreement designates the employer as the records owner. It will have little effect on other physicians, especially those physicians in independent practice. In that case, the physician who generated the record after treating the patient will be considered to be the "records owner," and, therefore, the requirements discussed above will fall upon the physician. In the case of an employed physician (whose employment agreement designates the employer as the records owner), this responsibility is placed upon the employer.

It is important to note that the Board of Medicine has adopted a rule that imposes certain requirements on physicians who relocate or terminate their practices and are no longer available to patients. Rule 64B8-10.002(4), Florida Administrative Code, requires physicians to publish a notice once a week for four consecutive weeks in a local newspaper of greatest circulation. The notice must contain the date of termination or relocation and include an address where the records may be obtained from the physician terminating practice or another licensed physician. A copy of the notice must be submitted to the Board within one month from the termination or relocation. The rule also gives physicians the option of either placing a sign in a conspicuous location in or on the façade of the physician's office or notifying

patients by letter of the termination, sale or relocation of the practice (this is NOT required, however), in addition to publishing the notice in the local newspaper. The sign or letter must notify patients of their opportunity to transfer or receive their records. The requirements set forth in the Board's rule are separate and apart from the requirements set forth in Section 456.057, Florida Statutes, and must be followed by all licensed physicians.

Vacation and Other Leave. Your contract should state the amount of vacation you may take with pay. In more modern employment contracts, time off will be referred to as paid time off (PTO), instead of vacation. Most often your vacation or PTO will be stated either as a number of weeks or days. A new physician usually will get a minimum of two weeks' vacation, but three weeks is more common. Most employers do not allow vacation to accrue or carry over from one year to the next. Moreover, the employer will not pay the physician for unused vacation. Most practices count sick days as a PTO day.

Larger practices also will have a staff physician handbook that will include the group's policy for sick leave and other absences. If maternity leave is a concern, ask the practice for its maternity leave policy. The Family and Medical Leave Act (FMLA) only applies to employers with more than 50 employees. Leave for military service is also covered by federal law, and you should get specific advice on it if you can be called to active duty.

Caution: *Larger employers and hospitals control the physician employee's vacation use by requiring advance notice and prior permission. Be sure to understand how vacation is scheduled and whether physicians with senior tenure have priority in scheduling vacations, particularly during highly desirable holiday and spring break periods.*

Caution: *If your compensation is strictly based upon a productivity formula, any vacation you take will reduce your productivity, and in essence, you pay for your own vacation.*

Continuing Medical Education. CME is an important component of your employment contract, as CME is required by all licensing and board certification authorities. Most contracts allow one week for CME in addition to your vacation. The employer should pay the cost of your CME, such as registration fees, lodging, and travel, but most contracts will state an upper limit on these expenses. A common reimbursement amount is $2,500, but can range from $1,500 to $5,000.

A Word About Professional Liability. The following paragraphs discuss medical liability insurance, so a brief discussion about your professional liability is in order. A physician always has personal liability for his or her negligent acts or omissions that injure a patient. Even if you are employed, you have personal liability. Because you are an employee, the employer is also liable. Thus, professional liability insurance is a must.

Lawyers will disagree on how much insurance to have. Some lawyers will say that excess insurance induces personal injury lawyers to sue for greater amounts. Nevertheless, some

minimum insurance is necessary to pay an attorney to defend against even frivolous claims. Although Florida law does not require physicians to carry malpractice insurance, professional liability insurance also is most often required to obtain and maintain active hospital medical staff privileges as noted below.

Professional Liability Insurance. The contract should state that the employer pays for your professional liability insurance. You should be interested in the amount of coverage, known as the "policy limits." You also will want to know the policy's deductible, which is the amount you must pay before the insurance company becomes responsible. Most hospitals require a minimum amount of insurance in order to have active medical staff privileges. These limits are customarily $250,000 for each occurrence and $750,000 in the aggregate for all occurrences in a year, though hospital-based practices, such as pathology and radiology, will often be required to carry higher limits, usually $1 million per occurrence and $3 million in the aggregate.

Prior Acts. Your employer-provided insurance will only cover the period of time that you work for the group. Thus, consider whether you need to arrange for insurance coverage predating your employment, sometimes called "nose" coverage. If you are taking a position out of residency or fellowship, you probably do not need to worry too much about insurance covering that period, although it is not unheard of for a resident to be sued after leaving training.

"Claims-Made" vs. "Occurrence" Policies. Most policies issued now are on a "claims-made" basis, meaning you are insured for a claim if it is made while the policy is in effect. The other type of insurance is "occurrence," meaning that you are insured for any injury occurring during the policy period no matter when the claim ultimately is made against you. Occurrence policies are attractive but can be expensive at the outset.

Self-Insured Coverage. Large institutional employers, such as large hospital systems or nationally managed practices, often choose to self-insure. If that is the situation for your employer, be sure to obtain information about the terms of the self-insurance, as there is possibly no actual insurance policy but an accounting reserve, perhaps not funded, that has been entered on the employer's books for possible claims. Self-insurance is distinctly different from a traditional insurance policy.

An insurance policy is a contract between the insurance company, insuring against the risk of loss, and the insured — to wit, the physician. Thus the physician is named in the professional liability policy and looks to the insurance company to defend the claim and pay any loss. Self-insurance is an accounting arrangement by the employer, which estimates the expected cost of claims and reserves the estimate.

Unlike insurance, the employer handles the risk. It controls the defense of the claim and the ultimate decision to go to trial or settle. A patient may allege claims against the hospital for its acts or omissions and against the physician for his or her acts or omissions. The hospital's

self-insurance program will address both diverse components of the patient's claims. The hospital's risk management team may choose to settle the professional claim to "manage" its exposure and avoid surprises. Remember that any settlement of a medical liability claim must be reported to the National Practitioners Data Bank.

Caution: *Ask institution employers about the professional liability insurance the employer agrees to provide for your benefit. If the insurance is self-insurance, ask the employer to buy an individual policy that names you as the insured. Under an individual policy, an insurance company is responsible for your coverage, as opposed to a risk management team employed by the hospital and answering to its executives.*

Caution: *Feel free to ask that the hospital employer provide traditional indemnity professional liability insurance. A number of the larger institutions have been known to accommodate this request.*

Disclosure in Application. Before the insurance company will issue a policy of insurance, you must apply. In the application, you will be required to disclose any prior claims made against you or any events you know about that might give rise to a claim. While no one likes to air dirty laundry, it is important to give the insurance company full disclosure. If there is an inaccuracy in the application, the insurance company will have a basis to deny coverage when a claim arises later.

Notice of Claims. The insurance policy will require you to give prompt notice of any claims. Some states, like Florida, require a plaintiff to give the physician a notice of a medical claim before filing suit. If you receive a notice, you should promptly notify the insurance company even though a lawsuit has not been filed. If a lawsuit is filed, the insurance company is required to provide a defense for you. It will hire an attorney. This attorney has ethical obligations to both you and the insurance company.

While the insurance company may select the attorney to defend you, you should insist that the attorney is acceptable to you. Make sure the attorney has the experience necessary to defend the type of claim being asserted against you. Not all claims fall within a professional liability insurance policy. Some claims are covered by general liability policies, so always err on the side of notifying all insurance companies who have issued insurance policies for your benefit. It is not unheard of that claims may fall within directors and officers liability insurance policies, general liability policies or automobile insurance policies.

Tail Insurance. Tail insurance is a description for insurance that covers you after you leave the practice. Even though you are no longer employed with the group, a patient may still assert a professional liability claim made against your employer and you relating to the time you were employed. As a result, your physician employment contract will contain provisions on who is responsible for buying the tail policy. If you had an "occurrence" policy while employed, there is no need for a tail policy; you only need a tail policy if your insurance policy was based on "claims made."

Extended Reporting Period Endorsement. Tail insurance is not a new policy but is an endorsement to your professional liability policy that extends the period that claims may be reported to the insurance company for coverage under the policy. The extension can be as short as one year or as long as seven years or in some cases, depending on the insurance company, indefinitely. The cost increases with the length of the extended coverage. An injured person has only a limited period of time ("limitations") to sue for malpractice. Most states, Florida included, require the injured person to bring a medical liability suit within two years of the injury or, if the injury is not known, within two years after the injury is discovered. Thus, the longer the extension of time to report the claim, the greater the protection will be.

Caution: *The two year limitation on bringing a claim can be extended to 7 years in certain circumstances and does not apply to an action brought on behalf of a minor on or before the child's eighth birthday. Be aware that some employment contracts require you to obtain a tail policy for the maximum period of limitations, which could be indefinite. If your contract has a provision requiring a tail for the maximum period, ask the group to state that the tail need only be for two years. Remember, however, that the tail insures you for claims as well, so be judicious in its length.*

Who Pays the Tail Premium? The tail insurance premium, due when the extended reporting period endorsement is purchased, is usually a multiple of the annual premium. Most often the physician employment contract will say that the physician is responsible for purchasing the tail policy at the end of the contract, no matter who ends the contract.

If that is true in your contract, consider asking the employer to buy the tail policy if it terminates your employment without cause, and in all other instances, you will buy the policy. Explain to the employer that it controls whether to terminate you without cause, not you, and therefore in that event it's only fair that the employer pay for the tail policy. Another strategy is to ask the employer to split the tail premium with you.

Frequently, the contract also will authorize the employer to buy the policy for the physician if the physician fails to do so and collect the cost from the physician or withhold the cost from amounts due to the physician.

It should be noted that most hospital employment agreements will offer to provide tail insurance to the employed physician at the hospital's expense when the employment ends. Sometimes the offer to provide tail insurance is conditioned on the physician being terminated without cause and not otherwise in violation of the contract's covenant not to compete. This distinction between hospital employment and private practice employment is certainly favorable to you. Nevertheless, remember that most hospitals self-insure their physicians' professional liability, including the tail coverage. Reread the paragraphs in this guide on self-insured plans.

Alternatives to a Tail. If your contract obligates you to buy a tail, ask that the contract allow you, as an alternate arrangement, to maintain a claims-made policy with a prior effective

date that precedes the date of your employment. If you go to work for another employer, you can ask the insurance company providing your insurance coverage to begin the insurance coverage as of the start of your prior employment, the "retroactive date."

Sometimes this form of coverage, which has the net effect of a tail, is cheaper than buying an outright tail. If the premium for a policy with a prior effective date is more than a policy that begins when you start with the second employer, consider reimbursing the second employer for the difference to save money. This alternate option may not work if you relocate out of the state where you worked.

Benefits. Employment benefits will typically include participation in health, disability, and life insurance programs and participation in qualified retirement, e.g., 401(k) plans. Your contract should list all the benefits the employer extends to you as a result of your employment. Even though the benefits are listed, don't be surprised if the employer reserves the right to change or terminate any of the listed benefits at any time during your employment.

Summary Plan Descriptions. Participation in insurance and retirement plans is governed by the plan documents. Ask for summary plan descriptions (SPDs), which are preprinted documents prepared by the benefit provider, so you will know how they will benefit you. SPDs are a quick way to know what is provided and the conditions for participation.

Health Insurance. Most employers will pay the cost of your health insurance but require you to pay the premiums for your spouse and dependents. Sometimes larger groups will provide life insurance, dental insurance, disability insurance (discussed in a subsequent section), and long-term insurance.

Cafeteria or 125 Plans. You are not taxed on premiums your employer pays for your health insurance coverage. Many groups will allow you to obtain dependent health insurance coverage and other types of insurance coverage, such as dental, disability, long-term care, and other health care benefits through a cafeteria plan or 125 plan (meaning Section 125 of the Internal Revenue Code) by using pretax payroll deductions. These plans allow you to save the taxes on additional benefits.

Disability Insurance. If your employer does not furnish disability insurance, make sure you obtain this type of insurance coverage. Actuarially, your disability is much more likely than your death early in your professional career. If you pay for the insurance, the disability benefits will be tax-free when paid to you. If your employer pays for the insurance, the benefits will be taxable to you as ordinary income. If your family situation allows, get quotes for a longer exclusion period, such as 90 days, which will help reduce the cost of the insurance. While policies vary, the disability insurance benefit is usually paid monthly up to five years.

Retirement Plans. Retirement plans will have very detailed specifics on your participation, such as minimum years of service before you become vested in employer contributions.

Some retirement plans, such as a 401(k) plan, allow you to defer some of your compensation ($18,000 in 2016) to the plan (plus an additional $5,500 if you are older than 50 years). These contributions are always 100-percent vested.

Complex Internal Revenue Code provisions govern qualified retirement plans, but one overriding concept, with few exceptions, is that all plan participants must be treated equally. You will not pay income taxes on the contribution to plans not otherwise treated as Roth plans, and the subsequent earnings on the contributions will be tax deferred. Any withdrawals before retirement age (55 years) can lead to significant income tax penalties in addition to ordinary income taxes. If possible, try to maximize your contributions to the retirement plan to provide for future retirement income.

Other Employment Benefits. Other benefits include cell phone, pager, subscriptions and journals, and membership dues in medical societies and board specialization. Often the contract will state a cap on the amount the employer will spend on benefits other than insurance and retirement.

Some groups give its physician employees an expense account, having a maximum stated amount from which the physician may select benefits. Thus, one physician may choose to attend CME in an exotic location and another may choose the latest laptop computer. The group's certified public accountant will have significant input on these arrangements to make sure the employer may deduct the expenditures as legitimate business expenses.

There also could be one-time benefits, such as reimbursement of your moving expenses. A typical relocation allowance is $10,000. Consider asking the group to add to the contract that you will be eligible for all benefits maintained for physician employees.

Mandatory Expenditures. Your contract may require you to maintain a car and a business telephone line at home at your expense. These provisions are included not so much to shift the cost to you as to allow you to personally deduct these costs for tax purposes. Your accountant should advise you on the deductibility of these expenses on your individual tax return.

Mandatory Reimbursement. Your contract may have a provision to the effect that if the employer is denied a tax deduction for business expenditures made on your behalf, you must reimburse the employer for them. Sometimes you will see a reference to Revenue Ruling 69-115, which allows this type of provision. If the practice includes this requirement in the contract, don't be alarmed. It allows you to deduct the amount reimbursed to the practice on your personal return.

Indemnification. Employment contracts now quite often obligate the physician to indemnify the employer for any claims or losses resulting from the physician's acts or omissions while employed. Indemnity is a legal concept that requires one person to pay another person for losses. An indemnity provision will require you to reimburse your employer for any losses it incurs as a result of a mistake you make.

If at all possible, seek to delete these types of obligations. The group should rely on a professional liability policy covering it, instead of your promise to indemnify it. The employer undertakes business risks when it employs you and profits from your services. This author considers these types of indemnity obligations unfair to the employed physician. If your employer won't delete an indemnity provision, ask that it not cover any losses that are covered by insurance. Also ask for a reciprocal indemnity of you by the group be added.

Restricted Activities. Physician employment contracts have become very sophisticated. Employers now add a variety of restrictions to protect the goodwill and investment in their practice. Primary among these restrictions is the covenant not to compete, which is discussed immediately below. Other restrictions will include your promise to maintain and not disclose the employer's proprietary and confidential information, such as its patient list, referring physician list, and unique policies and procedures. In addition, you may be asked to promise that you will not attempt to hire the employer's employees after you leave. A discussion of these restrictions starts with the covenant not to compete.

Covenant Not to Compete. Covenants not to compete have become ubiquitous to physician contracts. Contrary to popular wisdom, covenants not to compete are enforceable if they meet certain common law, and in some states, statutory requirements The covenant not to compete is a serious contractual matter that can severely limit your professional options when you decide to terminate your employment.

Minimum Requirements. Courts view a covenant not to compete as a restriction on trade that will be enforced only to the minimum extent necessary to protect legitimate interests the employer has in the employment relationship. As such, the employer must have an interest that requires protection, such as the medical practice's goodwill, trade secrets, and confidential information. In addition to the foregoing, the covenant's restrictions also must be reasonable as to three specific items: geographic scope, duration, and restricted activity.

Geographic Scope. Typically, non-compete covenants are described as a radius from a location. Be familiar with the geographic area described, as it is a measurement based on a linear radius and not the distance traversed on streets by an automobile. Typically, primary care practices will use a smaller radius than a specialty practice, since the primary care practice has a larger base for its patients located nearer to the practice than the specialty practice. In large metropolitan areas, a radius exceeding five miles should cause some concern. On the other hand, a radius of 25 miles may be entirely reasonable for a medical practice located in a less densely populated region.

Length of Time. The non-compete covenant may only continue for a reasonable period after the end of the physician's employment. Most lawyers believe a covenant should not extend more than two years, with a one-year limit being very common. Keep in mind that even if the restriction only lasts for one year, you may be forced, in order to pay your bills, to move to another community.

Activity Restricted. The covenant should be very specific as to the type of medicine restricted. If a subspecialty is involved, the restriction should be limited to the subspecialty and not the general practice of medicine. Consider asking for limited exceptions to preserve your options, such as working at a medical school, locum tenens, or at the Department of Veterans Affairs, without being considered in competition.

Florida Requirements. For physicians practicing in Florida, a specific Florida statute governs covenants not to compete. This statute provides that:

One who sells the goodwill of a business, or any shareholder of a corporation selling or otherwise disposing of all of her or his shares in said corporation may agree with the buyer, and one who is employed as an agent, independent contractor, or employee may agree with her or his employer, to refrain from carrying on or engaging in a similar business and from soliciting old customers of such employer within a reasonably limited time and area, so long as the buyer or any person deriving title to the goodwill from her or him, and so long as such employer continues to carry on a like business therein. Said agreements may, in the discretion of a court of competent jurisdiction, be enforced by injunction. However, the court shall not enter an injunction contrary to the public health, safety, or welfare, or in any case where the injunction enforces an unreasonable covenant not to compete or where there is no showing of irreparable injury. However, use of specific trade secrets, customer lists, or direct solicitation of existing customers shall be presumed to be an irreparable injury and may be specifically enjoined. In the event the seller of the goodwill of business, or a shareholder selling or otherwise disposing of all her or his shares in a corporation breaches an agreement to refrain from carrying on or engaging in a similar business, irreparable injury shall be presumed.

Buyout Amount. There does not appear to be any prohibition on a buy-out agreement within a covenant not to compete, which may be worded as an amount of "liquidated damages." There are two common buy-out procedures. One type is to defer the decision on the buyout amount to an arbitrator when your employment ends. Obviously, the buyout amount will not be known until the arbitrator makes a final decision. Although arbitration is often thought of as an expeditious resolution of disputes, it can still take up to a year to reach a decision. This delay can only frustrate you. If you choose to compete, you'll be forced to pay to your former employer whatever amount the arbitrator decides. If you want to avoid being locked into a payment of a then unknown amount, you'll need to sit on the sidelines until you know whether you can afford to pay the buyout amount.

A second type is for the employer to state the buyout amount in your employment contract, either by giving a specific dollar amount or tying the amount to a formula. To date, there is no authoritative guidance on what is the correct buyout amount. Most often, the employer will peg the buyout amount to one year's compensation. As you can imagine, a buyout amount equal to your annual salary is in effect no option at all. Even if one could afford to write such a check, it probably would not be a wise investment.

Notwithstanding the foregoing convention, this author believes the correctly stated buyout amount should be an amount that is representative of the harm that would occur to the practice if the covenant is violated. Usually this amount is the revenue that would be generated by the physician less the practice's operating costs associated with the physician, to wit, the profit the physician would otherwise generate for the practice.

Caution: *Covenants not to compete are in a constant state of development, and both court decisions and new laws could affect the statements in this guide. For this reason, consult with an attorney if your contract contains a covenant not to compete. Some states, such as California, flatly prohibit covenants not to compete against employed physicians by law.*

Negotiations. Always ask the employer to delete the covenant not to compete. If the employer insists on the covenant, ask that the covenant not apply if (1) you leave for any reason in the first year, or (2) the employer terminates your employment without cause. Sometimes employers will agree to limit the non-compete under those conditions.

Caution on Non-compete Covenants. A non-compete covenant can have a very dramatic impact on your professional career. It is not unusual that your first employment opportunity will not work out. Unfortunately, the non-compete covenant can have a very chilling effect on your ability to find employment.

As part of your employment, you selected a community that is attractive to your family and you. You may have bought a house and started to put down roots. The non-compete may result in your having to relocate to a new community, or at a minimum, if you live in a large metropolitan area, having to join a practice far from your home and/or your emerging referral base.

While you may have the right to buy out the restriction, you may not be financially able to do so. Or if an arbitrator is to decide the buyout amount, a decision on the amount may be an inordinately long time in coming. Bottom line: Think about the possible consequences of the non-compete before you sign a contract with one in it.

Confidentiality Covenants. Employers now want to protect confidential information used in their practice. This information extends beyond patient privacy issues and focuses on information that gives the group a competitive advantage. The employment contract will typically state that the employer will share with you confidential information about the practice during your employment. You are asked not to disclose that information during your employment and after you leave. Very frequently the period of nondisclosure after your departure will be stated in years, with three years being common. However, unlike the covenant not to compete, the covenant not to disclose confidential information may have an indefinite duration.

Caution: *Even if your contract does not contain a confidentiality provision, employers have protected rights in confidential trade secrets. Some lawyers will ask that "carve-outs" be added to the covenant. These carve-outs exclude confidential information that you learn from other non-restricted sources or that is generally known to the public.*

Non-solicitation. Non-solicitation covenants come in two varieties. Your contract may have one or both versions. First, employers ask that the physician employee promise not to solicit for employment or to hire any employees of the employer for a period of one year after the physician leaves the group. The promise may be extended to include both existing employees at the time of the physician's departure and any employees who were employed by the employer during one year prior to the departure. A second variety on non-solicitation is the promise that you will not contact patients or referring physicians with whom you had contact during your employment.

Consequences of Violating Restrictions. If your contract has post-employment restrictions on your activity, it also will list legal actions your employer may take if you violate a restriction. You will be asked to acknowledge that a violation of the restriction may cause irreparable injury that cannot be satisfied by monetary damages. As a result, the employer will have the right to seek injunctive relief, a temporary restraining order, or an injunction. What this statement means in practical terms is that the employer may seek an expedited court order prohibiting you from continuing a restricted activity that you agreed not to do in your contract.

In their zeal to provide maximum protection for the employer, its attorneys also will add self-serving language to the effect that you acknowledge the restrictions are fair and reasonable. The employer can use these admissions against you in court if you breach the restrictions. Unfortunately, employers and their attorneys are loath to eliminate these admissions from the employment contract.

While I find the language to be one-sided, I typically do not try to negotiate around these provisions. Either the restriction to begin with is acceptable or not, and if it is acceptable, I believe the physician should observe the restriction upon departure.

Ownership of Medical Records. Medical records are an important asset to every practice. Because of their value, your contract will almost always say that the employer owns any medical records you create. If you leave the practice, you may need access to these records (e.g., for a malpractice suit.) If the contract is silent on this issue, you should ask your employer for limited access for medical board complaints, governmental investigations or liability claims. The practice may be sensitive to this request because of its concern for protecting its confidential information. This access was previously discussed in the section on confidentiality covenants.

Inventions; Intellectual Property. Many times, an employment contract will include a section discussing the employee's inventions. The contract will provide that anything you invent, discover, or write while you are employed that constitutes intellectual property belongs to the group. It will go on to say that you agree to assign your ownership of the invention to the group and will assist it with patenting or otherwise protecting it.

I suspect the invention provisions have emerged in physician contracts more from attorney's copying general employment contract forms used in other industries than an outright concern that the group own a physician's inventions. If you see this provision, ask that it be deleted, particularly if you are engaged in research or activities that could lead to an invention. While inventions are concrete examples, the contract provisions can extend to writings, protocols, and processes as well.

Equity Ownership. Your employer likely will be an entity of some type, such as a professional corporation, professional association, or professional limited liability company. At some point, you may want to become an owner in the entity, which is frequently, though incorrectly, referred to as becoming a "partner." Typically a group will consider you for "partnership" after some minimum period, which may range from one to five years, with two years being the most common. If you want to be considered for "partnership," ask your employer to add provisions to the contract committing it to consider you for equity ownership. Usually these provisions are not very specific, because the group does not want to commit in advance that you will become a partner until you have proven your productivity, but at least you have a commitment to be considered.

Specifics. You will want to ask the employer what the terms are for becoming a "partner." For example, is there a buy-in and how much is the buy-in? Will the group finance the buy-in for you, or will you have to borrow the money from a bank? Ask for a copy of the agreements among the owners that govern their ownership. These papers go by a variety of names but generally are referred to as a "buy-sell agreement" and/or a "deferred compensation agreement." Most importantly, try to get an understanding of how the physician owners are treated differently from the staff physician.

Ancillary Services and Entities. The business of medicine now requires physicians to take advantage of revenue-producing ancillary services. For example, many practices own labs, x-ray, diagnostic imaging, and the like. While a number of regulations apply to physician ownership of ancillary services (notably the Stark law), many practices legally operate ancillary services. You should understand which ancillary services the group's patients receive, their revenue potential, and who provides them — your group or another entity (perhaps affiliated). For example, some practices use one entity for professional services and another to provide ancillary or technical services. These distinctions could affect your compensation. If you are entitled to a production-based compensation, you will want to receive credit for revenue generated from these ancillary services for your patients. Hospital employment contracts uniformly exclude ancillary income opportunities from the physician's compensation.

Related Investment Opportunities. You should inquire whether the owners of the practice group own other entities related to the practice. For example, the senior owners of the practice also may own the building where the practice is located. The owner of the building rents it to the practice group. Thus, part of the group's overhead becomes additional revenue for a subset of the practice's owners. Similarly, related entities may lease equipment or provide management services.

Be aware of these possibilities, and if they exist, make sure you will at some point have the opportunity to buy into these related entities. The discussion below about equity ownership applies equally to these related entities. In the hospital employment setting, the employment contract will specifically prohibit the employed physician from owning interests in ancillary facilities that may generate additional income for the physician, such as imaging facilities or ambulatory surgery centers. The hospital views such opportunities as competitive with its core businesses.

Dispute Resolution

Governing Law; Location and Time Limits. Your contract will say that the laws of the state where you practice govern the enforcement and interpretation of the contract's terms. It also may say that any lawsuits arising from a dispute must be brought in the courts of a particular city or county. Many states have laws that allow the party who wins a lawsuit over a contract to be awarded the cost of bringing the suit, including attorney's fees, and your contract may reiterate the law.

Rarely, a contract will limit the amount of time in which the physician may bring a claim against the employer, such as all disputes must be raised within 6 months of the occurrence. In the absence of a time limit, either party to the contract may sue the other party over a dispute within four years after the occurrence giving rise to the dispute, such as a failure to perform the contract. The period to sue is longer in some states. All states impose a time limit after which a contract claim cannot be brought, to wit, statutes of limitation.

Mediation. Mediation is a process by which the parties can attempt to resolve a disagreement through a fairly informal process. The process may be described in the text of the employment contract, or the contract may require the parties to follow the rules of a neutral dispute resolution organization described in the next section. Some lawyers prefer mediation to afford the employer and the employed physician a chance to reach a resolution without resorting to a lawsuit or arbitration. By definition, mediation is not binding on the parties. As a result, the only downside to an agreement with mediation is the delay in complying with mandated mediation before initiating a suit or arbitration that will be binding.

Arbitration. In lieu of bringing a suit in the courts, some contracts specify an alternate means for resolving a dispute, such as binding arbitration. Parties who agree to binding arbitration are precluded from using the courts to decide the dispute. The contract's arbitration provisions should, at a minimum, state where the arbitration is to be held, the number of

arbitrators who will decide the dispute, and the rules that will govern the arbitration. The most common set of rules are the commercial arbitration rules of the American Arbitration Association (AAA), a nonprofit national dispute resolution organization (www.adr.org). Other organizations are also used, such as the American Health Lawyers Association Alternative Dispute Resolution Service (www.healthlawyers.org).

Which Is Better? Attorneys differ on whether it is better to have binding arbitration. Factors in favor of arbitration are speed of resolution, a professional decision maker, and reduced costs. Factors in favor of traditional lawsuits are well-defined rules of procedure and evidence, opportunity for jury trial, and opportunity for appellate review of trial court decisions. Your individual attorney will be in the best position to advise you on arbitration.

Part III: Hospital Income Guaranty and Relocation Agreements

Introduction to Hospital Agreements. Up to this point, we have focused our attention on employment agreements between an employer and you. In Part III, we turn our attention to an additional type of contract, which I call a "hospital assistance contract." This contract is in addition to your employment contract. It will come directly from the hospital offering the assistance, but it is usually negotiated and signed at the same time that you negotiate and sign your employment contract. The hospital assistance contract can be between just the hospital and you or among the hospital, the employing group, and you, but the hospital agreement will be separate from and in addition to your employment agreement.

I think it's important that you approach the hospital assistance contract with a heightened degree of caution. These contracts are quite seductive, in that they seemingly offer "free" money to the recruited physician. In reality, the "free" money is a loan, which must be satisfied in one of two ways: either through continued service in the community for a minimum period, or actual repayment in cash of the loaned amount with interest. Caution is admonished because the continuing commitment to the service community may limit your professional opportunities. If you take advantage of the hospital's assistance, use the support to build your practice to the point where you no longer need the financial aid.

Caution: *Hospital assistance contracts are in reality equivalent to a bank loan. The assistance is not free and must be repaid either in cash or through continuing service in the hospital's patient community. The hospital will hold you accountable to the contract's repayment obligations.*

Hospital Assistance Agreements. Many hospitals will offer contractual recruitment incentives to physicians to encourage you to establish your medical practice in the hospital's service area. Even if you are completing training in the same area as the hospital, the hospital may still offer a contract for you to remain in the same locale.

While the hospital is performing an admirable community service in attracting high-quality physicians and helping them base their medical practice in the hospital's community, it also

is highly motivated by the referral relationship that the arrangement will foster. In fact, most hospital systems have staff dedicated to recruiting new physicians to join existing practices or to open a private practice upon completion of their training.

Limited Benefit; Limited Term. The hospital's financial assistance usually lasts only one year, which is usually called the "guarantee period." The assistance is limited to supporting you in starting your practice or subsidizing the group employing you. As you will see below, the assistance is stated as a fixed amount, which is usually referred to as the "guarantee amount." The contract will state the assistance as a monthly maximum amount and an aggregate maximum annual amount.

Names Used for Hospital Assistance Contracts; Technical Language. As a result of use or custom, the hospital assistance agreements go by a variety of names. The contract names most commonly used are a "relocation agreement," an "income guaranty agreement" or a "collection guaranty agreement." The common elements of these contracts are discussed later. If you have trouble reading the contract, don't be alarmed; these contracts can be particularly difficult to understand even though they may only be a few pages long. After reading the Elements Common to Most Hospital Assistance Agreements section below, you will find it easier to dissect the technical language in the contract and spot the type of contract the hospital is offering.

Retention Provisions. Hospital assistance contracts are cleverly designed to encourage you to stay in the community to which you are being recruited by imposing financial disincentives to moving away from the hospital's service community. In exchange for the hospital's financial assistance, you are expected to remain in the hospital's community at least four years, although a three-year period is sometimes used. If you leave the community, the hospital can demand immediate repayment of its advances to you.

Regulatory Issues. While hospital assistance contracts are becoming almost routine, the sponsoring hospital must provide the financial benefits in a way that complies with applicable health care law and federal tax laws. For example, if the hospital is a (501(c)(3) nonprofit organization, the contract must comply with Internal Revenue Service (IRS) regulations unique to entities that are exempt from federal income taxation. In addition, because of the possibility for the referral of patients to the hospital, all hospital contracts must comply with the Stark law and the approved "safe-harbor" exceptions, which are discussed in greater detail below.

Elements Common to Most Hospital Assistance Agreements. Even though hospital assistance contracts may be worded differently and go by different names, they typically share very common elements.

First, the contract guarantees the physician a minimum level of income or collections. Second, the contract offers the physician additional benefits, such as a signing bonus and

assistance with marketing, moving to the hospital's service area, practice management and software, and professional liability insurance premiums. Third, the contract will address the repayment of the financial assistance. Fourth, the contract imposes a variety of conditions to the hospital's ongoing obligations, such as maintaining a full-time practice in the hospital's community, billing for services promptly, covering emergency department call, maintaining your medical license, maintaining enrollment in Medicare/Medicaid programs, and maintaining active staff privileges with the hospital.

Remember, as with employment agreements, hospital assistance agreements can be negotiated. Keep in mind, however, that the hospital system may be a group of hospitals over a wide geographic area; therefore, the contracting officer likely will resist changes that deviate from the hospital's contracting policy or uniform provisions. You should feel empowered to negotiate the amount of the guarantee; the ancillary benefits, particularly the starting bonus; and the repayment time frame.

Guaranteed Financial Assistance. Almost all hospital assistance contracts are in the form of a fixed amount the hospital will guarantee as your income for one year, and in rare instances, two years. In other words, the hospital will guarantee that you will make a certain minimum amount annually, such as $350,000.

The actual contract terms contain provisions that measure your collected revenues, and the hospital pays a supplemental amount if you don't reach the targeted collections. The payment is added to your collections to ensure you make the minimum annual salary stated in the contract.

As stated at the outset of this part of the guide, the payments are not "free." The supplemental payment now is almost universally in the form of a loan in order to comply with the federal fraud and abuse laws, including the Stark and the Anti-Kickback statutes. In fact, don't be surprised if the hospital contract has various exhibits, among which may be a promissory note equal to the full amount of the guarantee. The supplemental payments are in reality loans that you must repay in some manner.

Procedure — How Do You Get Paid? The contract will state the specific procedures you must follow before the hospital will pay you monthly assistance. First, you must timely bill all your patient charges. Second you must provide the hospital a certificate that states how much you collected for your services during the prior month. Third, you give the hospital the right to inspect your records to confirm the amounts you billed and subsequently collected. The contract usually is specific about the fact that you will practice full time (e.g., 40 hours per week, and no more time off than two weeks for vacation).

Example. Typically, the hospital will guarantee you will receive a fixed amount monthly for the first 12 months of your practice. The payments are made in arrears, meaning that you will receive a monthly payment following a month of service. The hospital arrives at the stated

guarantee amount using a projection of your monthly salary and your practice expenses for one year. Thus, a hospital might guarantee you will have a minimum of $30,000 per month, out of which you will be paid a salary, such as $150,000 per year, and the balance of which will be used to defray the expenses of operating your practice, such as rent, staff, supplies, and the like.

Caution: *Like compensation, you may negotiate the guaranteed amount with the hospital. The guaranteed amounts applicable to your specialty and region of practice are available from the same regional salary surveys discussed previously in this guide.*

What the Guarantee Really Means. The stated guarantee amount is a maximum amount of assistance the hospital will pay to you. It is expressed both as a monthly maximum and as an annual maximum. However, the guaranteed amount is not in addition to what you make. In other words, the hospital's assistance is measured against your actual collections. In the first few months of the term of the hospital contract, the hospital might pay you the full monthly guarantee, because you haven't yet started receiving collections for your billings.

After a few months, you will start collecting for your patient encounters and have revenue. The revenue that you collect will be deducted from the guaranteed amount, and the hospital will pay you only the shortfall. Continuing the prior example, if you collected $35,000 in a month, the hospital would not pay you anything, because you collected more than its $30,000 monthly minimum guarantee. Thus, if the total guarantee amount is $360,000 ($30,000 per month), you may receive only a fraction of the annual guaranteed amount because your practice is collecting on the claims you submit for your patient encounters.

Caution: *The prospect of guaranteed income that the hospital recruiting agents offer to the new physician is tantalizing. For the first time in many years of training, the physician will make a competitive salary, even if the physician's services do not yield that level of collections. Nonetheless, it cannot be emphasized enough that the hospital's payments are only a loan.*

Use the hospital's support for its intended purpose — developing your medical practice by establishing yourself with patients, referring physicians, and the community. At the end of the guarantee period, you want your collections to exceed what the hospital guarantees. Failure to invest in yourself during the guarantee period will result in a very rude awakening when your compensation drops precipitously at the end of the guaranteed assistance.

Excess Collections. If your collections in a month exceed the amount guaranteed for that month, the excess will be rolled forward to succeeding months. In that event, the hospital's guarantee for the succeeding month will be correspondingly reduced. So, if you collected $35,000 and the hospital guarantee was $30,000, the hospital's guarantee amount for the succeeding month would be reduced to $25,000. If you collect more than $25,000 in the following month, you will not receive a payment from the hospital, and the excess will reduce the following month's guarantee.

When you think about it, the reduction is only fair. The hospital is offering its assistance to make sure that you can earn enough to pay your salary and expenses while you establish your practice. Sometimes, you are not permitted to keep collections over the guarantee amount and you must pay any excess to the hospital as repayment of prior advances, though this type of provision is rare.

"True Up" at the End of the Guarantee Period. At the end of the initial assistance or "guarantee period" (e.g., the first year during which the hospital pays you monthly assistance), the hospital will tally your collections and the hospital's payments to you. The collections tally will include collections received during the 60 days after the end of the guarantee period. In other words, the hospital will add all collections you receive during the first year of assistance plus collections for 60 days after that period. The rationale for the additional 60 days is to capture the collections that relate to your services leading up to the end of the guarantee period.

At the end of the guarantee period, you will be asked to provide an accounting of your billings and collections, and the hospital's accounting staff will review the statements. Based on this information, the hospital will determine the final amount it paid to you over the guarantee period, a "true up." You will owe this amount to the hospital. Most hospital assistance contracts will begin to charge interest on this net amount, usually at the prime rate used by a bank.

The contract language to cover the true up is usually very tortured reading, but it is written to arrive at the net amount the hospital paid you. Many hospital assistance contracts now include examples in the exhibits to show how your collections reduce the guarantee amounts and how the net amount due to the hospital is calculated.

Repayment. You must repay the net amount plus the accrued interest due to the hospital, but if you satisfy a series of conditions, the hospital will forgive the amount due over time. Under the most common repayment arrangement, the hospital will forgive a monthly installment for each month that the physician remains in its service community, (e.g., 1/36th of the balance due per month of continued practice in the service community).

If you leave the service community before the end of the contract or otherwise fail to meet the performance conditions, the remaining, unforgiven loan balance will be due. In many contracts, the amount is due in 60 days, and in some contracts, the amount may be paid over six months. Thus, as introduced at the beginning of this part, the hospital infuses the hospital assistance contract with serious financial disincentives from moving away from the service community.

Performance Conditions; Breach of the Agreement. As mentioned above, the hospital's assistance obligations are predicated on a number of conditions with which you must comply. If you do not observe the conditions stated in the contract, the hospital may declare you to be in breach of the contract, immediately stop making monthly assistance payments, and declare prior assistance it paid to be immediately due and payable.

Examples. Many of the listed performance conditions are in the nature of serious, catastrophic events, but they are usually events under your control, such as the loss of your medical license, the loss of staff privileges with the hospital, or ceasing to actively practice in the community. As a consequence of a breach of the contract, the hospital can terminate its assistance and declare the loan amount due. Typically upon termination of the contract due to your default you will be given six months to repay the loan, usually with interest at the prevailing prime rate.

Remaining in the Hospital's Patient Community. As mentioned above, all hospital assistance agreements are conditioned on the recruited physician practicing full time in the hospital's service community for at least the contract period, usually four years — that is one year for the guarantee period, followed by three years of service commitment. The federal Anti-Kickback law defines the geographic boundaries of the service community by the least number of contiguous ZIP Codes from which the hospital draws 75 percent or more of its in patients. In a large metropolitan area with competing hospital systems, the defined area may be fairly restricted. If you move your practice outside of this area, you will be in breach of the assistance agreement, and the hospital may seek repayment of the loan from you.

Caution: *The requirement to continue to practice in the defined area is very important to the hospital. If you do not fulfill the full term of your practice commitment in the defined service area, you can and should expect the hospital to take steps, including possibly legal action, against you to collect the remaining balance of the assistance.*

Thus, it is critically important that you carefully evaluate the community to which you are being recruited to practice. You are making a very long-term commitment, and you cannot just abandon your commitment after the hospital's payments to you stop. When you think about it, the commitment you make in the hospital agreement is just as significant as your obligations in a non-compete agreement with a group employing you.

Caution: *After the hospital's guarantee period expires, you will be on your own to earn a living from medical services. Your compensation can be significantly influenced by the payor mix in your ongoing service area. In other words, if you must remain in a community whose population is indigent or uninsured, you may not be able to earn a salary that is competitive with other markets with a better payor mix. Understand the payor mix before you sign on to receive a hospital guarantee.*

Special Issues of Concern. In addition to the conditions described above, the breach of which can cause you to be in default of the contract, hospital assistance contracts frequently provide for termination upon the death or disability of the physician. If the hospital contract is terminated before the end of its four-year period, the loan becomes due. You should ask the hospital to delete any provision that makes the loan due upon your death or disability — as those events are largely beyond your control. Truly, those events are risks for which the hospital is in a better position to bear than your family and estate.

Restrictions on Investments in Competing Enterprises. Most hospital assistance agreements impose certain investment restrictions on the physician. A common example is to prohibit the physician from owning an interest in a hospital, diagnostic imaging center, or ambulatory surgical center (ASC). Some hospital contracts prohibit the physician from engaging in any activity that would compete with the hospital's business. Obviously, the hospital is protecting its sources of revenues from physician encroachment.

Caution: *The restrictions described are for the duration of the hospital contract (e.g., four years). During that period your practice will mature, and you may be offered opportunities to invest in entities, such as ASCs, that compete with the hospital's business. The restriction could preclude you from taking advantage of an investment opportunity that could supplement your practice income.*

Other Financial Assistance. The hospital's assistance contract almost always includes "up-front" monetary assistance paid at the beginning of the contract to help you establish your practice. Subject to meeting the regulatory requirement that the assistance meets fair-market-value standards, this assistance can be somewhat customized to the physician's particular practice needs.

Examples of Other Assistance. Types of assistance include (1) a fixed amount up to which the hospital will reimburse the physician for relocating to the hospital's community, usually in the range of $10,000 to $15,000; (2) the first year's professional liability premium, not to exceed a stated amount, or alternatively, the premium for a tail policy; (3) marketing expenses, up to fixed amount, to market your practice through advertisements in the media; (4) specific practice needs, such as billing software; and (5) monthly payments of medical education loans. The last example, payment of medical education debt, is rapidly becoming popular.

Sometimes the upfront assistance includes a one-time signing bonus of $5,000 to $25,000, which may be payable in part at the time of signing the contract and the remainder when you begin practicing in the service community. Some contracts will offer to send your staff or you to programs relating to practice operations, such as billing, coding, accounting, and marketing. The foregoing are just examples of what you will commonly encounter, but this part of an assistance contract is one in which you can negotiate for payments that will best help your practice to succeed.

Repayment of Other Assistance. As in the case of the monthly income guarantee, most hospitals will treat the additional assistance as a loan. However, unlike the monthly guarantee, the loan for the "up front" assistance usually does not have to be repaid or is forgiven on the same basis as the guarantee amount. Sometimes it must be repaid if you do not remain in the community for the minimum contracted period, e.g., four years, or if you were to otherwise breach the agreement. It has become common for signing bonuses and relocation reimbursements to be amortized over the first two years of the contract. In other words, if you leave before two years, you must repay the hospital the amount paid divided by 24, times the number of months remaining in the two-year period.

Loan Forgiveness. As mentioned, the hospital will forgive the loan amount that you owe to it over the period of years after the initial guarantee period, usually three additional years, though sometimes two years. If you maintain an active practice in the service community for the term of the contract, you will not owe the hospital anything. The mechanics of the loan forgiveness vary. Sometimes the hospital will forgive a prorata amount for each month served. Others forgive the loan annually, e.g., 25 percent per year.

Tax Consequences of Loan Forgiveness. While the loan forgiveness sounds great, you must remember that any amount forgiven will be income on which you must pay federal and state income tax. The hospital will send you annually a Form 1099 that states the amount that was forgiven, and will also send the form to the IRS. You must report the forgiven amount on your tax return and pay the associated federal income tax. Florida does not have a state income tax, but be aware most states, and some cities, have an income tax that would also apply to the forgiven amount.

Caution: *Consult your accountant about the tax treatment of the hospital's assistance payments and the subsequent forgiveness of the repayment obligation. Loans are not subject to federal income taxes, but the amounts forgiven are subject to taxes. Nonetheless, hospitals will issue a Form 1099 for the total amounts that are loaned to you as assistance.*

Your tax advisor and you should understand at the outset of the hospital assistance contract how the hospital treats its loan advances to you and subsequently the forgiven amounts. The proper, though cumbersome, treatment is not to give a Form 1099 for the assistance amounts advanced to you but to give the Form 1099 for the amounts as they are forgiven.

Coordination With Group Employment. Much of the above discussion speaks to the hospital recruiting you as an individual to the community to practice. The same concepts apply to you when you are recruited to join a group in the hospital's community. However, instead of a contract between just the hospital and you, the contract is with three parties: the hospital, the employing practice, and you.

Only the Incremental Cost. When a hospital assists an existing practice to recruit you, the Stark law is specific on the amount of assistance it can offer the employer and you. The hospital may only assist the employer with the incremental cost of adding you as a member. This amount would include your salary and the added cost the practice will incur to support your position, such as a nurse or additional equipment. By contrast, the hospital may more fully assist the physician setting up his or her solo practice. In that vein, it is not uncommon to encounter several solos, each contracting separately with a hospital, but who plan to combine into a group when the initial assistance period ends. If they started as a group, the assistance might be diminished because the hospital can only assist with the incremental cost of additional physicians.

Along these same lines of thinking, an existing practice may not employ the recruited physician directly. The recruited physician will practice "solo" during the assistance period, which gives the hospital greater freedom in reimbursing the physician's overhead. The recruited physician in this arrangement would contract with the existing practice for facilities, staff, and administrative support, the total expenses of which would be reimbursable overhead to the solo practitioner. At the end of the assistance, the physician will become an employee of the existing practice. The arrangement allows the hospital to pay more than the incremental costs of adding the physician. It also offers the existing practice an avenue to escape financial liability for the payment, as discussed in the next paragraph.

Responsible Parties. The hospital contract may provide that the assistance will be paid directly to the employing group. In that the instance, the group must sign the contract and use the payments only for the employed physician's benefit. In addition, the group must also agree to repay the loaned amount of assistance if the recruited physician doesn't satisfy the contract conditions, such as practicing in the community for the requisite period of time.

As an alternative, the contract can provide that the assistance will be paid only to the physician. In that instance, only the recruited physician is liable for repayment. In some contracts, the employer is responsible for repaying the portion of assistance that relates to its incremental costs in adding the physician as an employee, and the physician is responsible for the remaining assistance payments.

Collateral for Repayment. The hospital assistance contract often will require the employing group to pledge the receivables attributable to your services to secure the repayment of the guaranteed amount. The contract also may require the group to pay your receivables to you if you leave the group's employ before the end of the hospital's guarantee period. This latter requirement is added to make sure the employee has a means to repay the loaned assistance.

Contracting Challenges. While the foregoing rules applicable to hospital assistance to employing groups are somewhat straightforward, the actual contract terms for the arrangement can be more problematic. For example, if the payments are made to the group, and the recruited physician meets the requirements for loan forgiveness, who gets the Form 1099 and who pays the income tax on the forgiven amount? If the payment is made directly to the physician, how does the money pass to the practice that is incurring the cost of the physician? If the physician doesn't satisfy the continuing practice requirement, how does the group protect itself when the hospital is looking to it for repayment? There are solutions to these questions, but they do require careful drafting and consideration of the consequences.

Federal Anti-Kickback and Stark Law Provisions.

Federal Laws. As hospitals receive the bulk of their revenue through payments from the federally sponsored Medicare and Medicaid programs, federal laws restricting payments to physicians for referrals apply to hospital assistance contracts. The two principal laws are

the Anti-Kickback Statute and the Stark Law. In the context of hospital assistance contracts, the two laws and their exceptions overlap in many respects. The following highlights the portions of both laws and their exceptions that apply.

Anti-Kickback Statute. The federal Anti-Kickback Statute outlaws payments made for referrals of patients covered by federally sponsored health programs. As hospital assistance contracts can significantly benefit communities that do not have a sufficient number of physicians, the U.S. Department of Health and Human Services has adopted a "safe harbor" that contains a series of conditions. If the conditions are met, the contract falls within the safe harbor and, the contract will be safe from a violation of the Anti-Kickback Law.

As written, the safe harbor requires the physician to be recruited to a health provider shortage area (HPSA) among its conditions. Nevertheless, a 2001 CMS Advisory Opinion, 2001-04, allows a hospital to satisfy the HPSA condition by demonstrating that its community suffers from a shortage of physicians trained in the recruited physician's specialty.

Anti-Kickback Safe Harbor. In addition to the physician shortage requirement, the safe harbor lists the following conditions:

1. There must be a written agreement signed by the hospital and the recruited physician.
2. The recruited physician, if leaving an established practice, must receive 75 percent of his or her revenues from new patients not previously seen by the physician in his or her prior practice.
3. The hospital's benefits may not last for more than three years, and the assistance may not be renegotiated during the assistance period.
4. The recruited physician is under no obligation to refer to the hospital or generate business for it.
5. The recruited physician must be free to establish privileges at other hospitals.
6. The amount or value of the hospital's assistance may not be tied to the physician's referrals to the hospital.
7. The recruited physician must agree to treat patients receiving federal health care assistance in a nondiscriminatory manner.
8. The payment or exchange of anything of value must not benefit, directly or indirectly, any person (other than the recruited physician) or entity in a position to make or influence referrals of items or services payable by a federal health care program to the hospital providing assistance to the recruited physician.

Stark Law. The Stark law prohibits a physician from referring a Medicare patient to a hospital if the physician has a financial relationship with the hospital, unless an exception applies. Consequently, the Stark law would otherwise prohibit a hospital assistance contract unless

an exception to the arrangement applies. Fortunately, the Stark law and its regulations contain an exception specifically for hospital assistance contracts. This exception is referred to as a "safe harbor." The term "safe harbor" means that, if the conditions specified in the regulations are observed, the contractual relationship will not violate the Stark law.

Stark Law Safe Harbor. The regulatory safe harbor outlines the following conditions with respect to hospital assistance agreements entered into in conjunction with a physician employment agreement:

1. The hospital assistance contract must be in writing and signed by the parties to it.
2. Except for the costs incurred by the employer in recruiting the new physician, the remuneration must be passed directly through to or remain with the recruited physician.
3. In the case of an income guarantee of any type made by the hospital to a recruited physician who joins a physician practice, the costs allocated by the employer to the recruited physician do not exceed the actual additional incremental costs attributable to the recruited physician. If the employer is located in a rural area or a health professional shortage area HPSA, the rules in this condition are relaxed.
4. The records of the actual costs and the passed-through amounts must be maintained for five years and made available to the Secretary of Health and Human Services.
5. The hospital's assistance is not determined in a manner that takes into account (directly or indirectly) the volume or value of any actual or anticipated referrals by the recruited physician or the employer (or any physician affiliated with the employer) receiving the direct payments from the hospital.
6. The employer may not impose on the recruited physician restrictions that unreasonably restrict the physician's ability to practice medicine in the hospital's service community. 42 CFR §411.357(e)(4).

Fair Market Value. Central to the federal regulations on physician recruiting is the fundamental premise that the hospital's assistance must be for fair market value. The hospital may not pay more than the fair market value of the assistance provided to the physician or the employing group. This requirement means that the hospital must only pay assistance that would be needed to attract the physician to the hospital's service area.

The salary must be competitive but not in excess of what a new physician would be paid to come to the community. The additional overhead assistance must be at its fair market value, such as the actual projected cost of staff, rent, and insurance premiums. Frequently, the hospital will document the fair market value of the assistance through written opinions of valuation consultants or internal evaluations that the assistance does not exceed what the services would cost in the open market.

Relocation. To prevent abuse, the regulations impose additional conditions on the recruitment of the assisted physician. If the physician is coming out of training or has been in practice for less than one year, the physician can be recruited from any geographic area, including from the hospitals servicing the community in which the physician trained. If the physician has been practicing for more than one year, the physician must relocate from outside the community.

The regulations allow the physician to satisfy this relocation requirement in one of two ways. First, and easiest, the physician must physically relocate his or her practice at least 25 miles from the prior practice location. Second, the physician must relocate in a manner that results in at least 75 percent of his or her patient encounters coming from patients the physician hasn't treated in the last three years.

Non-compete Covenant. Prior to 2007, the Office of the Inspector General (OIG) of the Centers for Medicare & Medicaid Services (CMS) interpreted the regulatory conditions as prohibiting an employer of a physician who also was receiving hospital assistance from imposing a covenant not to compete. The OIG reversed course in 2007, stating that covenants not to compete were not categorically prohibited. In Advisory Opinion 2011-01, CMS reached a much broader conclusion.

In essence, CMS believes that an employer may subject a physician to a covenant not to compete even if the physician and/or the employer are receiving payments from a hospital under a hospital assistance contract. It seems CMS believes that a covenant that otherwise satisfies the applicable state's law on restrictive covenants does not "unreasonably restrict the physician's ability to practice in the geographic area serviced by the hospital." In the opinion, the OIG concluded that a one-year, 25-mile post-employment restriction met the safe harbor's conditions.

Caution. *Many employers will only add you as an employee if the hospital will provide financial support through a hospital assistance contract. As seen in the discussion of employment contract terms, the employer may impose restrictions on your ability to compete with the employer for a period after your employment ends. Moreover, the employer may discharge you on short notice without cause.*

As a result, you may be prohibited from practicing medicine in the restricted area for one or two years. If your employer and you receive hospital assistance, you must remain in the service community or be forced to pay back any amounts that the hospital advanced. This situation is a lose/lose one for the employed physician. In these arrangements, attempt to negotiate an arrangement that either allows you to remain in the community or obligates the employer to repay the hospital if you cannot due to a covenant to compete.

IRS Requirements. As mentioned at the beginning of this part, 501(c)(3) tax-exempt hospitals face additional requirements under the Internal Revenue Code and its regulations

pertaining to tax-exempt organizations. The charitable hospital must satisfy these requirements, in addition to the Anti-Kickback and Stark requirements, to maintain its tax-exempt status. The IRS has summarized these requirements in Revenue Ruling 97-21 (April 21, 1997).

Public Benefit. To be exempt from taxes, a charitable organization must demonstrate that no part of its profits or income inure to the benefit of private individuals. The favorable tax status is conditioned on the premise that the charity's mission is for the benefit of the community as a whole. Thus, the benefit that the private physician receives as a result of the assistance is outweighed by the benefit to the community in recruiting the physician to the community.

Community Need. There must be a need in the community for the recruited physician in the physician's medical specialty. The hospital must be able to show that its community is underserved in the particular medical specialty by demonstrating a need for the specialty of the physician recruited.

Part IV: Other Agreements

Independent Contractor Agreements. A physician independent contractor agreement is very similar to a physician employment contract. Both contracts are professional services contracts. They differ in two principal respects. First, under general common law principles, the employer does not have responsibility for the actions of an independent contractor. The independent contractor exercises independent control of his or her actions, for which the employer is not responsible, unless the employer is ignoring activities of the independent contractor that would likely lead to injuries.

The facts and circumstances of the relationship with the employer determine the contractor's status, not the designation "independent contractor." If the employer exerts control over the relationship, such as the ability to approve or direct the scope of work, the means of work, the location of work, and similar items, the relationship will be deemed to be an employment relationship even though it has been designated an independent contractor relationship. As discussed above on employment contracts, an employer has equal liability with the employee for negligent acts.

The second difference for independent contractor agreements is the employer's responsibility for employment taxes. Employers must pay employment taxes on the wages of employees. Independent contractors are responsible for those employment taxes, commonly called "self-employment taxes." Again, the denomination of the relationship is not controlling. The IRS will apply 20 factors in determining the nature of the relationship to distinguish between employee and independent contractor.

These factors are much like those described above. In addition to paying self-employment taxes, the independent contractor is also responsible for making quarterly income tax deposits. In the independent contractor relationship, the employer is not responsible for

withholding income taxes from payments to the independent contractor. Other than these two principal distinctions, virtually all other aspects of the independent contractor agreement are similar to the employment contract.

Letter Agreements. Almost all of the preceding discussion has been with respect to formal, multipage contracts. I have seen on more than just a few occasions the entire employment arrangement embodied in a "term sheet" or offer letter. These usually are very informal in style and typically written by the office manager or the managing physician.

A term sheet or offer letter or expression of interest can be a really useful tool in physician employment contracts, but it should not supplant a carefully written, thorough employment contract. The term sheet should outline the major points for the new physician. If the parties agree on the major points, then the group asks its attorney to prepare the formal contract. The term sheet allows the parties to make sure they are both on the same page on key items, such as salary and vacation and bonus.

Usually the attorney doesn't review the letter agreement until after the recruited physician is unhappy and wants to leave the group. Needless to say, that is too late in the game to be concerned about what your rights are.


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