Cal Ortho On-Line

REPORT III—2012—SPECIAL EDITION

Index:

[Summary]
[Advantages]
[Disadvantages]
[Am I compatible?]
[How do I Negotiate an Employed Contract?]
[Expenses and Benefits]

Orthopaedic Surgeon Employment Issues

"Where are we going?" "Are we there yet?" "What'll we do when we get there?"

These are questions more and more orthopaedic surgeons in California, and nationwide, have been asking in the context of their practice or employment arrangements. While there are no black and white answers to these questions, this article analyzes the pros and cons of moving to an employment arrangement and gives you model language that you should consider in any employment contract.

California generally prohibits direct hospital employment of physicians – Business and Professions Code 2400[1] - commonly known as the "corporate bar." The law, however, has a number of exceptions. Accordingly, community clinics, state and county hospitals, as well as those operated by the University of California may directly employ physicians. In addition, hospitals that are not exempt from the corporate bar have developed alignment strategies with physician groups. These strategies enable hospitals to achieve varying degrees of clinical and financial integration. This is often done through medical foundations and outpatient departments. Many of these models are outlined in the January 2012 edition of Cal Ortho On-Line which can be found online at: www.coa.org. Further, some hospitals that are not expressly exempt have entered into employment arrangements with physicians in various capacities, such as teaching, administration, etc. As employment of physicians becomes more prevalent, courts may start to question more and more the legality of these arrangements. Similarly, lawmakers may question the corporate bar.

So, throughout this document, please keep in mind that technically, the employment of physicians by hospitals for the most part is illegal in California. For simplicity, while acknowledging that ban, in this analysis we will refer to this as hospitals employing physicians. This article will discuss the emerging trend toward hospital employment of physicians, the trend's pros and cons, cautions for orthopaedic surgeons considering this

[1] Business and Professions Code 2400

option, and, lastly, what specific contract provisions orthopaedic surgeons ought to be aware of when negotiating an employment arrangement.

Where are we going?

Employment in Uncertain Economic Times

For the last few years, the economy has been uncertain at best. Given the recent economic decline in our country, and particularly in California, and the continued uncertainty about any recovery occurring, the desire for secure employment has grown. Plus, there are the complexities and expense of going into private practice, trying to get into payor networks, setting up a practice, dealing with billing and collection issues, and an uncertain patient base. Therefore, some orthopaedic surgeons just entering practice, or those wanting to slow down their practice, are finding starting or maintaining a private practice to be nearly impossible.

For these orthopaedic surgeons, this has meant looking for hopefully longer-term, secure arrangements. This can mean joining larger orthopaedic groups or looking at hospital employment arrangements. There are trade-offs in each setting.

Compared to working on your own, an employment contract generally offers more certain working hours and better quality of life. Historically, most orthopaedic surgeons could not hope for, much less demand, a 9 to 5 working life. Maybe it was feasible later in their career, but certainly not early on. Employers, however, find more and more that employees—including professionals—are satisfied with the compensation arrangements offered in exchange for less work hours, less practice hassles, and more certain employment benefits. In the healthcare setting, quality of life generally goes up as managerial headaches go down.

The other trades that many orthopedic surgeons who are moving to employment arrangements are making is to give up managerial control of their practice in an effort to: 1) reduce their own stress and 2) focus more on what they went to school for in the first place, treating patients. The desire for less managerial responsibilities, less "running the practice's business," combined with a desire for a secure future, income, patient flow, and integration with other physicians has all led—in part—to a national explosion of hospitals acquiring physician practices. This is done by management, employing physicians, or forming close alliances with local physicians.

While there are benefits to doctors in working for a larger entity, like a hospital, or a large "hospital friendly" type group, there are also benefits for the hospitals, such as coverage benefits. By directly employing doctors, or affiliating with a group, hospitals can take care of a major concern regarding hospital-patient coverage—especially in emergency departments.

With more direct control over doctors, hospitals can reduce their "who will be where?" dilemma by hourly guaranteed staffing. Plus, they can bring back to the hospital, profitable services that are currently being performed in a physician's office (MRIs, CT scans) or in physician-owned ambulatory surgery centers.

But hospital employment is not simply caused by economic uncertainty or by generational shifts from entrepreneurial to guaranteed-employment goals. The healthcare market itself is uncertain, separate from the economic problems of the day.

Employment as a Means to Improve Care Coordination

Regardless of health reform legislation, as a matter of economics, more hospitals, physicians, and payors strive to achieve better coordination of care even in the absence of a mandate; thus, they are considering forming private or Medicare compliant Accountable Care Organizations (ACOs).

There is a driving notion that ACOs and other integrated delivery systems will reduce expenses to hospitals resulting from integration. Simply, a large group, or hospital, can contain costs and integrate medical records resulting in an efficient healthcare team working together. Payors are also aware of this integration and are seeking to form private ACOs with physicians and hospitals. Moreover, patients may benefit because their care is more coordinated. In theory, if structured properly, costs go down and care goes up. It remains to be seen if there is actual cost savings or care coordination; hence, more uncertainty.

Safety, and Payment, In Numbers

Another looming question involves the relationship between providers and insurers. With respect to insurance negotiations and collections, large groups have advantages: leverage and specialization. A hospital providing multiple disciplines, treating numerous patients, with a strong reputation in the community, and employing prominent doctors simply has more bargaining power with payors than a physician in solo practice or in a small group. Plus, hospitals have more human resources to devote to the collection process. Where insurance-reimbursement negotiators and collection departments exist solely to perform those tasks, most physicians exist to care for patients. As such, the tasks solo practitioners most loathe are the specialties of others in a hospital. Therefore, both hospitals and physicians could benefit by joining forces when it comes to getting paid. There is better leverage with more doctors, and there is better alignment with the employees' training: doctors treat patients, business administrators wrestle with getting the money in the door.

The more doctors a hospital has, the more beneficial payment terms it can negotiate. This does not simply flow from volume. It can also flow from reputation. If a hospital can brand

itself, or position itself well in the community, it gains still more leverage. This can be done by bringing in not just more doctors, but also more prominent doctors. Done on a large scale, hospitals can make themselves “the only game in town”—especially for certain services. While this typically does not approach a true monopoly, it nevertheless increases the pressure on insurers to come to the bargaining table in ways a solo doctor, no matter how prominent, could not cause.

This additional market clout clearly can be beneficial to hospitals, but it remains to be seen how beneficial it will be for physicians – long term.

The questions swirling around healthcare nationally and in California have furthered this trend. Thus, leading to our next question.

Are We There Yet?

No.

The New England Journal of Medicine last year published an article right on point; its opening lines: “U.S. hospitals have begun responding to the implementation of healthcare reform by accelerating their hiring of physicians. More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery systems” [2] The article showed that within the last few years, hospital ownership of practices has surpassed physician ownership. Nationally, it is anticipated that by the end of this year, 40% of all Primary Care Physicians and 24% of all Specialists will be employed directly by hospitals. These employment projections were in contrast to 2000, when the corresponding numbers were 18% and 6%.

In addition, a recent survey of the AAOS State Societies Committee shows a dramatic increase in the number of employed orthopaedic surgeons. Of the 417 respondents to the AAOS member survey, 55% are employed by a hospital or hospital/medical foundation (hospital-employed), 27% are in private practice, 9% practice in an academic setting, 2% are in a contractual arrangement to co-manage a hospital orthopaedics department (co-managers), and 7% practice in other settings. According to this study, orthopaedic surgeons are well ahead of predictions that the number of hospital - employed orthopaedic surgeons could very well exceed 20%, up from 15-16% in 2008.[3]

[2] “Hospitals' Race to Employ Physicians — The Logic behind a Money-Losing Proposition,” Robert Kocher, M.D., and Nikhil R. Sahni, B.S., N Engl J Med 2011; 364:1790-1793, May 12, 2011.

[3] See, Laura Miller “What Percentage of Orthopedic Surgeons Will be Employed in 5 Years? 10 Responses” Beckers Spine Review (June 3, 2011), http://beckersorthopedicandspine.com/orthopedic-spine-practices-improving-profits/item/4122-what-percentage-of-orthopedic-surgeons-will-be-employed-in-5-years-10-responses

The trend towards physician employment is increasing, but how far these trends will go is still uncertain. This leads to the next question.

How Do We Get There?

So will California physicians and hospitals keep pace with the national trend toward direct employment? There are different ways to work with hospitals. But, if they wish to align with hospitals, physicians need to examine both the upsides and downsides of the different strategies. How can orthopaedic surgeons evaluate their practice options and whether they should decide to enter into an employment arrangement? What are the pros and cons?

The Potential Advantages of Physician-Hospital Alignment

With all models that approach direct employment, there are pros and cons. On the "pro" side of consolidation for orthopaedic surgeons are:

- more consistent working hours;
- employee benefits such as employer provided healthcare coverage and pension plans;
- increased referral potential;
- less managerial, collection, and administrative duties;
- greater access to capital;
- greater bargaining power with insurers;
- greater bargaining power with malpractice premiums;
- greater coverage of in-hospital patients;
- less commuting and coordinating with multiple clinics;
- potential ACO opportunities; and,
- in the short-term, greater and guaranteed compensation.

At the same time, the hospitals see benefit by having:

- clinical integration;
- greater cost control;
- greater recruitment options;
- greater control over scheduling, thus increasing coverage and patient flow;
- better coordination, rather than competition, with orthopaedic surgeons;
- potential ACO opportunities;
- increasing prestige and brand image in the community; and
- greater bargaining power with insurers.

In essence, both sides see benefits in the economies of scale, with hospitals and orthopaedic surgeons working cooperatively. The hope is that this will increase hospitals' and physicians' reimbursements, reduce costs, increase patient care and coverage, and position both sides well for the future.

The Potential Disadvantages of Physician-Hospital Alignment

The advantages may not offset disadvantages for some orthopaedic surgeons. There are trade-offs.

Increased Legal Complexities.

The alignment options in California tend to be more complex than simple hospital employment. The added legal complexities can:

- increase the costs of forming the relationships;
- increase the difficulty in managing the relationship; and,
- increase the uncertainty of knowing whether the relationship violates the corporate-practice ban.

Reduced Control. As the lists above show, the hospitals benefit by greater control of the physicians—most notably with patient referrals for services under the hospital's control, reimbursement from insurers, compensation, and scheduling. The physicians must, therefore, sacrifice control. Physicians move from being an employer and boss to being an employee and worker. This is the case functionally even where direct employment is not technically occurring. This will have both short-term and long-term ramifications. It also raises questions regarding whether the parties are complying with the corporate-practice ban which prevents lay entities, such as hospitals from controlling a physician's professional judgment. Since the Medical Board of California can discipline the doctors' licenses, this can have significant—and potentially fatal—professional licensure ramifications. Moreover, individual members of big groups (with many doctors and managers involved) are not automatically free from corporate-control violations, any more than a solo practitioner controlled by an office manager would be. Meaning, there is not "safety in numbers" when facing professional discipline.

This threat can be heightened in larger practices, which are closely aligned with corporations such as hospitals, because individual doctors do not have as much "say" on day-to-day issues regarding patient care. Plus, frankly, the law on corporate control is unclear. Where permissible "management" ends and control of professional discretion begins is not stated in

the law itself. The California Supreme Court has said that doctors and managers cannot simply divide a professional practice into "professional" and "business" compartments[4].

However, Corporations Code Section —part of the Moscone-Knox Professional Corporations Act—allows professional groups to employ non-doctors to handle managerial and clerical tasks. Neither the courts, the Legislature, nor the Board have precisely defined every instance when management crosses the line to corporate control. Hospital alignment tends only to further blur that line.

Under these circumstances, it is essential that physicians, in conjunction with an attorney experienced in this area, carefully review any proposed agreement to ensure that there is unlawful control over the practice of medicine. If possible, if seeking employment with a "hospital friendly" medical group, ask to review the professional-services agreement between the group and the hospital to ensure that the hospital is not exercising undue control. Further, with direct hospital employment contracts, it is advisable that the contract contain language (model language is provided below) that expressly protects the physician's independent medical decision-making. Even when the contracts are correct, actual implementation may violate the ban. Essentially, how a practice actually runs is as important as what the contracts say.

Uncertain Future. Professional discipline, however, is not alignment's only threat to physicians. There are long-term issues too. If the historical, entrepreneurial model for doctors—working towards personal ownership of a practice—fails, and the secure-employment model takes hold, long-term physician options will diminish. While lucrative and secure employment offers are available now, what about tomorrow? Market consolidation of physician employment could lead to market control. Today's employees' market would change to employers' market tomorrow. If hospitals are the only employers, physicians' bargaining power may diminish.

Some hospitals admit they currently pay more, and lose in the early years, to employ physicians they want to join their hospital. They have the long-term view in mind. Over pay physicians now, control referrals and patients, and recoup lost profits tomorrow. This can only mean that there will be ongoing and perhaps more concentrated pressures on the employed physicians to continue to reduce costs and practice the way the hospital administration dictates. Physicians must think about these issues before they give up on private practice and enter into employment arrangements. What do you do if the secure and high-quality lifestyle options are pulled back?

[4] *Parker v. Board of Dental Examiners*, (1932), 216 Cal. 285, 295-296.

At that point, the skills of managing, promoting, and growing a practice will be harder to achieve—along with independent referral networks. And ownership profits likely will be gone too. Plus, the professional networks needed for referrals and collaboration will all be inside large, hospital-controlled networks. Insurance companies will have even less need to negotiate with orthopaedic surgeon in independent practices.

No going back. This raises another question: If the market dramatically moves from solo-practitioner to mega-groups (whether hospital or doctor controlled), could it ever move back? Could doctors who do not find the mega-group appealing go out on their own again? Probably not. The doctor-as-employee model might permanently eliminate the doctor-as-owner model. Given that no one can guarantee whether every doctor (not to mention patient) will approve of the mega-group, the biggest "con" of consolidation might be the extinction of other options.

Orthopaedic surgeons in solo or small-group practice may have fewer options in today's healthcare marketplace given the economies of scale that is needed for them to compete effectively. Some consolidation most likely is needed for physicians practicing in small or solo practice, either amongst themselves (through a jointly owned management-services organization, for example) or with other groups or hospitals[5]. If the later, there is no one simple structure for alignment. Given the corporate-practice ban, there are numerous models to achieve hospital alignment, even without direct employment. Each model, in turn, has its own advantages and disadvantages.

Medical Foundations

One of the increasingly popular approaches is the Medical Foundation model. These are generally hospital-affiliated groups, permitted by Health & Safety Code Section 1206(l). They often are a subsidiary of the hospital, or are under the same parent organization as the hospital. Medical Foundations are non-profit 501(c) (3) corporations, which must do medical research and health education. The governing board should be a blend of physician representatives along with other board members taken from the hospital and the community.

Medical Foundations provide healthcare to patients through a group of 40 or more independent-contractor physicians. This group must represent 10 or more board-certified

[5] For more information on strategies physicians in small and solo practice can take, see Chapter 9, "Retaining Independence while embracing accountability: Care coordination and integration strategies for small physician practices", ACOS, CO-OPS and other provisions: A "how-to" manual for physicians navigating a post-heath reform world_ 2nd Edition, American Medical Association. http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf

specialties. Plus, at least two-thirds of the doctors must work full time for the affiliated clinic. The clinic staff handles the administrative issues and the independent-contractor physicians provide the professional services. In many ways, the structure parallels a more simple management-services organization contracting with a medical group. There is also a parallel to the Kaiser-Permanente model, discussed below. But, in essence, the foundation, not the medical group, holds the contracts with managed care payers, owns the physical assets, and handles the management, and contracts with the physicians to provide professional services.

This gets hospitals and physicians relatively close to direct employment as permitted in California law. Moreover, it provides the facility, maintenance, overhead, and managerial relief physicians are seeking, along with the integration, coverage, patient-flow, and referral options hospitals want. Both sides increase bargaining power with insurers and are positioned for a better integration of healthcare services.

Kaiser-Permanente

At a recent panel discussion on the future of healthcare, a prominent Newport Beach doctor noted the rise of the Kaiser Permanente model. Kaiser Permanente is currently the largest group health insurer in California. She stated that when she first started practicing, Kaiser was not much of an option for the top graduates in her class. Today, she claimed, the exact opposite is true. As noted above, the lifestyle options Kaiser offers and the security are key. Kaiser's model is well ahead of the health reform curve and the formation of ACOs. This can make Kaiser an attractive option for orthopaedic surgeons just out of their residency/fellowship training programs.

The Kaiser-Permanente model involves multiple entities working together. It is similar to the Medical Foundation model—with a group of doctors and an affiliated hospital—but adds a health-plan component that is a closed panel. The Permanente medical groups treat Kaiser Plan patients at Kaiser's clinics. In addition to the "pros" listed above, other advantages to this model include:

- Long-term experience of running the Kaiser model since 1940;
- Legally secure employment model under California law;
- Physician involvement on the governing Board; and,
- Ancillary healthcare professionals rendering services that the orthopaedic surgeon would; and likely have to perform in an independent practice.

Hospitalists

Another newer approach is the "hospitalist" groups. These are groups of providers that are directly affiliated, and usually only, with a single hospital. They are hired by the hospital to

undertake certain quality assurance functions and also contract to take ER call and to follow-up the emergency room visit. Orthopaedic hospitalists are also being asked to do the post-operative care for musculoskeletal patients while they are in the hospital.

This model can be attractive to the hospital and the surgeon. Surgeons tend to lose time and money on post-surgery visits to multiple hospitals. Time commuting, parking, visiting with hospital staff is simply time out of their practice. Most of the time is not reimbursable. This could result in a change in the reimbursement system in which the surgeon is not paid for the post-surgical follow-up care. Instead, that reimbursement will be added into the hospital's DRG. It remains to be seen whether orthopaedic surgeons will embrace this model and have another orthopaedic surgeon provide the care immediately after the surgery.

The benefits for the orthopaedic hospitalist is that they get one practice location, a steady stream of patients and reimbursement, no practice overhead costs, and increased coordination with hospitals.

Medical Directorships

Hospitals and insurance companies have also sought to increase ties with orthopaedic surgeons by hiring them as their medical directors. In some cases, insurance companies are required to have a physician as their medical director since they are making medical decisions. This typically gives the hospital or insurance company a prestigious-name employee that helps them with marketing, recruiting, and branding. There are, however, generally limitations on the director's ability to practice elsewhere. Plus, there are not that many opportunities available to physicians, making this an option for a select few, but not practical on a large scale.

Joint-Ventures and Out-Patient Departments

Two other approaches bear mentioning. The Joint-Venture and Out-Patient Department models have also been used to foster physician/hospital alignment. The joint venture arrangement can only exist when there is a sincere willingness for the orthopaedic group and their hospital to work together, typically in the running of a specialty hospital. They allow for co-ownership of the personal and real property the group requires. This provides hospital capital to the groups and reduces competition for the partnering hospital. Typically, hospitals maintain majority control in the venture.

Another option for physician-hospital employment is the Out-Patient-Department allowed—like the Medical Foundation—by Health & Safety Code Section 1206(d). Hospitals can operate clinics as outpatient departments, which can enter into contracts with physicians, though more likely group practices, for services. This option, though statutorily allowed, has

generally raised more questions regarding corporate-practice violations since attempts have been made to hire physicians directly or otherwise control their professional judgment. It also, potentially, creates a separate clinic in essence just to work around the ban—thus increasing facility and equipment cost just to control, or contract with, doctors. But, where foundations are not possible, this model may provide an alternative.

Many Options, None Are Perfect, Raising More Questions

Unfortunately, there is no perfect model to address every concern. While the desire to find safety in numbers grows, the law in California does not allow for a simple solution. In the long term, if the employment market is consolidated under non-physician employers many questions still remain:

- Will they continue to provide the same compensation, benefits, and life-style options used to attract physicians at present?
- Will the physicians sacrifice too much control of their practices?
- Will physicians have the option of returning to a self-owned practice?
- Will consolidation actually yield lower costs and better care to patients?
- Will physicians benefit from any increased profits from consolidation?
- Will hospital-physician coordination and communication continue to improve if doctors are captive?

The list of questions could go on. But, for the doctor that sees the benefits outweighing the risks, the issue becomes personal and practical. That doctor, at the point of moving away from independent practice into some form of hospital-affiliated practice, regardless of model, must now ask.

Am I Compatible?

First and foremost for a physician to assess is how compatible the parties are to the deal, regardless if the other side is a physician group or hospital. Potential questions to ask include:

- Does the environment seem comfortable?
- Do the parties share the same professional values?
- Will you receive adequate facilities and support staff?
- Are you satisfied clinically with the physicians that you will be working with and referring your patients to?
- Will you be comfortable practicing in accordance with any protocols or other clinical guidance that the potential employer requires of its physicians?

No matter how good the deal may appear, it will not be successful unless compatibility exists.

Have I done my homework?

Partnering with anyone or an entity requires a considerable amount of due diligence. With the assistance of business advisors and attorneys to help with the transaction, physicians should understand the dynamics of the situation. For example:

- What is the financial condition of the hospital?
- What are the hospital's strategic plans going forward?
- Does it plan to merge with another hospital or health system?
- Does it wish to partner in an ACO?
- Does it have or plan to create a medical foundation?
- How are the HIT systems working and are they effective?
- Is the hospital financially secure?
- What does the hospital's managed care portfolio look like and does the hospital contract sufficiently make any potential arrangement with it financially secure?
- How is the hospital managed? Does it have an active medical staff or does administration attempt to control the quality agenda?
- What type, if any, clinical protocols has it adopted to achieve efficiency and savings?
- How willing is the hospital to listen to community physicians and patients?

It is critical that physicians understand who they are partnering with BEFORE any deal is reached.

What'll We Do When We Get There?

Once at the stage of becoming an employee, an orthopaedic surgeon must contract with the employer. Thus, what follows is a practical, contract-review discussion—just some of the issues individual physicians must consider when entering into a contractual-employment relationship. The issues are numerous and complex and go beyond the scope of this article. Nonetheless, physicians have help out there. In addition to obtaining the advice of an attorney, there are at least two model contracts that physicians may wish to review when drafting and negotiating an employment contract. The first is part of the California Medical Association's legal library, CMA's On-Call #213 "Employment Contract Model" which covers commonly raised issues in physician employment contracts with physician groups. The American Medical Association also has published an Annotated Model Physician – Hospital Employment Agreement that contains a discussion and sample language that benefits

a physician when entering into an employment contract. Both of these documents are valuable resources and can be found:

- CMA Model Employment Contract- http://www.coa.org/docs/cma_employmentcontractmodel.pdf
- AMA Annotated Model Physician-Hospital Employment Agreement, 2011 Edition- https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1870016
- Chapter 8, "Hospital physician employment agreements," ACOs, CO-Ops and other options: A "how-to" manual for physicians navigating a post-health reform world", AMA - http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf

Regardless, all contracts should be reviewed by counsel familiar with California and federal healthcare and employment law. In addition, it is important to understand that no two contracts are necessarily alike. The fact that there are other physicians, including orthopaedic surgeons, who have employment contracts with a particular employer does not mean that whatever contract is presented to you is good for you or even the same as the contract offered to your colleagues. Contract terms and personal circumstances often change and it would be unwise to rely on the fact that a colleague signed an agreement as a reason to avoid careful contract review. The following is not legal advice for any specific situation, but instead a primer, or overview, on contract issues generally.

Medical Control

Just because it may be permissible for a hospital to employ a physician or align itself with a medical group, does not mean that the hospital may control the practice of medicine. As is discussed above, there are many decisions that impact medical practice, such as the decision as to which medical equipment should be purchased, that must be made by physicians under California law. Therefore, the contract should be reviewed carefully to ensure that the hospital is not entitled to make medical decisions. Even where the physician is contemplating an employment arrangement with a hospital-friendly group, the physician may wish to assess the professional-services agreement between the group and the hospital to ensure that proper boundaries are met.

Further, in the context of an employment agreement with a hospital, the physician may wish to negotiate a provision protecting independent medical decision-making. The AMA sample language on this point provides:

> "Physician shall have the unfettered right to exercise his/her professional judgment in voting, speaking, and advocating on matters regarding (i) patient care interests, (ii) the profession, (iii) health care in the community, (iv) medical staff matters, and (v) the independent exercise of medical judgment. This shall

> include the unrestricted right to refer patients to other physicians and facilities as per the professional judgment of Physician. Also, Physician shall not be deemed in breach of his/her employment agreement, nor shall Physician be subject to employer retaliation, including, but not limited to, termination of employment, commencement of any disciplinary action, or any other adverse action, based on Physician's exercise of the foregoing rights."

Term and Termination

Term

Any hospital[6] hiring physicians will require that you sign a contract that will be valid for a specific period of time. This period varies depending on the medical facility's needs and goals and the doctor's goals and position. The duration of the contract is negotiable and must be mutually agreed upon by both parties. The term of the contract is important as it sets the time period during which the contract's conditions will be legally binding. Physicians should consider whether they prefer the certainty of a long-term contract or the flexibility of a shorter one. Note, however, that no term may exceed seven (7) years under California law. [7] Hospitals can also choose to terminate the contract early.

At the end of the specified term there are a number of situations that may occur. The contract may terminate, in which case the doctor would have to sign a new agreement to continue working. Another possibility is the contract will automatically renew. If this is the case, physicians must be aware of any deadlines that would allow them to reject the renewal. If they plan on negotiating any new terms in the contract, it is important that they inform the employer of their intent not to renew within the agreed upon timeframes, otherwise they will likely have to wait until the next open time allowed under the contract. If you miss the notification deadline, the prior terms would remain in place.

Given the uncertainty in the market, physicians' desire for security in their employment, and a consolidation trend, the term of a contract becomes very important. Hospitals may resist long-term contracts as it gives them the maximum amount of flexibility in how they negotiate with their physician employees and limits their commitment. Other hospitals may be willing to sign longer term contracts to create stability and loyalty in the physicians they employ, particularly surgeons who are prominent in their community. It is important to note that there is no legal requirement that the hospital has to offer all employed orthopaedic surgeons the same employment contract. Terms and benefits of their employment could vary among the employed orthopaedic surgeons.

[6] This is, again, not normally direct employment, but rather through an affiliated group, but for purposes of this discussion, we will refer to these simply as the "hospital."

[7] Labor Code §2855.

Termination

But physicians who enter into contracts with lengthy terms should understand that contracts can also end before their term date. Thus, contracts generally contain a section that addresses the reasons for early termination by either party. Usually the employer will retain the right under the contract to terminate doctors immediately if:

- They lose their license to practice;
- They lose or fail to obtain a board certification;
- They commit a crime;
- They lose or fail to obtain medical-malpractice coverage; or,
- They are debarred or fail to qualify for a federal healthcare program

There can also be no-cause termination—"at will"—provisions allowing termination with sufficient notice, typically somewhere between 30 and 90 days. This means that a hospital's commitment may really only be for a few months and that the hospital can end the relationship without going through any due process procedure.

Employee doctors may negotiate the right to end their employment agreements as well. However, most contracts will require them to provide advance notice of their intent to terminate employment. It is important that they are aware of the time they have to provide notice, as the requirement varies based on the circumstances. If they fail to provide adequate notice, they may be liable to their employer for any damages the hospital sustained as a result of the early termination. Generally, it is also important that the notice provision be equal to that required of the employer. This period affects how long it will take a doctor to leave one employer and start with another.

Scope of Physician Services

While this may seem to be a straightforward issue, "scope of services" provisions can be fraught with problems for the physician. For example, it is important to review the job description carefully so that the physician has a complete understanding of the type and amount of services he/she is expected to perform. Contracts should be specific on those points. They should also state how much time is required for administrative efforts and if call coverage is required. The contract should not impose vague language requiring that the physician provide call "as needed." Rather, most believe that the contract should state that coverage will be divided equally. The AMA Model provides:

> "Physician shall participate in a call schedule for unassigned patients in Physician's specialty who presents to Employer for medical services, on an equitable and rotating basis with other employees of Employer (or physicians in the same specialty)."

Some provisions may impact a physician's outside activities and even require the payment of royalties to the hospital resulting from the physician's creative/scientific endeavors. If the contract requires that the physician abide by the hospital's policies, it is important for the physician to review those policies beforehand so that unknown obligations are not agreed to.

Compensation

The federal government, as well as most states, has laws prohibiting self-referrals, fee-splitting, the payment of unearned rebates, and/or the payment of kickbacks for the referral of patients. California is no exception. Despite the various names, all of these types of laws are aimed at preventing doctors from doing one thing – referring patients based on financial incentive - instead of what is best for the patient. For ease of reference, this article refers to any such prohibited practices as "fee-splitting."

1. **B&P 650 and Labor Code 139.3**

   In California, the fee-splitting statutes are Business and Professions Code Section 650 and the Workers' Compensation equivalent, Labor Code Section 139.3 (hereafter generally referred to as "Section 650"). Section 650 prohibits the payment or receipt of compensation for the referral of a patient. Section 650 defines an offense that contains five elements:

   1. An offer, delivery receipt, or acceptance;
   2. By physicians and other specified licensed providers;
   3. Of consideration to or from any person;
   4. As compensation or inducement for; and,
   5. Referral of patients, clients, or customers.

   Section 650 represents a typical prohibition against fee-splitting. As the current statutory language indicates, liability may be imposed under this statute if: (1) a physician pays or is paid for the referral of patients; (2) a physician's return on investment is based on the number of referrals a physician generates or the proportion of revenue generated by his referrals; or, (3) a physician makes referrals that are not medically necessary.

2. **Federal Law**

   Section 1877 of the Social Security Act (also known as "Stark Law") also restricts the manner in which physicians may be compensated. At its core, Stark is a statute aimed at preventing illegal self-referrals. The related doctor-compensation law is the Anti-Kickback Statute, found at 42 U.S.C. Section 1320a. Together, the laws prohibit self-referrals, fee-for-referrals, and kickbacks. Section 1877(a) provides that a physician

cannot: (1) refer patients to an entity; (2) for the furnishing of certain designated health services;[8] and, (3) if there is a financial relationship between referring physician and the entity. However, Stark created a "group practice" exception that permits referrals between doctors in the same medical group.

It is essential for physicians to understand that these laws require that hospitals provide only "fair market value" total compensation (including base salary and bonuses) to physicians through either employment or independent contract agreements. In fact, in 2009, the US Justice Department required an Iowa hospital to pay $4.5 million to settle its lawsuit alleging violations of the Stark law where it was alleged, among other things, that the employed physicians, including orthopaedic surgeons, were paid up to three times that paid to comparable physicians. [9] Determining the fair market value for physician compensation can be extremely complicated and courts have been increasingly scrutinizing arrangements to ensure compliance in this area. The Center for Medicare and Medicaid Services defines "fair market value" as:

> "... The value in arms-length transactions, consistent with the general market value. "General market value" means the price that an asset would bring, as a result of *bona fide* bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement, as a result of *bona fide* bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. (42 C.F.R. §411.351.)"

The IRS looks to the following factors, among others, when determining whether a physician's compensation is reasonable:

- Whether the compensation was established by an independent committee;
- Whether reliable compensation data supports the physician's salary;
- Whether there is an arms-length relationship between the parties or whether the physician impermissibly participates in the organization in a manner that affects the compensation agreement;

[8] The types of health services covered by Stark include: clinical laboratory services; physical therapy, occupational therapy, and speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthopedics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

[9] See *In Re Covenant Medical Center (*2009) - www.justice.gov/opa/pr/2009/August/09-civ-849.html.

- Whether there is a ceiling or reasonable maximum on the amount the physician may earn to protect against projection errors or substantial windfall benefit;
- Whether the arrangement takes into account measures of quality of care and patient satisfaction; and,
- Whether the compensation is really a device to distribute the hospital's profits to the physician. [10]

As can be seen, reliance on a single compensation survey may not be enough. Many outside firms can assist with this process.

The federal and California laws inevitably make compensation arrangements between doctors and hospitals far more complicated than general employment agreements. As such, each contract needs to be carefully reviewed and legal counsel consulted.

Salary

In order to qualify for the exceptions found in Stark, physician compensation agreements must be in writing, set in advance, signed by the parties and must be for a minimum of 12 months. This will push employers to offer set salaries, rather than offering profits—which cannot be set in advance. Any agreement for services must cover "all" of the services provided by the physician (or an immediate family member) to the corporation by incorporating by reference all of the agreements between the parties or cross-referencing to a master list of contracts that is maintained and updated centrally.

Physician compensation must also comply with California wage and hour laws. Under California law, medical doctors are exempt from overtime obligations under the professional exemption. To qualify for the professional exemption under California law (thereby avoiding the payment of overtime), physicians must: (1) receive at least twice the minimum wage ($33,280 annually); and (2) spend more than 50% of their time on exempt professional duties. Finally, licensed physicians who are paid at least $55.00 per hour are also exempt from the overtime obligations imposed by California law, Labor Code § 515.6.

Bonuses

Doctors may receive bonuses, as long as such bonuses are not based on the value or volume of referrals. Typically, medical corporations issue bonuses to physicians based

[10] See IRS Information Letter 02-0021 which can be found at www.irs.gov/pub/irs-wd/02-0021.pdf

on either an equity or incentive basis. Equity-based systems compute physician bonuses as a portion of the corporation's profits commensurate to the professional's ownership interest in the corporation. Incentive systems, on the other hand, reward physicians based on the volume of services personally performed by the physician. As hospital-employment grows, the trend is to offer bonuses.

Specifically, under Stark, group-practice professionals may be compensated using certain forms of percentage compensation and can receive productivity bonuses based on personally performed services. Stark permits some percentage compensation if:

- the methodology for calculating the compensation is set in advance;
- it is objectively verifiable;
- it excludes certain designated services; and,
- it does not change over the course of the arrangement in any manner that reflects the volume or value of referrals, or other business generated by the referring physician.

Stark prohibits the consideration of "incident to" services in determining and paying compensation to physician employees or independent contractors *unless* they are in a group-practice that complies with the law's exception for in-office ancillary services. Outside of this limited context, employee and independent-contractor physicians can *only* be compensated for services that they "personally perform."

Payment Recoupment

Some contracts enable the employer to recoup payments from a physician in the event the insurer claims that too much money was paid, the physician terminates the contract early or certain productivity benchmarks are not made. The entire contract should be reviewed carefully to understand if and when such payments are authorized. Assuming such provisions cannot be negotiated out, then the financial impact of these clauses should be taken into account when terminating the contract.

Non-Competition vs. Non-Solicitation Provisions - Important Differences

As discussed, the consolidation trend is in part fueled by hospitals' move to, among other things, gain market share. As such, they do not want "their doctors" working for other hospitals. Therefore, physicians should be aware of non-competition provisions. A non-competition agreement is a provision in which one party agrees not to compete with the other. These agreements are frowned upon in California. Business and Professions Code 16600 provides that "every contract by which anyone is restrained from engaging in a lawful profession, trade, or business of any kind is to that extent void." Courts have applied B&P Code Section 16600 to invalidate non-competition agreements in various forms. California

Courts have effectively eliminated the lawful use of non-competition agreements in California except in certain limited circumstances. Courts reason that California law favors open competition and freedom for employees to move from employer to employer.

A non-solicitation agreement, on the other hand, is an agreement in which one party agrees not to solicit the customers/patients, vendors, or referral sources of the other party. In the healthcare context, employers often require that physicians enter into non-solicitation agreements to prevent the physician from soliciting the employer's patients, vendors, and referral sources. As the name implies, non-solicitation agreements only prevent the contracting party from soliciting; they do not prevent customers/patients, employees, and vendors from independently contacting, and ultimately contracting with, the physician. Recently, courts have subjected non-solicitation agreements to the same analysis as non-competition agreements, and also found them to be illegal in many cases because they act as a restraint on trade.

These rulings have been helpful to physicians who may want to leave their employed arrangements and still practice in the community. The CMA Model has useful language that protects the physician, the employer, and the patients in the event the physician is no longer employed. The CMA Model Contract provision provides:

> "17. Patient Records Upon Termination
>
> a) All original patient records are the property of the Employer. Upon termination of this Agreement, Physician shall return any such records as may be in Physician's possession to Employer, subject to the Physician's right to copies of records, as follows.
>
> b) Upon termination, the Physician is entitled to copies of patient charts and records upon a specific request in writing from a patient. Moreover, upon and after termination, full access to review and copy patient records will be allowed to the Physician [at Physician's expense] for any reasonable purpose, e.g., in the event of a malpractice action against or administrative investigation of the physician, for medical research, to compare a new case with an old one, etc.
>
> c) [When the Physician requests copies of medical records, the physician must pay $0.25 per page, $0.50 per page for records copied from microfilm, or actual costs for reproduction of oversize documents or those which require special processing, [as well as reasonable clerical costs incurred in making the records available.]]

d) The Physician shall have the right to inform his or her patients of the fact that the Physician is leaving the group, and to give his or her patients the opportunity to choose whether to remain with the group or go with the Physician. The notification shall be as specified in Schedule C. The right to notify patients of a new practice does not extend to patients who were not treated by the Physician."

As the law currently stands, employers may still require employees to sign non-disclosure and confidentiality agreements that restrict employees from using trade secrets. An enforceable non-disclosure agreement will put employees on notice that they have access to the employer's confidential information, including trade secrets, and the employee may only use the information for the employer's benefit.

Expenses and Benefits

Expense Reimbursement

Under California Labor Code Section 2802, an employer must indemnify an employee for any expenditures or losses incurred by the employee on the job. Thus, if an employer requires that an employee attend an educational seminar, they must pay the registration fee and the costs associated with attendance at the seminar (mileage, parking, meals, etc.). Physician employers, however, do not have to pay for licensing fees and requirements the physician has independent from their employment. These, therefore, can be negotiated for in the contract, often in the form of a continuing education credit or allowance. In fact, there are many professional costs the employer may still agree to reimburse you for, such as:

- Continuing medical education costs;
- Licensure fees;
- Medical student loans;
- Professional dues;
- Subscriptions to professional journals;
- Medical staff dues;
- Equipment and supplies; or,
- Other expenses related to your professional practice.

AMA Model contract language on this point provides as follows:

"The Physician shall be entitled to reimbursement by the Employer for reasonable and necessary expenses incurred in the performance if the services hereunder, including travel expense for hospital visits during working hours, provided that for all expense

reimbursements, Physician furnishes Employer with records in compliance with Internal Revenue Code Section 274.

Additionally, Employer shall reimburse Physician the following:

a. Continuing Medical Education (CME) costs, (all) Employer-approved costs of CME tuition/enrollment (including reasonable travel, food and lodging) up to $_____year.
b. Subscriptions to journals, costs of books (and cost of online services) (or a percentage of such costs) (up to $___year).
c. Up to $____per month for all legitimately deductible professional entertainment and promotional expenses. Prior written approval is necessary for reimbursement for costs in excess of $______.
d. Cell phone and pager expenses necessary in the Physician's medical practice."

Malpractice Coverage

Most physicians' contracts require professional-liability insurance covering the doctors and the facility. In some cases, the employer will cover the medical malpractice premiums for their employees. In the event that a professional employee is sued for malpractice, the hospital will also be named as the employer. It is important that any contract identify: (1) who will pay for the malpractice insurance; (2) the amount of the policy limits; (3) whether there will be additional insured (i.e. the hospital); and (4) who, if anyone, will obtain and pay for "tail" coverage. Typically the employer pays for general liability coverage. If the physician is responsible for tail coverage, it is important that the physician obtain estimates of the cost of such insurance prior to signing the contract as the amount can be quite high. Further, as a matter of fairness, the physician should only be obligated to pay for tail coverage where he/she terminates the contract without cause or is terminated by the employer for cause. The CMA Model provides such a case:

"14. Professional Liability

a) Patient care services performed during and within the scope of Physician's employment shall be covered by professional liability insurance within a policy limit of at least [$1] million per claim with an aggregate limit of at least [$3] million at the expense of Employer.

Employer shall pay deductibles, as necessary, before [and after] contract termination. Physician may review a copy of the policy upon reasonable request.

b) [Except as provided in subsection c, below], the [Employer] [Physician] shall purchase extended reporting period coverage ("tail" coverage) for [ ] years after termination of Physician's employment.] The Physician shall have the right to a copy of the policy on request.

c) In the event that either the (i) Physician terminates employment without cause, or (ii) Employer terminates physician's employment for cause, the Physician shall obtain professional liability tail coverage for Physician's acts or omissions during employment, for a period of no less than [ ] years].

d) In the event that Physician knows of a professional liability incident involving Physician or receives notice of a claim or of an intended claim that alleges that Physician or any other of Employer's employees is or may be liable for a professional act or omission, Physician shall promptly notify Employer of that fact."

Other Benefits

And, of course there are a multitude of additional employee benefits that can be part of the contract. These include, vacation, sick leave, holidays, family/medical leave, leave of absence, pensions, etc. Both the CMA and AMA models have useful language in this regard.

Amendment

At first blush, the "amendment" provision looks like boilerplate language that appears towards the end of the contract. But this issue can be a landmine throughout the contract. Some agreements enable the employer to change critical terms unilaterally during the contract term on such material matter as compensation, duties, protocols to follow, etc. Such authority may appear not only in the "amendment section" but virtually every other section in the agreement. So that such terms are not changed without the physician's agreement, there should be restrictions in the contract preventing either party from amending it. Sample language could read:

> "Notwithstanding anything to the contrary in this contract this agreement may be amended or modified only by a written document signed by both parties hereto."

Independent Contractors

In certain situations, it may be feasible for the hospital to enter into an independent-contractor arrangement, either with an individual physician or a group of physicians. Under this arrangement, the hospital would bill for the services performed by the physicians, and pay the doctors a contractual amount for their services.

There are a number of governmental agencies who have an interest in whether a person is an employee or independent-contractor, and who have the authority to make their own determination and reclassify the independent-contractor as an employee. Any reclassification would include some type of penalties. For instance, if the IRS reclassifies a person who has been treated as an independent contractor into an employee, they will be demanding from the "employer" amounts that should have been withheld, plus interest and penalties.

What's worse, recently enacted SB 459 severely increases the penalties for the willful misclassification of individuals as independent contractors. Under SB 459, employers may be held liable for a civil penalty ranging from $5,000 to $15,000 per misclassification. If a pattern or practice of misclassifications is found, the civil penalty is $10,000 to $25,000 per violation. This law also provides that any person who knowingly advises an employer to treat an individual as an independent contractor to avoid employee status for the individual shall be equally liable for any consequences.

The risks can, however, be reduced significantly with a properly structured and documented relationship. The arrangement should be structured so that it will meet the IRS guidelines concerning independent-contractor relationships. The IRS follows a 20-factor test and evaluates the fact situation by this test. If, on balance, the arrangement looks more like an employment relationship as opposed to an independent-contractor relationship, then the IRS can administratively reclassify the person as an employee, which will likely result in money due from the employer. Thus, before entering into an independent-contractor, doctors should first consult legal counsel. Nevertheless, we offer the following guidelines that may be helpful in successfully establishing an independent-contractor relationship:

1. Use a written, non-exclusive, contract.
2. The physician determines the course of treatment for each patient.
3. The physician provides their own malpractice and Workers' Compensation coverage and pays any expenses they incur.
4. The physician does not receive any benefits from the hospital – vacation, health insurance, dental, and the like.
5. The physician chooses the times when they will provide their services and provides their own equipment.
6. The physician, not the hospital, employs or engages any assistants and aides.

Notice, many of the independent contractor factors run against the very purpose hospitals seek to directly employ physicians. Hospitals have not been as supportive of these arrangements as the orthopaedic surgeon maintains more autonomy and independence. This

arrangement also does not satisfy the goals of a physician seeking an employment arrangement as they still have the costs and administrative hassles of setting up a practice.

Conclusion

That brings us back to the beginning, as we reach the end. Current California law prohibiting employment of physicians does not fit with emerging trends for integrated healthcare systems that tend to employ physicians. There are employment options for physicians, but they must be approached by weighing the long-term implications for the profession in a reduction in the number of physicians in private practice, the potential loss of autonomy regarding your patients, how reimbursement levels will be impacted should the majority of physicians become employees, and other quality-of-life considerations. There are multiple strategies, but each one presents advantages and disadvantages, and raises many long-term questions. While the law sorts itself out, we recommend consulting closely with counsel before any significant change in your employment status, or before signing an employment contract. ■

Keith W. Carlson, Esq.
Jehan N. Jayakumar, Esq.
Carlson & Jayakumar
2424 SE Bristol St. #300
Newport Beach, CA 92660
Email: keith@cjattorneys.com