What You Need to Know About Physician Employment Agreements

A better contracting process leads to better physician employees.

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In recent years, podiatric practices have been inundated with a myriad of compliance issues and challenges. The constant deluge of acronyms—HIPAA, HITECH, OSHA, RACs, ZPICs, MU, MACRA, and MIPS, just to name a few—is enough to frustrate even the most meticulous, process-driven practice. And while many practices have succeeded in addressing these concerns, and adapting their operations accordingly, something usually has to give. And all too often, more traditional bedrocks of practice management have been relegated to secondary concerns—including one of the most fundamentally important practice management tools: the physician employment agreement.

My discussions with physicians or practice administrators about employment agreements usually start off in one of two ways. First, I will get a call from a practice exclaiming the virtues of a particular candidate that they interviewed for an associate position and explaining that they need a contract to offer them right away, before they take another offer. Or second, I will get a call from a practice furious about some dispute with an existing associate, and looking for guidance on how to properly address the issue and protect the practice. And while most lawyers will gladly bill you to address these issues, practices which approach physician contracting like the former call are far more likely to have to make the latter. Indeed, more often than not, employment issues with clinical staff members are "self-inflicted" wounds.

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But there is a better way: a more

Continued on page 98

Agreements (from page 97)

holistic and comprehensive approach to physician contracting that results not only in a better contract, but more importantly in an employment relationship that makes ever having to rely on that contract far less likely. That approach is two-fold. First, we need to address the process by which a physician contract comes to be—because when making the kind of investment one makes in an associate physician, simply buying a contract "off the rack" is unwise to say the least. And then second, assuming the pre-contracting process is buttoned-up, we need to understand the "must-haves" that every physician agreement should include, and what some of a practice's options may be in that regard.

The Physician Contracting Process

The first call a practice makes to its healthcare lawyer to discuss a physician employment agreement should happen before the first interview is even scheduled. This is not so the lawyer can get started drafting; instead, it's to collaboratively come up with a game plan to define both what the practice is looking for and also what it is willing to offer. This ongoing process should eventually include the practice's other subject-matter experts as well, including the practice's accountant and insurance professionals. After all, how can a practice meaningfully engage a candidate if it does not know what it wants or what it can actually offer. This is not a detail that should wait until after an interview has already occurred!

To that end, one of the biggest mistakes practices make is waiting to negotiate deal points until they have tendered an actual contract proposal to a candidate. This can be a grievous error for several reasons. First, nothing stifles a negotiation like surprises—and often a candidate will feel sandbagged or otherwise hoodwinked by a contractual term—like a restrictive covenant, for example—that was not discussed during the interview process. Second, the formality with which contracts are typically drafted can be intimidating for any non-lawyer, let alone a young doctor facing the dual pressures of student loans and a marketplace in flux. So to add formality to uncertainty typically exacerbates the issue, and often leads to an irreparable breach of trust. And finally, even the most adroitly-prepared contracts are just words on a page, and if the parties to that contract do not have the requisite meeting of the minds before formalizing their agreement to a written contract, the relationship will inexorably fail.

So the game plan for presenting an offer to a candidate must involve a comprehensive list of "deal points" to be discussed and agreed upon before tendering a contract. All too often, the focus is understandably on compensation. But duties, hours, benefits, and restrictive covenants in particular are all items that should be discussed and agreed to before anyone puts pen to paper. In that regard, the drafting of the contract should really be just the "papering" of an already-consummated deal. Not only does this ensure that a candidate is not surprised by a term or provision in the contract, but it sets the stage for a more successful relationship by making sure everyone is on the same page with respect to expectations. Without this, an employment contract is not worth the paper that it's printed on.

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Physician Contract "Must-Haves"

Having established that a full and complete employment negotiation should precede contract drafting, the next step is to lay out some (but not all) of the deal points to negotiate and ultimately include in the contract. We will address each in turn:

Employment Duties

It should go without saying that one of the most critical points that needs to be fleshed out during negotiations and ultimately included in a contract is what the job duties of the employed physician will be. Nevertheless, 99% of the physician employment contracts contain nothing more than some vague or generalized description of rendering professional podiatry services. But as we all know, the practice of podiatry is varied, as are the tasks that some practices assign an associate physician to perform. This gets to the heart of why a practice may be bringing on an associate in the first place.

If, for example, the associate is being hired to handle all of the practice's surgeries, then this should be disclosed during the interview process and written into the contract. If, on the other hand, the associate is being hired because the practice owner does not want to work on evenings and weekends anymore, this should also be discussed up front and included in the contract. The same thing goes for marketing responsibilities, recordkeeping and/or compliance obligations, facility privileges, and really anything else that the practice is going to expect the physician to do while employed by the practice. In many ways, this is the most critical portion of the employment contract, and so it should be customized not only for the practice, but also for the specific physician being hired.

Term and Termination

This one is unfortunately an easy one to whiff on for several reasons. As a starting point, the term of a contract should really be an afterthought. Whether one year, three years, or five years, the initial "term" of an agreement is just an arbitrary number. A physician agreement should have two key features that illustrate this point. First, every physician employment agreement should have an "evergreen" provision, i.e., a

Continued on page 100

Agreements *(from page 98)*

provision that automatically renews the contract upon completion of the initial term, unless one party or the other opts to terminate in advance of the renewal date. The only thing worse that not having an employment agreement with a clinical staff member is having one that expired and thus is no longer unenforceable in the event an issue arises. An evergreen provision eliminates this possibility.

Second, in addition to "for cause" termination provisions, every agreement should have a "no cause" termination clause whereby either party can exit the agreement upon some pre-determined amount of notice. After all, sometimes employment relationships are just not a good fit, and both parties should have an out in the event that a situation is not working out. Allowing this to happen with advance notice and a winding down period protects both sides; to say nothing of the value it offers a practice during the negotiation period, when a candidate can be afforded the opportunity to resign if not happy. Indentured servitude is not, after all, typically a pathway to a successful employer-employee relationship.

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An Assignment of Claims

Obviously, one of the reasons a practice will guaranty a salary or other compensation (more on this below) to an associate is because the practice anticipates that it will generate revenue from the services provided by that physician. In order for this to happen, the practice must be able to bill for that physician's services. Yet an inexplicably large number of employment contracts contain no express assignment of the right to bill and collect for an employed physician's services. This is pure lunacy.

But it goes beyond mere services. A few years ago, when meaningful use incentive checks were being widely distributed among the profession, many practices found themselves in a pickle when an employee, or in some instances, a former employee pocketed an incentive check despite the practice having advanced

Continued on page 101

Agreements (from page 100)

the costs associated with EMR. But these practices did not have a provision in a contract making it clear that the associate was assigning the right to any such incentive payments to the practice, creating undoubtedly an absurd scenario. It is, therefore, critically important that both during the negotiation process and in the contract itself, the practice makes clear that it is the sole and exclusive owner of the fruits of that employee's labor—at least in the event of full-time employment.

Compensation and Benefits

Here again, a relatively straightforward concept—compensating an employed physician for the fruits of their labor—is rife with potential pitfalls. But there are two situations in particular that are the most common. First, the percentage-based compensation or bonuses are routinely structured improperly. An employed physician can certainly be paid a percentage of revenue generated by services personally provided or supplies personally dispensed by that physician. But an employed physician cannot be compensated based on a percentage of revenue generated from referrals made by that physician for the designated health services subject to the Stark law. For example, such a referral includes any DME that is ordered, but not personally fit and dispensed by that physician. As you can see, non-Stark compliant compensation structures are pervasive in podiatry.

Second, all too often, candidates focus on base salary instead of the overall "value" of a compensation and benefit package. For example, comparing one position with a $60,000 salary and another with a $100,000 salary is not always simple math. If the $100,000 salary is fixed, but the $60,000 comes with a percentage bonus, discretionary bonuses, health and pension benefits, and all licensing and association fees included, then it is pretty clear which is the more generous package. Practices need to be comfortable explaining this to candidates, particularly those coming off of residency who often are foolishly fixated on a salary figure.

Confidentiality and Restrictive Covenants

These are the provisions that often scare away great candidates. They do so because their purpose and context are not often explained properly to potential candidates. It is critical that before a candidate reads about such a restriction in a legal document, some discussion of why these protections are needed should occur. It should be a relatively easy conversation. Practices literally hand associates the keys to the kingdom—access to patients, referral sources,

Continued on page 102

Agreements *(from page 101)*

and even contacts within the community-at-large. Practices need to feel safe being "all in" on a candidate from day one if that future associate is going to be integrated into the practice and culture of that office. One critical piece to this is by protecting the secret sauce—i.e., I will show you everything, because you can't turn around and steal it from me. When put in these terms, candidates are far more receptive to reasonable restrictive covenants.

So, what is reasonable? Here again, a contract off the rack might not fit a particular practice. For example, a non-compete restriction of 25 miles might be reasonable in rural Iowa, but 25 blocks in New York City can place you squarely in another universe. Non-competes are disfavored in some jurisdictions, but in those where they are permitted post-termination, it is critical that a practice not overreach. Most states follow the "rule of reason" in determining the enforceability of a geographic restriction on post-employment restrictive covenants. So, in the scenario listed above, 25 miles would never be reasonable in New York City; but perhaps more than 25 miles would be in rural Kansas. So, when a practice calls and asks, is two years and 10 miles reasonable, my first response will usually be, "I have no idea, but tell me about where your offices are located." In terms of time, anything more than a year is pushing it. Remember, restrictive covenants are disfavored. They are a restraint on trade, and they negatively impact the ability of a licensed professional to earn a living. So, not only must be they reasonable in scope, but also duration.

But non-competes are not the only critical restrictive covenant that should be both negotiated and included in a contract. For example, non-solicitation provisions are typically as important, if not more so, and are enforceable even in jurisdictions where a non-compete may not be. First, terminated employees should be prohibited from soliciting your staff to leave their employment. Imagine an associate leaving suddenly. Now imagine that associate takes your office manager and your biller. This could be a death knell to even the most vibrant practice—one that is easily avoided. Second, terminated physician employees should not be permitted to solicit the practice's patients, which admittedly requires some nuance, as patients are certainly entitled to hear where their treating physician is moving his or her practice to. A physician employment agreement absolutely must include language spelling out a process by which the practice will control all communications with the practice's patients upon termination of the relationship, and that process must be in compliance with that particular state's patient notification or continuity of care regulations to ensure enforcement.

Engaging an associate is often a practice's largest investment.

The above list is hardly exhaustive, but the larger point is two-fold. First, the practice should first focus on what they want and need out of an associate physician, and then make sure they are clear about that and all of the corresponding conditions of employment before an agreement is drafted. Second, once an agreement is prepared, it is critical that it be particularized to that practice and that future employee, as opposed to something out of a form book or a template picked up at a conference or off of a website. Engaging an associate is often a practice's largest investment. Skimping out on the contract is penny-wise but pound-foolish. **PM**

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