

The
North
Carolina **Family Physician**
Hospital Affiliation White Paper





INTRODUCTION

Changes in health policy and reimbursement are forcing independent private practice physicians to consider integration with hospitals. From the strategic perspective of the North Carolina family physician, this White Paper explores the reasons driving these trends, the advantages and disadvantages of various hospital-physician integration options, and finally, provides a detailed analysis of the hospital employment model. We conclude that there are compelling “offensive” and “defensive” reasons to consider integration and specific guideposts to assure a successful and sustainable hospital-physician partnership.



WHY AFFILIATE?

A. Reasons Family Physicians Are Considering Affiliations

A.1 Overhead Outpacing Income

The Center for Studying Health System Change reported that the average physician's net income, adjusted for inflation, declined 7% from 1995 to 2003. The current economic recession is increasing financial pressures on physicians, which is increasing the trend toward physician employment, particularly by hospitals or large clinics. Insurance reimbursement is not keeping pace with practice overhead, and more patients are uninsured or underinsured. The need for acquisition of expensive electronic medical records ("EMR") and other health information technology ("HIT") exacerbates the problem. Even if financing for acquisitions is available, practices with just a few physicians, or with physicians nearing retirement, may be reluctant to sign personal guarantees.

Regarding the Hospital Employment Option

Practicing as an employee of a large hospital corporation offers a number of advantages over owning and operating your own practice. One such advantage is financial security. Specifically, under most agreements, your salary is at least partially guaranteed and less dependent on the revenues and expenses of your practice. The financial security of hospital employment is particularly advantageous given the failure of physician reimbursement rates to keep pace with the rising costs of providing health care. Hospital negotiated reimbursement rates with health insurers are usually much more competitive than the rates family physicians are able to negotiate on their own. In addition, the hospital will pay for your medical malpractice insurance, including "tail coverage" after the employment relationship ends. As malpractice insurance costs continue to rise as well, this is yet another financial advantage to hospital employment over private practice.

A.2 Increasing Complexity of Practice

Related to increased overhead, family physicians see that to be successful, their practices need sophisticated infrastructure, information technology systems, negotiation expertise, accountants, billing professionals, and legal counsel. Physicians went to medical school primarily to treat patients—not to become business people. Complex regulatory and professional liability climates force attention to detail and paperwork. Health reform promises potentially remunerative, but increasingly complex, arrangements.

Regarding the Hospital Employment Option

In addition to financial security, hospital employment may relieve you of a number of the administrative burdens of operating your own practice. For example, a large hospital corporation is better equipped to provide administrative and technical support, such as compliance solutions, human resources departments, and billing functions. By relieving some of these administrative burdens, hospital-employed physicians often have more time and energy to focus on practicing medicine, as opposed to practicing the “business of medicine.”

Hospitals offer a greater degree of stability than smaller private practices because they can rely on economies of scale. The depth of a hospital’s financial resources allows it to function more competitively in the tightening health care market. Such economic depth often allows physicians to have access to state-of-the-art medical equipment and information technology systems. Furthermore, in the midst of the current financial crisis, hospitals will likely have easier access to capital than private practices, which may provide further assurance of the continued viability of your medical practice.

A.3 Clout

Physicians are aware of the consolidating insurance industry and the lack of negotiating leverage of the typical medical practice. Another driver to consider affiliation is that it may bring economies of scale, leverage, and clout.

Regarding the Hospital Employment Option

Some hospitals recruit physicians based primarily on the fact that their managed care reimbursement rates will be higher immediately upon becoming employed.

A.4 Benefit from the Patient-Centered Medical Home (“PCMH”) Model

Closer integration enables physicians to finance, develop, and implement the infrastructure necessary to collect, track, and report clinically valid data to implement the PCMH model and other emerging quality-based reimbursement mechanisms. Peak performance requires a physician-driven continuum of care (the right care, at the right place, by the right person) on an HIT platform with evidence-based best practices, a complete patient record, and performance data. As stated by one family physician, the successful PCMH must be “community-based, evidence-based, outcome driven, cost-efficient, and centered on the care of the patient.”

Regarding the Hospital Employment Option.

The community hospital is a natural collaborative care partner for the PCMH model. Relaxation of Stark regulations allows the hospital to support physician HIT expenditures. Hospitals and employed specialists can equalize the patient coordination administrative burdens historically falling disproportionately on primary care physicians, achieve critical mass of expertise, allocate management time for strategic planning, and keep abreast of rapidly changing health-care policy.

A.5 No Market to Sell Practice

Physicians who have worked hard to build up a practice are often seeing little or no interest by potential buyers. Gen-X and Gen-Y physicians increasingly doubt the ability to keep independent practices alive and maintain a balanced life.

Regarding the Hospital Employment Option

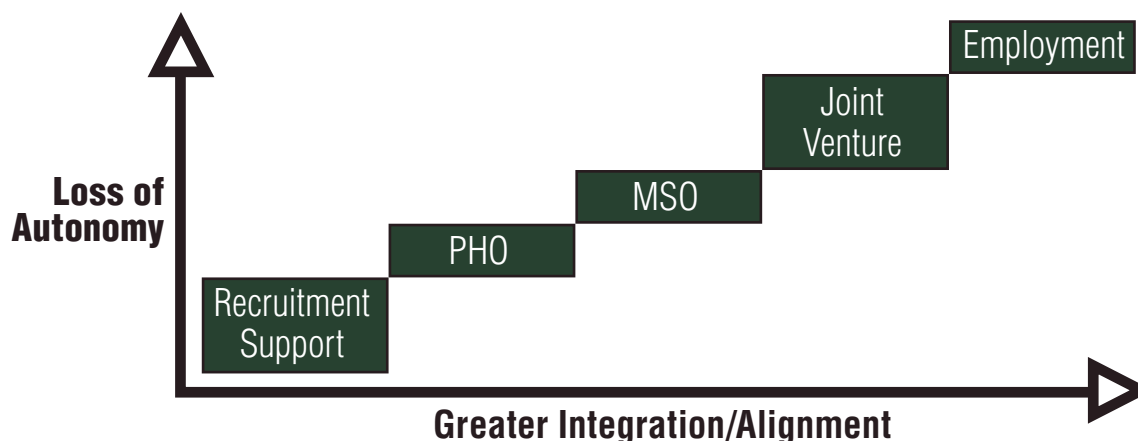
Today, hospitals represent one of the few purchasers for value of a practice as part of a hospital employment transaction.

B. Reasons Family Physicians Are Resisting Affiliation

B.1 Loss of Autonomy and Job Security

The main reason physicians resist integration, merger, or affiliation into large organizations is fear of loss of autonomy and control. By definition, the greater the integration and interdependence, the greater the loss of independence. Physicians often choose the integration option that preserves the most autonomy.

The following diagram¹ shows the structural options in reference to relative loss of autonomy:



Regarding the Hospital Employment Option

While hospital employment provides numerous advantages, there are also disadvantages that come with such employment. The fundamental disadvantage is the loss of control you would otherwise have operating your own practice. For example, your work schedule, call coverage, administrative tasks, record-keeping requirements, and general business operations will more than likely all be dictated by the hospital. In addition to business management, the hospital may have the authority to oversee and provide guidance regarding your clinical practices. Furthermore, the hospital will establish the fees that you will be allowed to charge for the medical services you provide. By relinquishing such control to the hospital, you will essentially be surrendering a great deal of the autonomy and independence that you experienced in private practice.

In addition to loss of control, there is also potential risk regarding the security of your employment. Specifically, a typical employment agreement may allow the hospital to terminate your employment at any time, and for any reason (or no reason at all), by simply giving you 90 days' notice. In other words, there is really no guarantee that you will remain employed, other than for the 90 days required in the notice provision. While such "no cause" termination provisions are quite common in physician employment agreements, you must be aware of the possibility that the hospital could end your employment relationship at any time.

There are significant potential disadvantages should your employment relationship with the hospital end. For example, most contracts include a non-solicitation period during which you may not employ or solicit for employment any employee of the hospital. This may be particularly problematic if members of your current staff become employed by the hospital. After your contract has terminated, you will not be able to employ these individuals during the non-solicitation period. Similarly, most employment contracts contain non-compete provisions that can limit a physician's ability to provide care in the community if the hospital terminates employment. If you sell your practice, your initial purchase agreement should include an option to buy back your practice. Otherwise, if either you or the hospital terminates the agreement, you may find returning to private practice challenging given the non-solicitation agreement and lack of buy-back guarantee. Finally, your reimbursement rates, which have been out of your control, may be too low. Essentially, you would have to start from scratch in building a new practice.

B.2 Start-Up Costs

The transaction costs can be substantial for major structural integration. Physicians, already strapped financially and reluctant to lose their independence, are often deterred by the upfront costs.

¹ Adapted from Debra Beaulieu et al., *Physician Entrepreneurs: Strength in Numbers – Consolidation and Collaboration Strategies to Grow Your Practice* (The Coker Group, 2008).

C. Reasons Hospitals Are Considering Affiliation

Often overlooked, it is important for a physician to understand the perspective of the party with which they are negotiating and with which they may be partnering for the rest of their careers. This empowers them to craft win/win scenarios that are more likely to be fair to the physician and sustainable for the long run. Some of the reasons hospitals are seeking affiliation may come as a surprise to many physicians.

C.1 Demand Exceeds Supply

Experts predict that by 2020, there will be a deficit of 150,000 to 200,000 physicians. Hospitals fear that the traditional medical practice model is unsustainable. Particularly in rural communities, they fear that without affiliation, there will not be enough primary care or key specialist physicians to staff community health care needs.

C.2 Gain Market Share

Hospitals seek to employ or otherwise affiliate with physicians to gain market share through primary care and specialist employment. Employment secures the hospital referral base.

C.3 Prepare for Value-Based Reimbursement

Hospitals desire to integrate into high performance practice organizations. They see employment as a way to obtain desired physician behavior and align incentives. Quality indicators, public report cards, and state quality scores show the need to work with physicians to achieve the best outcomes results. Recently enacted federal health care system reforms may accelerate this trend with the creation of bundled payments and Accountable Care Organizations (“ACOs”).

D. Conclusion

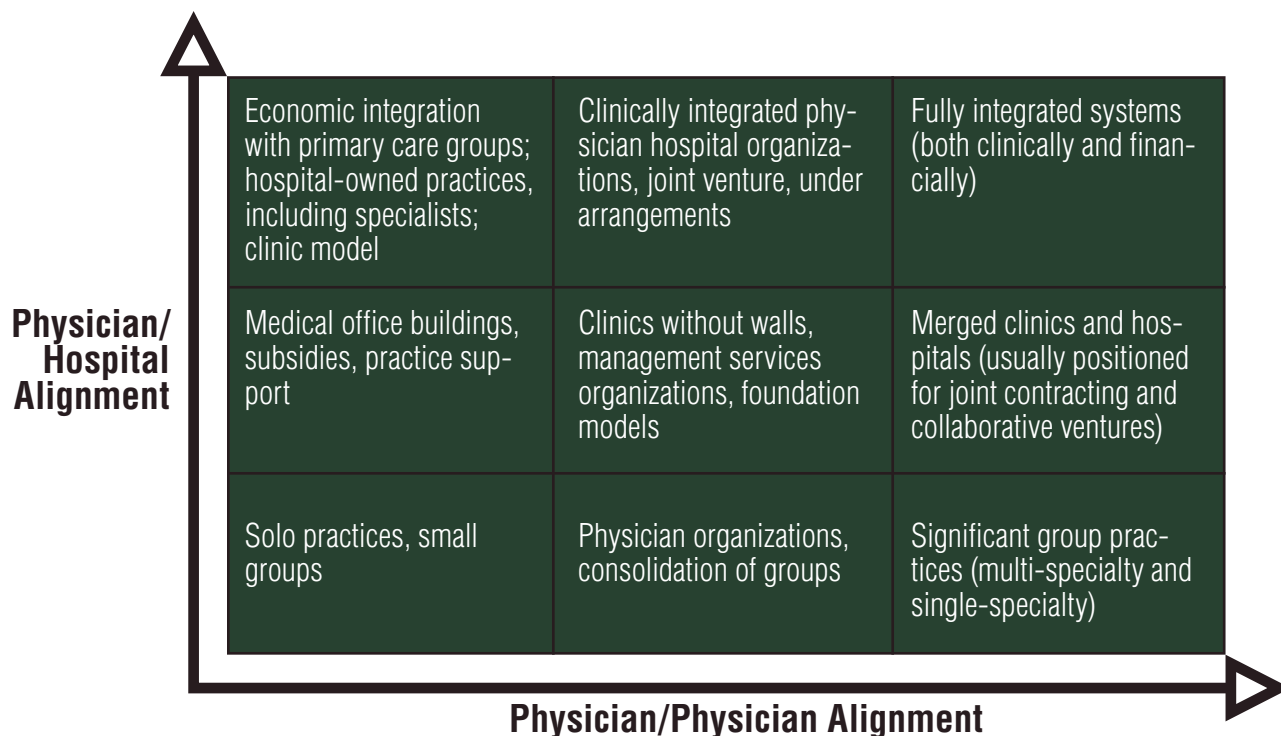
In considering the pros and cons of affiliation, the sacrifices must be weighed against the potential benefits. The option chosen and the shape of the arrangement should maximize the upside potential and minimize the downside risks. It always needs to be win/win for the long term. Doing nothing and its consequences in tomorrow’s environment should also be compared as an option.

¹ Adapted from Debra Beaulieu et al., *Physician Entrepreneurs: Strength in Numbers – Consolidation and Collaboration Strategies to Grow Your Practice* (The Coker Group, 2008).

AFFILIATION OPTIONS

A. Matrix of Physician/Physician and Hospital/Physician Integration Options

Integration of some sort seems inevitable for many family physicians. We are aware, for example, of successful physician-to-physician family physician practice mergers and networks to consolidate scale, infrastructure, and expertise to prepare for the PCMH and other PCP-oriented health reform. Before focusing on hospital-physician options, for context, the following is a diagram² of possible physician/physician and physician/hospital affiliation options:³



² *Id.*

³ For more on physician-to-physician integration, reference is made to AMA: *Competing in the Marketplace*, "How physicians can improve quality and increase their value in the health care market through medical practice integration" (June 2010).

B. What Are My Physician/Hospital Affiliation Options? What Are the Pros and Cons of Each?

Due to space constraints, this White Paper addresses only the main alignment options. There are myriad strategic alternatives. Do not be afraid to work with your consultants and counsel to fashion the most appropriately tailored “win/win” relationship for your situation. The following are the most common options:

B.1 Recruitment Support

Recruitment assistance from a hospital to a private practice provides needed clinical staffing and promotes hospital-physician alignment while allowing the private practice physician the most independence. Recruitment assistance to fill a community need must meet specific regulatory exceptions to the anti-kickback and Stark laws. Support can come in the form of income guarantees, medical school debt payments, malpractice premium payments, and relocation expense reimbursement. A downside is that the impact fades after the income guarantee period ends, but this is an opportunity to create a win/win relationship culture, while the practice remains independent. It is important to meet the very specific regulatory constraints and mesh the financial support with the practice’s compensation plan. In sum, this option provides very weak integration, very high independence, and a good first step toward a collaborative culture.

B.2 Professional Services Agreements (“PSAs”)

PSAs, such as medical directorships, compensated call coverage arrangements, and clinical co-management agreements, can be effective to shape a collaborative environment and achieve specific targeted, mutually beneficial strategic and financial objectives. PSAs must be structured to meet regulatory requirements and cannot exceed fair market value. Hospitals usually obtain a third-party fair-market-value opinion. To move a promising venture to closure, it is often a wise investment for physicians to obtain or share costs of securing such an opinion, as the fair-market-value documentable benefits of many of these programs are substantial. The integrative benefits of some of these PSAs are quite positive, while the practice remains independent. This can be used as a stepping-stone towards fuller hospital/physician integration. The potential for these arrangements is growing rapidly as reimbursement paradigms shift to quality reporting and value-based reimbursement. Opportunities for hospital PSAs are usually greater for specialists than for family physicians due to their common focus on managing inpatient service lines and departments.

B.3 Networks

The early managed care networks, IPAs, and PHOs, were loose contracting alliances without sufficient infrastructure or integration to create a sustainable quality or efficiency-enhancing business model or to meet antitrust muster to negotiate collectively. The new networks, sometimes now called Accountable Care Organizations or Medical Home alliances, are designed to yield performance improvement through collaborative care, evidence-based best practices, and HIT connectivity.

They are organized to realize better clinical outcomes, and if implemented properly, they can meet the antitrust regulatory standard of “clinical integration,” which allows negotiation with managed care through a single fee schedule. A clinically integrated physician/hospital network holds promise, as health reform moves toward pay-for-performance and federal proposals specifically endorse the PCMH and ACO models. Pay-for-performance contracting, EMR connectivity, and creation of a communitywide health information exchange data repository are natural components of modern network structures. Physicians remain independent.

While theoretically quite attractive to achieve many physician and hospital goals, even these modern voluntary networks still tend to lack the cohesion to take full advantage of the efficiencies offered through full integration.

B.4 Affiliate Staff

Under the Affiliate Staff model, medical staff physicians who choose not to be hospital employees agree to engage in collaborative activities and to integrate their practices operationally to promote timely and patient centered care. A common EMR system is encouraged. They are targeted for specific needed services. A progressive family physician practice prepared to lead PCMH activities is the typical target of a hospital. For example, the Carilion Health System in Virginia recently transformed into the Carilion Clinic and sought integrated care by all medical staff physicians, either through employment or Affiliated Staff membership. Physicians are often financially rewarded at fair market value through PSAs or as part of a physician/hospital pilot, PCMH, ACO, or bundled payment project. Recruitment and EMR acquisition support is also available. This alternative appears attractive to a family physician, if the health system partner is after true integration and improved outcomes. This may be a first step in consideration of fuller integration, such as employment.

B.5 Full Practice PSA

One increasingly popular, tightly integrated option manages to retain some measure of independence for the medical practice. It is often called a Full-Practice Professional Services Agreement. Under this model, the hospital owns and operates a physician clinic and provides administrative and technical services. The hospital-owned clinic contracts with an independent physician group practice to provide professional services to the clinic. The physician services are billed by the hospital-owned clinic. The contract obliges the practice to provide a specified level of services, often including call. The physicians contract as independent contractors and usually receive a productivity-based payment for all professional services that covers salaries, fringe benefits, and insurance costs. This arrangement usually follows the sale of the practice’s tangible assets at fair market value.

This model allows the contracting physician group practice to retain autonomy over how to divide income among its physician members. A key benefit of this model is the ability to bill health insurers through the hospital-owned clinic, which is likely to have more negotiating clout.

Under the full practice PSA model, many of the perceived benefits of integration are fulfilled, yet the practice remains independent, albeit without tangible assets or staff. There is still a substantial loss of autonomy, and the slower decision-making of a hospital may prove frustrating. While independent in name, unwinding an arrangement like this can prove difficult. Nonetheless, when compared to full employment, on balance, this affiliation option has become the choice of more and more physicians.

B.6 Employment

Employment is the most tightly bound physician/hospital integration option. However, it creates the least regulatory issues. Some hospitals create a department or subsidiary to employ physicians. Larger hospitals often distinguish between primary care and specialty care providers. Physicians sell their practices at fair market value, are paid reasonable compensation through competitive compensation arrangements, preferably with an incentive component, access sophisticated expertise, increase contracting clout, and mesh into a vertically-integrated care platform readying for the future. Hospitals are attracted to employment for the reasons physicians most resist it—it ties the physician most closely to the hospital and it is most likely to result in the desired physician behavior change through aligned incentives and outright control.

STRATEGIES REGARDING PRACTICE ACQUISITION BY THE HOSPITAL

A. Introduction

In today's climate, a hospital may be one of the few viable purchasers of a family physician practice's assets. For regulatory purposes, it is important that the acquisition be for fair market value. While many physicians believe that the paperwork for the acquisition should be simple once the price is established, there are in fact many important issues that must be negotiated. Careful review of the key transaction issues outlined below will help family physicians considering a practice acquisition avoid unpleasant surprises.

B. Key Transaction Considerations in Acquisition Negotiations

B.1 Representations and Warranties in the Purchase Agreement

Most physicians will feel that the purchase price is the most significant element of the purchase agreement, but an equally important part of the purchase agreement are the representations and warranties that the physician makes to the hospital regarding the assets that are being sold and the operations of his or her practice. Typically, the purchasing hospital will make limited promises to the physician; for example, that the purchase of the physician's assets has been authorized by the hospital's board of directors, that there is no legal prohibition to the hospital purchasing the physician's assets, and that the signing of the purchase agreement will be a binding obligation on the hospital.

It is important for the physician to read carefully and understand each of the representations and warranties. The representations and warranties may relate to specific time periods, such as, "the seller has never been in violation of any laws regarding billing for health services," or "the seller is not currently in violation of any laws regarding billing for health services," or "since January 1, 2003, the seller has not been in violation of any laws regarding billing for health services." To the extent that something makes a representation untrue, it will need to be listed on a "disclosure schedule."

Some of the typical representations and warranties made by the physician include that the physician has title to all assets being sold, that the physician has been operating the practice in compliance with all laws, including in particular coding of services and billing payors (private and government) for such services, that the physician has been paying all taxes in a timely manner

and abiding by all laws with respect to taxes, that there are no pending litigation matters against the physician or his practice, that the physician has received all consents and approvals (whether from governmental agencies or other contracting parties) to the sale, and the status of the seller's financial condition at and prior to closing.

B.2 Indemnification in the Purchase Agreement

A section directly connected to the representations and warranties that may be heavily negotiated relates to indemnification by the seller and the buyer for any damages either party incurs related to a breach of the purchase agreement. A physician seller will likely be asked to defend and pay damages to the hospital in the event that, after the closing, one of the representations or warranties made in the purchase agreement turns out to be untrue. A selling physician could attempt to exclude an indemnification section altogether and instead require that the hospital sue for breach of contract. "Why should a small physician practice in effect be an insurance company for a huge hospital?" we would argue. However, indemnification provisions by the seller are fairly standard.

Therefore, it is very important to negotiate limitations on the physician's indemnification obligations. For example, a cap on the total dollar amount of the indemnification obligations is often used (i.e., a quarter, one-half, or the full amount of the purchase price). The hospital will likely request that any caps only apply to breaches of certain representations, warranties or covenants; in other words, the cap would not apply to the most important representations and warranties regarding taxes, title to assets, billing and coding compliance, or compliance with certificate of need laws. In addition, a physician should attempt to limit the time frame that he or she will be required to indemnify the hospital (i.e., one year after closing or three years after closing). Again, the hospital may request that the time limit be indefinite for significant representations and warranties that typically do not have statutes of limitation (i.e., taxes). Another recommended limiting option is to cap your exposure to the amount of your insurance coverage for indemnification.

B.3 Coding and Billing Compliance

Typically, the government can bring a case under the federal Civil False Claims Act for up to six years from the date of claims submission. Accordingly, a hospital that buys a physician's practice will be concerned about coding and billing prior to purchase (particularly if the physician is going to be employed). Because a hospital likely cannot purchase the stock of a professional practice (because North Carolina law requires all shareholders in a professional corporation to be licensed physicians), a hospital's potential liability is reduced by purchasing a physician's assets (rather than stock). The hospital's liability protection through an asset sale is reduced if the hospital agrees to assume the billing numbers and payor contracts of the selling physician (to the extent allowed by law or contract). Sometimes a hospital will request that an audit be performed by an independent billing and coding company before finalizing the purchase agreement. Often, a hospital will ask for diligence materials related to the practice's compliance plan, coding and claims submission, any audit or overpayment determinations from payors, and a random sampling of charts to review in-house.

B.4 Safe Harbors/Exceptions to Anti-Referral Statutes

The parties will need to take care to structure the purchase of assets of a physician who refers patients to the hospital or who will become employed by the hospital within the safe harbors or exceptions to various anti-referral statutes. This White Paper does not provide detailed analysis of the statutes and safe harbors/exceptions, but rather raises this issue because the statutes are important for both parties to be aware of, as both sides to the transaction could face penalties for violating them. The safe harbors and exceptions will play a very important part in how much the hospital can pay the physician. Generally, fair market value will be a requirement for any amounts paid to the physician, which may mean that the hospital has to engage in a valuation based on the specific community for the purchase price of the physician's assets. Paying for things like "goodwill" may prove hard to value and a hospital may not be willing to risk paying an amount for intangibles that cannot be supported by independent valuers.

Under the Stark law, there is an exception for isolated transactions, the example being a one-time sale of property or a practice. See 42 C.F.R. § 411.357(f). Among other things, it requires that (i) the compensation paid to the physician be fair market value, commercially reasonable, and not determined in a manner that takes into account the volume or value of any referrals by the selling physician or other business generated between the physician and the hospital, and (ii) that there be no other transactions between the parties for six months after closing, except for transactions covered by other exceptions to the Stark law and post-closing adjustments that are commercially reasonable and not determined in a manner that takes into account the volume or value of any referrals by the selling physician or other business generated between the physician and the hospital.

B.5 Certificate of Need

There are certain actions that may require the hospital to seek the approval of, or submit a request to, the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Certificate of Need Section (the "CON Section"). The CON Section regulates certain types of equipment and facilities and certain dollar amounts spent on "new institutional health services," and requires parties engaging in such regulated activities to obtain a certificate of need prior to acquiring the equipment or facility, or spending the money on the health service. There are certain actions that are exempt from obtaining a certificate of need, provided that the parties provide prior notice of the action to the CON Section. Relevant examples include the purchase of an existing health service facility and all equipment located therein and the purchase of a physician office building, regardless of cost. N.C.Gen.Stat. §§ 131E-184(a)(8)-(9). Physician practices may qualify as "health service facilities" if they have a sufficient amount of diagnostic equipment such that they constitute a "diagnostic center" or if they are licensed as an ambulatory surgical facility. The statute only requires that prior notice be provided to the CON Section; however, a hospital may want to wait for confirmation from the CON Section if there is any doubt as to the exemption.

If a physician owns certain types of regulated equipment, such as a linear accelerator, lithotripter, magnetic resonance imaging scanner, positron emission tomography scanner, or simulator, then the hospital will be required to obtain a certificate of need for such equipment prior to acquiring it. Certificates of need are issued at certain time periods during the year, and a typical time frame for completing the application, filing it, waiting for the CON Section's response, and waiting to make sure the certificate of need is not challenged by other parties can last from five to eight months.

B.6 Tax Considerations

Due to the limitations on who can be an equity owner of a professional entity, a hospital generally may not purchase the equity interests of a physician practice. Therefore, most sales of practices to hospitals will be structured as asset sales. Upon the sale of assets, the selling practice will recognize the full gain or loss on the sale of its assets. The shareholders of a practice that is a C corporation will not realize taxable gain or loss on the corporation's sale of assets unless and until the corporation liquidates. When the C corporation liquidates, its shareholders will recognize gain or loss (usually capital gain or loss) from the disposition of their stock in the liquidation. Each shareholder's gain or loss is measured by the difference between the shareholder's basis in his or her stock and the amount of cash (and/or fair market value of any property) received by the shareholder in the liquidating distribution. Accordingly, there is generally a double tax when a C corporation sells its assets and distributes the proceeds to its shareholders in liquidation: (a) the corporation pays tax on the gain realized on the sale of its assets (usually part capital gain and part ordinary income, depending on the corporation's assets), and (b) the corporation's shareholders pay tax on their gain from the disposition of their stock and liquidations (generally at capital gain rates).

If the practice is an S corporation or entity taxed as a partnership (e.g., PLLCs), however, the entity can generally sell its assets and distribute the proceeds to its owners while triggering only a single level tax. If the entity is an S corporation or a partnership, the owners, rather than the corporation itself, will report and pay tax on the gain of the sale of the assets and the owners' basis in their ownership interest in the practice increases by the amount of the gain on the asset sale so that a liquidation of the entity will not result in double tax on the gain from the sale of the assets. With respect to an S corporations with a C corporation history that became an S corporation within the ten (10) years prior to the transaction, a special corporate level tax may be imposed on all or a portion of the gain recognized on the sale of the corporation's assets. The corporate level tax is imposed on that portion of the corporation's gain on the sale of its assets that was built-in gain when the corporation made its S election. Accordingly, the two levels of tax cannot be avoided by a last-minute S election.

B.7 Other Miscellaneous Issues Related to the Acquisition

Often, hospitals will want to include a non-competition provision (which may or may not be tied in with the employment relationship) that would limit the physician's ability to set up a competing practice. Under North Carolina law, non-competition provisions in connection with the sale of a business are enforceable and have often been permitted to last for a longer time period

than in connection with an employment agreement (i.e., five years).

If part of the assets that the hospital is purchasing includes patient medical records, the physician should insist on compliance with the North Carolina Medical Board's position statement regarding closure of a practice and patient records. In general, the patients should receive a letter (and possibly notice in a local newspaper) stating that the records are being transferred, that the patient has a right to request that they be transferred to another physician than the new hospital practice, and that the hospital and physician must honor the patient's request. The North Carolina Medical Board expects this notice to be sent at least thirty days in advance of a closure/transfer.

STRATEGIES REGARDING EMPLOYMENT BY A HOSPITAL

Negotiation of the employment arrangement is focused on maximizing the aforesaid benefits of hospital affiliation while minimizing the downsides, primarily loss of autonomy. Before discussing the employment agreement, it is important to remember that shaping the successful employment relationship involves extra-contractual considerations, as well:

A. Success Factors Beyond the Contract

- Formalized win/win vision and objectives.
- Parity of physicians with hospital units—attention to cultural and governance issues.
- Trust/Relationships.
- Critical mass of physicians.
- Improved financial performance through increased integration provides reimbursements, economies of scale, financial security, clearly aligned incentives, meaningful physician leadership.
- Expectations are clearly defined; failure exposes lack of planning or trust or both.
- Compensation/incentives to foster recruitment and retention of physicians and to promote collaborative behaviors consistent with the organization's goals.

B. Key Employment Contract Negotiation Considerations

B.1 Compensation

Compensation will likely be the primary concern for physicians moving from private practice into a hospital employment relationship. While compensation arrangements can vary dramatically from one hospital to the next, compensation will typically consist of either a fixed salary, productivity-based salary, or a combination of both. Regardless of the compensation method used, physicians need to understand exactly how they will be compensated and ensure that their expectations are clearly set forth in the employment agreement.

Furthermore, physicians must be aware of the limitations imposed by the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b), and the Stark law, 42 U.S.C. § 1395nn, with regard to their compensation. The anti-kickback statute includes a safe harbor for compensation paid by an employer to an employee who has a bona fide employment relationship with the employer, for items or services payable under Medicare, Medicaid, or other federal health care programs. See 42 C.F.R. § 1001.952(i). Furthermore, pursuant to the bona fide employment relationship exception to the Stark law, 42 C.F.R. § 411.357(c), the physician's compensation must be consistent with fair market value

and cannot be based on the volume or value of any referrals by the physician. In determining fair market value, hospitals may refer to resources such as the Medical Group Management Association's Physician Compensation and Production Survey, as well as opinions of outside consultants. Physicians who do not meet the requirements for the employment exception/safe harbor (such as independent contractors) may alternatively fall within the personal services safe harbor under the anti-kickback statute, 42 C.F.R. § 1001.952(d), and personal services exception under the Stark law, 42 C.F.R. § 411.357(d). Both provisions require, among other things, that the compensation paid to the physician be set in advance, consistent with fair market value, and not take into account the volume or value of any referrals by the physician, and that the agreement be in writing, signed by the parties, and for a term of at least one year.

B.2 Term and Termination

Hospital/physician employment agreements will typically include terms ranging from one to five years. The agreements may also contain "auto-renew" provisions such that at the end of the initial term, the agreement will automatically renew for successive terms until the agreement is terminated as provided for in the agreement. While a relatively long initial term combined with an auto-renew provision may create the appearance of job-security, physicians must also be aware of the all-too-common "without-cause" termination clause. Without-cause termination provisions allow either party to terminate the agreement for any reason whatsoever (or for that matter, no reason at all) merely upon giving notice to the other party. The required notice period usually ranges from 60 to 180 days. The obvious risk here is that physicians may believe that they are entering into secure, long-term employment relationships, only to find that they may be terminated in a matter of months after beginning employment.

B.3 Control

One of the advantages of hospital employment is that physicians may be relieved of a number of the administrative burdens of operating their own practices. For example, a large hospital corporation is better equipped to provide administrative and technical support, such as compliance solutions, human resources departments, and "back-office" billing functions. By relieving some of these administrative burdens, hospital-employed physicians often have more time and energy to focus on practicing medicine, as opposed to practicing the "business of medicine."

With this advantage, however, comes a significant disadvantage: loss of control. Under typical employment agreements, the physician's work schedule, call coverage, administrative tasks, and record keeping requirements will all be dictated by the hospital. Furthermore, the hospital will usually have control over the hiring and firing of staff, as well as the purchase of supplies and equipment. These functions are all fundamental to the business operations of the physician's day-to-day practice. By relinquishing such control to the hospital, physicians will be surrendering a great deal of the autonomy and independence that they would otherwise experience in private practice. This should be a priority area for negotiation to have reasonable input on clinical decisions and clinical personnel decisions.

B.4 Business Expenses

Before entering into an employment agreement with a hospital, physicians should carefully consider which party will be responsible for the physician's business expenses, including, for example, malpractice insurance, continuing medical education, license fees, and periodicals. Whether or not the hospital covers such items and the amount the hospital agrees to pay should be considered in connection with the physician's compensation. Furthermore, the physician should pay particular attention to whether "tail coverage" is needed upon termination of the employment relationship and if so, which party is responsible for purchasing tail coverage after the employment relationship ends.

B.5 Post-Employment Issues

Finally, physicians must consider the potential consequences of terminating the hospital employment relationship. Often, physician employment agreements will contain both "non-competition" and "non-solicitation" clauses. These contractual provisions may prevent the physician from practicing within a specific geographic area for a set period of time following employment, and from soliciting any of the hospital's patients or employees. As a result, physicians may find returning to private practice to present a daunting challenge.

CONCLUSION

American health care delivery may be moving to a golden age for primary care leadership. However, it will require new skill sets, collaboration partners, technology, and system sophistication. It is the goal of this White Paper to provide some assistance to the North Carolina family physician in understanding the opportunities and pitfalls in hospital affiliation in order to acquire those tools.

The North Carolina **Family Physician**
Hospital Affiliation White Paper

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