Employed Physicians: Your Contract and Future Buy-In

When it comes to your future, details matter.

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Considerations for Employment Agreement Negotiations

Here are some keys to be privy to:

1) Contracts normally run for an initial term of one year, and they'll generally run with the same terms until you're at the threshold of partnership. So, it could be for one year or five years, depending on when partnership hits. The initial couple of paragraphs will likely speak to your exclusive work with the practice, unless you receive written authorization to go outside of your duties, a word or two about proper notice of intent to terminate, etc.

2) Compensation will normally be delineated in a paragraph. Make sure that you understand the language, especially if there are bonuses or other distributions involved in your compensation. If the formula to calculate a bonus is complicated, putting it in writing and understanding it as you read it can be challenging. Ask for it to be delineated in simple numbers so you can at least, in theory, understand how the calculations work and how the dollars might flow to you. This delineation assures that there are no misunderstandings.

3) There may be a paragraph discussing your duties for the business, where and when you're expected to work and offering which/what types of medical services.

4) There will be a discussion about your vacation, meetings, and CME travel, and the related costs and allowances on an annual basis.

5) There will be a handful of paragraphs full of boilerplate legalese that have meaning to attorneys and their ilk (e.g., what defines this, what defines that, etc.).

6) Something will be tucked into the contract regarding non-competes. Just so you know, many courts (this is anecdotal) have not recognized non-competes because in some areas of the country, it has been deemed that there is a need for the specialty (e.g., an underserved area). The courts have recognized the community's healthcare needs over the needs of the practice. However, even if a non-compete could be invalidated by the court, many times there are com-

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pensation components woven into the non-compete in the event that the non-compete does not hold. There would be a fairly robust cash outlay due from you to the practice immediately upon terminating your contract to protect the practice from the downside of an unenforceable non-compete, should you decide to see patients in the practice's current geographic or service area. A non-compete should also be well defined and reasonable.

7) Paragraphs speaking to med/mal insurance you must carry (due to a corporate decision) are usually $1,000,000/$3,000,000, meaning you're covered for $1 million per occurrence and $3 million in aggregate if you are hit with a med/mal lawsuit. Discussion will also address the prospect of tail coverage (prior acts) if the practice is on a claims-made policy versus an occurrence policy. Ask the group what their med/mal insurance is, claims made or occurrence. Most groups will not pay your tail coverage from your prior employer; but they may be willing to split the cost or work out some other arrangement, depending on their situation. Remember, these points may be negotiable.

8) A paragraph will cover reimbursable business expenses and the like.

9) Another paragraph will discuss, very specifically, termination with and without cause and what conspires to make either, such as loss or forfeiture of medical license, abuse of controlled substances, etc. Make sure that with/without cause is defined very clearly so that nebulous definitions open to interpretation are not included in your contract.

10) There'll be discussion of disability pay and what qualifies a physician as disabled.

11) A paragraph may be included dealing with the medical records and who owns them (usually the practice).

This is not an exhaustive list. These are some basic components you might look for in your contract. When you've found that magical, nirvana-esque position, you should work a little to negotiate components of the employment agreement that you'd like, knowing there may be push back and knowing, once again, what your balance is. What can you live with and live without? You might also ask whether all contracts are uniform.

Remember, if it's not in writing, your agreement is predicated on recollection and memory.

In terms of negotiating your contract, remember there are a couple of points that may be malleable and open to discussion. They include:

1) If the contract contains salary guarantees with financial assistance provided by a local/area hospital, the agreements can get complicated; but the onus, generally, falls on you and the hospital. Those agreements can no longer be between the hospital and the practice you'll work for, due to the government's concerns regarding kickbacks and the like.

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2) There may be an opportunity for some student loan forgiveness.

3) There may be the opportunity for a one-time sign-on bonus.

4) Maybe the group will offer you and your family health and dental insurance.

5) There may be a dollar allocation for moving expenses if you need to relocate to take the position.

The Buy-In

After the employment period, in most cases you'll be offered the option to buy into partnership. It is worthwhile, after interviewing and moving the process forward, to contemplate the buy-in/buy-out entailed in partnership. You want as much information as possible before you sign your employment contract, which means you need to know what the future may hold in store for you after the term of your employment has run its course and you are preparing to buy into the business.

The reason for this is your buy-in path may equate to upwards of a two-year hitch as an employee. You would hate more than anything to be in a job you love, in an area you adore, with a quality of life you've dreamed about, to find out, when the partnership documents arrive, that you are basically an indentured servant for the next five years while you work off your buy-in or work into an equity position within the practice. Could you elect to overlook some of this because you love the job? Entirely so. But, why would you? This is a time when you need to look out for "number one," no matter how collegial the group. Ultimately, there is the possibility that on your way to buy-in you get slugged with some surprises that make you very unsettled, that fracture the fragile shell of comfort you've established with your employers and soon-to-be partners.

Remember, if it's not in writing, your agreement is predicated on recollection and memory, which oftentimes is open to interpretation and can be hampered by convenient amnesia. Having opined that, once you have an offer on the table and your foot in the door, ask to see the partnership agreements and documents. Obtain the buy-in information when you're near a deal. Promises that "we'll take care of you" are

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cozy, neat, and make a physician feel loved, but those promises become malleable when stretched over the employment period.

Many of the promises and their value depend on who in the practice you've talked to, who in the group is pulling the strings, and who, ultimately, has the authority. These "warm fuzzies" are probably rendered from the heart, but when push comes to shove, you have no one to fall back on but yourself, and hollow commitments of "love" will quickly leave you heartbroken on the shoals of disenchantment in the years following your employment. Remember, people—especially busy people—have very short memories. Getting things down in writing is invaluable.

If the group will not offer the partner documents, an alternative might be for a senior physician, the managing partner, or even the administrator to give you a very simple example of how the buy-in works, in easy-to-use round numbers with no sharp edges (e.g., $100 to buy 10 shares of stock, etc.), so that you can draw some conclusions of your own to craft better and more salient questions to ask your prospective employer. Even round, soft numbers can give you an idea of how the process works, and that is most of what you want to know. Practices should not hide the calculations of the buy-in formula from you unless they have something to hide.

Once you have some basic numbers, sit with your accountant and/or an experienced advisor. Don't slough this stuff off on your neighbor Fred who's "good with agreements" or equally "good with numbers." Healthcare management is not rocket science; conversely, rocket science is not healthcare management. Each requires its own set of disciplines and attention to detail. An experienced advisor can offer insight into the agreement, can compare its demands and peculiarities with those of other agreements he or she has seen in the past, and offer you comprehensive counsel.

While some agreements may not offer you much wiggle room on the language (i.e., "this is the contract we've used forever"), it will at least give you a heads-up on some of the pitfalls you're about to encounter. At least knowing how deep the water is prior to jumping in will lend some comfort to the prospect of landing. Quite frankly, if the group you're courting loves you that much, they should be willing to offer reasonable concessions in the agreement, to undergo a little give and take, if you will.

Occasionally you'll hear, "We don't change our buy-in for anyone." That may or may not be true. There can come a time when the need for a new subspecialty necessitates some flexibility on the negotiating side regarding the contract. Say, hypothetically, that the practice's last physician hire was 10 years ago. Now suppose that, due to growth in the tiny community, the group finds itself with the need to add two more physicians. They go out expecting to pay $100,000/year plus med/mal, maybe some life insurance, three weeks of vacation, and a three-year track to buy-in. They run an ad with their local and national specialty associations and receive very impressive CVs.

When they begin the interview process, they learn at the outset that the new crop of physicians wants $250K, a sign-on bonus, five weeks off (including one week of CME), and partnership in two years. What to do? Well, if all candidates seem in line with these demands, the practice may need to ponder working with the selected candidate and get the deal done. There are myriad ways to bring all to the table and make a fit.

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Performing this legwork, painful and slow though it is, may save you considerable heartburn when you're getting ready to pull the trigger with your partners.

As an aside, your employment contract is just that. It is exclusive of partnership commitments or offers. In fact, some contracts actually say that the owners will review the employed physician's prospect of partnership when the time comes. As you can see, just as with life, there are no guarantees with contracts, so be sure to examine the language in your contract relative to a potential future offer of partnership.

Oftentimes, the buy-in is constructed of a variety of components. Many agreements have boilerplate language that is fairly basic and somewhat similar to an employment contract, involving such things as non-competes, delineation of assorted agreed-upon benefits, your commitment to work only for the group while you're employed, etc. The key aspects to the partnership agreement lie in the dollars and cents of the buy-in and its timeframe. These take a variety of forms, shapes, and sizes, and this is not the venue to delve into each in depth. Outside of the general language in the contract, a non-exhaustive list of possible components incorporated into a buy-in includes:

Goodwill: Generally an intangible derived from a perceived value of the practice based on its history in the area, basically, how long it has built a reputation and standing in the community. Some practices have managed to generate "negative" goodwill by acting like, well, jerks to area referrals, clinicians, and patients. Regardless of

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the mathematical machinations involved, this measure becomes somewhat subjective in nature.

Inquire as to whether the goodwill number includes the purchase of any other practice in the past. Sometimes, practices purchase other practices and their goodwill. This can involve purchasing of depreciated hard assets, too. If charts are purchased from other practices, a dollar value is attributed to this transaction.

Charts have an ongoing value of between $0 and $0 _ 1 (translation: worth nothing). Why? Quite simply, it's because you can't buy a chart. Look at it pragmatically. Let's say Fred X, DPM has 10,000 charts in his vast collection accumulated over 20 years in practice. Good Dr. X has decided he's tired of working hard, 80 hours a week, and making less than he did in the early 1980s. Dr. X brings in consultant Y to help him value the charts.

In theory, what you'd be looking for is some innate value in continued patient visits, generally based on patient history or medical condition. This might translate into future revenue streams, but how can you be assured of continued access to this patient population? You can't. Remember, patients vote with their feet (even more so today).

If you, as the new kid on the block, are not liked by Dr. X's patients, for whatever reason, they can leave. If you've paid $10,000 for their charts, a mere $1/chart, you are now out some piece of $10,000, depending on how many folks remain with you. Not a good buy. Sometimes, these deals are thrown into practice purchases. In buying a practice, almost NO argument can be made for purchasing charts of patients. Again, patients are under no obligation to see you and there are no guarantees that they will.

Hard assets (equipment and the like): Generally some depreciated value of an asset or assets is included in a buy-in. The reason for this is that the assets have a value on the balance sheet and can fairly easily be quantified. The depreciated value of the asset is delineated as such. If the practice purchased a $1,000,000 Oooga. agmobomitor three years ago, using straight-line depreciation for five years (the asset depreciates in equal amounts over the Oooga's useful life) would mean that the Oooga is now worth, as a depreciated asset, $400,000. $1,000,000/5 years of depreciable life = $200,000/year in depreciation. Three years of depreciation is $200,000 x 3 = $600,000. So, the Oooga would be valued at somewhere around a $400,000 asset on the books of the practice, and shows that the practice has assets worth at least $400,000, something tangible to buy into.

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Accounts Receivable: AR, or accounts receivable, are the outstanding revenues that the practice has on the books for charges out to Medicare, private-pay insurance companies (e.g., BC/BS, United Healthcare, etc.), and patients. AR in a normal business model would be the money we are waiting to be paid by our business clients for performing services. The same holds true for healthcare.

When looking at this component, make certain that AR, when included in a buy-in calculation, is reduced to a collectible amount. While in normal business we might expect to collect everything we bill, healthcare is not that animal. Instead, you'll expect to collect a percentage of what you've billed. That is to say, the practice will not collect its entire AR. Most importantly, you should ask the practice you are courting what their collection percent of collectible money is and what percent they collect on their accounts receivable.

While you're at it, ask them what their AR value is. More than informative for you, this can serve as a test for a practice manager or senior partner. A practice with good management and a good handle on their dollars outstanding should be able to reel this figure off with little or no problem. AR can be a component of the buy-in process, so understanding what AR means is essential.

Conclusion

Aside from the dollars and cents, let's say you have a three-year buy-in track, maybe a fixed salary that creeps up incrementally after each year of employment, and then the big watershed moment: you buy in. What else are you buying into, exactly? What's your role in the group? Do you want a more active or passive role in the day-to-day decision-making processes? Are you paying into a pyramid scheme, the results of which amount to you propping up unproductive senior docs who begin phasing out their effort but not tweaking back their pay commensurate with their workload reduction (e.g., a reduction in call or reduction in office hours)?

If there are 10 partners in the group, where do you fall? Is there a seniority ranking? Or are you just becoming a partner and paying a premium to have no voice and no vote? This scenario is where structure may be important to you. You'd want to know that your voice has some value to the organization, either on a standing or ad hoc committee or some other avenue (like a budget finance committee, a marketing committee, or physician disciplinary committee.)

When all is said and done, make sure that you have a qualified attorney review your contract. The money invested in this process can protect and offer you peace of mind. **PM**

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