Advanced Health Practitioners: Structuring Employment Agreements for Physician Assistants, Nurse Practitioners and More

THURSDAY, SEPTEMBER 8, 2016
1pm Eastern    |    12pm Central   |   11am Mountain    |    10am Pacific

Today’s faculty features:

Ericka L. Adler, Partner, Roetzel & Andress, Chicago
Holly Carnell, Esq., McGuireWoods, Chicago

The audio portion of the conference may be accessed via the telephone or by using your computer’s speakers. Please refer to the instructions emailed to registrants for additional information. If you have any questions, please contact Customer Service at 1-800-926-7926 ext. 10.
Tips for Optimal Quality

Sound Quality
If you are listening via your computer speakers, please note that the quality of your sound will vary depending on the speed and quality of your internet connection.

If the sound quality is not satisfactory, you may listen via the phone: dial 1-866-819-0113 and enter your PIN when prompted. Otherwise, please send us a chat or e-mail sound@straffordpub.com immediately so we can address the problem.

If you dialed in and have any difficulties during the call, press *0 for assistance.

Viewing Quality
To maximize your screen, press the F11 key on your keyboard. To exit full screen, press the F11 key again.
Continuing Education Credits

In order for us to process your continuing education credit, you must confirm your participation in this webinar by completing and submitting the Attendance Affirmation/Evaluation after the webinar.

A link to the Attendance Affirmation/Evaluation will be in the thank you email that you will receive immediately following the program.

For additional information about continuing education, call us at 1-800-926-7926 ext. 35.
Advanced Practice Clinicians - Employment Agreements

September 8, 2016
Summary

I. Trends
II. Role of APCs in the U.S. Healthcare System
III. Legal Considerations
IV. Compensation
V. Key Employment Agreement Provisions
I. Trends
I. Trends

- **Affordable Care Act (“ACA”)**
  - Since its passage in 2010 – nearly 18 million Americans have gained health insurance coverage
  - More than 58 million Americans live in areas indicated as having primary-care physician shortages
  - Increased demand for physicians’ services

- **Shortage of Primary-Care Physicians**
  - Over the next decade, hundreds of thousands of new patients will gain access to medical care and *one-third of primary care doctors will retire*

- **Concern from Medical Societies**
  - Some medical societies have concern about states’ full practice legislation—arguing that NPs are not able to provide the same quality of care as a licensed physician
  - Physicians argue that though NPs and MDs are not interchangeable, they can work together in a team
I. Trends

- According to the Government Accountability Office, non-physician practitioners are the fastest growing division of the primary health care industry

- The Emergence of New Health Care Delivery Models
  - Emphasis on low-cost, high-quality care
  - The industry focuses on integrated, team-based delivery of care
  - APC now play an integral role in outpatient settings as a way to improve access, lower the cost, decrease wait times, and improve the quality of health care
II. Role of APCs in the U.S. Healthcare System
II. Role of APCs in U.S. Health System

- Nurse Practitioners and Physician Assistants perform similar functions, but there are some subtle distinctions between these two types of health care professionals:

- **Nurse Practitioners** (NPs)
  
  - **Training and Education**: NPs are registered nurses, licensed and certified through state nursing boards; advances the bachelor's degree to a master’s or doctoral degree
  
  - **Supervision**: NPs may work independently or in collaboration with a physician (depending upon state laws)
  
  - **Licensure**: more than 222,000 currently licensed in the U.S.
II. Role of APCs in U.S. Health System-Nurse Practitioners

- **Privileges**: 49.9% of NPs hold hospital privileges; 11.3% have long term care privileges
- **Prescriptions**: 95.2% of NPs prescribe medications, and those in full-time practice write an average of 22 prescriptions per day. NPs hold prescriptive privileges, including controlled substances in all 50 states and D.C.
- **Average Years of Practice**: 12 years
- **Average Age**: 49 years

** Data from American Association of Nurse Practitioners
II. APCs In U.S. Health System-NP

NP Certification

- Acute Care
- Adult+
- Geront + PC
- Family
- Gerontology
- Neonatal
II. APCs In U.S. Health System-PA

- **Physician Assistants** (“PAs”)
  - Approximately 80,000 PAs practicing in the United States
  - **Training and Education**: PAs must complete an accredited PA educational program – earning a master’s degree – and pass the national exam
  - **Supervision**: PAs work under physician supervision
  - **Prescriptions**: Those in full-time practice write an average of 50 prescriptions per week. PAs hold prescriptive privileges, including controlled substances in 49 states and D.C. (not Kentucky)
  - **Average Age**: 37 years
APCs In U.S. Health System-PA

PA Primary Specialty Areas

- Primary
- Surgical
- Other
- ER
- Internal Med
- Pediatric
APCs In U.S. Health System-PA

PA Practice Setting

- SS Group
- Inpatient
- Solo
- ER
- MS Group
- Outpatient
III. Legal Considerations
III. Legal Considerations

- **Scope of Practice**
  - 1. Nurse Practitioners
  - 2. Physician Assistants

- **Stark Law**
  - Pertains only to physician referrals under the Federal health care programs
  - Does not pertain to APCs such as NPs or PAs
  - New exception for APC’s recruitment

- **Anti-Kickback Statute (“AKS”)**
  - Affects anyone engaging in business under the Federal health care program (including APCS such as NPs or PAs)
  - Productivity Bonus Could Implicate the AKS
Scope of Practice: Nurse Practitioners

- 21 states and Washington DC have “full practice” status: NPs can independently:
  - Assess
  - Diagnose
  - Interpret Diagnostic Tests
  - Prescribe Medications
  - Open A Clinic
Scope of Practice: Nurse Practitioners

- **FULL**
  NPs can prescribe, diagnose, and treat patients without physician oversight.

- **REDUCED**
  NPs can diagnose and treat patients, but need physician oversight to prescribe medications.

- **RESTRICTED**
  NPs need physician oversight to prescribe, diagnose, and treat patients.
Scope of Practice: Nurse Practitioners

- **Prescriptive Authority**
  - Florida is the only state that does not allow NPs to prescribe controlled substances, even with a collaborative agreement with a physician
  - 8 states allow NPs to prescribe schedule III, IV, and V controlled substances
  - 41 states and Washington D.C. allow NPs to prescribe schedule II, III, IV, and V controlled substances
Scope of Practice: Nurse Practitioners

- **Supervision of Prescriptive**
  - 13 states permit NPs to prescribe (including controlled substances) *independent* of any physician involvement
  - 28 states permit NPs to prescribe (including controlled substances) with some degree of physician involvement
  - 9 states permit NPs to prescribe (excluding controlled substances) with some degree of physician involvement
Scope of Practice: Nurse Practitioners

- Most states require that a specific supervision or collaborative agreement be filed and approved with the state. The only states that do not require this: Alaska, Arizona, Colorado, DC, Idaho, Iowa, Maine, Montana, Nevada, New Hampshire, New Mexico, north Dakota, Oregon, Rhode Island, Vermont, Washington and Wyoming.

- Contents of Agreement:
  - Scope of practice and the services the APC is approved to provide
  - How the quality of the APC’s performance will be evaluated and reviewed and the designated collaborating physician
  - Every state’s requirements should be reviewed to meet requirements

- Often integrated into an Employment Agreement.
Scope of Practice: Physician Assistants

- Supervision
  - Services Agreements set the parameters of the PA and supervising-physician’s relationship
    - 34 states require the supervising physicians and PA to establish a written agreement defining and outlining the PA’s scope of practice
  - 11 states have a specific list of tasks that physicians are permitted to delegate to PAs, including:
    - Taking patient histories
    - Performing physical exams
    - Ordering laboratory tests
    - Creating and setting patient treatment plans
    - Prescribing medications
    - Providing patient education
Scope of Practice: Physician Assistants

- **Supervision**
  - 25 states have specific requirements as to how often a supervising-physician must be on-site
    - Frequency of site visits
    - Distance or travel time restrictions
    - Example: Colorado requires the supervising physician to be either onsite or readily-available by telecommunication
    - Required approval by state medical boards of physician’s plans
  - 24 states require the supervising-physician’s signature on a specific percentage of the PAs patient charts
  - Permissible Ratio of PAs to Supervising-Physician
    - 16 states permit physicians to supervise up to four (4) PAs
    - 13 states permit physicians to supervise up to two (2) or three (3) PAs
    - 11 states have no restrictions
Scope of Practice: Physician Assistants

- **Prescriptive Authority**
  - All states allow PAs to prescribe medication, but 9 states place some limitations on this authority regarding the types of medications that PAs are allowed to prescribe
  - PAs are not authorized to prescribe Schedule II medications in:  
    - Arkansas
    - Georgia
    - Maine
    - Missouri
    - Virginia
  - PAs are not authorized to prescribe Schedule II depressants in **Iowa**
  - PAs are not authorized to prescribe controlled substances, general anesthetics, and radiographic contrast materials in **Florida**
  - PAs are not authorized to *prescribe or administer* scheduled drugs in **Kentucky**
  - Board defines the scope of prescriptions that a PA may prescribe in **Oklahoma**
Scope of Practice: Physician Assistants

- Most states require that a specific supervision or collaborative agreement be filed and approved with the state. The only states that do not require this: Colorado (registration required), Delaware, Florida, Hawaii, Iowa, Michigan (except for RX authority and limitations on practice), New Jersey and New York.

- Contents of Agreement:
  - Scope of practice and the services the APC is approved to provide
  - How the quality of the APC’s performance will be evaluated and reviewed and the designated supervising physician
  - Every state’s requirements should be reviewed to meet requirements

- Often integrated into an Employment Agreement.
Stark Law

- The Stark Law prohibits physician referrals (unless an exception applies), but does not regulate non-physician referrals.
- Before 2015: an exception only for “physician” recruitment
- Effective as of January 1, 2016: New Stark Law exception expands recruitment exception and permits remuneration to recruit non-physician practitioners
- Hospitals, federally-qualified health centers, or rural health clinics can compensate, or provide remuneration, to physicians so that the physicians, or physician organizations, can recruit primary care non-physician providers
- CMS recognizes the limited supply of primary care physicians, especially in rural communities, and the need to increase access to primary care – the root of the evolving health care delivery models
Stark Law

- Final Rule: Assistance to Compensate a Non-Physician Practitioner, 42 C.F.R § 411.357(x)

- Requirement to fall under Exception:
  - Arrangement set out in writing and signed by hospital, physician, and APC
  - Substantially all of the services provided by the non-physician provider must be primary care or mental health services
  - Remuneration provided to the physician shall not exceed 50% of the aggregate compensation paid to the non-physician provider
  - The non-physician provider must not have practiced in the hospital’s applicable geographical area within one year
  - Arrangement cannot be conditioned on referrals of physician or non-physician provider
  - The compensation, signing bonus, and bonuses provided must not exceed the fair market value of the services that the non-physician provider will provide
  - Applicable hospitals and providers may provide recruitment remuneration to the same physician only once every three (3) years (there are exceptions)
IV. Compensation
Compensation of PAs (Forbes 2016)
Median:$95,000 Mean:$98,387

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $40,000</td>
<td>3.1%</td>
</tr>
<tr>
<td>$40,001-$60,000</td>
<td>4.5%</td>
</tr>
<tr>
<td>$60,001-$80,000</td>
<td>13.2%</td>
</tr>
<tr>
<td>$80,001-$100,000</td>
<td>35.1%</td>
</tr>
<tr>
<td>$100,001-$120,000</td>
<td>24.6%</td>
</tr>
<tr>
<td>120,001-$140,000</td>
<td>10.8%</td>
</tr>
<tr>
<td>$140,001-$160,000</td>
<td>5.2%</td>
</tr>
<tr>
<td>Over $160,000</td>
<td>3.5%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>
Annual mean wage of nurse practitioners, by state, May 2014

Annual mean wage
- $22,880 - $90,490
- $91,000 - $93,220
- $93,230 - $100,490
- $100,530 - $115,870
Compensation

- **Productivity and Incentive Bonuses**
  - Both APCs and their employers should have an understanding as to what the APC actually brings to the practice
    - Track the top five (5) billing codes and the applicable reimbursement rate in order to ascertain the revenue each APC generates
  - Adding APCs can add the much-needed depth to a primary care practice and generate revenue
  - Productivity and incentive bonuses, based on objective factors, can ensure and motivate a APC’s productivity to ensure a return on investment
  - Bonus formulas can be based on: productivity, quality, profit, and patient satisfaction
  - Timing of the bonus (i.e., after six (6) months of employment)
Billing and Profit Sharing Restrictions

- PAs and NPs are permitted to bill their evaluation and management codes incident to a physician
- Physicians in a group may share the profits for services “incident-to their services (i.e., if a physician performs any portion of a service or a visit, the entire combined services, even if majority are performed by a non-physician can be billed at the physician fee schedule)
- Services delivered by NPs and PAs are billed under their own Medicare provider numbers – and the revenues are not considered “incident-to” a physicians’ services – therefore may not be attributed directly to the physician
Factors That Influence Provider Compensation

- Geographic Location of Practice
- Population/Demographics
- Size of Group
- Productivity of Group or Hospital
- Specialty
## Models of Provider Compensation

<table>
<thead>
<tr>
<th>MODEL</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Salary</td>
<td>• Easy to administer</td>
<td>• Discourages entrepreneurial spirit</td>
</tr>
<tr>
<td>Base Salary + Bonus</td>
<td>• Fosters a sense of security</td>
<td>• Large percentage of income based on “subjective” standards</td>
</tr>
<tr>
<td></td>
<td>• Allows providers to increase income through performance</td>
<td></td>
</tr>
<tr>
<td>Productivity (wRVUs or collections)</td>
<td>• Encourages peak performance</td>
<td>• Requires substantial accounting management</td>
</tr>
<tr>
<td></td>
<td>• Rewards professional effort</td>
<td>• Encourages overutilization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discourages activities not directly related to patient care</td>
</tr>
</tbody>
</table>
Trends in Hospital Compensation

- Trend for payment in exchange for call coverage
- Other?
Fringe Benefits

Health, Life and Disability Insurance

* Negotiate
  * Cost Sharing - % of Contribution
  * Covered Individuals – Employee + Spouse, Children

Retirement Benefit

* 401 (k) Plans
* 403 (b) Plans
* Profit Sharing

Dues, Subscriptions and Education

* Negotiate
  * Tuition and Travel Expenses
  * Reimbursement Amount

Miscellaneous Reimbursement

* Negotiate
  * Moving Expense or Reimbursement
  * Cellular Phone
  * Automobile Allowance
V. Key Employment Agreement Provisions
Preconditions to Employment

- Licensure in state,
- DEA registration (state and federal)
- Enrolled with Medicare/Medicaid or particular payors
- Malpractice Insurance in place
- Clinical privileges

**Practice Alert:**

The representation that the pre-conditions are satisfied should apply as of the date the employment commences and not the effective date of the Agreement. Providers often sign the Employment Agreement months before the start date.
Job Description

Duties and Responsibilities

- What is exact job description? Is it accurate?
  a) Hours and schedule to be worked/call to be taken
  b) Attendance at meetings
  c) Perform certain marketing tasks
  d) Completion and timely submission of medical records
  e) Follow all rules and regulations

Practice Alert:
Make sure all references to rules and regulations require that they be in writing and actually provided to the provider. The employer should be sure to provide copies of all referenced policies/handbooks to providers that might impact provider understanding of the job. Provider’s counsel should make sure copies are requested and obtained.
Location of Work

Where will work be performed?

- Provider perspective: try to include exact locations and limit Employer’s ability to send provider anywhere that expands covenant or requires a commute.

- Employer perspective: maintain ability to send provider anywhere, protect covenant area by leaving Employer’s rights open.

Special Considerations:

- Watch out for sweeping language that allows the provider to be sent “anywhere designated by the Employer”

- Consider mutual agreement for new/future locations to which the employer may want to send the provider
Location of Work

- Limit locations by mileage, if appropriate (e.g. 20 miles)
- Remember that location of services can impact covenant
- Example: Provider shall perform services at such locations as may be designated by Employer from time to time; provided, however, Employer may not require provider to render services at a location that is more than twenty (20) miles from [DESIGNATED HOSPITAL OR OFFICE] without provider’s agreement.”
Call Coverage

- Specify weekend, evening and holiday call coverage, if applicable.
- Call should be spelled out or should be “equal” or “equitable” among similar providers. Sometimes seniority plays a role but equal is most common.
- Does the provider have any say in the call schedule?
- Is there pay for call?
- Differentiate between group call and call that may be required by hospital
Call Coverage

Drafting Consideration: Be specific but allow the parties flexibility:

“Employer and Provider will cooperate with other providers in the group in developing a call schedule that is reasonably equal, taking into account the scheduling needs of Employer and the professional sharing call.”
Exclusivity

- Clinical Services: Patient care/medical services
  - Are outside professional services allowed?
  - Impact on malpractice insurance?
  - Consent required?
  - Ability to retain income?
  - Carve-out from covenant may be needed

- Non-patient care services that use provider’s knowledge and experience
  - May include expert witness testimony, lecturing, writing, teaching, etc.
  - Is consent required?
  - Can income be retained? Shared?
  - Separate malpractice coverage?
Exclusivity

“Provider further agrees that Provider shall provide exclusive services on behalf of Employer’s patients and that all compensation received by Employer from all professional sources, including, but not limited to, salaries or income from the practice of medicine, shall be delivered to Employer and deposited in Employer’s account and shall be treated as income of Employer. Notwithstanding the foregoing, Provider shall be permitted to engage in indirect medical-related activities that do not involve the delivery of patient care services such as teaching, lecturing, publishing and expert witness and other legal consultations (“Permitted Activities”) as long as the Permitted Activities do not conflict or interfere with the obligations of Provider to Employer hereunder. Any income that may be earned by Provider from the Permitted Activities may be retained by the Provider.”
Exclusivity

Drafting Considerations:

- Make the process of how a provider gets approval clear via policy
- Clarify the difference between clinical and non-clinical outside services are handled, if applicable
- Clarify what happens to income if approval is granted. In some cases, employment agreements have language that require income earned by a provider to be turned over to the Employer in a different section of the document. This conflict needs to be corrected.
- Make any expectations known: malpractice insurance, credit to Employer on published materials, no interference with work, etc.
Term of Agreement

- Finite Period or Self-Perpetuating (Evergreen)
- Time period linked to Recruitment Agreement/Partnership
- Notice to Terminate Without Cause
  - Applies during first year?
  - What time period? Is it the same for both parties? (Avg. 60 days)
  - Payment during notice period
    - Production based compensation
Term of Agreement

For-cause events:

- Censored or sanctioned by a professional society
- Suspension or revocation of license, DEA registration
- Loss of privileges
- Conviction of crime (Note: “arrest” or “commission” language)
- Bankruptcy or assignment for the benefit of creditors
- Inability to obtain or maintain professional liability insurance
- Substance/alcohol abuse
- General neglect of professional responsibility
- Material breach of agreement; right to cure (one-time only?)
Term of Agreement

Practice Note: Should an employer allow a provider a right to cure an alleged breach?

“Provider’s employment may be terminated upon thirty (30) days’ prior written notice, subject to the opportunity to cure the alleged breach to the Employer’s reasonable satisfaction during the notice period.”

Less clear grounds for termination:

- Employer goes bankrupt or reorganization/out of business, loses hospital contract. Note to Provider counsel: Try to require notice to be provided to provider, watch that this provision is not “for-cause” that would trigger tail obligation.
- Violation of the “canons of medical ethics”
- Subjective grounds for termination: reputation, getting along with others, etc.
- Violation of rules/regulations (right to cure?)
- Note: Employer should use good faith/reasonableness.
Termination Considerations

- Accrued Wages/PTO
- Accrued Bonus (prorated bonus payable upon termination?)
- Unused PTO
- Patient Records and Right to Notify
- Accounts Receivable (“run out” in production model)
- Forfeiture of unvested retirement benefits
- Severance (if owner)
Restrictive Covenants

- Generally enforceable in most states if reasonable
  - Duration
  - Geographic Scope
  - Activity Restriction
  - “Clean Hands Doctrine”

- Enforcement Provisions
  - Liquidated Damages
  - Injunctive Relief

- Case Law
  - Every state different
    - Work for 2 years before covenant enforceable unless consideration paid
Restrictive Covenants

Questions to Consider:

- Should covenant apply if termination without cause by Employer, or for cause by Provider?
- What to do with extremely large covenant area—challenge it?
- Who should pay the legal fees for covenant enforcement?
Non-Solicitation

- Prevent terminated provider from soliciting referral sources, staff and patients
- Reasonable in time and duration
- Avoid language that prevents the provider from treating a patient. Patients always have the right to choose their own provider
- Cannot generally charge more than law allows to transfer records (HIPAA)
- General advertisements/mailing to postal codes generally OK
Non-Disparagement

- These provisions prevent bad-mouthing of the other party following termination
- Can protect discussion of internal matters with third parties during employment as well (disputes, etc.)

Example: “Provider and Employer agree that during the term of Provider’s employment by Employer, and at all times subsequent thereto, Provider and Employer shall maintain a professional relationship and shall conduct themselves with office staff, Hospital personnel and other third parties with whom they come into contact, whether in a direct or indirect professional capacity, in a professional manner and specifically agree not to disparage one another or otherwise discuss practice-related internal matters of Employer of any kind with any third party. Provider hereby agrees that this covenant shall be in force during the term of this Agreement and forever subsequent thereto.”
Miscellaneous

Entire Agreement Provision

- An “entire agreement” provision means that everything the parties have discussed should be in the document
- No oral discussions, e-mails, side letters, etc., will be applicable unless properly included in the document itself

Letter of Intent

- Negotiable?
- Binding?
Malpractice Insurance

- **Occurrence Coverage** - Preferred by providers because the purchase of extended reporting endorsement ("tail") is not required at the end of the policy.

- **Claims Made Coverage** - The most common type of insurance coverage offered by employers. Tail coverage is required.
Tail Coverage

- Also known as, “Extended Reporting Endorsement”
- Tail provides “seamless” coverage for alleged acts of malpractice that occurred while a claims made policy was in effect and for which coverage has expired
- Must be purchased within 60-90 days of termination, depending on the jurisdiction
- Tails is most frequently required upon:
  - Separation from a practice due to relocation, termination, or buy-out of provider-shareholder
  - Switching from a “claims made policy” to an “occurrence policy”

**CAUTION:** Tail typically costs between 150% to 200% of the price of a mature claims-made policy
Sample Contractual Language

**Professional Liability Insurance.** Employee shall provide Employer with proof of professional liability insurance coverage for the period of time before he or she began work for Employer. During the term of this Agreement, Employer shall provide Employee with *claims made* medical malpractice coverage of equal coverage to other provider-employees of Employer. Upon the termination of this Agreement for whatever cause and cessation of all work for Employer, Employee shall procure *tail* insurance to cover Employer and Employee for Employee activities under this Agreement. Instead of “tail” insurance, Employee may obtain professional liability insurance that covers prior acts (*Nose Coverage*) to the effective date of this Agreement.

If the insurance Employer provides required a surplus deposit, an amount equal to such deposit shall be repaid to Employer. If Employee fails or refuses to pay for such tail coverage or prior acts coverage or the surplus deposit, then in such event, Employee authorizes and directs Employer to withhold from his or her last paycheck any monies to purchase such insurance or to reimburse such deposit.
Nose Coverage

- Also known as “retroactive coverage” or “prior acts coverage”
- Does the same thing as tail coverage, but you don’t pay a separate premium for it *(Refer to specific carrier)*
- Nose coverage must be purchased at the *same* time “claims made” coverage is purchased from a *new* carrier
- Nose coverage covers alleged acts of malpractice or omissions that occurred before the beginning of the new insurance relationship, but for which *no* claim has been made
Negotiation Strategy

- Employer pays full cost of tail (RARE)
- Provider pays full cost of tail
- Cost of tail is divided evenly between the employer and the provider
- Tail is paid by the employer if termination is without cause or Provider leaves the practice for cause
- Employer pays full cost of tail after provider works X number of consecutive years
- Provider pays full cost of tail MOST COMMON
Paid Time Off (PTO)

PTO
- Vacation = Average 15 days 1st year, 20 days 2nd & subsequent years
- Sick Time = Average 5 days
- CME = Average 5 days

Sample Contractual Language:
Employee agrees that he/she shall not be absent from the offices of Employer for more than ten (10) consecutive working days without Employer’s prior written consent. Employee agrees to coordinate with Employer his/her time off for vacation and continuing medical education and shall promptly notify Employer when he/she is sick. Written requests for time off must be given to Employer within a minimum of ten (10) days advance notice. Priority for time off will be based upon the seniority of employment of provider-employees with Employer.

Caution: Don’t get over zealous with PTO. Maybe perceived as “difficult” or “high-maintenance.”
PTO - Continued

- Disability

*Sample Contractual Language:*

If Employee is unable to perform his/her duties hereunder because of a physical, emotional, and/or psychological condition for a period of more than thirty (30) days during any twelve (12) month period, the employment of Employee shall, thereupon, *terminate.*

Employee shall be paid to date of such disability, plus any accrued vacation and sick leave. Employment may be reinstated at the sole discretion of the Board of Directors of Employer.

If Employee suffers a *partial* disability which restricts him/her from providing the same services that were provided before such disability, then in such event Employer agrees that Employee may continue to work for Employer with the understanding that the compensation shall be *modified* so that it is commensurate with the services provided by Employee in relation to his/her productivity and profitability.

- Maternity

  - Average PTO for Maternity = 4/6 weeks
  - Family Medical Leave Act (FMLA) up to 12 weeks job-protected *unpaid* medical leave
Assignment Provisions

- 2016: Year of “Merger-Mania”

- Consent to Assign Provisions: Some employment agreements contain provisions that the contract or agreement may not be assigned without the consent of the parties
  - Slow-down the transaction process

- Mergers could be a vehicle to maneuver around consents to assign
  - Some states provide that a merger is not legally an “assignment” – therefore does not require consent
Indemnification

- Common to see indemnification for breach of representations and warranties, i.e. no other agreements that conflict with agreement.
  - Mutuality?
THE END

Ericka L. Adler
Roetzel & Andress
312-582-1602
eadler@ralaw.com

Holly Carnell
McGuire Woods
312-849-3687
hcarnell@mcguirewoods.com