This article is the third in a series exploring alternatives to the traditional private practice.

Most physicians join a hospital or health system for the economic security offered by an employment contract. These contracts typically run from one to three years — and a lot can change over that time.

Markets can change radically, and new payment models can emerge. Perhaps you are producing far more than your employed peers — but earning less. Or, maybe you’ve been contacted by a headhunter with an offer of a higher salary at another institution.

The good news is that an employment contract nearing its end can provide leverage. Ultimately, it’s easier and cheaper for a hospital to keep you — and even pay you more — than to go out and find your replacement. So, assuming that you’ve been a strong producer, you might be in an excellent position to restructure or renegotiate your contract. Here are a few tips for doing so:

• Understand “fair market value.” First, understand that the amount a hospital can pay you is limited by the legal principle of “fair market value.” This concept is firmly embedded in the anti-self referral and anti-kickback laws. That said, fair market value can fluctuate with the productivity of the doctor or the difficulty of attracting other physicians into a particular specialty.

• Understand your position. Are you in a highly competitive market? Is there a shortage in your specialty? Has the hospital had difficulty recruiting doctors to your area? Any of these things can provide more leverage — but, again, only within the parameters of fair market value. Decide what your acceptable range will be for each negotiable benefit — and be prepared to make counteroffers.

• Think it through. Before you renegotiate, think carefully about the consequences. If you renegotiate and don’t get what you’re looking for, you may have to settle for less or move out of the area if you have an enforceable non-compete clause in your contract.

• Make your case. Clearly establish the value that you bring to the table. Perhaps it’s increased productivity or the fact that your specialty is under-represented in your community. Likewise, point out any blatant unfairness in your compensation — for example, if your billings place you in the 90th percentile but you are only earning what someone in the 50th percentile is making. You might also be able to justify a raise if you can show that another hospital is offering you a substantially larger salary.

• Watch the particulars. Take a close look at not only the compensation arrangement, but also the termination clause, non-compete agreements and other restrictive covenants. Perhaps there’s some negotiation room there — or at least the opportunity to go back

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Know Your Retirement Saving Options

A recent study of physician savings habits concludes that physicians are falling well short of the savings necessary to enjoy a sound retirement.

Financial-services giant Fidelity Investments conducted the in-depth study of 5,100 physicians and concluded they were on track to replace only 56 percent of their income in retirement, contrasting sharply with Fidelity’s suggested income replacement goal of 71 percent.

When it comes to saving for retirement, physicians face some unique challenges. In many cases, substantial education debt drags docs down in the early years. Factor in residencies and other training requirements, and doctors typically don’t start earning significant incomes until they are into their 30s.

In fact, the Fidelity analysis finds that it takes the typical doctor until age 50 or later to be able to set aside 15 percent or more of annual income for retirement.

How Much (and Which Plan)?
With such a late start, physicians must often make substantially higher contributions during the 20 or 30 years they have before retirement. In fact, it is not rare for physicians to need to contribute more than 20-30 percent of pre-tax income toward retirement.

Of course, the right retirement plan can help focus your efforts. But which one? Ultimately, the plan you choose will depend on your employment status and take into account your current age, as well as when you hope to retire. The main options typically include:

- **W-2 employed physicians** (taxes are withheld by an employer) – A 401(k) is a popular choice here. For 2014, W-2 employees can contribute up to $17,500, or $23,000 for those age 50 or older.

- **Self-employed physicians** (and those who receive 1099 income as independent contractors) – These physicians have a few more options, such as a SIMPLE IRA, SEP-IRA, solo/individual 401(k), profit sharing plan and cash balance plan.

  For 2014, a 1099/self-employed physician may contribute $12,000 ($14,500 if age 50 or older) plus company matching contributions to a SIMPLE IRA. He or she may contribute the lesser of 25 percent of compensation or $52,000 to a SEP-IRA.

  In the case of a solo 401(k), a self-employed physician may contribute a combination of 100 percent of compensation up to $17,500, plus employer contributions up to 25 percent of compensation as defined by the plan. Typically, this is defined as net earnings from self-employment after deducting one-half your self-employment tax as well as contributions for yourself. Total contributions, not counting catch-up contributions totaling $5,500 if you are age 50 or older, cannot exceed $52,000 for 2014.

Begin With the End in Mind
Planning for a sound retirement requires some serious number crunching. Working with a competent financial advisor, you can compute different outcomes for different scenarios based on your age, investment returns, market volatility, contribution rate, etc. In addition, consider these steps:

- **Contribute more.** While some physicians do save up to the IRS limits each year, the Fidelity research shows that only 40 percent of physicians under 50 did so. As these physicians reach 50, their savings rates increase, and many max out their contributions.

  Note that all of the most popular tax-favored retirement accounts — 401(k)s, IRAs and 403(b)s — allow contributors age 50 or older to make special catch-up contributions, ranging from an extra $5,500 in a 401(k) to $1,000 in an IRA for 2014. It doesn’t sound like much, but every additional dollar you save will help boost your retirement nest egg.

- **Contribute even if you can’t deduct.** Remember that as long as you have earned income, you can still contribute to an IRA each year. Strategies also exist for converting nondeductible traditional IRA contributions to a Roth IRA to generate tax-free retirement income.

- **Avoid the “home run” mentality.** With such a late start, some physicians “swing for the fences” with their investments. The Fidelity analysis found that a high percentage of doctors in their 50s and 60s have particularly aggressive asset allocations, with substantial funds tied up in higher-risk equities. If that’s your case, get some guidance to adjust your asset allocation according to your risk profile and target retirement date.

- **Consider a non-qualified plan.** Once you have maxed out contributions to a tax-qualified retirement plan, you might want to look at a non-qualified plan. For example, a 457(b) plan will allow you to defer a much larger portion of compensation, and to defer taxes on the money until it is actually paid.

- **Look to cash balance plans.** A cash balance plan is a type of defined benefit plan that acts like a defined contribution plan [e.g., a 401(k)]. This type of plan may be useful for older physicians looking to catch up on their retirement savings, as they provide a way to enhance annual contributions.

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Our experienced accounting professionals can “run the numbers” and help you plan for a solid retirement. Contact our office for additional guidance.
Renegotiating Employment Contracts

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and address overly restrictive clauses that were in the original agreement.

• Understand where hospitals come from. Many hospitals base compensation for their employed physicians on volume (i.e., RVUs). Make sure any renegotiated contract clearly distinguishes loss of productivity that may not be in the physician’s control versus lower performance from lack of effort. Being certain on what basis the compensation can change over time is equally critical. Perhaps you can negotiate language that allows you to walk away if the hospital proposes a compensation change that is more than a pre-determined percent lower than your original compensation.

• Address future concerns. Payment reform is creating plenty of yet-to-be-addressed issues. For example, in 2015, the value-based payment modifier will apply to groups of 100 or more physicians who report through the same tax identification number — based on 2013 performance. If it is not spelled out in your current contract how this will be handled, this could become a point of negotiation.

Ultimately, it’s easier and cheaper for a hospital to keep you — and even pay you more — than to go out and find your replacement.

Likewise, Meaningful Use and Physician Quality Reporting System (PQRS) bonuses are often assigned to the hospital and not passed on to physicians. But what happens when penalties kick in for PQRS reporting failures?

• Get help. While a lawyer may not always be needed during the actual negotiations, an attorney familiar with physician contracts can point out pitfalls in the contract and raise concerns. It’s worth the time and expense to enlist a lawyer who knows the right questions to ask — and can bring clarity to the process so that future misunderstandings and litigation can be avoided.

Also be sure to take advantage of all the resources available to you. Start by checking with your state medical society. On a national level, the AMA offers an Annotated Model Physician-Hospital Employment Agreement free to members. And the American Academy of Family Physicians provides an array of guidance to members on its website (http://aafp.org).

As you evaluate employment contracts, you may find the guidance of an experienced accounting professional helpful. Contact our office today to learn more.

Antitrust Risks in Physician-Hospital Mergers

As more providers make the leap to employed status, scrutiny of the financial relationships between physicians and their hospital employers has increased dramatically. Consider some of these steps you can take to minimize the risk of running afoul of fraud and abuse statutes:

• Understand the law. Minimize risk by learning about all of the laws that apply in your specific case — including anti-kickback laws, the Stark statutes and the False Claims Act. You’ll find a comprehensive overview of these regulations on The Office of the Inspector General’s website (http://oig.hhs.gov).

• Understand the entity. Health systems may employ physicians through separately established corporations.

In other cases, physicians may be employed by the same entity that holds the hospital license and tax ID number. Of course, different entity structures trigger different compliance concerns.

For example, additional restrictions may apply when a physician is employed directly by the hospital — such as the prohibition against compensation for “incident to” services provided by hospital personnel. But if employment is through a separate practice of the hospital, employed physicians may be eligible to receive “incident to” revenue as part of a productivity-based compensation arrangement.

• Confirm Stark Act and safe harbor compliance. In general, a physician contract must provide for compensation that is set in advance, is consistent with fair market value and is not determined in a manner that takes into account the volume or value of referrals or other business generated between the parties. Additional requirements may vary depending on the safe harbor or Stark exception being utilized.

• Get sign-off. Someone from the hospital compliance department or committee should specifically sign off on any financial arrangement between a hospital and a physician. This includes employment contracts, management agreements and medical directorships. In situations where a substantially full-time physician employee has the right to earn outside income, even greater levels of review and approval should be considered to minimize risk.
Understanding Key EHR Contract Terms

When purchasing an electronic health record system, you are ultimately entering into a long-term relationship that will completely change your practice workflow. It is critical, therefore, to understand all the elements of your EHR contract.

The Office of the National Coordinator (ONC) for Health Information Technology at the Department of Health and Human Services (HHS) has released a guide for healthcare providers that helps explain some of the technical jargon and key contract terminology, including these terms:

- **Limitations of liability** – This is a common business practice designed to place a financial cap on damages against the vendor and/or EHR technology developer should a claim arise. Limitations may also exclude certain types of damages.

- **Dispute resolution** – Another common element of most contracts, the dispute resolution provisions of an EHR contract outline how a dispute between the vendor and physician is to be settled (typically by litigation or arbitration).

- **Termination and wind down** – This critical area addresses how the provider and the vendor will handle transitioning between EHR technologies (i.e., when the provider wants to switch to a new EHR vendor). This contract language should very specifically spell out the procedure for terminating and winding down the relationship so that providers are ensured access to patient data during the transition.

In addition, you'll want to see language that ensures that your EHR is certified if you are looking to achieve meaningful use incentives. Likewise, make sure that your EHR meets all of the regulatory requirements for privacy and security.

The ONC further encourages practitioners to consult an attorney experienced with health IT contracts for assistance in contract negotiations.