November 2015

Partnership Pitfalls: Preparing For The Unexpected

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I. INTRODUCTION

When one enters into a group practice, there is usually a base level of trust and an expectation that one's partners will conduct themselves in a professional and appropriate manner. That is not to say that every partner will develop into or remain the "perfect partner," but at a minimum, one expects that a partner's conduct will not lead to complete disaster—litigation, criminal investigations, negative publicity or mass employee defections. Sometimes that happens, however, and the group is left to deal with what can be very uncomfortable and difficult issues.

Most group practice agreements are only marginally helpful with the disastrous partner, since they typically only deal with easily foreseeable problems. Often, however, issues will present whereby such agreements are silent or woefully inadequate. While it is not possible to anticipate every quirk or personality defect a partner might develop, a group practice would be well served to anticipate as many such "bad" behaviors or problems as possible and attempt to formulate an approach or philosophy to handling such problems in advance.

These materials will identify many of the unexpected "problems" we have had to deal with over the years, and will offer recommendations as to how they can and should be dealt with. These "problem" partners can be categorized as follows: Substance Abusers, Sexual Harassers, Out-of-Control (angry or emotionally disturbed) Partners, Non-Compliant Partners and Distracted Partners. After a few words about the different "flavors" of problem partners, we will offer a few general suggestions for anticipating and dealing with such partners. Then we will look at two special categories of "problem" partners—the Sick/Disabled Partner and the Short-Timer (terminated or soon to be terminated partner). We deal with these separately because they present some special concerns. Lastly, once a decision is made that a partner should leave or is leaving, there may be a pay-out, and one very critical issue is how to protect the ongoing group. As such, we will finish with a discussion of ways to protect the group from the unexpected during a pay-out.

II. GARDEN VARIETIES OF PROBLEM PARTNERS

A. **Substance Abusers**. Unfortunately, this has become an all too common problem. The national statistics regarding alcohol and drug abuse in the medical community are hard to ignore. Left unaddressed, this problem will result in the abuser ruining his or her career to be sure. But (at the risk of not seeming sympathetic) more importantly, a group that allows a substance abuse problem to go unchecked puts itself and the individual partners at great risk, not to mention patients whose very lives may be endangered.

B. **Sexual Harassers**. As society becomes more sensitized to the concerns of female employees and more and more cases make their way into the media, the risk that a practice will face a sexual harassment charge, in one form or another, has increased

significantly in recent years. Unfortunately, many physicians, like many other employers in society, are not as careful and informed as they need to be as to what types of conduct, communications, and actions could put the practice at risk for a harassment claim. A physician having an affair with or who makes a pass at an employee is not simply making an individual moral choice. It is a choice fraught with legal consequences of potentially devastating magnitude for a group. All too often, though, groups turn a blind eye to the impropriety of such a relationship. That's obvious; not so obvious, though, are the risks associated with seemingly less offensive behavior. Seemingly innocuous comments regarding an employee's dress or hair style have come back to haunt many employers. While many employers face what turns out to be a frivolous claim, the fact remains that the practice has to take time and spend money defending itself in investigations or hearings that could have easily been prevented. And yet, too many practices allow their partners to talk and act as if it was their right to comment on the physical attributes of their staff.

C. **The Out of Control (Angry) Partner**. Through the years, we have seen partners who have trouble controlling their tempers, and who are prone to tantrums in the office or at the hospital. Anger issues have caused more than a few practices to fork out money to employees or face investigations because a disgruntled (or former) employee got tired of the abuse.

D. **Non-Compliant Partners**. Perhaps you might be faced with a physician who refuses to answer his or her page or keep up with appropriate chart documentation. These actions can cause administrative hassles or worse. You may also be dealing with a partner who upcodes his charges in order to game the group's compensation system, or who submits claims for work not really performed—the consequences of which can be jail (for him or her), and a whole lot of money having to be repaid (or worse) for the group.

E. **The Distracted Partner**. Sometimes situations arise in a physician's personal life that dramatically impacts the physician's ability to focus and adequately perform his or her responsibilities—a family member's illness, or more commonly, divorce.

Sometimes the distractions are less personal and more business related—performing drug studies, expert testimony, independent medical evaluations, professional organization efforts--all on the "company clock", but which provide no benefit to the group. The cause of the distraction is not important. The consequences are. And all too often the consequences are the same as for the other "problem" partners—potential malpractice, liability (if they aren't paying attention), reduced productivity, exposure to civil and criminal liability (depending on the degree of distractedness) and worse. And, distractions can lead to emotional outbursts or other acting out (see "Out of Control Partners" above) and lead to more complications.

III. YOU'VE IDENTIFIED PROBLEM PARTNERS—WHAT DO YOU DO?

Dealing with a "problem" partner can, of course, be extremely difficult. Denial and strong egos will usually create resistance to dealing with the issues. Nonetheless, it is important for the other members of the group to observe and take action on any problems early on, before they develop into very serious matters threatening the practice. With alcohol and substance abuse, a group must be vigilant in detecting the common warning signs of changes in behavior and performance. And once a problem is detected, it may not be enough just to deal with the problem internally. In most states, there is a legal obligation on the part of any physician to report an impaired physician to the State Medical Board. Failure to do so puts one's own license in jeopardy.

With regard to sexual harassment, everyone must be educated on the types of conduct and statements that land employers in serious trouble, and then police each other to ensure that there is compliance. Similarly, groups need to pick up on the evidence that a partner is non-compliant with the policies of the practice, hospital or third-party payor and then be prepared to take action. So, too, with the angry or out-of-control partner. The longer such problem conduct continues, the more difficult it is to deal with.

How a group deals with the problem will differ with the specific philosophy of the group and the severity of the problem behavior. Sometimes, as in the case of a partner distracted due to family illness, the answer might just be to cover for him or her. Unfortunately, group practice agreements don't usually provide any guidance or terms to deal with the problem partner short of termination--which may not even be an option. For example, a partner with an alcohol problem might be protected under the American With Disabilities Act, which would prohibit a termination without the practice taking specific steps to accommodate the employee's disability. (The same legal requirements, however, do not apply to a substance abuse problem.) So what to do? We have advised some groups that their documents should provide (in addition to normal termination language) for indemnification by a partner for any fines or losses due to his or her actions-- billing misconduct, sexual harassment, non-compliance with policies, or other "bad" behavior. Unless practice documents are clear on this point, subsequent actions to recover from the problem partner will be difficult. Other groups will implement policies that will allow a group to impose financial penalties or make adjustments to compensation shares in the event of continued noncompliance or problematic behavior. Other options include suspension, buy back of stock or ownership interest, reduction in any pay-out and requiring problem partners to undergo addiction counseling, anger management or other therapy/counseling. Even such specific provisions may not be enough, and we suggest, as a result, that the group be given as much discretion as possible to deal with such issues as they arise. This means making sure that a group's documents don't inadvertently hinder that discretion. For example, if a change in compensation is warranted, the agreements should not provide that the compensation arrangement can only be changed by unanimous vote of all the partners.

Obviously, if the conduct is of such a nature that makes it impossible for the group to continue to employ the partner, or if such conduct continues despite sufficient warnings, then the group might need to terminate the partner's employment. Here again, the group practice documents need to be consistent with what the group wants to be able to do. The group needs to decide in advance what the appropriate voting requirements will be for such a termination. Some will require a unanimous vote excluding the partner at issue, and others will require a lesser standard such as a super majority vote (perhaps set at 75%) or

even in some cases a simple majority vote. But, in no event should a partner ever have a say in his or her own dismissal.

IV. SPECIAL VARIETIES

A. **The Sick or Disabled Partner**. A less emotionally charged, but difficult situation nevertheless, is the sick or disabled partner. Most agreements deal with the amount of sick pay a physician is entitled to receive while he or she is out on sick or disability leave. Many employment agreements provide that a physician might be entitled to a certain number of weeks or months of continued salary during the period of their absence. They may even tie the amount of sick pay to the amount of accounts receivable that the physician may have on the books at any point in time. In this way, the practice ensures that any such sick pay is affordable to the practice, and that there is revenue coming in even while that physician is not able to work.

It is also common for agreements to address how long a physician can be out on disability leave before their employment is terminated. It is not uncommon in group practice arrangements for physicians to be allowed six months to a year of disability leave (not necessarily all paid though) before the practice may terminate their employment. Those two issues are usually sufficiently covered in most group practice co-ownership agreements.

There are, however, a number of other issues that present themselves when a member becomes disabled that many co-ownership documents fail to sufficiently address. For example, one very important question to address is whether there is an appropriate adjustment made to the practice's compensation arrangement while the physician is out on disability leave. Suppose a three doctor corporation divides income entirely on an equal basis and provides three months' full salary as sick pay. Suppose also that each physician's basic salary is $20,000 per month. Dr. Smith is absent for 3 months, July through September. At the end of the calendar year, there is a surplus of $120,000, and the group's accountant reports that $40,000 of that surplus was earned and received during the July through September months. If Dr. Smith receives an equal $40,000 bonus, he would receive (through the bonus mechanism) more than just his sick pay for the months he was absent. To deal with this, we have advised groups to reduce any bonuses, pro rata, to account for the disability. A further question to be addressed if there is to be a reduction is whether the reduction should be from the beginning of the illness, or whether the group should agree that for some period of time, perhaps three months, the group will "carry" a disabled physician, in which case the pro rata reduction would only account for absences in excess of whatever the agreed upon "carry" period of time is.

For those groups splitting income on a production basis, there is a whole different set of issues that needs to be considered. In some regards, a production-based compensation takes the approach of "eat what you treat", and, therefore, any sick pay would automatically be self adjusted in the compensation formula. This may be true, but what groups typically fail to address is the way that sick absences could leave a physician who is out for a period of time with a significantly reduced share of income, and when that physician returns, if the compensation arrangement is based on collections rather than charges, it will take a period of time for that physician to again ramp up his collections even though he is back working. That could leave a significantly reduced amount of compensation for that physician, even though he has returned and worked hard.

There are a number of other approaches which can be considered when addressing this issue. First, some groups make no special provisions in calculating this other partner's income share without regard to his absence, his sick pay thus being a mere part of his annual income as though he were solo. Some groups will recognize a disabled partner's sick pay as part of his income but calculate the yearly share by "grossing up" his production for his absence, thus essentially minimizing the importance of his sick pay figure. Still, other groups will create a special income division for the portion of the year a partner's out sick (paying his sick pay as though it were an expense and excluding him from the income division), and include all the partners in a regular calculation for that part of the year when no partner is out sick.

Each of these approaches will have a different effect on the healthy partners as well as the disabled physician. For example, if one physician assumes most of the extra production obligations, he will probably receive a greater share under the third approach. No one approach works for every group; rather each group must consider and discuss the options. Silence on the issue, however, is <u>not</u> a good option.

Another issue raised by the sick or disabled partner is what happens, if anything, to his or her pay-out. Frequently, a physician's pay-out is in the form of deferred compensation, which incorporates in some way that physician's interest in the practice's accounts receivable. However, should a physician, whose employment ends after a disability, be paid for an interest in the practice's accounts receivable? After all, his or her sick pay was already funded by the receivables in existence as of the date the illness commenced. Groups will need to consider this issue and decide whether there should be an adjustment to the pay-out to reflect any amount of sick pay that the physician may have received prior to the termination of his or her employment. We generally recommend that, if a physician has been back to work full time for at least as long as he or she was absent, there be no reduction. He or she will have been able to "refresh" the receivables. If not, however, it would be "double dipping" to pay them again.

Finally, groups should anticipate, and deal with, the partner who can only return to work from a disability on a part-time basis. Most agreements require full-time services, and do not contemplate part-time arrangements, but most long-time partners probably feel entitled to some deference and that they "should" be able to go part time if they wish. The problem is, most groups cannot accommodate part-time partners. And each case is different. We recommend that groups address the general parameters of a limited work arrangement by establishing a mechanism for the group, and the maximum length of time that such arrangement can remain in effect before continued approval is again required, and whether such an arrangement is automatic or even allowed. Setting the parameters for how such a request is to be considered in advance is preferable over waiting until the time when that disability occurs. The specific terms of the limited work arrangement, such as compensation and work hours, should be left to the time when a request is made, since it is unclear at any point in time what kind of work arrangements that physician will need or require.

B. **<u>The Terminated Partner (or Short-Timer)</u>**. Another area where "unexpected" problems can arise is when a physician partner terminates employment with the practice (or where the practice has decided for other reasons (see above) to terminate him or her). In the ideal world, one would expect that the termination process could be handled amicably, maturely and responsibly by all parties involved. The reality, of course, is that most of the time such terminations, especially if they are the result of the practice

terminating the employment, tend to be uncomfortable and are a breeding ground for a number of problems that test the thoroughness of your corporate documentation. One set of issues arises during the period after the termination notice has been given, but before actual termination. Although partner level employment agreements should (and most do) provide for certain "for cause" conditions whereby the practice can terminate a physician partner immediately, most practices will opt to terminate a partner without cause (even when they are a problem partner) rather than deal with the hassle of confronting the partner with regard to his or her behavior. Under most "no cause" termination provisions, the practice is obligated to give some notice period (usually between 90 and 180 days) before the termination will occur. Similarly, when a partner decides to terminate employment with the practice, he or she, too, will have to provide the requisite amount of notice as set forth in the partnership or employment agreement. The problems arise once someone (often the partner) decides not to play fair. Perhaps they put in only minimal effort or no effort at all. Perhaps they schedule extra vacation or start to ignore other rules. Maybe they start to contact patients, take lists or equipment, talk to employees, or even disparage the practice. The possibilities for mischief are endless. A few suggestions to consider:

1. Make clear that any expenditure on the part of that partner, even if it had already been approved by the group, can be re-evaluated. Too often we see physicians who have been terminated attempting to rack up CME time and cost, or incur other expenditures which frequently might be unnecessary and are simply a way of retaliation on the part of the unhappy terminated partner.

2. Give the practice the right to make sure any vacation time taken during the notice period is subject to the discretion of the practice. Trying to take all remaining vacation time during the notice period is frequently at the source of many disputes. Documents should be clear about that.

3. The documents should make it clear that the practice should have the right to terminate that physician's employment immediately but, in lieu of the notice period, pay him or her compensation (and possibly health insurance) during the notice period. In this fashion, if the relationship is just so strained that it is not productive or wise to keep the physician working during that period of time, the practice should have the clearly-stated right to end the relationship if, in its reasonable discretion, it deems the physician to be in violation of his or her duties. If, however, a practice compensates its partners on a production basis, an attempt to terminate, short of the requisite notice period without the clearly articulated ability to do so, might violate the contract expectancies of the terminated physician by reducing his or her income rights. Quite often, documents are silent on this, so by default, the practice can't terminate the employee but rather can only instruct the physician to stay at home and not work during that 90 day period. This can be uncomfortable and cost the practice more than just salary, since malpractice insurance and costs continue to be incurred on an ongoing basis.

4. Make sure your agreements are clear that the practice's restrictive covenant, non-solicitation, confidentiality and/or loyalty or non-disparagement provisions continue to apply during the notice period. Failure to abide by such provisions should be met with clear penalties.

V. PROTECTING A GROUP WHILE PAYING OUT A PARTNER

While most agreements provide for what a terminated partner will be entitled to in terms of his pay-out (usually in the form of stock re-purchase and/or deferred compensation), it is important that the remaining practicing partners remain protected. Payment of any deferred compensation or severance pay which the departed physician is entitled to is going to come out of ongoing earnings. The ones left behind will be working hard, so what is to protect against working harder (and in today's reimbursement environment) making progressively less money as they pay-out some retired "fat cat" dozing in the tropical sunshine? Given that it is the ongoing group that will be funding the payout, the first priority in payout arrangements has to be to protect the ongoing practice--and this really is for the retiring physician's benefit in the long run. Having certain protections will make the group, as a whole, more willing to fund a significant payout, knowing that if certain events take place, the then current owners won't be going to the poor house. The following limitations should be included in any payout arrangement:

A. **Percentage of Gross Income**. Partners in group practices are often afraid that very generous payout arrangements will not be affordable. This concern can usually be addressed by imposing a maximum ceiling on the amount of deferred compensation that can be paid out in any one quarter. For example, the arrangement should include a provision that the total deferred compensation payments shall not, in any fiscal quarter, exceed somewhere between 4% and 10% of that fiscal quarter's corporate gross income. Thus, if the group's activity should significantly falter after a partner's departure, the total payout obligation would not be more than a modest overhead item. The amount not paid because of the limitation is usually deferred to the next quarter when it can be paid. Any amounts that remain unpaid because of the percentage cap after seven years could be forfeited.

B. **Competitive Practice**. A departed partner should not be entitled to funds representing the practice's ongoing earning power (goodwill value) if he or she leaves and practices competitively with it. He or she would, in that case, have taken the earning power with him or her in the form of patients and referral patterns. A departed partner who enters into competitive practice and who continues to receive his or her payout would actually be receiving an improper doubling-up of benefits upon his or her departure.

For this purpose, "competition" may be broadly defined. Note that this does not preclude a partner from leaving and competing with the practice (absent any restrictive covenant). It merely deprives him or her of the right to the goodwill portion of the payout. Some agreements provide for *total* forfeiture of separation pay -- loss of the accounts receivable payout as well as the goodwill value -- as a form of a penalty for the decision to compete. Some practices view such competition as so serious an offense that they require a former partner, who waits a year or two before entering into competitive practice, to repay any separation pay he or she previously received.

C. **Reduction for Short Notice**. Some groups feel a partner should not be entitled to as much deferred compensation if he or she voluntarily withdraws without giving advance notice to the group to plan for the departure. The physicians remaining should be given enough time to recruit for a replacement physician.

A common approach is to reduce a member's right to deferred compensation by one-sixth for each month less than six months' that notice of the decision to voluntarily withdraw is given. (The penalty would not apply, of course, in a case of someone's death or disability.) Some groups ask for as much as a year's notice, and a few we work with even tie the notice period into the recruiting season to make sure there is plenty of time to find a suitable associate replacement.

D. **"Bad Boy" Clause**. Another limitation some groups implement is that upon a physician's employment being terminated on account of being expelled, suspended or otherwise disciplined by a hospital, facility or professional organization as a result of professional misconduct, that physician's deferred compensation entitlement is forfeited. In addition, some groups also provide for forfeiture of deferred compensation in the event the physician is convicted of a felony or criminal offense involving moral turpitude. Bad acts can adversely impact the income (see above) prospects of a group, and so, the thinking here is that termination following a bad event affects the goodwill being left behind--and if there is less of it, the one who should suffer is the one who caused the decline.

E. **Other Concerns**.

1. Governance. Another area of potential problems relates to the terminated partner's role in the governance of the practice. In other words, should the partner who has given or been given notice be entitled to vote as a member of the Board of Directors and as a shareholder during that notice period. The issue can be considered in two distinct ways based on the philosophy of the group. One approach is that the terminated physician remains a full voting partner until the date of termination and should continue to have a vote on all matters as if he weren't leaving. On the other hand, especially in a situation where the physician has been terminated by the practice, a strong argument can be made that that physician should not have the right to participate in such ongoing business decisions, especially those that will have implications for the practice after he or she has departed. One middle ground approach that is worth considering is to limit the governance participation of that physician who has given notice of termination to only those issues that relate to matters that will be relevant to that physician while he or she remains with the practice, but that such terminated physician would be excluded from voting on such matters that would apply after his or her termination. For example, discussions related to the hiring of a new associate in the following year or the opening of a new office should be matters that only the ongoing partners should have a vote on.

2. Post Separation Liabilities. Another area of dispute involving a terminated partner is the handling of post separation liabilities. That is, after a partner has left the practice, what should happen if the IRS or Medicare or any other third party decides to bring a claim against the practice which relates to an incident that occurred while that partner was still there. For example, your partner, Dr. Smith, just retired on June 30, 2015. On October 1, 2015, the practice receives a letter from Medicare regarding an investigation of upcoding of level 4 office visits. After the investigation, the practice is hit with a $100,000 repayment to Medicare. The claims at issue occurred in 2013 and 2014 when Dr. Smith was a full shareholder, director, officer and, most importantly, income sharer of the corporation. As an income sharer, Dr. Smith clearly benefited from the increased revenues which were the result of the upcoding. The question now becomes, should Dr. Smith, who is now retired in Arizona playing golf, be responsible for any share of that payment. Most corporate agreements are silent on this, yet it is too important to be ignored. There really are two basic philosophical approaches to this issue. First, the argument can be made that

when a physician leaves, there should be a “clean break”. If any Medicare, tax or other liabilities arise after the date of termination, that physician should not bear any responsibility. This is consistent with the idea that, since the departed physician is not going to be sharing in any profits or benefits of the ongoing practice, he or she should not bear any of the liabilities or responsibilities of the ongoing practice.

The second approach keeps the physician “on the hook” for certain liabilities depending on their nature and origin. If the physician was involved in setting the policy for the corporation which led to the creation of such liability (no matter when the liability is actually incurred by the corporation), that physician should be responsible for his or her pro-rata share of such liability, or at least to the extent of any payout which he or she may be receiving.

Arguably, if the documents are silent the corporation could possibly have a right of contribution against that departed physician if, in fact, it took place as a result of his or her actions as a director or officer of the corporation. Those type of actions can certainly be difficult to bring and very expensive.

We advise our clients to address these issues at the outset and in the buy-sell agreement long before someone decides (or is forced) to leave. In this way, the practice can clearly lay out its intentions in this area, whether it be holding a departed physician responsible only for his or her actions or a pro-rata portion based on his or her ownership. One common approach we’ve seen is for groups to limit the exposure of that departed physician to only the amount of any remaining payout that he or she may be receiving from the practice.