Partners and Partnerships: Trends in Private Oncology Practice

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Articles about private practice partners and partnerships are often written by lawyers and, as such, take a decidedly legalistic approach to the subject. In any discussion of the business aspects of such partnerships, the bottom line is that the regional market determines what tolerable practice is, and this is translated into covenants that address ownership, governance, and compensation. Although lawyers and accountants are essential for creating a legal and operational framework for any organization, the structure and function of an oncology practice are largely a result of the personalities and politics of whoever constituted or controls the practice. It is unfortunate that the majority of smaller oncology practices have not fully thought out—much less codified—entrance, retirement, and exit plans. Although many models for such plans exist, it is important to note that what is prevalent in another professional field it is not necessarily appropriate for medicine.

The philosophical core of this discussion is the reconciliation of the individual needs of the partners with those of the practice as a business. This is as much personal in nature as it is legal and/or financial. In healthy practices, the desired metrics of personal and professional success are clearly stated and benchmarked against metrics of success of the practice. When a partner's performance fails to meet agreed-on thresholds for success then this failure should trigger a discussion, intervention, or termination. If the structure and function of a practice fail to produce the necessary environment for realizing thresholds for success, they too should be addressed, prompting a change in governance or structure or even dissolution. Thus the practice and the underlying partnership are intertwined, in a relationship that should be revisited and refreshed often. Reassessments should be triggered by any number of milestones, such as a change in partnership, merger, practice expansion, incurring of major liability, or acquisition of real or major capital assets.

Realities of the Oncology Medical Market Place

The practice of oncology is different from the practice of other medical specialties. The confluence of the art, science, and business is directly affected by long courses of cancer treatment, individual responses to that treatment, the buy/bill economic environment, myriad regulations, and reimbursement practices.

There are approximately 6,500 medical oncologists working in private practice in the United States.¹ Regional vacancy rates can range from 30% to 50%, putting enormous stress on exist-

ing providers (Thomas A. Paivanas & Associates, unpublished observations). Regulatory, financial, and emotional burdens continue to restructure the medical marketplace, drawing both experienced and newly trained oncologists into larger single- and multiple-specialty groups, staff model practices, direct hospital employment, industry, and so on. From 1996-1997 to 2004-2005, the percentage of oncologists practicing in groups of fewer than six decreased from 45.8% to 18.7%. Conversely those practicing in larger groups ([mte] six full-time equivalent hematologist/oncologist) increased from 16.0% to 37.4%. Similarly, the percentage of employed oncologists increased from 38.2% to 44.0%² (Table 1). Ultimately this affects the availability, quality, and cost of oncology care. Physician turnover is increasing dramatically in this specialty and approaches 50% in some geographic areas, especially within the first 5 years after postdoctoral fellowship (Thomas A. Paivanas & Associates, unpublished observations). Unquestionably, many aspects of health care reform under consideration will affect the business practice of oncology in the United States.

Assumptions and Nomenclature

The nomenclature around this discussion has to change. For example, the terms "buy-in" and "buy-out" denote an exchange of additional monies for assets that typically do not exist or are at best contrived. Unless a practice is in ownership of tangible assets such as real estate, imaging equipment, and so on, there is really no basis for such transactions. These are rationalizations on the part of senior partners to garner additional compensation, ostensibly for risk they took earlier in the practice's history. In reality, such risk/reward benefits are (or should have been) realized on a near real-time basis and should not depend on a potential future liquidity event (eg, a buy-out or increasing net revenues). Unfortunately, once the basis for a buy-in is established, a buy-out comes to seem more logical, irrespective of reasonableness.

In this changing health care business environment, one should consider the practice itself as a stakeholder separate from the physician partners in the clinical enterprise. This is an important philosophical concept that will affect consideration of organizational continuity, overhead accounting, profit sharing, and the definition of professional duties and relationships.

So, Why Recruit New Oncologists?

It is important to remember the reasons for a practice to increase the number of physicians: new physicians increase the practice's overall revenue stream, increase available personal

Table 1. Changes in Practice Size

No. of Oncologists	1996-1997	2004-2005
1 to 2	29.3%	12.3%
3 to 5	16.5%	6.4%
≥ 6	16.0%	37.4%
Other*	38.2%	44.0%

* Includes physicians employed by medical schools, health maintenance organizations, hospitals (including those in office-based practices), community health centers, freestanding clinics, and other settings, as well as independent contractors. Adapted from Center for Studying Health System Change (HSC) Community Tracking Study Physician Survey, Tracking Report No. 18, Supplementary Table 1.

time for existing physicians, protect or increase market share, and replace retiring partners. The magnitude of these outcomes will directly determine how much the partners should be willing to pay to expand or renew the partnership. However, it is unrealistic to assume that the addition of a new physician will immediately increase revenue, market share, or available personal time. In fact, it may be many months or years before these benefits materialize across the board. This understanding should be a clearly enunciated to all stakeholders in concert with realistic expectations for growth and performance.

Conversely, successfully ensuring long-term retention involves consideration of the quality of work relationships, equitable performance expectations, and equitable compensation. An onerous work life, rather than inadequate compensation, is one of the top reasons new physicians leave a practice despite years of personal time invested.

The New Oncologist (the *de facto* buy-in)

Generally, there is a period of mutual assessment between the practice and the new physician. Typically a 1- to 3-year period is prescribed, during which a competitive salary with fixed bonus based on specific performance goals is paid. Partnership (n.b. profit sharing) is then offered, either in total or phased in over 1 to 3 years. It is this differential between negotiated salary and actual collected net revenue that serves to compensate (1) the practice for infrastructure support and (2) the partners for monitoring and feedback as well as for income and time offsets. Variations in this process include the following:

- Extended phase-in to full partnership can occur over as long as 5 years but is usually driven by the existence of capital equipment or real estate that is not held in a legal and financial entity separate and distinct from the practice. An extended partnership phase-in can also be a device to extract significant revenues from the newly recruited physician partner and thus should be viewed with great caution.
- Junior partnership or permanent salaried position will result in a disproportionately lower number of shares being accorded to the oncologist who elects to take this position. Interestingly, this is occurring more because of planned short-term tenure, interest in time more than money, or lack of interest in the ownership or governance roles that accompany partnership.
- Recruitment of an experienced (> 5 years) oncologist often requires a shorter tenure (eg, 12-18 months) as a salaried

physician or is based on a productivity trigger. Usually a more generous productivity-based bonus program exists for an experienced oncologist than for a postfellowship recruit. Profit sharing can also be accelerated (ie, front loaded) but should be for the same period of time. It is often a sensitive situation for the practice to bring in both new and experienced oncologists under substantially different terms of compensation. These arrangements need to be transparent, with an eye kept on precedent and harmony within the practice.

Base salaries vary considerably across the United States and are driven by regional market conditions and specific practice circumstances. A highly desirable area will allow offers for slightly lower starting salaries, lower fixed bonuses, and longer partnership phase-in (profit sharing). Unfortunately, some partnerships include buy-in schemes or promote “investment opportunities” (aka “golden handcuff” strategy) as incentives to join. However the national increase in base salaries, the minimization or elimination of buy-in provisions, and a growing paucity of available oncologists reflect an increasingly competitive marketplace for medical intellectual capital. Many practices recruit for years before learning the lesson of the market, securing a viable candidate only with the offer of fair and equitable employment terms.

In the contemporary health care market, there should be no separate financial consideration for goodwill, no consideration for minor capital assets, and no additional consideration for accounts receivable (A/R) or drug inventory, because these are all part of what the practice itself contributes to the enterprise in the guise of overhead. This again speaks to the concept of the practice itself as a stakeholder. Thus, given the realities of the current oncology marketplace, as a general rule there should not be additional financial consideration (ie, cash buy-in) on the part of the newly recruited oncologist as a requirement for partnership.

The Stock Purchase

The purchasing of stock in a professional corporation is an important milestone that allows the newly vetted physician to become a partner. Partnership conveys both benefits and liabilities stemming from the practice's operations and is an essential gateway to exercising ownership and governance of the practice and in determining compensation and benefits. Typically stock is purchased at some nominal amount (eg, < \$25K to \$50K) with reasonable payment terms, such as salary reduction or loan. This amount often stays (and should stay) relatively constant over the life of the practice. Note, however, that this has to be paid in total before there is a transfer of shares (with accompanying liabilities and benefits) to the new partner. It is also important to note that in this instance the shares of stock do not reflect some inherent value of the practice. The absolute number of shares is immaterial as long as the final split results in an equal distribution among the full partners. Possible exceptions include the following:

- Phased-in partnership, with percentage of overall stock used to determine a graduated profit-sharing arrangement over time

- Partnership opportunities in other related joint ventures (eg, capital equipment, real estate)
- Deliberate intent by the senior/managing partners to retain majority control over governance of the practice
- Partial or junior partnership to reflect a permanent salaried position

Commonly, funds arising from such stock purchases flow back to existing partners, who must relinquish some of their shares to expand the partnership. However, in an ideal world, this money should be placed in a legal and fiscal “lockbox” (eg, trust, reserved bank account, segregated long-term revolving certificate of deposit) and not distributed to existing partners. Theoretically, these funds should be protected from even the threat of bankruptcy or litigious action. When a physician leaves the partnership for any reason, their shares have to be repurchased at the original established price plus any accrued interest. These funds cannot be forfeited. The surrendering and repurchasing of shares are legally binding acts that officially remove the former partner from any liability, responsibility, or reward stemming from the future activities of the practice. This is yet another reason to keep the purchase amount relatively constant, as the remaining partners will need to generate personal funds to repurchase shares from a departing partner. The practice itself cannot buy the shares back for the partners but can possibly facilitate a loan vehicle to enable them to repurchase shares. Although share prices are established at a relatively modest amount, multiple unexpected retirements or departures could create financial hardship for the remaining partners. Death of a physician should result in their estate being paid for their shares. Again, it should be stated that shares should not be viewed as an investment but as evidence of ownership and governance and basis for compensation.

The Buy-Out

As a general rule, there should be no buy-out provision for an exiting partner of a professional oncology corporation. (Possible exceptions can and should be made for separate specific capital investments and/or for separate, specifically invested joint ventures.) Note this is not to be confused with the pay-out, which is described elsewhere in this article. The existence of a buy-out provision often reflects one or more of the following:

- A strong emotional belief on the part of senior partners
- Guidance naively and inappropriately drawn from other professional or manufacturing fields
- Improvident retirement planning on the part of retiring partners
- Greed

Prevalence of buy-out provisions within medical oncology is directly related to ignorance as to the business of medicine—and resulting acceptance of such provisions—on the part of newly minted oncologists. Any legal or financial vehicle that stipulates buy-outs is driven by the senior partners through inertia, ignorance, or greed. This is a harsh declaration, but this situation repeats itself all too often and invariably ends in emo-

tionally distasteful resolution, a large financial liability, and/or a break in individual career path as a result of separation.

It is often argued that the senior or retiring partners took the initial risks, nurtured key relationships, and invested capital, and that they deserve whatever tithe that they can extract from each subsequently hired physician. However what is often not considered is that those same partners enjoyed 100% of the rewards, ostensibly in real time. Whether such additional tithe can be extracted from the recruited partner is entirely driven by regional market and the naiveté of the negotiating physicians on both sides of the table. Recruitment of new physicians is not done to recoup prior investments but to provide relief in terms of case load, hours worked, and other practice responsibilities. Thus any such loan to the practice (which should have been formally set up with clear fair market value terms) should be paid back from operating revenue streams under the terms specified. Failure to specify such terms should not put any unexpected burden or responsibility on the surviving partners.

In some cases, a departing partner will underscore the contribution of their unique relationships and skills that made the practice successful and suggest that this contribution should be the basis for additional remuneration on departure. The counterargument could then be made that because the departure of an invaluable senior partner in fact reduces the value of the practice, they are materially harming the practice. Perhaps they should pay an exit fee?

So what happens when the issue of buy-out is presented to the partnership? Often this is presented as part of a discussion about valuing the current practice and forcing the surviving partners to purchase the percentage of the practice from the exiting partner. This is an extraordinarily dangerous situation that should be avoided at nearly all costs by new physician partners as well as existing partners midway through their career. Without fail, this topic of discussion will be raised as some of the senior partners get within shouting distance of retirement. For all the reasons stated above, buy-outs will substantially harm the practice and the respective physician partners before, during, and after any such valuation. Failure of the senior partners to personally plan otherwise should not become the burden of the surviving partners. Unless there are specific major tangible capital investments (which should be codified in a separate legal entity), there is little justification to support a required buy-in for full partnership.

The Pay-Out

Simply, the pay-out should be based on the residual amount of anticipated but uncollected billings (ie, A/R) minus overhead arising from professional work performed before the separation date. Regardless of the amount owed to the newly separated physician, the actual pay-out of residual net A/R usually occurs over a period of 6 to 24 months in order not to harm the practice and place an onerous burden on the remaining partners. The greater the pay-out amount, the longer the pay-out period. This formula has to be codified with protections against unexpected disruptions in future revenues.

Because an efficient and effectively operated contemporary oncology practice endeavors to carry little debt (ie, drug inventory), rationale for repayment of expenses, supplies, drugs, biologics, and so on is a specious and spurious argument. These should be viewed as components of the practice's overhead and thus belonging to the practice in its guise as a stakeholder.

Several pay-out variations do exist, and although they have no basis in accounting or law, they are relatively common and could be called "gold watch" provisions. Simply put, this additional pay-out is based on an emotional appreciation of the departing physician's work and collaboration. Often this is restricted to senior physicians who have practiced for a certain length of time and are departing amicably. As an example, 100% of average net revenue (ie, collected A/R minus overhead) of the departing physician for a defined period (eg, 3 to 12 months) is additionally paid out. This double payment would be an additional charge to the practice's overhead and would reduce the remaining partner's net income. Again, although this absolutely should be codified in the stakeholder's agreement it unfortunately doesn't mean that it is reasonable, logical, or fair.

Onerous retirement provisions are one of the most common reasons for practice dissolution. Failure to fully codify these provisions and to model them can, under the most extreme circumstances, create disharmony among the partners or even potentially drive the practice (and possibly the individual partners) into fiscal insolvency. Because regulation, reimbursement, and the marketplace will change substantially over time, it is not advisable to engage in a highly structured buy-in and buy-out. This is simply too heavy a burden on the practice and on the surviving partners. Failure to fully and transparently evaluate the impact of such provisions can effectively preclude recruitment and retention of new partners. Given the severe shortage

of oncologists and the increasing turnover rates of new partners, this consideration should not be dismissed lightly.

It is strongly advised that pay-outs be based primarily on residual net collected A/R that is owed to the departing physician. This pay-out formula should be clearly stated and illustrated, frequently reviewed, and ultimately codified in the stakeholder agreement. Again, any formula should be evaluated with an objective understanding of the precedent that such a formulation will set. Any additional compensation or remuneration should be handled separately in order not to obfuscate this important issue.

Every major event in the life of a practice should trigger a review and update of the stakeholder agreements. The external health care market will change, the operational requirements of the practice may change, the individual needs and desires of the principal stakeholders' may change, and the rules and regulations governing the practice of medicine will change. It is incredibly important that not only are the terms of the initial employment contract spelled out, but also the terms to achieve full partnership as well as those for retirement.

Accepted for publication on January 19, 2011.

Author's Disclosures of Potential Conflicts of Interest

The authors indicated no potential conflicts of interest.

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DOI: 10.1200/JOP.2010.000047

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