

Tips for Reviewing Your First Physician Employment Contract

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After residency, physicians may obtain independence for the first time. They can choose where they want to live, and often will be purchasing their first home. There are many big decisions to make, and these decisions often hinge on employment selection.

This article is intended to guide new physicians.

The first question to ask yourself is: Are you pursuing a job—or a career? Will your role be free of third-party payment headaches, or do you view these as a necessary evil? Turning down a seemingly predictable salary from a large hospital system can be difficult. We all know that entering the role of an employee will place us in the middle of a war we were never meant to fight, one between third-party insurance companies, hospital administrators, and government bureaucrats. When evaluating these agreements, physicians need to consider many details to make an appropriately informed decision. This review attempts to identify these issues in a concise manner.

Here are the three most common and deadly mistakes physicians make:

- Undervaluing flexibility;
- Assuming that all physicians sign the same agreement and that terms are not negotiated; and
- Allowing vague terms when specifics are needed.

Take care to avoid these three flawed assumptions:

- A large employee handbook means that a medical services organization delivers high quality care.
- A complicated credentialing process assures that you will only work with high quality colleagues.
- A long contract means your employer has thought of everything.

Recruitment

Your recruitment is typically when the conversation begins. Ideally you located the practice opportunity on your own. When reviewing online advertisements, be skeptical of one that focuses exclusively on the benefits of the geographic location rather than the work environment. Be wary if a recruiter contacted you unexpectedly by email or telephone, especially if you are speaking with an outside recruiter (rather than an inside recruiter employed by the same practice you might be joining).

Physicians should know that recruiting with an outside recruiter is typically more expensive. Recruiters have an

average compensation varying from \$62,000 to \$95,000 per year.¹ These recruitment costs should not be necessary. Bonuses for recruiters likely mean fewer bonuses for physicians. It is in this recruiter's interest to tell you things you want to hear about the position. These statements have no legal weight and could easily conflict with the contract you ultimately receive. Outside recruiters are mostly paid based on whether the physician signs the contract, and not based on retention. It is in their interest to keep you on the job treadmill, with relocation every two to three years.

Goals

Before you indicate your interest in a position, you should know what you want. Have a target compensation level, hours, clinical expectations, procedural opportunities, teaching opportunities, etc. Speaking with your potential future colleagues is critical. Are these physicians happy? Are they honestly answering your questions? Would you like to work with them? Are you about to inherit a panel full of patients on controlled substances when you do not plan to prescribe these in the same pattern as the former physician?

Compensation

Survey data from Medical Group Management Association (MGMA), Merritt Hawkins, or AMGA should not be an excuse to decrease your total compensation.² In settings that are dependent on traditional government payers, hospitals often cling to MGMA as if it were the only accepted measure of "fair market value" for clinical services. Even if both parties to the contract agree that MGMA is an acceptable fair market value, this amount only represents a cap on the clinical component of your salary, not the administrative component. Most hospital contracts will attempt to avoid compensating you at all for administrative tasks, but these can be compensated outside of clinical fair market value caps.

How much of your salary is guaranteed? How long does this guarantee last? Does the guarantee last as long or longer than the term of your contract (mentioned below)? How much of your salary or other compensation is at risk? Is this risk tied to your production? If it's tied to production, how is your production tracked (most commonly by relative value units or RVUs)? If you have the potential to generate a bonus, how is this bonus determined (quality, RVUs, net collections, gross billings, patient encounters, etc.)? If there are quality metrics used for your bonus, do you agree with the

objectivity of those metrics? Ask how many physicians in the group have historically received each possible bonus. When determining whether you might want to work longer hours in attempting to reach an RVU goal, ask yourself whether this is the most efficient way to increase your income. You might often be better off doing part-time moonlighting work for an hourly rate in a different setting.

Benefits and Tax Considerations

Determine whether the following are offered and predict their tax impact:

Health insurance, dental insurance, vision insurance, disability insurance, professional liability (medical malpractice) insurance, and a CME allowance are not taxed.

Tax treatment varies for a 401(k) or similar retirement plan.

A signing bonus is taxed as income in the year payment is received. Your repayment obligation varies.

A loan repayment is also taxed as income in the year payment is received, and you need to find out about your repayment obligation.

For relocation expenses, favorable tax status is possible, and there may be a repayment obligation.

Timing

Agreeing on a start date is usually the easy part, but there are many other timing concerns. Do you agree on how long the initial term of the agreement should last? Three-year terms are the most common. Have you paid attention to the automatic renewal terms of the agreement? After the first three-year term, does the agreement renew for subsequent annual terms, or repeat three-year terms? Shorter terms usually work out in the physician's favor because the physician has a chance to negotiate salary increases more frequently.

What are your terms for ending the agreement? Do you have a notice obligation? Most contracts carry a notice obligation of between 90 and 180 days. If you end the agreement early, do you now owe money to your employer? Contracts commonly include payback provisions related to the signing bonus, loan repayment bonus, relocation expenses, and/or medical malpractice tail coverage (if under a claims-made plan). Do you have a non-compete agreement in place? Is the contemplated geographic restriction a problem for you? If so, does your state tend to enforce or disregard non-compete agreements? If your nurse wants to leave the practice with you and join you in another setting, are you restricted from bringing the nurse with you due to a non-solicitation clause?

Liability

Your professional liability insurance policy should be covered. Pay attention to the minimum amounts of liability

coverage recommended by your state. Note that some states cap medical malpractice non-economic damages, but the cap may only apply if you purchase the minimum qualifying amount of coverage.

An occurrence policy is preferred over a claims-made policy. Occurrence policies cover all acts that occurred during the term of coverage, even if the claim is filed after termination of the policy and/or your employment. Claims-made policies only cover claims announced during the life of the policy, and thus "tail" coverage must be purchased upon cessation of the claims-made policy. Employers will often attempt to burden the physician with purchasing tail coverage, especially if the physician terminates the contract early.

Is your employer willing to provide liability coverage for potential liability under the False Claims Act (FCA) or the Health Insurance Portability and Accountability Act (HIPAA)? HIPAA fines can vary from \$100 to \$50,000 per violation.³ FCA provides that a person who presents a false record or statement to get a false or fraudulent claim paid or approved by the government is liable to the federal government for a civil penalty of \$11,000, "plus three times the amount of damages which the government sustains because of the act of that person" and that "no proof of specific intent to defraud is required."⁴

Hospital-employed physicians are often pressured to use third-party billers. These billers will read through the chart and either change coding, or recommend coding changes, based on their analysis of the documentation. When these groups make errors, they are generally contractually absolved of all FCA liability. Your medical malpractice policy may not cover FCA liability. Governmental FCA claims can exceed \$100 million in damages.⁵

Work Expectations

Will your role be more exhausting than advertised? Note that vague job descriptions (all duties "as assigned") could be a black box of never-ending tasks. The employer will often specify minimum hours, but almost never lists maximum hours. If you are to be paid on an hourly basis, look for a discussion about overtime and holiday compensation. Ask which days and hours of the week will you work?

How often will you take call? How are call weeks and holiday coverage assigned?

Find out who will schedule or approve your vacation. Is your vacation time guaranteed?

If not taken, does vacation time roll over from year to year, or could it be "cashed out"?

Is there a complicated RVU scheme? Most RVU targets are difficult to reach, and chasing RVUs can often mean spending too little time with patients. Although it is often easier to earn more through moonlighting, the contract may contain an "outside professional services" (moonlighting) prohibition or restrictions. Your employer should list any

specific competitors that you are to avoid, rather than asking you to request permission to moonlight with various entities. Do not sign an agreement that prohibits moonlighting.

Be sure to retain rights to all your work. Many contracts contain phrases attempting to give an employer rights to any revenue from your original research, authored books, authored websites, and/or software development. If additional income is earned from other activities such as teaching, you should not give your employer a contractual right to take it away.

Look out for assignability provisions that may require you to work for a new boss. Default contract terms generally provide for a change of ownership with a continuing employment obligation on your part. If you know that a change in ownership would result in your desire to leave, then this preference should be put in writing.

Will you have an obligation to supervise mid-level practitioners? Are these nurse practitioners (NPs) or physician assistants (PAs)? If they are NPs, do they have independent practice rights in this state? If so, this lowers your medical malpractice risk, since charts are not co-signed. Have they been trained by other physicians, or are they new graduates? Will you have a say in future hiring or firing decisions?

Conclusions

These recommendations should allow you to better evaluate employment opportunities. But you should also

be aware of independent practice options, as explained by physicians in many specialties at www.aapsonline.org/freedom. Direct primary care physicians and other third-party-free practices are always seeking to grow!

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AAPS PRINCIPLES OF MEDICAL POLICY

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access. Government and other third-party payment or price-

fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.