

Income Distribution and Partner Buy-Ins & Buy-Outs

2015

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Introduction

This guide addresses two complex and related practice issues that impact individual physician finances. Physician compensation formulas are needed to divide and distribute practice income both to practice owners and to employed physicians. Partner buy-in arrangements take the basic compensation formula a step farther and provide a means by which physicians may participate in the owner's share of practice income.

Note: This guide is intended for physician-owned independent practices and does not specifically address hospital-owned compensation arrangements.

Income Distribution and Compensation Formulas

How can the pie be divided so that all of the incentives work together toward a more profitable practice and the physicians are happy with their pay? Looking for the perfect compensation plan for your practice? Don't count on finding it! The reality is that once you've seen one compensation plan, you've seen one compensation plan. There are almost as many formulas to distribute income (and/or expenses), as there are practices. What works for one practice might not work for another and what works now may need changing in a few years.

The key is to keep the compensation plan as simple as possible. Generally, most practices choose some split between equal pay (you work hard as a team to make the practice succeed) and productivity-based compensation (you build in incentives to be productive and/or efficient and/or high quality). Another way to express it is group strength vs. individual contribution. Value-based payment and other incentive/penalty programs further complicate fair distribution of income (or penalties). The process of finding the formula that will work best for your practice will take data, a little soul-searching, a lot of planning, and plenty of just plain communicating.

First and foremost, you need to decide amongst yourselves what is fair and what will enable you to work as a team rather than as competitors. It is critical that the income distribution plan be easily understood by each physician and easily administered on a monthly basis. If you can't define it, you can't measure it. If you can't measure it, you can't manage it. If the incentive system has too many factors, even a good practice computer system may have trouble generating the backup data reports on which to base the bonus. Worse still, as you are busy seeing patients, you may have trouble understanding just what your incentives are. Thus, simplicity in the formula is critical.

How to divide the pie

Because there is no single way to divide the pie, the important question is not which formula is the "right" formula, but which is best for the practice at the current time. Any method may be valid depending on practice goals and what the owners as a group want to achieve. Some practices divide everything equally—we all work hard and we all benefit equally. Others divide up the revenue based on productivity. Some use gross revenue (charges), some use net revenue (charges minus contractual adjustments), some use net income (receipts minus refunds and

expenses), some use charges multiplied by an agreed collection ratio (usually the average for the practice), and some use RVUs (most often wRVUs). Charges are the easiest to calculate and thus probably the most commonly used method. Using revenue or income is a little more accurate but also more complicated to calculate. Using RVUs requires practice management software that can calculate RVUs by provider. Another approach is to divide all expenses equally or use a formula that allocates certain expenses certain ways. Table 1 shows the advantages and disadvantages of teamwork vs. productivity models, plus a blended option. In the end, all methods take some pot of money and find a way to distribute it as fairly as possible.

Table 1

	Pros	Cons
Team-Oriented Model (income - all expenses = amount available to divide equally)	<ul style="list-style-type: none"> • Recognizes group reality & promotes teamwork • Easy to calculate • Easy to understand 	<ul style="list-style-type: none"> • Doesn't work if large variation in individual productivity • Weak individual incentive to work harder • Limited incentive to save costs or work efficiently • Can lead to perceived inequities
Full Allocation Model (each physician operates as a separate economic unit, such that MD revenue – individually allocated expenses = MD compensation)	<ul style="list-style-type: none"> • Promotes responsibility for costs and working harder • Accommodates “eat-what-you-kill” philosophy • Can be linked to benchmarks 	<ul style="list-style-type: none"> • Potential allocation disagreements and expense micro-management • Potential lack of group perspective • Potential Stark issues • More difficult to calculate • Can be “gamed”
Blended Model (practice expenses divided equally but revenue allocated according to individual productivity)	<ul style="list-style-type: none"> • Easy to calculate • Easy to understand • Promotes shared responsibility for costs as well as maximum individual productivity 	<ul style="list-style-type: none"> • If a base salary is provided, the group must agree on the remaining % of income to be productivity based • Weak incentives for cost control • Hard to apply when resource utilization varies significantly among physicians

Let's start with the Team-Oriented Model of equal division. To use this method, the practice collects all the revenue, pays all the bills, including physician base salaries and benefits, and then splits any remaining income equally among the physicians. Thus the expenses are paid off the top as a shared cost of doing business then the remaining pot is evenly divided amongst the physicians. This method strongly supports group unity and is very easy to administer. There are a couple of downsides to this method. First, if there is significant variation in productivity,

then someone eventually will get frustrated. Second, there is no incentive to work harder, more efficiently, or more cost effectively. And participation in programs such as quality reporting or meaningful use can further complicate matters.

The Full Allocation Model follows the “eat what you kill” philosophy--dividing up the expenses and revenue according to a formula based on individual physician production. For example, at the end of the month revenue would be divided proportionately and then the related share of practice expenses subtracted from each physician’s potential income. The trickiest aspect of this method is calculating expenses accurately. because it requires allocating staff and other resources by physician. Thus the full allocation approach can be difficult, but it may work well for some groups, especially those in which certain physicians provide specialized ancillary or procedural services not offered by all members of the group and where revenue and expenses can be easily attributed to the particular service as a “cost center.” In cases where all physicians provide essentially the same services, differences in personal practice style may also affect the volume of resources utilized and therefore justify using this approach.

The full allocation model assumes that a more productive physician will use more staff time (both clinical and administrative) to see more patients, however, this factor may not matter much until staff are fully utilized and would have to be increased in number to accommodate more productivity. To calculate individual use of supplies and other resources accurately requires a detailed cost accounting system. And, without a detailed time study, it is difficult to know exactly what percentage of staff time each physician consumes. Consequently, to avoid the extra costs and effort required to track actual physician expenses, most practices simply choose to divide expenses in the same ratio as total charges per physician.

Although most practices use total charges as the basis for allocating income and expenses, some prefer to use actual receipts. In theory, this method is more accurate and could more fairly reflect any significant variation in payor mix among the physicians. For example, reimbursement for the same service from self-pay, Medicare, managed care, and indemnity may differ significantly. Charges fail to reflect these differences. However, the cost and burdens of using actual receipts usually outweigh the benefits, due to inadequate practice computer systems and complications resulting from the time lag between billing and collections.

A good compromise between the Team-Oriented and Full Allocation Models is the Blended Model. Probably the most common model used in smaller practices, it combines equal division of expenses with productivity-based distribution of income. This is accomplished by first paying all the operating expenses, leaving net income available to be divided according to productivity. Often an agreed monthly base salary (set below the physician’s anticipated share of total income based on productivity) is paid first. Then, the remaining practice income is distributed based purely on individual production.

While splitting expenses evenly is simple and provides extra incentive for lower producing physicians to increase their productivity to the level of higher producing physician(s), this method is less accurate in recognizing the usage of resources than allocating expenses proportional to productivity. Normally this disadvantage is minor. However, it could be important in a heavily capitated practice where controlling expenses is critical to managing capitation contracts profitably. The same might be true in practices with significant variations in resource utilization by physicians due to differing specialties or services provided.

Although capitation is less significant in practices today, other alternate payment models that share some similarities to capitation are being tried. It is easiest to divide the PMPM payments in the same ratio as other revenues are divided (i.e., the PMPM payment is included in the total pool to be distributed). Again, if production varies greatly from one provider to another, the capitation payment may be based on the charges generated by capitation patients. The compensation formula in a heavily capitated practice normally should include expense allocations, since the underlying economics of capitation are designed to stress expense and utilization control.

Basing pay on relative value units (RVUs) is often touted as the fairest methodology, because it reflects work effort rather than financial results. Using RVUs requires the availability of a computer system capable of tracking utilization by CPT code by doctor, but that too is more commonplace now. This method may be most useful in multispecialty groups where significant variations in reimbursement may exist between the specialties, or in single specialty groups where there is wide variation in the types of patients seen.

The most important factor in determining the optimum methodology for the group is that all physicians are in agreement on what will be accomplished. Simplicity is key. Most successful compensation plans are based on some simple, easily calculated combination of equal division and productivity.

What behaviors should you reward (if any)?

When a practice moves beyond equal pay systems, and value-based payment factors in, it begins rewarding (or dis-incentivizing) particular behaviors. Most commonly, income division formulas are designed to increase productivity, save costs, or both. Other “value-based” factors can be built into the pay scale such as clinical quality, practice “citizenship” (e.g., hospital committee work or medical society activities), resource utilization, or patient satisfaction; however, inclusion of too many variables in the formula can, and frequently does, make it too complex for physicians to understand intuitively and more difficult for staff to calculate. If nothing else, compensation should reflect the physician’s contribution to the practice’s income. Revenue production usually translates into hard work and plenty of hours. However, over-treating a patient or over-coding or spending too much money on operating or capital expenses can also cut into profits, but these can be tracked through audits and other techniques.

Expense-driven formulas are more difficult to calculate and can be more controversial. Only a few overhead expenses really make a difference in the practice’s bottom line: personnel expenses (including benefits), physician benefits, equipment and major supplies, office space, and malpractice insurance premiums. Variations among them usually are not great, and most are not directly controlled by individual physicians. Disparities in the last three may result from some specialties requiring more space, more expensive equipment, or higher risks, which in turn trigger higher malpractice premiums. Personnel expenses are sometimes affected when physicians are assigned particular staff, e.g. for ancillary services, or truly need more intensive personnel support. Physician benefits generally are the same except for some personal preferences—what kind of car you drive, how much entertaining you do, what kind of CME courses you attend, where they are located, how many professional societies you belong to, and so forth. Such personal preference items are easy to take off the top before calculating pay.

But when you begin trying to calculate how much nurse time Dr. Specialist vs. Dr. Primary uses and how many more patients Dr. Speedy can see than Dr. Slow thereby using more of the receptionist's and biller's time, it becomes much more difficult. Dividing up expenses may require a partial cost accounting system and agreement on how to divide various direct expenses fairly while dividing indirect shared overhead expenses equally or according to some agreed production ratio.

Pay based on quality is growing in importance due to pay for performance programs, but can also be difficult to quantify. If your IT system is capable of tracking patient satisfaction or other performance or quality measures, these incentives can be built into your compensation system. Clinical quality indicator incentives might be more easily tied to a group bonus pool than incorporated into the individual physician's compensation. And, instead of reviewing them monthly, they may only be worth analyzing yearly or quarterly.

A simple incentive formula based on straight production is easy to calculate, easy to understand, and rewards working hard and helping the practice become successful, but may not work in today's value-based world.

Changing the Formula

No compensation system lasts forever. As times change so should your income distribution system. If you are changing from an equal split income division to one based on revenue and/or expenses, but you are concerned about the first year's impact on personal incomes, it might be prudent to consider a 2-3 year phase-in period. For example, to lessen the initial compensation impact during the first year, a portion of pay could continue to be paid based on an equal split with the balance paid according to productivity and expenses. Gradually over the remaining transition period, the amount paid based on productivity would increase as a percent of the total pay. This phase-in period would allow lower producing physicians time to bring productivity up to the level of the more productive physicians.

A Word about Stark – Protecting Yourself

The Stark Self-Referral Regulations, or the Stark Law, prevents physicians from referring to outside ancillary services in which they hold ownership or investment interests. Stark allows an exception for referrals within a group practice but places strong legal constraints on how physicians may be compensated for their referrals to such in-office services. When setting up your compensation system, you must consider how to divide the revenue from these ancillary services, such as a lab, so that no portion of physician compensation is directly linked to the utilization of these services. Allocation of income generated by ancillary services, however, can be based on broader considerations such as allocations proportional to the overall productivity of individual physicians. The Stark Law requires that the overhead and income of the group be distributed in accordance with methods "previously determined." Thus, the compensation method cannot simply reflect the number of lab tests or stress tests ordered by a physician, and it must be in place prior to payment for the services that generate the income or accompany the expense. Stark permits alternative allocation methods so long as they are effective prospectively and the compensation to physicians meets certain tests. See the ACP's guide "The Stark Law --

Self Referral Regulations” (<http://www.acponline.org/private/pmc/selfref07.pdf>) for more details on how to protect your practice from violating Stark rules in your compensation plan.

Supervision Compensation

In practices that use NPs, PAs, or other non-physician providers, there may be some time spent doing oversight. In practices that use production-based compensation, such as wRVUs, this can be an issue because the time spent supervising is non-productive time. It is possible to structure compensation to include a production credit or a supervisory stipend. The important thing to keep in mind is that, in the end, in any compensation formula, the total compensation should be fair and end up in the fair market value range.

Leadership Pay

Sometimes physicians do more than just see patients. For instance, the “managing partner” may require a certain amount of time each day, week, or month to take care of the business aspects of the practice. Other physicians could be active on the staff of local hospitals, training residents, or in the local medical society leadership. These activities enhance the practice as a whole because the better known a physician is in the medical community, the better his or her reputation and the more referrals that are likely to come to the practice as a result. Although important to the practice’s success, such leadership activities take time away from seeing patients and generating revenue. Therefore they need to be separately rewarded in the compensation formula.

Paying the managing physician for his or her efforts to manage the practice can be done a couple of ways. First, the practice could pay a percentage of overall profit, thus rewarding the managing partner for doing a good job and making the practice more profitable. Second, a set amount could be paid based on the estimated time spent performing practice management duties instead of seeing patients. This method’s chief weakness is that it does not directly relate compensation to performance of the managerial duties, e.g. successfully managing expenses or the billing staff. The third approach would be to “gross up” the managing partner’s income to make up for the lost production time. For instance, if the managing partner spends one-fifth of his/her time doing administrative work, then the pay would be 120% of what the compensation formula would otherwise have specified.

Compensation for leadership roles outside the practice is more difficult to quantify, but the time lost seeing patients in the office can have an overall positive outcome on the practice’s reputation. For instance, chairing a committee at the hospital or being president of the local medical society may take a good deal of time, but the familiarity with other physicians in the community can help earn referrals.

These suggestions are merely options to consider. You and your partners will have to weigh all the factors including the availability of good data to serve as a basis, and then decide what is a fair and equitable compensation formula given your particular circumstances and what will work for you.

Partner Buy-Ins & Buy-Outs

After a physician has successfully worked as an employee for a specified period of time, the practice may offer the physician an opportunity for “partnership” or “ownership” in the practice. This means that the employee must “buy” his or her share of the practice. Unless the buy-in formula was spelled out in the physician’s original employment agreement, the buy-in must be negotiated when the physician actually is invited to become an owner. Because this process can be complicated and sometimes even contentious, it can take a while. Once a price has been set, the new owner either pays the full amount up front or pays it over a few years, with or without interest. While the new owner receives no tax deduction for the investment, the selling owners must report any gain on the sale of the stock (the portion that they are selling to the new owner) as a capital gain.

A buy-in (a.k.a. “purchase”) agreement is a formal document outlining the specific conditions and formula by which a physician may become a part owner of a medical practice. Executing a buy-in usually increases the physician’s income, status, and responsibility within the organization and, hopefully, employment security. One vehicle for setting the conditions of a possible future buy-in agreement is the new physician’s initial employment contract. However, both parties may want to reserve their rights to make a future judgment about whether the buy-in agreement will actually be executed. Ideally, a group should decide on a basic buy-in methodology before recruiting a new physician. How and when the numbers get filled in, however, may be subject to negotiation upon hire. A buy-in may be needed when a solo physician decides to take on his/her first partner, in which case the buy-in will be decided then.

The value of the practice is a major element of the buy-in agreement. Three main factors – tangible assets, accounts receivable, and goodwill – are used to determine the value of the practice and therefore the physician’s share or buy-in amount. The tangible assets are the easiest to determine because they include cash, furniture, equipment, and other items with measurable cash value. The accounts receivable are monies owed to the practice for services already rendered. Goodwill is the value of the practice’s expected future earning power. Theoretically, determining the amount that should actually be paid for the buy-in involves multiplying the sum of these three values by the proportion of ownership interest that the new doctor will receive in the practice. However, the absence of any single, reliable methodology for calculating goodwill complicates the matter considerably.

There are several ways to go about determining buy-in value. Some practices pay for a full-blown practice valuation by an outside consultant each time a partner buys into the group. Even such “professional” valuations are imprecise, however, since there is no single generally accepted methodology for calculating practice value. Thus most valuers use several methodologies to construct a range of value. Other practices use crude rules of thumb or comparable practice sales data to calculate goodwill. Some practices use a pre-determined amount and phase in the buy-in over several years through salary reductions (“sweat equity”). Some practices choose to ignore goodwill and tangible assets and instead base the value solely on accounts receivable. Some include all tangible assets and accounts receivable and leave only goodwill out of the formula.

The Inexact Phased Buy-In

One pragmatic solution to the valuation problem of assigning a dollar value to a practice is to side-step it by substituting salary reductions spread over several years instead of calculating the traditional purchase amount. However, this does introduce the difficulty of having to agree on the annual percentage reductions in salary and the number of years over which they will be imposed.

An “inexact” and phased buy-in method calls for reducing an incoming partner’s share of ownership salary over several years (usually three to five) as part, or all, of the buy-in “payment.” This is often accomplished by gradually, usually on an annual basis the percentage of a full owner’s share that the new owner will receive until he or she attains 100%. For example, year 1 would be at 60% of a full owner’s share of practice income, year 2 at 70%, year 3 at 80% and year 4 at 90%. A production bonus during this introductory period may also be included to encourage getting up to full speed and contributing to the practice’s bottom line more quickly.

The salary reduction concept assumes that a new owner initially will be less valuable to the practice than the more experienced owners but will, over time, grow in experience and value. Although the likely pace of this development can be debated, the current and prospective physician owners may find reaching agreement on this subjective judgment much easier than trying to assign an arbitrary monetary value to the practice’s “goodwill.”

Why is the new owner less valuable? Principally because the senior partners possess longstanding patient and referring physician relationships, assume more leadership positions in the hospital and the practice, and have more experience in practice management. Thus it makes sense to give the new owner gradually increasing shares of practice profits over the first few years of ownership until he or she has established a reputation in the community, built his or her own patient base, acquired more experience in management, and assumed more leadership roles.

This methodology need not even require using the word “buy-in,” and the absence of an actual “purchase” can be very appealing to a new recruit. It avoids negotiating over the very difficult-to-determine value of goodwill. And on “D-Day” when the new physician officially takes an ownership share, there may be no need for the new physician to borrow – unless a nominal “purchase” price is established for tax purposes.

The Exact Buy-In

The exact buy-in consists of setting a price for the practice and paying over a period of years. This method is particularly appropriate for an experienced outside physician who will literally “buy” his/her way into the group, for example someone moving to town from another location. However, a solo physician down the hall who decides to close down his or her practice and join your group may bring patients into the practice and is already well established in the community, in which case the buy-in will need to reflect this value added to your group.

Let’s say the practice is valued at \$2 million (including goodwill) and the group of four is adding one new physician. The new doctor must somehow pay \$400,000 (1/5 of the total value)

to the four existing owners. This amount could be paid in a lump sum (perhaps with a bank loan) or paid over a period of 3-5 years, or both.

One way to do it is to set up a structured plan to reduce income over a period of time, similar to the method described above in the inexact buy-in section. This way the new partner pays more or less depending on how profitable the practice is during the buy-in time period. Some prefer to use a specific purchase value for the receivables and goodwill instead of a percentage income reduction.

The Buy-Out

For the partner who is leaving, such as a retiring senior partner, the buy-out is just as important as the buy-in is for a new physician owner, and the same issues of value and methodology must be addressed. Occasions for a buy-out include death or disability of a partner, a partner moving to another city or leaving to start his or her own practice. If a practice already has determined a method of valuing the practice for purposes of buy-ins, the same factors may be used to determine a departing partner's pay-out (or buy-out).

However, if the partner is leaving to practice in the same service area, the valuation and payment schedule may need to reflect a different set of considerations. The departing physician may be taking patients, and therefore goodwill, to the new practice, and could in the near future be competing directly with the remaining doctors, including securing provider contracts from the same payors for the same panel of patients. Therefore, the buy-out agreement can be adjusted to account for this loss of practice value by reducing the pay-out amount. State laws vary significantly on what is and is not allowed with regard to pay-out limitations and "non-compete" clauses, so it is important to seek competent legal advice.

Typically, when a physician is retiring or leaving the area, the buy-out is structured as deferred compensation, which is a tax-deductible expense to the corporation. (If the buy-in was paid through reduced salary, or pre-tax dollars, it seems logical and fair that the buy-out should be paid as deferred compensation, which is taxable to the outgoing partner.) The buy-out arrangement should however be reviewed by the practice's tax advisor. The period selected for the pay out should be long enough (such as 2-5 years) that it does not overburden the corporation yet short enough so the departing owner does not wait too long for "closure." Payments to the retiring doctor for his or her share of the practice are designed to recognize years spent helping build the practice to its current size and value.

The agreement may also seek to address possible unforeseen future contingencies, such as significant reductions in practice income or increases in expenses after the physician's departure that might preclude the practice from sustaining its planned level of pay-outs without jeopardizing practice solvency. Under such extraordinary circumstances a provision in the buyout agreement permitting renegotiation of the pay-out provisions or a fixed formula for reduced pay outs over a longer period of time might help save the practice and thus the retired physician's hope for future pay outs.

Another important consideration is any practice liabilities that may arise after departure, such as those from tax audits, Medicare audits, or malpractice claims. Depending on the circumstances, some groups may wish to exempt the departing member from such

claims while others may prefer to build into the agreement a reduction of benefit in an appropriate proportional amount.

Protecting the Practice

A well-structured buy-in or buy-out is a complicated endeavor. Co-ownership is like a marriage—it is a long-term relationship that requires a lot of work, communication, dedication and perseverance. If the buy-in is not planned and written well, it could lead to an unhappy divorce. If the buy-out is not done fairly, it could leave both parties in uncomfortable positions and with hard feelings. It is therefore critically important to involve an experienced healthcare attorney in drafting the buy-in and buy-out agreement in order to protect the financial interests of all parties: the practice, incoming partners, and outgoing partners.

Restrictive covenants (for owners as well as for employees), protective limitations and caps (to protect practices that encounter financial problems after the partner leaves), “lookback” clauses (to protect against liability claims that arise after departure), and benefit carry-forwards (such as malpractice or disability premiums that will follow the outgoing partner), reductions for sick pay (for those pay-outs resulting from an illness) are all elements for possible inclusion in the buy-in or pay-out agreement. Appropriate treatment of them requires competent counsel to draft the legal language. State variations in the law as well as individual circumstances of the practice and partners involved requires detailed knowledge of tax, liability, and other legal implications to draft an agreement that is best for everyone.

Buy-Sell Agreement

One of the most important legal documents that can tie all of this together is a buy-sell agreement approved in advance of the events for which it is needed. Without an up-to-date, well-thought-out buy-sell agreement in place, a medical group can find itself in a costly fight among its owners over a change in ownership. The purpose of the buy-sell agreement is to facilitate an orderly purchase or sale of ownership occasioned by a new partner’s desire to buy in or the death, retirement, disability, or other voluntary or involuntary departure of an existing owner.

A carefully drafted buy-sell agreement should address at least the following issues:

- Triggering events;
- Purchase price;
- Disbursement;
- Tax issues;
- Restrictive covenants;
- Review and amendment; and
- Dispute resolution.

While these issues may be difficult to agree upon in advance, doing so is well worth the effort. Any dispute arising at the time of the buy-in or pay-out will be far more difficult to resolve and could result in severe damage to the group’s solidarity and therefore future prospects. The best time to establish a buy-sell agreement is prior to the first ownership purchase into the group. The agreement should be reviewed and updated periodically (annually or bi-annually) to minimize the adjustments needed at the time of future transfers in or out of ownership.

Resources

Much is written on this subject, some of which goes into great depth. This guide was intended to provide an overview of the subject. The sources below are only a couple of those available although ACP has reviewed all of these documents and believes them to be high quality resources. ACP cannot endorse the work of other organizations but can recommend them as reliable in terms of content.

Medical Group Management Association (MGMA): Several products, articles, and tools are available to help in the development of income distribution, buy-in or buy-out plans. Go to <http://www.mgma.com> and search using the topic or title. Some resources are for MGMA members only, some are available for purchase, and some are available to the public.

Health Care Group: “Buy-Ins and Pay-Outs” – this 110 page book describes the legal and business arrangements for physicians both becoming partners and those leaving the practice. It helps physicians understand what it means to be a partner and how to structure the agreement. Includes sample promissory note, stock option, buy-in agreement, and deferred compensation agreement. (\$105) <https://www.thehealthcaregroup.com/pc-27-2-medical-practice-buy-ins-and-pay-outs.aspx>