I. Introduction

The business of healthcare in the United States is complex and challenging. To a patient, trying to navigate a system that is fractured with whimsical policies from one insurer to the next; confusing and often conflicting payment and enrollment explanations, limited time and communication with providers; and exorbitant costs of drugs and medical procedures, makes them concerned, frightened, and, many times, angry. Hospitals no longer can function as places of involved patient care due to financial restraints, increased financial performance demands, increased competition from stand-alone centers and “medical tourism”, shifting free care, changing community need measurements and other governmental regulations. Insurers operate with little financial or legal oversight and sometime infringe on medical decision making. And, the federal government, having inherited a payment program that is unsustainable, finds itself looking for solutions to curbing costs, including the alleged mountain of fraud it maintains exists among all providers. Ironically, what each of the participants of healthcare have in common is that notwithstanding their enormous political power and resources, each very publicly blames the physician for most of its problems. As such, the physician has become a type of “poster child” for all that is wrong with healthcare. And yet, it is the physician industry that has the most at risk and currently is facing a huge decline of the independent physician practice.

This paper will seek to provide guidance and thought to both the lawyer and physician as to the ways to maintain a physician’s independence in today’s healthcare world. This discussion will describe some of the history which brought the healthcare industry to where it currently is and will further discuss where it seems to be going. In addition, there will be a discussion of the internal and external challenges facing independent practices and how a practice can respond. Finally, a snapshot of the strategies a practice may employ to survive will provide further guidance on this goal.

III. Reviewing Historical Medical Practice Challenges - And the Physicians All Survived

It is always helpful to look at what has happened historically to physicians as healthcare has evolved and to learn from their past resiliency.
Prior to 1965, physicians, for the most part, were predominantly primary care physicians who established fees schedules that were paid in cash (or chickens or crawfish, depending on where you lived). When Medicare was enacted in 1965\(^1\), physicians, for the first time, became providers to government patients and were paid “reasonable” costs. Medicare, very soon after it was established, began to look at ways to average those costs and developed various parameters of what constituted a “reasonable” cost. Physicians again adjusted their payment expectations with the establishment of the Medicaid program\(^2\), which provided federal matching dollars to the states to cover the healthcare of the most financially vulnerable of patient populations, including children and pregnant women. It was only the Medicaid programs that ever provided any type of screening or preventive care. It would take Medicare almost 30 more years to agree to some levels of preventive testing \(^3\) (e.g., mammograms) but to this day, Medicare beneficiaries have very limited screening capabilities.

In the early 1980’s, the cost of healthcare continued to escalate and Medicare changed the reasonable cost reimbursement scheme first for hospitals by instituting the “Diagnostic Related Group” or “DRG” payment for hospitals.\(^4\) This was one of the government’s earliest interventions in cost control and effectively a DRG payment forced a hospital to consider the costs of patient care on a per diem basis. The government was looking to limit its costs but many hospitals would say the government looked to “shift” its costs to the hospital provider causing less revenue to drop to its bottom line. This change in reimbursement to hospitals in the 1980’s coupled with the serious recession of the mid-80's caused many hospitals to declare bankruptcy or go out of business. This financial instability saw a great move by larger hospital systems or companies, both for-profit and non-profit, acquiring or “aligning” for better efficiencies. Some of these alignments were for shared services and shared equipment. Some were outright hostile takeovers of healthcare markets that greatly piqued the interest of the regulators of the Federal Trade Commission. This change in hospital reimbursement permanently changed the hospital world.

In the 1990's, the federal government finally shifted its focus to physicians and changed the reasonable cost reimbursement method to the “Resource Based Relative Value Scale” or the “RBRVS”.\(^5\) This was a complicated formula determined by the Healthcare Financing Administration, now known as the Centers for Medicare and Medicaid Services, or “CMS”, which took into account a general payment structure (such as the cost of an office visit) and then factored in the variables such as regional costs of living and malpractice costs.

At the same time that Medicare was seeking to standardize payments to physicians, most

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\(^4\) Prospective Payment Systems for Inpatient Hospital Services, 42 C.F.R. § 412 et seq. (1983)
\(^5\) Omnibus Budget Reconciliation Act of 1989, Pub.L. 101-239, 103 Stat. 2489 (1989); this act instituted the Physician Fee Schedule
of the country was seeing the growth of health maintenance organizations (HMOs) and other forms of managed care. This was the private insurers’ answer to containing costs and threatened all providers of care. As so many of the initial managed care models were dependent on the “gate keeper” or primary care physician (PCP), and as the payment environment became more and more hostile, physicians, particularly primary care, became very vulnerable to these economic changes. Hospitals, seeing this vulnerability and having a need to control those PCP referrals, began purchasing these primary care practices and employing the physicians. Many of these hospital-based primary care practices exist to this day.

Physicians, especially specialists, became very vulnerable to this loss of control to the provider panels created by managed care payors and the employment of the physician’s primary care referral sources by hospitals. The need to negotiate better managed care rates caused physician practices to merge to gain market share and use the combined group for negotiating leverage. Some physician practices joined hospital managed care organizations such as “Physician-Hospital Organizations (“PHOs”)” or formed “Independent Practice or Physician Associations” (“IPAs”) to try and gain some type of competitive advantage with insurers, and primary care physicians and to gain access to additional patients. Unfortunately, this caused great concern to the Federal trade Commission (“FTC”) who was forced to confront a physician healthcare market that was unfamiliar and the FTC found itself trying to regulate in new territory. It is at this time the FTC passed its initial guidelines on practice mergers or physician networks such as IPAs and coined the phrase “clinical and financial integration” to be the tests used by the FTC to determine if a group was sufficiently integrated to avoid the repercussions of antitrust, including group boycotts and monopolies. Unfortunately, the requirements for clinical and financial integration became very costly and required organizations with significant infrastructure, technology, and capital. Many physician and/or physician-hospital organizations failed because they could not comply with these requirements.

Throughout the mid-1980’s through the late 1990’s, the regulatory changes that affected physicians became more and more restrictive. The enactment of the Stark legislation was a direct assault on physician growth and development. Stark’s general prohibition on physician referrals of a Medicare patient to an entity in which the physician, or immediate family member, had a financial interest, saw many physician-owned joint ventures cease to exist or be bought out by competitors who did not have the same physician ownership issues. Physicians could no longer own ancillary businesses such as laboratories, DME companies, hospitals, physical therapy or diagnostic radiology, without demonstrating compliance with certain “exceptions” to the Stark law, including where the service was offered and how it was billed. Years would go by between the passage of the legislation, publication of proposed explanatory regulations and the adoption of final regulations published. The regulations used uncommon legal or


7 42 U.S.C. 1395nn.
business terms such as “stand in the shoes”. How ironic that the one provider who could best control the delivery of all these services no longer could own or refer to such.

At the same time as the development of Stark, the Office of Inspector General (“OIG”) evolved into a leviathan organization, to ferret out fraud, with a budget that equals, or sometimes exceeds that of CMS. The OIG has enormous power under the federal antikickback statute which is a criminal statute with little or no accompanying regulation. The OIG, throughout this same time, focused on billing issues and had great success, when partnered with the Department of Justice, in assessing enormous penalties and fines (See: 1994 National Medical Enterprises Settlement with the Department of Justice - $379M; Columbia/HCA Healthcare - $734M under the False Claims Act;). These successes did nothing but strengthen the OIG’s regulatory power and enhanced its budget. Notwithstanding all of these efforts, the costs of healthcare continued to escalate.

From 1995 to date, CMS has initiated multiple projects that have evolved into significant changes in the ways it pays for patient care. This included the establishment of the Medicare Choices program, or Medicare HMO’s (now known as “Medicare Advantage” Plans) that steered patients to a group of providers that were paid a fixed sum per patient/member per month, which required the physicians to manage the patient’s care based on the money received. These demonstrations, including physician payment schemes, began to focus more and more on the “quality” of patient care, along with its costs, and the development of the various “quality initiatives” from the federal government. Hospitals, in particular, were studied and issues involving lengths of stay, readmissions, and hospital infections became critical points. Physician payment projects were introduced, seeking ways to have physicians enter into more pro-active discussions with their patients and payment “rewards” were initiated to require physicians to respond to the overall health of a patient which included smoking cessation information or materials or other pro-health initiatives. Doctors were now going to be paid for “performance”, not just for treating a patient on a fee-for-service basis. Hospitals were encouraged to create clinical initiatives that followed a patient from admission through discharge to discourage readmissions.

Finally, in March 2010, the Patient Protection and Affordable Care Act of 2010 (PPACA) was passed that included major reforms to the U.S. healthcare system. These reforms included major health insurance reform; expansion of healthcare for currently non-participating or non-covered individuals; as well as expansion of primary care programs both in medical schools and in communities at large. PPACA also has several Medicare payment initiatives proposed, all attempting to link payment to quality outcome. PPACA’s overall effect on the physician is to increase the importance of quality care to a patient, increasing the value of the service; enhancing the use of data and technology, including the electronic health records; seeking ways to integrate the delivery of healthcare for a patient from the preventative state through hospitalization and recovery;

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9 42 U.S.C. 1320a-7b.
and finally, to provide several innovative ways to accomplish these goals.

The enactment of PPACA saw healthcare providers scramble; particularly hospitals that all seemed to be racing to do exactly what they did in the 1990's in response to managed care: buy physician practices; employ physicians (including primary care and other specialists, such as cardiologists); and to create clinically and financially integrated organizations with their medical staffs or community physicians, whether in the form of an “Accountable Care Organization” (which is the term for an entity organized under Title III, Part III of PPACA), 12 or other organizations used to negotiate payment rates. This flurry of activity, along with the uncertain economic and political times, has seen the erosion of the independent physician practice. Whole markets of primary care physicians and certain specialists have become employed by a hospital which leaves very few options for the remaining physicians. Notwithstanding all of this action, there is still room for the independent physician practice if certain strategy and planning is in place.

III. An Overview of the Current Healthcare Market

An independent physician practice is most often a small business with the same, or in some cases, even more challenges than other small businesses. As with other similar businesses, a physician practice has high employee costs, issues with benefits, needs for equipment, a changing competitive landscape and limited access to capital and fluctuations in cash flow, combined with limited exit opportunities. In addition, most independent physician practices have multiple payors, all with different reimbursements, billing requirements, pre-authorizations, and various renewal and payment schedules. And, unlike most other independent businesses, the physician practice is threatened by innumerable government regulations that go beyond standard government regulation (such as, wage and hour requirements) common to all employers to detailed oversight that prohibit ancillary revenue, 13 financial relationships, 14 or growth 15 (Federal Trade Commission). In most instances such regulations are increasingly complex and which do not directly address the clinical delivery of patient care, but rather, only the business of such delivery of patient care.

Many physicians have found that surviving in such a hostile business climate to be unsustainable and unbearable. The business obligations of maintaining and operating a medical practice leave less and less time for the delivery of actual patient care. Medical school training does not prepare a physician for these challenges and often “learning as you go” can be painful, costly and sometimes lead to unintended consequences. It is critical that the independent physician regularly assess its practice and determine its continued viability.

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13 See, 42 U.S.C. §1395nn; 42 C.F.R. §411.351 et seq.
14 See, 42 U.S.C. §1320a-7b.
IV. Challenges to Maintaining an Independent Practice

Independent physician practices face both external and internal challenges to maintaining autonomy. As in the past, some of the most at risk independent practices are the primary care physician practices. Primary care practices provide an array of services yet are often reimbursed on the lower end by payors. Declining reimbursement from standard services limits the financial viability of the independent practice. Working harder to make less is not an attractive option. Without access to ancillary revenue sources (how many primary care physicians are invited into an MRI joint venture) the declining reimbursements affect the practice’s ability to grow. Equipment, practice management and billing systems, and implementation of electronic health records, are all expensive (and costs are growing) and present great challenges to the primary care physician. The fundamental nature of owning and managing a small business is increasingly complex – employment and HR issues are a significant pitfall and uninformed or misinformed ventures into these areas can be costly for the medical practice.

V. Physicians Respond to These Challenges

Physicians throughout the country are meeting and discussing strategies to remain independent, competitive and successful. These strategies include medical practices aligning through mergers collaborating with local hospitals but as independent medical staff members; and specialists seeking to align with and secure their primary referral sources. This is a critical time for physician leadership in both the hospital and community-at-large. Other than selling to a hospital, medical practices are exploring a variety of options.

A. Medical Practice Mergers

Physicians seek to merge two or more medical practices as an alternative to selling to a hospital. A merger of two or more medical practices results in a combination of assets, liabilities, personnel, financial and operational systems and of ultimate decision making. Merger goals may include the following:

- Aligning providers to better coordinate and manage the care of a patient;
- Collaborative sharing of ideas
- Professional management and billing
- Providing higher quality care at lower cost;
- Increased total revenues;
- Reduced overhead costs;
- Increased access to capital;
- Greater geographic presence;
- Establish an organization that accepts responsibility to manage its physicians to comply with established quality goals and metrics;
- Develop a medical practice that enhances recruitment opportunities;
- Coordinated development of approved clinical processes;
- Assist with strategic planning and succession planning;
- Combined marketing and branding leading to increased market share and penetration
- Assist with physician manpower planning, including recruiting/hiring
nurse practitioners or other physician extenders;

- Develop new service lines possibly in imaging, therapy or outpatient surgery;
- Participation in bundled payment programs or ACOs.

Notwithstanding the strategic goals identified above, mergers also need to identify business goals. Such goals include determining practice efficiencies such as combined management; consolidation of insurance lines; consolidation of billing and related software and the sharing of such costs. Further cost savings can be realized in health insurance premiums, malpractice costs and administrative costs associated with pension or profit-sharing plans. Finally, the use of single professional services such as lawyers, accountants, marketing representatives or practice administrators can significantly reduce costs for a practice.

A medical practice merger is a specific legal transaction and planning for the transaction may require the parties to conduct not only standard external due diligence on each other, but also consider whether the event will give rise to possible dissenter’s rights under applicable state law. In most instances, a merger will involve a strategically stronger party and a strategically weaker party – but both parties will have specific challenges – leadership changes, compensation declines, payor disputes, legal liabilities, governmental investigations, or employee challenges that will not simply disappear upon the closing of the transaction. Both parties must conduct thorough due diligence on each other in order to make sure that the attraction and desire to merge is strong enough to also address the often hidden challenges that must be addressed either before or immediately following the transaction.

While the FTC’s attention to hospital mergers and hospital acquisitions of medical practices is widely known and highlighted in the popular press, there is an increasing attention to physician practice mergers and whether such could potentially violate applicable antitrust laws. In general merging parties are only required to notify the FTC if the planned merger surpasses certain dollar thresholds. However, post-closing antitrust violations can be costly and the parties should carefully consider whether they are prepared to operate as a merged entity – not just in name, but in fact. Just because a transaction may fall below the Hart Scott Rodino filing obligations does not mean that the transaction (and its post-closing operations) are insulated from antitrust investigation.

B. Medical Practice Affiliation – Divisional Merger


Just as a medical practice may not be inclined to sell to a hospital, the practice may not be interested in merging with another medical practice. The loss of control (actual or perceived), influence over direction, staff integration issues and obligation to take on the liabilities (known or unknown) of the other party are all barriers to a traditional merger. However, the desire to combat increasing cost structures, decreasing market power and slowing revenues may drive the parties to attempt a “loose merger” or creation of an umbrella organization from which the physicians practice medicine and consolidate much of the administrative efforts in order to reduce expenses, but while maintaining control and autonomy over the day to day operations of separate “divisions”. Often described as “easier” and “less costly” than a traditional merger, and touting the ability to be easily unwound, such ventures quickly capture the interest of many medical practices. The challenges with such “loose merger” or umbrella organizations include extensive, complex and ongoing attention to administrative issues necessary to prevent antitrust violations, increased management obligations at the “umbrella” organization mistaken notions of how much autonomy may be retained by the individual medical practices. Such organizations are possible and can result in the objectives desired, but the parties must understand that there is no “We want to merge, but remain separate.” Often such endeavors face the inherent challenges of providing the significant level of financial, clinical and operational integration necessary for the parties to achieve the desired level of payor integration and collective negotiation. Furthermore, in order to maintain Stark “group practice” compliance, the legal entity must be a “single legal entity” and pass the unified business test, among other requirements.19

C. Hospital Affiliation – Other than a Sale

Apart from a direct sale to a hospital, a medical practice may consider a variety of other affiliations, each of which may offer varying degrees of integration and autonomy regarding the day to day operation of the medical practice:

- Recruiting Agreements
- Call Coverage Agreements
- Exclusive Provider Agreements
- Co-Management Agreements
- Ancillary Joint Ventures
- Professional Services Agreements

Though detailed analysis of each of the above is beyond the scope of this paper, each offers a medical practice the ability to retain its independence, its day to day control or over operations and future growth opportunities, while addressing many of the concerns that threaten the medical practice (i.e., decreased revenue, access to patients, schedule flexibility, management input and market share). In addition, each of the above options provide the medical practice with the option to “test drive” a closer affiliation with a

19 42 C.F.R. § 411.352.
hospital for a limited period of time with the ability to easily walk away and unwind the arrangement if the practice’s goals and objectives are not satisfied.

D. **Securing the Primary Care Physician**

While there are many successful multi-specialty practices, there are also many failures at integrating primary care and specialty practices. Some of the reasons for failure, by observation, include different management styles; the treatment by specialists of primary care as “less important” due to the income differential; or inequitable governance and sharing of compensation. If a specialist practice seeks to survive and integrate primary care, it must overcome these past failings. Equitable governance and management are critical. Also, creating compensation set-asides and bonuses to share with primary care are ways to legally reward the participation of a primary care physician in the overall “enterprise”.

E. **Recruitment**

Independent practices are competing with hospital as well as other medical practices for the top physician talent. In many instances, a hospital may be perceived as offering benefits such as security and continuity that may not be offered by a medical practice. In addition, a hospital may have the ability to offer increased cash compensation and a better benefits package. Nonetheless, hospital employment is not a fit for every top physician and a competitive medical practice can offer unique benefits such as increased flexibility, ownership and leadership participation that may be lacking at a hospital.

Typical recruitment benefits include:

- Offering competitive base compensation
- Health insurance (possibly including dependents)
- Disability insurance
- More days off
- Provide access to specialized training
- Greater scheduling flexibility
- Shared medical directorships

Some examples of standard language used with recruitment benefits:

- Permit moon-lighting

**Example:** Other than with the Employer’s express written consent, the Employee hereby acknowledges and agrees that he/she will practice medicine and his/her specialty of [SPECIALTY] only as an employee of Employer, and he/she shall not, during the term of this Agreement, either directly or indirectly, be connected
with or engaged in the practice of medicine in conflict with the terms of this Agreement. All remuneration and other benefits earned by the Employee from activities related to the practice of medicine and conducted for parties other than the Employer during Employee’s otherwise regularly scheduled office hours (i.e., not conducted during Employee’s own regularly scheduled vacation, holiday or meeting time), shall belong to the Employer except as noted below. Employee shall be entitled to retain his earnings from such activities so long as the following conditions are met to the reasonable satisfaction of the Employer: a) the remuneration is earned on the Employee’s own time and does not materially interfere with her duties to the Employer hereunder; b) the remuneration is not related to the care and treatment of the Employer’s patients, including but not limited to the conduct of any clinical drug studies; and c) the source of the remuneration is disclosed to the Employer in advance.

- Offer stipends while still a resident or sign-on bonus

**Example:** The Employer shall pay the Employee a signing bonus in the amount of [______________] and no/100ths Dollars ($X,XXX). The signing bonus shall be paid within five (5) business days of Employee presenting to Employer sufficient written evidence of a valid and unrestricted license to practice medicine in the State of [STATE] and a valid and unrestricted DEA license authorizing her to prescribe controlled substances. Notwithstanding the foregoing, if the Employee fails to receive full active medical staff privileges at [HOSPITAL] by [DATE], Employee shall repay the full amount of such signing bonus upon five (5) days written notice.

- Provide relocation allowance

**Example:** The Employer shall reimburse the Employee for the reasonable relocation costs associated with moving the Employee’s family and practice to [COMMUNITY], with the amount of such reimbursement limited to the lowest of three (3) bids obtained by the Employee from reputable moving companies and, in no event to exceed the amount of [________________________] and no/100ths Dollars ($X,XXX). The Employer shall reimburse the Employee or pay directly the appropriate amount following receipt of itemized expenses with proper documentation. **[CONSIDER:** The Employer shall reimburse the Employee or pay directly the appropriate amount following receipt of itemized expenses with proper documentation; provided, however, that such reimbursement shall be considered an advance on the Employee’s base compensation, subject to the following: At the end of each month during the Initial Term of this Agreement, assuming that the Employee remains employed with the Employer under the terms of this Agreement, [%] of the total amount of reimbursement under this Section shall be forgiven, such that it will not have to be repaid by the Employee to the Employer. Notwithstanding the foregoing, in the event that this Agreement is terminated at any time during the Initial Term (either by Employer "For Cause," as defined below, or by the Employee for any reason)
the Employee shall reimburse the Employer for any portion of such advance not forgiven or, alternatively, the Employer may offset any remaining amounts against money due the Employee at termination.

- Provide call-coverage assurances

**Example:** Employee shall share responsibilities for night call and holiday and weekend coverage (collectively referred to as “Evening, Holiday and Weekend Coverage”) substantially equal with the other physicians employed by Employer.

Current recruits, especially residents, while certainly interested in financial benefits, often are looking for “quality of life” benefits so a medical practice should be ready to proactively address what is often perceived as a generational shift among professionals. Where there are differences between the schedules, benefits and tasks granted to senior physicians versus junior physicians, the medical practice should be ready to explain such.

An independent medical practice may accept recruiting assistance from a hospital in order to bring additional, needed specialties to the community. Important to the medical practice, however, is the protection provided to it if the recruited physician departs. In most instances, the medical practice will be required to guarantee the recruited physician’s financial obligations under the recruiting agreement. A recruited physician who leaves the area (and thereby defaults on his / her obligation) may cause the medical practice significant financial harm. Short of obtaining a security interest in significant assets, the ability to obtain contractually obligated indemnification from the departing physician is a “best practice” that must be incorporated into the physician’s employment agreement:

**Example:** Concurrent with their execution of this Employment Agreement, Employer and Employee executed the Recruitment Agreement with [HOSPITAL]. (“HOSPITAL”). Pursuant to the Recruitment Agreement, Employer will pass through to Employee, in full, net of the actual incremental expenses attributable to Employee, any financial support received from HOSPITAL under the Recruitment Agreement. To the extent Employee defaults on any of her obligations under the Recruitment Agreement such that Employer is required to repay to HOSPITAL any monies owed to HOSPITAL by Employee pursuant to the Recruitment Agreement or Promissory Note attached thereto, Employee hereby agrees to reimburse Employer for all such payments. Employee further agrees to indemnify, defend and hold Employer harmless from any and all claims, costs, liability, judgments or other damages suffered by Employer as a result of or related to the Recruitment Agreement or the Promissory Note attached thereto, including attorney’s fees and other expenses of litigation incurred in Employer’s defense of the claims brought against it by HOSPITAL as well as attorney’s fees incurred by Employer in enforcing this indemnity provision. Employee further agrees that in the event HOSPITAL initiates any legal action against it to enforce obligations under the Recruitment Agreement or the
Promissory Note attached thereto, Employer may join Employee as a third party in such legal action without first having to be found liable for or made payments related to such obligations. This Section shall survive the termination or expiration of this Employment Agreement for any reason whatsoever.

F. Enhancing Practice Revenue: Non Physician Revenue Producers

Declining practice revenues and increased costs combine to motivate many physicians to leave their existing medical practices for the consistency (if not security) of hospital employment. However, there are ways to maintain or increase revenues such as adding additional revenue producers, including nurse practitioners or other physician extenders. The integration of non-physician primary care practitioners is becoming a critical part of medical practices in delivering patient care. Also, if a practice can find the initial capital to fund new services, adding laboratory, bone-density, or participating in external joint ventures often adds significant revenue to the practice. Often overlooked, a medical practice that is expanding into new physical space, or considering renovation of current space, may also consider architectural designs that enhance patient flow, reduce “down time” and allow the revenue producers within the practice to increase patient throughput and thereby increase revenues.

G. Enhancing Practice Revenue: Supplemental Revenue Sources

Declining reimbursements from the federal government are not controllable. But declining reimbursements from the private insurer market can be addressed by effective negotiations and efficiencies in the practice. Failure to comprehend or analyze the physician’s payor system will keep a practice at the “whim” of the insurer. Negotiating with clinical evidence of efficiencies, quality, or other empirical indicators, almost always achieves better results for the practice. Payors are becoming more willing to share a physician’s outcome and other clinical evidence. If the physician constantly maintains a practice pattern that ranks its payments in the highest percentile or its patients present continued outlier payments, then, a physician’s agreement to change behaviors, and the possible sharing of such revenue, can be significant to both payor and physician. A physician who can demonstrate that his practice attracts a certain type of patient with co-morbidities or other acuities, due to some specialized service it provides, can possibly negotiate a differential in some relevant CPT codes due to these circumstances. While there are always many exceptions to this rule, healthcare reform seems to have payors more eager to engage in these discussions and collaborations. Providers have been successful in many circumstances, including:

- Providing a time study to a workers compensation board and rate setting committee which explained a surgeon’s work day in time increments, allocated a cost to each increment, and then superimposed the workers compensation time requirements and payments, to show providing such services were a financial loss to the practice.
• Providing clinical outcome data to a payor that showed certain spine procedures it was requiring be done in a hospital setting, were safe and effective in a physician-owned outpatient surgery center and cost the payor significantly less than if done at the hospital level.

• Developing protocols for certain disease-specific patients and showing the clinical and financial benefits of including the physician group as a type of “preferred provider” with guarantees of patient volume.

While certainly these are very limited examples, they are used to show that negotiating fees is not just, “I need more”, but requires presenting the physician payment profile to a payor and providing opportunities where both parties can benefit from improvements.

Another form of enhanced revenue has always been in the development or joint venturing of ancillary services. Ancillary revenue sources are central to the survival of an independent medical practice; however, they are not without barriers to entry. State level certificate of need requirements may limit the ability to acquire and use such equipment. In addition, state and federal prohibits against physician self-referrals may limit the ability to expand into the ancillary services arena if the medical practice cannot meet applicable safe harbors or exceptions. The addition of any ancillary revenue source must include specific attention to the federal and state fraud and abuse laws so as to avoid the establishment of a venture that runs contrary to such laws --which will result in overbilling and associated criminal and civil liability.

H. Concierge Medicine

One of the more frustrating aspects of continued medical practice independence are the payor-related policies, procedures, and reduced reimbursement associated with the varying types and forms of third party payor arrangements. In addition, many physicians are questioning the trade-off between the need to drive revenue and the corresponding need to treat more patients per day. In order to alleviate some of these challenges, many physicians are turning to concierge medicine.20

Concierge medical practices generally treat a relatively fewer number of patients – each

of whom pays an established annual fee for certain defined benefits. The concierge medical practice generally focuses on primary care services, rather than specialty care. Most concierge physicians offer in-depth annual physicals that may take an hour or more and focus on preventative care. This physical may include many tests not included in a shorter physical. Patients may have increased access to physicians under a concierge-practice model. Office visits are often longer and same- or next-day appointments often available under this model. Other preventative services that may be offered include nutrition and wellness programs, smoking cessation services, and patient education. Concierge physicians may be more involved in coordinating care when their patients are referred to specialists. They may also offer 24-hour pager, cell phone, or home phone access to the physician, email responses and weekend hours. Patients pay an annual fee for such services. The annual fee may range from less than $100 per year to more than $25,000 per year. The concierge practice may be independently organized by the interested physician, or the physician (and/or his medical practice) may affiliate with one of a number of national concierge medicine groups.

Establishment of a concierge medical practice carries a variety of legal issues, the primary issue is whether or not the arrangement violates Medicare billing rules. Opting out of the Medicare program would reduce risk of violating Medicare law to the greatest extent possible. Physicians who make this choice, however, must drop out of the Medicare program completely. To do so, they must follow the rules for opting out of the program, including the signing of an opt-out affidavit and having their patients sign opt-out contracts. In the affidavit, the physician/provider must agree not to submit any claims to or receive payment from Medicare for two years. The opt-out contract must be filed with the appropriate Medicare fiscal intermediary within 10 days of having entered into the first private contract with a patient and at least 30 days before the end of the quarter in which the first such contract goes into effect. This may or may not be a practicable option for physicians interested in providing concierge medicine.

Physicians who do not opt out of Medicare are subject to Medicare’s billing limits under one of two scenarios. Physicians who accept Medicare assignment agree not to charge the patient any amounts beyond the Medicare fee schedule amount (participating physicians are those who sign an agreement under which they take all Medicare patients

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21 These can include breathing, hearing, and complete vision tests, EKGs, an expanded battery of blood tests, including tests for heart conditions, screening for Alzheimer’s, depression, and sleeping problems, and discussion of diet and other health matters.

on assignment).  

Physicians who do not take assignment, but have not completely opted out of Medicare participation, must limit any extra billing (balance bills) to no more than 9.25 percent of the Medicare Fee Schedule amount received by those with participating provider agreements. Any billing above this limiting charge can be prosecuted under the federal False Claims Act.

This raises the question as to whether retainer charges under a concierge model are extra charges that violate the Medicare balance-billing rules. In 2002, the Secretary of Health and Human Services (HHS) indicated that if such retainer fee is truly for noncovered services, it would not appear to violate Medicare laws.  

In response to further queries on this issue, the HHS Office of the Inspector General (OIG) issued an “OIG Alert” about such fees in 2004. This Alert reiterated that extra payments are allowed only when services are not covered by Medicare. Further, the OIG indicated that services such as “coordination of care with other providers,” “comprehensive assessment and plan for optimum health,” or “extra time” spent on patient care could potentially be considered covered as part of Medicare services and not be enough, in and of themselves, to justify charging a retainer fee.

VI. Describing Goals and Strategies - Creating the Internal Documents

A. Governing Documents - Generally

Depending on the type of legal entity that operates a medical practice (e.g., professional corporation; limited liability company), all owners need documents to best reflect their understanding of decision-making, governance, and expectations of the behavior of a physician. These documents have many names and forms, including but not limited to: bylaws, operating agreements, partnership agreements, shareholder agreements, and employment agreements. Notwithstanding what these documents are called, all of the documents reflect a common set of terms that are agreed to for the overall good of the organization. Medical practice leadership must carefully balance the needs of the organization against their own individual interests. Documents that are too one-sided or unrealistic will serve only to cause the eventual dissolution of the organization. Medical practices that thrive tend to understand (and agree) that it is in the best interest of the owners to establish corporate policies, obligations and benefits that are larger than the

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23 Participating providers may, of course, charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements or Medicare law.
24 Letter from Tommy G. Thompson, Secretary of Health and Human Services, to Henry A. Waxman, May 1, 2002.
individual physician and which support the longevity of the organization.

B. Governing Documents - Important Areas of Focus

(i) Governance

The governance structure must provide each owner with a “voice”, yet also permit the delegation of certain day to day operational issues to a single individual or small group of individuals. The owners must have a certain level of trust and design specific mechanisms of reporting (accountability) if the organization is to operate efficiently. In most organizations, the owners regularly elect the board of directors or managers. Depending on the size of the organization, all of the owners may/may not be automatically elected to serve on the board of directors/managers. The board of directors or managers regularly elect the officers. Owners will retain very limited authority, such as, amending the bylaws or articles of incorporation, removal/replacement of directors/managers, merger, sale of substantially all of the organization’s assets, dissolution of the organization, termination/hiring of physicians, offering shareholder status to a current employee, or opening a new location. Day to day operations will generally be delegated to the President. So as to avoid any confusion, the duties of the President may be specifically set forth within the bylaws / operating agreement and may include the following:

a. Planning and chairing Board and Shareholder meetings;
b. Acting as the Corporation’s primary contact for outside parties;
c. Resolving disputes related to the interpretation and enforcement of office policy;
d. Monitoring the financial performance of the Corporation and providing the Shareholders with periodic financial reports;
e. Supervising practice administrator and delegating specific responsibilities to the practice administrator;
f. Selecting, evaluating and negotiating equipment purchases;
g. Developing the annual operating and capital budgets of the Corporation;
h. Approving the capital expenses not to exceed $xx,xxx per item unless otherwise approved by the Board;
i. Hiring, directing and terminating the activities of the Corporation’s accountant, attorney and consultants;
j. Coordinating with the Corporation’s retirement plan administrator and with other third parties which manage or consult on the Corporation’s benefit program;
k. Enforcing the provisions of each physician’s Employment Agreement, unless otherwise directed by the Board;
l. Evaluate or cause to be evaluated each physician’s performance under his/her Employment Agreement;

m. Appointing subcommittees (which can include any Shareholder of the Corporation) to research specific issues;

n. Administering the Corporation’s Shareholder Compensation Plan in accordance with that document;

o. Purchasing or causing to be purchased liability and other insurance to protect the Corporation’s property and business;

p. Entering into contracts for other services, equipment, and goods in the ordinary course of business, subject to Board approval for recurring financial obligations which exceed a cost of $xx,xxx per instance or $xx,xxx per year in the aggregate;

q. Employing and dismissing from employment any and all employees (except for physician employees) including midlevel employees and the practice administrator, agents and independent contractors;

r. Determining all midlevel employee compensation;

s. Determine all physician and clinical provider schedules and call schedules;

t. Keeping, or causing to be kept, full and accurate records of all Corporation transactions;

u. Preparing, or causing to be prepared, all tax returns and reports for the Corporation and, in connection therewith, make any elections that the Managing Shareholder deems advisable;

v. Preparing, or causing to be prepared, the Corporation’s call and vacation schedules;

w. Executing, acknowledging, sealing, and delivering any and all instruments to effectuate any and all of the foregoing;

x. Doing and performing all other acts as may be necessary or appropriate in the ordinary course of the Corporation’s business; and

y. Doing and performing all other acts deemed necessary or appropriate by the Board.

In very limited scenarios, as “senior” owner may attempt to retain certain veto rights or hold the right to unilaterally break all deadlocks (at the owner level or the board level). In addition, the “senior” owner may hold certain rights in the event of dissolution (e.g., practice name, phone number, website, etc.). In some cases, the “senior” owner may hold a particular office (e.g., President). In general, such exclusive “senior” rights (if agreed upon) would be limited in both scope (e.g., the veto could not be used to bring operations to a standstill) and time (e.g., an 18 month expiration). In order for the organization to survive and thrive, periodic new leadership is vital. If new leaders are not groomed and made ready to assume leadership in the governance of the organization, then the organization’s independent will be very short-lived. New owners must be provided with a “roadmap” to future leadership and assured that they will have equally opportunity to
assume such leadership, if supported by the owners. Very few investors will want to join an organization in which they will always be viewed as “junior” members.

If a medical practice’s governance is designed so as to limit delegation and encourage participation by all members, the group will need to learn to manage personalities which may become dominant or disruptive and harm the group. Options may include empowering other physicians with a particular task (e.g., reviewing the current pension plan) or using committees to allow more equal physician participation and dilution of a particularly strong single voice. Also, creating decision-making lists that require a “majority”, “super-majority”, or “unanimous” vote assures all physicians have a voice on certain critical decision-making. Important for medical practices to understand, however, one document cannot / should not attempt to define each and every decision point that will ever be encountered by the owners or the organization. Broad-based elements and definitions will generally suffice to address most (if not all) events and will serve to better protect the organization. The counterbalance to such, however, is that the individual physician will bear the risk of such broader based (but better for the organization) elements and definitions.

(ii) Duties

In additional to governance, each physician employee is expected to work a consistent and fair amount of time, taking on new tasks and opportunities as they are presented to the group. A standard employment agreement utilized for all physician employees can ensure that each physician employee has a clear and common mechanism for addressing the day to day practice of medicine among his/her peers and officers of the practice. Clearly enumerated expectations of a physician’s duties should include: expected administrative time, standard office hours (and days), call coverage obligations, and marketing duties. Too often physicians do not account for these additional duties in their compensation arrangements and expect their partners to do some or all of these things for “free”. Each physician employee should also be expected to dedicate 100% of his/her professional time to the benefit of the medical practice. While a physician may have outside interests, the medical practice and the satisfaction of all of its demands must be placed ahead of the physician’s personal pursuits:

Example: Other than with the Employer’s express written consent, the Employee hereby acknowledges and agrees that he/she will practice medicine and his/her specialty of [SPECIALTY] only as an employee of Employer, and he/she shall not, during the term of this Agreement, either directly or indirectly, be connected with or engaged in the practice of medicine in conflict with the terms of this
Agreement. All remuneration and other benefits earned by the Employee from activities related to the practice of medicine and conducted for parties other than the Employer during Employee’s otherwise regularly scheduled office hours (i.e., not conducted during Employee’s own regularly scheduled vacation, holiday or meeting time), shall belong to the Employer except as noted below. Employee shall be entitled to retain his earnings from such activities so long as the following conditions are met to the reasonable satisfaction of the Employer: a) the remuneration is earned on the Employee’s own time and does not materially interfere with her duties to the Employer hereunder; b) the remuneration is not related to the care and treatment of the Employer’s patients, including but not limited to the conduct of any clinical drug studies; and c) the source of the remuneration is disclosed to the Employer in advance.

Further, expectations of duties and performance also are the underlying foundation for the expectations of revenues which support staff and other overhead. A physician not performing duties creates financial pressures on the medical group which is one of the primary reasons of why physicians leave independent practices. Limiting the volatility of performance is important to the stability (and longevity) of a practice. Standard language includes:

Example: During the term of this Agreement, the Employee shall be under the supervision of the Employer, and shall devote his/her entire working time (other than charitable activities for which Employee is not compensated), skill and experience to advancing and rendering profitable the interests of the Employer, including the continuing development of his/her competence in the field of medicine in general and in [SPECIALTY] medicine services in particular. Employee’s services hereunder shall be rendered pursuant to Employer’s rules, regulations, policies and procedures, as the same may be amended from time to time. Full-time employment is defined to consist of service at the Employer’s offices, plus attendance to patients at those hospitals and facilities utilized by the Employer, and other duties as mutually agreed upon. In addition, full-time employment shall include Employee working a minimum average of [#] clinical hours per week [LIST DAYS]. Employee shall develop and maintain a courteous and cooperative relationship with all referring physicians and shall undertake such activities as will continue to encourage the growth of the Employer’s business. The Employee shall perform, discharge and be responsible for the provision of [SPECIALTY] services in such hospitals and at the Offices and in such a manner and at such times as the Employer may from time to time reasonably direct, and shall maintain the standards of professional skills established by the Employer from time to time. So as to avoid any confusion, and without limitation,
Employee understands that service hereunder may, at the Employer’s discretion, include the provision of [SPECIALTY] services in the evenings and on weekends, in addition to traditional Monday-Friday office hours. The Employee shall participate in night, weekend and holiday call on an [EQUAL/EQUIVALENT] basis with all of the Employer’s [OWNER] physicians on a schedule approved by the Employer. The Employee also agrees to provide such educational, research and administrative services as the Employer may from time to time reasonably direct.

(iii) Compensation

Often the primary aspect of any medical practice – the compensation mechanism is also one of the most frequently inaccurately recorded element in all of the ownership / employment documents. Rarely is there a “one size fits all” approach. However, critical to the arrangement among the parties, the written compensation formula must coincide with the approach used by the practice’s accountant when calculating the compensation paid to the physicians. Often time consuming, the drafting of the formula is often facilitated by review and study of the Excel (or other) spreadsheet used by the accountant. The written description of the formula should follow the excel spreadsheet line by line. In addition, it may be useful to attach an example to the compensation formula so as to avoid any confusion.

If a medical practice utilizes a production based formula, it is important that the regular draw is capable of frequent adjustment by the practice in order to proactively prevent the physician from digging too deep a negative compensation hole. If a physician incurs a negative compensation balance, his/her draw should be quickly adjusted and a plan for repayment immediately instituted. Extended “roll overs” of negative accounts only create dissention among the group.

The compensation formula must strictly adhere to Stark limitations and must not reward the physician for the volume or value of referrals for designated health services. There are a variety of ways in which compensation may be distributed to members of the practice, including the establishment of sub-groups, each of which may have its own method of distribution.26

(iv) Succession Planning - Buy-In/Buy-Out

“Succession Planning” or strategically stating how a physician becomes a partner and

buys-in or how a partner is allowed to “slow down” or retire and be bought-out, are almost always very emotionally charged issues. For a medical practice seeking to maintain its independence and looking to grow and/or survive, the philosophy that the requirements for new physicians to buy-in, or the requirements to buy-out a retiring physician are somehow going to be a huge windfall for the existing practice physicians or retired physician, are a fallacy. Buy-ins that are based on performance criteria (good patient outcomes; good physician/staff relations, etc.) are better recruiting tools than having a physician buy-in at some overly-inflated value of the existing practice assets.

New members will want a dedicated “roadmap” to their eventual ownership in the medical practice; however, providing a commitment to ownership is most often a bad decision for the medical practice. Ownership (and the resulting management participation) in a medical practice is dependent upon a variety of elements – not all of which are objective or stagnant. Elements that are critical at a particular point in time may fall out of favor prior to the actual buy-in. Rather than guaranteeing a buy in time or formula, the medical practice is most often better served to provide a general timeframe for consideration. A standard conditional provision follows:

Example: In the event that this Employment Agreement has not been or is not terminated on or before [APPLICABLE DATE], Physician shall be eligible to become considered for member status of Employer on the terms and conditions generally applicable to all members, but only if he is Board Certified in the Specialty, meets the criteria of Employer applicable to all non-members as defined by the Board of Managers, and demonstrates satisfactory performance to the Board of Managers. Nothing herein shall require Employer to offer Physician such membership status or confer upon Physician the right to such membership status.

Succession planning often focuses on the slow down or retirement of an existing partner on an agreed-upon timeframe. “Slowing down” is most often a defined term (e.g., less than 50% of average practice revenue over last 12 months not due to “exception” (illness; long vacation)), and with timing requirements (24 months’ notice; can’t slow down if under age 60), which is designed to provide the group enough time to replace the potentially retiring physician. Slowdowns also must describe how both the compensation and overhead will be allocated (but, if compensation on pure production, then such allocation is not a significant issue), and almost always have to be approved by the remaining physicians or governance board. This “slow down” process gives all parties both the operational and financial “heads up” to avoid an independent practice imploding upon a prompt, unannounced retirement of a senior physician.
Describing the requirements of retirement (e.g., age; years of service with the group; notice requirements) provides the medical group the planning tools it needs to be prepared for this inevitability. However, having two or more physicians retire in any small time period will cause the group to possibly become financially unstable. Therefore, the notice to retire must be staggered so as to prevent this type of scenario. The departure of more than a certain number of physicians within a certain time period may also cause departure payments to be adjusted – primarily extending the time period for full payment.

As with slowdowns, the issue of buying-out a retiring physician can place enormous financial burdens on a medical practice. Medical practices should have the ability to defer or lengthen buy-out years due to finances or more than one retiree; buy-out payments should be subject to annual aggregated “caps”; a buy-out of the medical practice should be a pre-determined and agreed to formula or amount; and, buy-outs should either be optional and/or carry penalties for bad conduct by a physician, including failure to provide proper notice(s).

One of the more challenging aspects of a buy-in or buy-out is when the medical practice enjoys the benefits of ancillary practice revenues and assets, not just patient care (MRI; CT). Some buy-outs are strictly based on cash flow which limits the risk to the medical group. Cash flow buy-outs include coupling a cash buyout of a physician’s professional revenues (i.e., collect for next 6-12 months and pay physician after deducting agreed upon overhead or administrative costs), and/or the allocation of cash from the ancillary revenue source, also over a period of time, possibly based on a kind of “vesting”. For example, if the physician has been a partner for 1-2 years, then there’s no buy-out; if a partner for 2-4 years, ninety (90) days of cash flow (dividends); if for 4-5 years, then 120 days, etc. This type of buy-out provides the retiring physician certain tax advantages (still considered capital gains) but controls the cash of the remaining medical practice, limiting its vulnerability to cash flow issues. Buy-outs can also be determined based on fair market value but even a fair market value determination should be based on a specific formula in order to avoid discrepancies and excess costs.

Some form of protective limitations:

**Example:** The purchaser of the former Shareholder’s stock, whether it be the Corporation, or the remaining shareholders, shall at its/their option, may pay the purchase price of the stock (i) in cash at closing for the full amount of the purchase price; or (ii) one-hundred percent (100%) of the purchase price payable in sixty (60) equal monthly installments evidenced by a promissory note of the
Corporation, with interest to accrue at the prime rate published in the Wall Street Journal, Eastern Edition as of the last day of the month preceding the effective date of termination of the former shareholder’s full time employment, plus one percent (1%). Notwithstanding the foregoing, the Corporation shall pay the purchase price of a deceased Shareholder’s stock in cash at closing, to the full extent of any insurance proceeds received by the Corporation as a result of the Shareholder’s demise the remainder of such purchase price, if any, shall be payable to the terms of this Section. The maker of the promissory note shall have the option to prepay all or part of the payments due to the former Shareholder, without prepayment penalty. The promissory note shall provide the holder thereof with the right of acceleration of the entire amount outstanding upon the occurrence of any one of the following events: (1) the default for thirty (30) days in the payment of interest or principal due thereunder; (2) the sale, exchange, or transfer of any kind of the shares by the remaining Shareholders of the Corporation, or the issuance of shares by the Corporation, or any combination thereof, resulting in the remaining Shareholders owning in the aggregate less than fifty percent (50%) of the total issued and outstanding shares of stock of the Corporation; (3) the sale, exchange, or other disposition of all or substantially all of the assets of the Corporation; (4) the cessation of all substantial business activities of the Corporation; or (5) the liquidation or dissolution of the Corporation.

Example: If at any time, three (3) or more shareholder-employees or shareholder-employee’s estate are receiving his or her stock buy-out at the same time due to any event, the Employer shall have the option of reducing all stock buy-out installment payments (but not the balance due) hereunder to the cumulative amount payable if only the first two (2) departed shareholder-employees were receiving stock buy-outs (the “Stock Purchase Capped Payment”), which may result in a longer payment term period hereunder. The Stock Purchase Capped Payment shall then be paid to the shareholder-employees in proportion to the unadjusted installment payment due to them. So as to avoid any confusion, the amounts and the installment periods adjusted hereunder will be recalculated as the number of simultaneous stock buy-out recipients is reduced.

Example: Notwithstanding anything herein to the contrary, if fifty percent (50%) or more of the Corporation’s Shareholders terminate their employment with the Corporation for any reason within any consecutive twenty-four (24) month period (such Shareholders being hereinafter referred to as the “Included Shareholders”), then the remaining Shareholder(s) by majority vote shall have the right to negate any obligation to purchase the stock of the Included Shareholders and to pay any further
Severance Compensation under the Shareholder Employment Agreement by electing to dissolve the Corporation. Any such election shall be made within one hundred twenty (120) days after the effective date of the termination of employment of the Shareholder whose termination results in fifty percent (50%) or more of the Corporation’s Shareholders having terminated their employment within a twenty-four (24) month period. Written notice of dissolution shall be provided to the Included Shareholder(s) promptly after the determination to dissolve is made. Any terminated Shareholder whose stock in the Corporation has not yet been purchased agrees to vote on such matter as directed by the other remaining Shareholder(s). Any such election to dissolve the Corporation pursuant to this Item ___ shall also negate (i) the obligations for indemnification of this Agreement hereof; and (ii) the obligations for personal guarantees in this Agreement, as the same may be amended from time to time. If any such election to dissolve the Corporation is made by the remaining Shareholders, then, in such event, (i) the Included Shareholders and the remaining Shareholders shall be treated as Shareholders for purposes of the dissolution; (ii) all payments made to the Included Shareholders during the twenty-four (24) month period will be treated as assets of the Corporation and advances to the Included Shareholders for purposes of determining liquidating distributions; and (iii) the Included Shareholders will only be entitled to the aggregate payments or other distributions (less the advances) that they would have received had they been Shareholders as of the date of liquidation. Notwithstanding the foregoing, any such election to dissolve the Corporation shall not negate the redemption or purchase of a terminated Shareholder’s stock in the Corporation, or the obligation to pay severance compensation to such terminated Shareholder pursuant to the Corporation’s Shareholder Employment Agreement, if such terminated Shareholder is not an Included Shareholder.

(v) Use of Restrictive Covenants.

Where permitted by State law, restrictive covenants may serve to protect the organization and its primary sources of revenue (i.e., patients and relationships with other providers) and its primary source of operation (i.e., employees). Typical issues addressed by these limitations include: non-compete provisions, non-solicitation provisions and non-pirating provisions. Where permitted by the State, non-compete must generally be specific and limited as to duration (e.g., number of years post termination), scope (e.g., specialty) and coverage (e.g., geographic distance). States may or may not enforce “blue-pencilling” so careful drafting applicable to the specific jurisdiction is vital.

While rarely popular with physicians, the restrictive covenants do protect the
organization. While “carve outs” applicable to senior or founding owners are popular items of conversation, they create an inherent sense of “unfairness” that is not palatable to incoming parties. Further, “sunset” provisions applicable to long-time owners only serve to weaken the organization as those owners who have been engaged the longest control the greatest portion of the organization’s business and/or reputation. By limiting exceptions such as “carve outs” or “sunsets” the organization can better present an image of consistency and certainty – both important elements to consider when competing with hospitals to employ the best physicians.

If the owners of the organization also hold investment in other practice-related ventures (e.g., real estate that owns the medical office building that house the practice), consider making a departure from 1 entity a trigger for mandated departure from all other related entities. The remaining owners may waive such application, but when provided for within the operative documents, it reduces the likelihood for follow on issues after an owner departs (regardless of the reason).

**VII. Dispute Resolution**

Specific dispute resolution provisions within an employment agreement and/or within the shareholders/operating agreement can serve to provide a venue for the address of disputes – short of waging battle in court. While certain actions / inactions should be addressed directly in traditional litigation, many typical disputes can be quickly addressed by other means and/or advance planning.

A. **Active Involvement in Decision Making**

A dispute may often be avoided if an individual is provided an opportunity to actively participate in the discussion of specific matters. For example, issues of compensation (including expense allocation and changes to such) or termination of physicians may be opened to a broader approval (e.g., supermajority of all owners) body. When an individual has a “seat at the table” for the discussion and decision process s/he may be less inclined to feel that the decision has been forced upon him/her and more likely to accept the change.

In a similar example of providing the physician some degree of participation in the decision making, consider adding cure rights to default provisions. While not every default event should have a cure right, limited (e.g., 10-30 days of diligent correction) opportunities are often useful, so long as the ultimate decision over whether or not the cure is satisfactory remains with the organization. Be mindful of cure rights that extend too long (e.g., 30 days for failing to adhere to policy may be too long) or which put the
organization at too much risk (e.g., 30 days to cure action/inaction that is detrimental to
the organization or its patients). Cure rights are best reserved for administrative oversight
(e.g., nonpayment of fees).

B. Use of Third Parties

While not always in the organization’s best interest or least costly option – the use of
independent third parties to determine certain calculations may provide the individual
physician with comfort that the result has not be inappropriately influenced by the
organization or its leadership. Notwithstanding the stamp of independence and presumed
objectivity that may be provided, this process can often be unwieldy and time consuming
as the parties each define, nominate and select an “independent” party. Also, such newly
introduced party lacks the institutional knowledge that is captured by the currently
professional service firm and as a result, significant time and effort may be wasted in
getting the new party up to speed.

C. Specific Escalation Processes.

In order to bring some order to the resolution of a dispute, it is useful to detail how/when
a party must bring a dispute to the organization. An escalating dispute mechanism can
often work to ensure that issues of miscommunication are not inappropriately escalated to
litigation without giving the parties an opportunity to resolve.

Example: Any controversy, dispute or disagreement (a “Dispute”) relating to this
Agreement will be subject to escalating alternative dispute resolution procedures.
In the first instance, the Dispute will be referred for a period of ten (10) business
days (or such longer period as the Parties may mutually agree) to a dispute
resolution committee (“Committee”) comprised of two (2) senior officers of
Practice and Physician (or Physician’s representative) of Practice. If the Dispute is
not resolved within such ten (10) business day period, the Practice chief executive
officer and Physician (or Physician representative) shall meet to attempt to
resolve the Dispute. If the Dispute is not resolved within thirty (30) days after
being referred to the chief executive officer, then the Dispute will be subject to
voluntary mediation at the request of a Party. The Parties shall jointly select an
independent and neutral person qualified to act as a mediator. No Party shall
unreasonably object to a qualified mediator proposed by the other Party, and the
Parties shall cooperate in the mediation process. If the Dispute is not resolved
within sixty (60) days following a written request for mediation, or if no Party
refers such Dispute to voluntary mediation, then any Party may seek to enforce its
respective rights and remedies under law. The Parties will continue to perform their respective obligations under this Agreement during the pendency of any negotiation and/or mediation in accordance with this Section.

Mandatory arbitration is an option to be considered, also. While not necessarily less expensive or timely, it is a private proceeding, versus the public nature of traditional litigation.

**Example:** Any dispute, controversy or claim arising out of or in connection with, or relating to, this Agreement or any breach or alleged breach hereof shall, upon the request of any Party involved, be submitted to, and settled by, arbitration in the City of [CITY], State of [STATE], pursuant to the commercial arbitration rules then in effect of the American Health Lawyers Association (or at any time or at any other place or under any other form of arbitration mutually acceptable to the Parties so involved), before a panel of [#] arbitrators selected by the Parties pursuant to those rules. The arbitrators are to apply [STATE] law, without regard to its choice of laws principles. Either party may invoke arbitration procedures herein by written notice for arbitration containing a statement of the matter to be arbitrated. Each party shall submit to any court of competent jurisdiction for purposes of the enforcement of any award, order or judgment. Any award, order or judgment pursuant to the arbitration is final and may be entered and enforced in any court of competent jurisdiction. The parties further agree that the arbitration process agreed upon herein shall be the exclusive means for resolving all disputes made subject to arbitration herein, but that no arbitrator shall have authority to expand the scope of these arbitration provisions. The arbitrator shall have authority to include all or any portion of costs of such arbitration in an award. The arbitrator shall not have the power or authority to award indirect, special, incidental, consequential, exemplary, or punitive damages. The arbitrator may include equitable relief. Any arbitration awarded shall be accompanied by a written statement containing a summary of the issues in controversy, a description of the award, and an explanation of the reasons for the award.

**VIII. Conclusion**

While there is no magic formula to assure the success of an independent practice in today’s erratic healthcare market, it will be critical that physicians be proactive and plan for their success, not just react, as so many other providers are doing. By placing the needs and interests of the organization ahead of the individual interests of the owners, the medical practice will put itself in a much better position to face the challenges ahead.