The Employment Agreement—Part 2

A financial and operational assessment are vital.

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This article is the second of three parts.

Any major investment requires careful assessment and due diligence. Choosing where to invest your professional time and career is no different. Part I of this series discussed the preliminary steps of conducting a self-assessment, assembling a personal advisory team, and performing a culture and value assessment of the organizations physicians are considering for employment. This article covers the assessment of financial data and practice operations.

Financial Assessment

Medical schools teach how to take a patient history and physical examination; they don't teach how to read a profit and loss statement. Therefore, the best advice for this part of the employment process is to enlist the support of an accountant. A good accountant acts like a pathology lab—you send off information and you get back a usable interpretation of that information.

The timing for requesting financial data from a potential employer is critical. Do not expect a practice or hospital to provide such material until both parties have expressed mutual, serious interest in pursuing an employment relationship. Once both parties' interest has been established, the extent to which a potential employer fulfills a recruit's data request says a lot about trust and transparency. Many organizations will request that a confidentiality or nondisclosure agreement be signed before releasing the data.

Figure 1 presents an exhaustive checklist of relevant financial information. Although it is highly unlikely that anyone will successfully acquire every item listed, pursue as many items as possible. If you foresee difficulties obtaining the information, ask your accountant to contact the practice or hospital's accountant (or other appropriate financial manager) to request or discuss these items. Often, more information will be divulged if a recruit asks his or her advisor to have the conversation directly,

Financial Statements: Profit and Loss and Balance Sheet

The balance sheet and profit and loss statement contain a significant amount of information about the organization's financial management and efficiency. Is practice revenue expanding or receding? How about expenses? Does the balance sheet indicate recent and significant new assets or liabilities such as real estate or equipment? Request this information for a range of at least three years, five if the practice or hospital will oblige. If the practice has cost centers such as physical therapy, imaging, an ambulatory surgery center, or a medical spa, ask for reports detailing the discrete income and expenses for each.

These reports are the most important to pursue, and ironically, the most likely to raise senior physicians' hackles in a private practice setting. An accountant-to-accountant conversation may help smooth this over. With some careful data sleuthing and good questions, your accountant can liberate essential expense data and explain the nuances of the balance sheet, educating you about assets and liabilities and what they mean to the organization's solvency and your future.

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Operating Overhead

Operating overhead (also known as expense ratio) is the ratio of expenses to revenues, for the entire organization as well as by cost center, when relevant. The data are derived from the practice's profit and loss statement. It's a key benchmark for how well the practice is managed, and it's important to examine the trend of

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this ratio over the last several years.

In most practices, operating overhead will hover slightly above or below 50%. Certain specialties, especially in surgical fields, often have ratios well below that. On the other hand, some primary care practices, where patient encounters produce less revenue than operating procedures and require a higher number of employees to support patient care, may see expense ratios above 55%.

Accounts Receivable Metrics and Report

The efficiency with which a practice collects its accounts receivable is a prime benchmark for the general efficiency of its management and per-

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	All Organizations
☐	*Profit and loss statements* for three years, including percent-of-total for revenues and expenses, budget-to-actual, and any cost center allocations
☐	*Balance sheets* for three years
☐	*Capital reserves* data and policy, if any
☐	*Operating and capital budgets*, with a discussion of pertinent assumptions
☐	*Projected major capital projects* and costs over the next three to five years
☐	*Debt position:* This includes the history for the last three to five years, short- and long-term debt, purpose for each loan, future debt forecasts, and repayment schedules
☐	*A/R metrics* for one to three years: These include days in A/R, percent greater than 90 days, and net collection ratio
☐	*Current A/R report* with insurance receivables and patient receivables shown separately, and including the categories 30, 60, 90, 120, 120+, and total
☐	*Current credit balance report*, showing the total amount owed to patients and insurers, and the policy for refunding patients and insurers
☐	*Payer mix* for the last three to five years
☐	*Existing and/or contemplated risk contracts.* These include any value-based, bundled payment, and full or partial risk arrangements. Ask for payer name and type of plan, details about shared savings or upside/downside risk, payment and bonus terms, reimbursement and/or bundled payment amounts, services covered (described by CPT and/or DRG), number of covered lives, expiration/renewal dates, termination provisions, and billing procedures.
☐	*Productivity report* (also known as CPT frequency report) for the last year, by practice or department
☐	*Realistic production scenarios* for the first one to three years, and their impact on the first few years of compensation
☐	*Tax returns* of the corporation or partnership for the last three years—including copies of any audits, if relevant
☐	*Outside income (moonlighting) policy:* Can you be a telehealth physician during off hours? Start a business? Are there any restrictions?
☐	*Malpractice insurance coverage* amounts
	Private Practices
☐	*Shareholder loans and policy* for all outstanding loans, purposes, and amounts
☐	*Retirement policy,* including the "pull back" policy and how it's funded
☐	*Current income distribution plan/model* and all previous plans and reasons for changes: This is extraordinarily important for any recruit to ask about because it affects budgeting, strategic decisions, and a recruit's future earning potential.

Figure 1: Checklist of financial information. Few recruits will be provided this much data, but an accountant can often help optimize the amount of information delivered. A/R, accounts receivable. A/R, accounts receivable.

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sonnel. There are two areas to pursue here: metrics and the accounts receivable (A/R) report. The following standard metrics are reviewed monthly or quarterly by physicians and administrators in any well-run practice, and, therefore, should be easy to produce. If they are not, or you are told that the practice leaders don't review these metrics, beware: it can be a sign of poor management. The A/R report is examined in Table 1, with details about how it should be generated.

Given the complexities of coding, billing, and revenue cycle management, many practices and hospitals do a less than adequate job of collecting the money owed them. Depending on the compensation agreement, this can directly impact a physician's pocket. It is best to go into the negotiation about compensation with eyes wide open.

Off–Balance Sheet Liabilities

Off–balance sheet liabilities include lease obligations, guarantees of others' commitments or obligations (such as bank debts), possible or existing litigation, and Medicare or malpractice audit potential. You won't find these on the financial statements; however, they are important pieces of information in an organization's financial and risk management profile.

For example, is the practice in the midst of an audit? If the audit goes poorly, the practice may have to pay back hundreds of thousands of dollars and enter into a costly agreement for monitoring of its coding and billing for years to come. By accepting an employment offer in such a scenario, you are making the practice's problems your problems.

Separately Owned Assets

It's not uncommon for the practice's office real estate or ambulatory surgery center to be owned separately by one of the physicians (or by a trust for his or her children) and leased to or contracted by the practice. In such cases, verify that the lease payments being made by the practice are at a fair market rate. If you are expected to buy in to a real estate entity, examine the basis on which such as purchase is priced.

Buy-In and Buy-Out Formula

Understanding the buy-in and buy-out formula helps assess how smoothly and sensibly the practice is managed financially. Ask how the last several new physicians were treated regarding the buy-in and whether there is a commensurate and compatible method for buying out partners. Often, practices show a "bipolar" pattern in which some of the more senior physicians are bought out of the practice according to a financial scenario that is not continued for the remaining physicians.

Retirement Policy

If there is no written retirement policy to review, ask for details about the last physician retirement, as well as whether a senior partner is considering retirement in the next few years. Of imminent concern for a recruit is whether and to what extent there is a "pull back" option, which allows a senior physician to, instead of retiring, gradually pull back his or her duties and patient volume. This can become a sore spot for other partners because the gradually retiring partner continues to take up space and staff but is producing an ever-decreasing amount of revenue. Further, the gradually retiring partner typically steps down or out of weekend call responsibilities, with the expectation that the new physician will take up the slack. In short, you are part of the retirement plan.

Operational Assessment

Efficient operations, capable management, and productive personnel are positive signs that an organization is professionally managed. One of the best ways to start an operational assessment is to perform the following reconnaissance:

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TABLE 1:

The Accounts Receivable Report and How It Should Be Generated

Metric	Equation	Acceptable Range
Days in receivable: the average number of days it takes for a claim to get paid	Average daily receivables/365	≤ 20–25 days
Percentage of A/R greater than days old	Sum of the 90, 120, and 120+ columns on the A/R report, including both patient and insurance	≤ 15%
Net collection ratio: the percent of collectible receivables that have been collected; measures the effectiveness of the revenue cycle	Total collections / [total charges – contractual adjustments]	≥ 98%

A/R, accounts receivable.

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1) Show up unannounced during office hours and take a seat in the waiting room.

2) Look around at the facility. Is it clean and modern, or does it look very old?

3) Look at the magazines in the waiting area. If they are years out of date, you have your first clue how patients are treated here.

4) Watch the staff interact with patients. Are the staff members friendly, or are they more like 1950s' Russian bureaucrats?

5) Pull out your mobile device and look up the practice's Yelp reviews. It's a great way to crowd source your due diligence.

You will learn more after 30 minutes in the waiting room than you will learn after hours of discussion with partners or hospital administrators.

Practice Systems

Practice systems are the procedures that control the day-to-day operations of the practice. They include telephone answering, appointment scheduling, check-in and check-out, claims submission, denial management, patient collections, clinic workflow, phone triage, and more. It's rare to find a practice in which all operating systems are optimized and running smoothly. An assessment of these areas will illuminate strengths and weaknesses.

Management

The highest-ranking non-clinical leader in the practice plays a critical role in how effectively the organization operates. Ask about the level of education this person has and the authority that has been granted to this role, and how it fits into physician or hospital leadership. In nearly all cases, a practice group or department that is managed by an experienced professional versus a front desk staff person turned office manager fares better operationally and financially. Ask to meet the practice manager early in the interview process. Typically, the level of the person's business savvy will quickly be apparent based on how they present themselves and articulate their responses to your questions.

Personnel

The number, experience, and caliber of office staff can tell you a good deal about the efficiency and management of the practice. Ask about the educational resources and publications provided to employees and whether staff are sent to off-site training courses at least annually. If there is no budget for continuing education, it's a clue that the manager is not savvy enough to recognize its importance or the physicians are too tight to provide it. Neither is a positive statement about leadership.

Coding and documentation affect an organization's risk profile and are essential to profitability under value-based care and bundled payments.

Staff Turnover

Losing poor performers can be healthy. But frequent turnover, especially if it is in management or a specific department, is a red flag that problems exist within the organization. It varies across industries, but if turnover is more than 10%, it's a signal to dig deeper about why.

Payer Mix and Models

The payer mix is the percentage of total revenue that comes from each payer type, such as managed care, Medicare, and Medicaid. How has it changed over the last several years? As fee-for-service slowly but steadily gives way to value-based care and other risk models, contracts are becoming increasingly complex. Is the organization part of an Accountable Care Organization? Is it a patient-centered medical home? What percentage of revenue is at risk through bundled payments, value-based payments (upside risk/bonus as well as downside risk), or capitation? The answers provide insight about the level of innovation of leadership, as well as an indication of the organization's biggest revenue sources.

Reimbursement Knowledge

Reimbursement knowledge is an extremely important area, because it affects the revenue to the organization and, in turn, the physician's paycheck. Many private groups and hospital departments employ mediocre (at best) staff to handle reimbursement, who are then are not sent to training or provided ongoing knowledge and resources about changes in coding and reimbursement. You will already have some indication about efficiency based on having reviewed the accounts receivable metrics and report. Ask also about the backgrounds and training of the staff in this area of the organization, as well as key protocols.

Coding and Documentation

Coding and documentation affect an organization's risk profile and are essential to profitability under value-based care and bundled payments. What is the expected turnaround time for physicians to submit codes and complete their documentation, and how are laggard physicians (a risk to the entire practice) handled? Is the physician expected to attend coding training or participate in internal coding audits? What kind of "corrective actions" are taken when physicians are identified as coding or documenting incorrectly?

Technology and Automation

The degree to which an organization is automated can have a huge impact on physician quality of practice and quality of life. Does the organization encourage the use of its patient portal and use secure text messaging and appointment reminders? Or are these tasks still done using paper and pen? How cumbersome is the electronic health record for physicians to use?

Call Coverage

Investigate the history of how the practice deals with and shares call coverage. What is the frequency with which a new physician is expected to be on weekend or emergency room

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call? Is there call pay, or is the physician only credited for work RVUs or collections? The latter will have relevance for certain subspecialties that have a high volume of Medicaid and uninsured patients.

Outside Advisors

What is the extent of the relationships between the group and its attorneys, accountants, consultants, financial planners, and others? Request an interview with one or two of these advisors to learn their perspectives about the physicians. Pay attention to whether the organization relies on any one advisor in particular, because this may indicate a lack of diversity in guidance and, potentially, tunnel vision on the part of leadership.

Compliance

Has the practice received a records review or audit notice from Medicare in the last two years? A "yes" answer to any of these indicates potentially noncompliant activity. Ask a healthcare attorney to investigate these issues sooner rather than later.

Consolidation and Networks

Are there any hospital mergers, practice mergers, ambulatory surgery center developments, accountable care organizations, or clinically integrated networks forming? It is important to be aware of such consolidations, particularly if they involve your specialty. Inquire about the extent of any such consolidation activities on the part of the group or health system, or their competitors.

Conclusion

Understanding the financial health of the organization is an important factor in the decision to accept an employment offer. Engage an accountant to assist in obtaining and explaining financial reports. He or she also may be successful at obtaining reports and data that the typical recruit cannot. An operational assessment goes hand in hand with a review of financial data. It's often overlooked due to the fact that many operational aspects of healthcare delivery are not understood by physicians. If that is the case, engage a consultant or other expert to advise you, but be sure to personally conduct the waiting room reconnaissance mission. Whether positive or negative, the results will be eye-opening. **PM**

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