

Hospital Employment of Oncologists

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Hospitals are employing physician specialists of all types, and oncologists are no exception. Oncology practices are increasingly being recognized as an integral acquisition for a hospital to ensure a profitable physician network. This article outlines some key considerations when reviewing and negotiating hospital employment offers and agreements.

Compensation

It is important to remember when reviewing an offer from a hospital or a health system that you bring to the table much more than your individual productivity and revenue. The sum of all parts is worth more than any one provider alone. Your practice is an integral component of a lucrative network of services and referral relationships. For example, urologists can be recruited and rewarded if oncology income remains within the network, and reconstructive breast surgeons can be assured a stream of referrals. Revenues enjoyed by the hospital from advanced diagnostic testing will also be increased by your presence.

What is the implication of this? Ask the hospital for more money (the worst they can do is say no—or they may meet you in the middle with a compromise). If a base salary increase is not accepted (or even if it is), a minimum bonus guarantee for a certain period of time may be provided.

Alternatively, a profit pool may be established that sets aside specified revenues for apportionment among the “network” of complementary providers that exist within this referral stream. Any approach will have to be carefully analyzed and properly structured to ensure

compliance with the law, but the effort to negotiate could be worth the reward.

Compensation and Bonus Models—and Their Pitfalls

Base compensation and/or bonuses are usually (although not always) contingent on meeting certain quantitative benchmarks—meeting and/or exceeding a work Relative Value Unit (RVU) threshold; meeting and/or exceeding a revenue threshold based on personal collections; or achieving surplus revenues at a particular practice office in excess of all the expenses attributable to the site, including base compensation and overhead (ie, a profit-bonus methodology).

The most common methodology is an RVU threshold. A work RVU threshold is the preferred methodology for the employee, because it insulates the physician from collection failures. As long as the code billing is generated, the physician is given credit. Current Procedural Terminology® codes have an RVU assigned to them that relate to their compensation value, and these code values can increase or decrease.

A code with a higher work RVU takes more time and/or requires more intensity. Some radiation oncology codes, such as treatment codes, have no associated physician work, and there are reductions looming for medical and radiation oncology.

Accordingly, any compensation based on reaching or exceeding annual work RVUs should consider these risks. For example, the parties could consider establishing a base salary commitment based on 90% of the previous year’s work RVUs, or otherwise could provide a “cushion” amount to allow for loss before



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any salary reductions would take effect.

A bonus is usually paid as a dollar amount for each individual work RVU in excess of an annual threshold, or as a percentage of collections in excess of an annual collection threshold. If a bonus is not offered, it is

critical to ask for one based on the foregoing common approaches.

It also should be requested that the bonus be estimated and paid quarterly, even though the bonus is based on annual achievement benchmarks. Reconciliation can be conducted at the close of the year, but a higher income stream over the course of the year is warranted.

In the event of termination, however, 2 often-overlooked pitfalls include (1) falling short of the annual threshold, or (2) not receiving credit for the accounts receivable collected after you leave. Regarding the former, the establishment of an annual bonus based on an annual threshold could result in the loss of any bonus-earning potential in the event that termination occurs short of the 12-month measuring period, because the threshold has not yet

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been reached. This means that a physician can work hard to the very last day, but a critical component of his or her overall compensation package is forfeited.

To avoid this unfair result, the annual work RVU, or collection threshold, should be prorated as of the effective employment termination date based on that portion of the 12-month measuring period worked. If employment is terminated 6 months into a given 12-month period, then the threshold should be cut in half for purposes of calculating the bonus earned at such time. In addition, if the bonus calculation (or the base salary for that matter) is based on collections, any accounts receivable attributable to the services rendered during the term of employment that are collected after it ends are usually not credited to the physician for purposes of calculating additional payments.

Third-party payer delays outside of the physician's control should not deprive a former employee of what has been rightfully earned. Accordingly, accounts receivable collected after termination should be tracked for a certain period (eg, 6 months to 1 year).

Personal Financial Exposure

It is becoming increasingly common in hospital acquisitions of existing practices that the hospital will offer a salary guarantee and fund the practice budget (as well as any cost overruns, unanticipated expenses, and cash flow shortfalls). This deal helps the physician to maintain a steady income in the face of claims reimbursement cuts, notwithstanding the ebbs and flows of collections. No one has to go without a paycheck, mortgage their property, or run to a bank to get a line of credit.

However, this "deal with the devil" comes at a potential risk. Although the health system hopes to leverage its power to ensure favorable payer rates, it may anticipate a period of time in which reimbursement levels are threatened because of factors outside of its control, and it may further plan on spending money for practice expansion; recruitment; electronic medi-

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cal record implementation; capital equipment acquisition; real estate acquisition, renovation, or expansion; and clinical integration of the oncology network. In short, the outlook for achieving the desired profitability could be a 3- to 5-year long-term game.

To hedge this risk, the hospital may consider your existing practice as a "profit center," and hold the practice owners personally responsible for any deficits attributable to its office. For example, the deficit is tracked for several years, and, if the agreement renews, it is then treated as the personal debt of the physicians to be forgiven over time, as long as the physicians in the practice remain on board for another several years.

This "forgiveness" option is not always provided. If the physicians leave at any time, the agreement may stipulate that they personally owe the deficit. This risk should be reviewed carefully, and the forgiveness time periods and terms should be evaluated carefully.

By contrast, if the physicians are going to assume such risk, there must be some reward when the practice goes from "red" on the balance sheet into the "black," where it is achieving a profit (ie, the profit-bonus methodology).

In any event, the options for sharing the risk should be discussed so that the physicians are not entirely on the hook should things not progress as planned.

Posttermination accounts receivable collections also should be credited toward reducing any deficit balance. In the event of death or disability, the imposition of such debt obligation may be eliminated because you no longer maintain the capacity to earn an income to pay it back and you did not voluntarily resign employment.

Restrictive Covenant

If the relationship ends, the hospital may expect to protect its investment by precluding you from working where you have developed your practice over decades, knowing that this obviously will discourage you from terminating your employment with the health system. Although the hospital's concerns may be valid, you cannot always expect to just pick up and maintain a viable practice far away from where you live, what you have become accustomed to, and the referral sources you know.

Efforts should be made to reduce the scope of the covenant and provide for its nullification under certain circumstances. For instance, if

the hospital terminates you without cause (ie, without fault on your part), fails to renew the agreement, or offers to renew it but under noncomparable adverse terms, then the covenant would not apply. It may also be designed to preclude employment or affiliation with another hospital or health system while not prohibiting employment by an independent private practice.

Real Estate Leverage

If a facility has been established that has undergone all of the necessary construction, withstood the test of certifying and credentialing authorities, contains high-value capital equipment, and has a viable location convenient for both referral sources and patients, then the hospital will most likely want to maintain the site and leverage it for possible expansion.

If the practice has ownership of the property, then any deal concerning the continuing control and utilization of the site will be made concurrent with the employment relationship. The practice should carefully consider whether it wishes to maintain ownership of the property and sublease it to the hospital, or whether it should sell the property to the hospital. The better the deal for the hospital on the real estate end, the better negotiations may go for the physicians on the employment end.

Conclusion

These are just a few considerations that should be taken into account when evaluating and negotiating employment by a hospital or health system. Every practice, agreement, and circumstance is fact-specific, and it is critical to involve competent and experi-

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enced legal and financial healthcare industry experts. At the end of the day, both sides stand to gain from making a deal happen, but a deal that is not fair to both sides is not a deal that should be made. ●

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