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EXITING PARTNERS FROM A PRACTICE WITH ATTORNEY JASON GREIS

David Mandell:

Hello, I'm David Mandell, host of the podcast. Today, we've got a special episode. We have our first repeat guest -- as we are early here in season three. We've got attorney Jason Greis, who was on an episode in season two. And that episode was all about ASCs --Accredited Surgery Centers. So if that's a topic that's of interest, make sure you go back and check that one out. And as we were preparing for that episode, he and I started talking about another topic, which is our focus today-- that I thought was so interesting and something that I know many of you will be interested in hearing about that I wanted to get him in early in season three. So I'm going to bring Jason on, let him tell you a little bit about his practice. We will, of course, link to his official bio at the law firm in the show notes, but I will let him summarize it. So with that, Jason, welcome to the program.

Jason Greis:

Thank you very much. And thanks for having me back. I'm glad I didn't screw it up too badly the first time around, and thanks to the audience for listening in. My name's Jason Greis. I'm a corporate healthcare partner with Benesch Healthcare Law. Benesch is a smaller national law firm. We've got about 350 attorneys around the country. I tend to focus on corporate healthcare law. And what does that mean? I help doctors and hospitals and ambulatory surgery centers, and physicians and physician practices with their deals, whether it's contracting, helping to establish surgery centers, ancillary investments, real estate, practice acquisitions, mergers in healthcare, private equity. So that's pretty much what my practice covers although the law firm covers pretty much the full scope of what you would expect.

David Mandell:

Excellent. Yes. And like I said, he's got a pretty impressive bio and we'll link to that in the show notes. And obviously feel free to reach out to Jason if any of this is of interest. So when you and I spoke before the first episode, you said, "Hey, have you guys had anybody come on and speak about sun setting partner, sun setting physicians." And I just like that verb, first of all. You could also use the word exit, but what is this topic? What are we talking about today? And what's the issue, big picture? And then we'll kind of dive into a little more depth.

Jason Greis:

What we've been seeing, I represent a lot of physicians and physician practice groups, is as the age of the average physician increases, we're seeing what I like to refer to as institutionalization of physicians in the sense of if you've ever seen the movie, The Shawshank Redemption, the scene at the end of the movie where they kind of laugh saying, "I've been institutionalized and it's hard to leave the four walls of the building." Physicians who've been practicing for 30, 40, sometimes 50 years have a hard time letting go. Lawyers are much the same way.

And this concept of sun setting the physician is to come up with an exit track that lets the exiting physician know what to expect, helps to transition patient care over time, maybe come up with a path to an employment relationship either full-time or part-time employment relationship that everyone's excited about so that you don't lose that leadership institutional knowledge, patient care for those patients who are obviously incredibly connected to some of these more senior physicians. And it also helps to set boundaries and helps the next generation to come up through the ranks, and hopefully to learn from physicians who are getting ready to exit in terms of finding a mentor of how to approach some of the practices, either patient care issues or business issues that the sun setting physician probably has seen and dealt with for many, many years.

David Mandell:

It makes sense. And when you brought it up, it clicked in my mind because a couple reasons. One, I know some other professions that deal with this, whether it be law firms or CPA firms, consulting firms, where they've had to think through how do they deal with this issue. Very senior people, they're getting in their sixties or seventies. How do we deal with them? How we do something that's fair, that's fair to the firm, et cetera. That make economic sense, that is, like you said, that is ideally turns a potentially acrimonious situation into something that's a win, win. I mean, that's the goal right? And medicine and physicians, I don't think, have dealt with this as much. And so for some people it may be we don't really have a plan yet. So let's talk about this with our lawyers. What have you seen as a trend in practices in terms of this issue? What have you been seeing in terms of exiting or buyouts, et cetera?

Jason Greis:

It's interesting. I started thinking more about this issue 10 years ago when we were just seeing a lot of litigation around physician exits, and it just struck me how many practices had no plan. p

David Mandell:

Right.

Jason Greis:

I think we all have this sense of not wanting to deal with our own mortality or moving on in the next sense of our career. And like you said, it's a lost opportunity. In terms of the issue of what trends are we seeing on buy-ins and buyouts, again, it's interesting. It used to be really common when you have physician practices that were 20, 30 years ago organized as a C Corp because that's really all there was back in the day and maybe there were some tax benefits in terms of establishing certain types of retirement plans associated with a C Corp and those days are long gone.

And I think the next trend you saw was seeing practices set up as an S Corp or a PLLC. And that's how I think most practices are now set up, thank goodness. But the most recent iteration is where are the values of practices? Doctors, this next generation of physicians who are coming up, the question that we're seeing a lot of is what does it mean to be a partner? And so they're asking the question of how much is it going to cost me to buy in? When am I going to be eligible for partnership? And of course the buy-in and buyout oftentimes reflect one another. And so you see, I'll call it, the old school, old model, which is very high buy and very high buyout. You really don't see that as much anymore unless the practice can quite frankly justify it in its particular marketplace.

Now, what we've seen is a shift to a very low dollar buy-in and low dollar buyout model. And even more recently, we've seen as kind of a generational shift, kind of a that... I've been working on creating what I refer to as a three tier partnership structure or an accounting firm structure, a law firm structure, where you set up an associate and non inequity and equity partner kind of three tiered system, because we're finding that increasingly doctors don't want to be a true partner meaning they're signing on the dotted line for personal guarantees and taking on the risk. And they're happy just taking home whatever their pay is plus maybe some bonus, which kind of falls into that second tier of partnership, this non equity partner, and that's fine by them. So that's the latest thing that we've seen, is this kind of three tier law firm or accounting partnership model.

David Mandell:

Interesting. It reflects the fact that not everybody wants the upside and maybe the headaches of equity partnership. Now, what do you think is driving physicians to implement sun setting policies? Is it they've had a couple headaches or potential litigation and they just said, "We got to do better than this." Are they learning from other people's mistakes? Are there lectures at conferences now where people are be made aware something that you're speaking on? What's driving them?

Jason Greis:

I started thinking about it and speaking on it when I saw, like I said, the increasing number of disputes, which kind strikes me as silly because it's, again, lost opportunity versus something that really should be, or is something that's become, as you said, acrimonious. And so what we are seeing is the elder statesmen in the group, driving the process and looking for a way to wind down and reduce or eliminate their call coverage requirements, transition patient care, and really get some sort of sense of what income continuity is going to look like for them as they move into retirement. And they started thinking about those sorts of issues in estate planning issues.

David Mandell:

So it goes beyond just, "Hey, this is what you're going to get." I mean, the sort of model I had in my mind that I've heard people say, "Well, you can leave when you want. You get six months of your receivables and that's it." Right? And it's either you're in or you're out. And it sounds like what you're saying is that there's a desire from physicians and it makes a lot of sense. It's not a binary one or zero here. It could be a transitioning in terms of hours, in terms of part-time, in terms going from equity partner to just an employed position. It could be for surgeons doing surgery to just consulting. There could be an element of their clinical responsibilities that there's basically a pathway created or maybe multiple pathways rather than starting from scratch and doing it on the fly. Is that reflective of what you're seeing, that all these elements are kind of on the table?

Jason Greis:

Yeah, for sure. And I think a lot of the disputes came up that I've seen around, everyone practices striking special deals with the first person. And then the second person's looking for something similar, and then the third person just either rides those coattails or throws some salt in the wound and is looking for something maybe a little bit different. And it just takes up a lot of time and administrative effort. And I think a lot of practices are saying, "There's really no reason why we can't or shouldn't standardize these sorts of things."

David Mandell:

At OJM we have mostly physician clients, but about 20% of our clients are business owners, entrepreneurs. I speak at some of the entrepreneur organizations and cover buy-sell agreements. And we have one at OJM Group with my partners, and we have life insurance tied to it and all that. And what I tell them, and I think this is reflective of what you're saying, is it's a lot easier to hammer out an agreement when neither of you, if it says two partners or five partners, are near retirement because you don't know which one's going to get sick or which one's going to want to retire or which one's going to get divorced.

So everybody's sort on the same page, and it's not a zero-sum game thinking, whereas you get to the person is retiring, it's all zero-sum games. Every dollar we give them, we don't get, right? It's right then, and it's much harder to feel good about a deal versus, "Okay, this is what we're going to do in the future whenever somebody retires." And maybe you might be a partner in your forties and know, "Okay. The guys in their fifties are probably going to be before me, but it's not so immediate that it seems like it's zero-sum." Is that a big part of what you're advising clients do?

Jason Greis:

It's better to have those conversations when there's no issue. It's a much easier conversation to have. And quite frankly, with the rash of healthcare private equity transactions that we're seeing as well, it's much better to sit down and talk with your partners who are on the verge of exiting because a lot of times they say, "Well, what happens if you guys happen to sell the practice? And I was here for 30 or 40 years, I helped to build this value. That doesn't seem fair to me that I get left on the sidelines while you take the value." And so there's discussions around those sorts of issues too. Oftentimes you'll see what's referred to as a claw back, get put into agreements that if a doctor happens to exit within a couple of years after the practice does a sale, that he gets some portion of the proceeds. So yeah, all good discussions to have.

David Mandell:

And I think it all probably also works the opposite way too meaning if you think you're going to be there the whole time and earn out, and there might be a claw back of your percentage if you don't practice that the whole time. Maybe a health issue comes up and you have to retire, you are not getting the full compensation as the folks who are earning it out over the next five, seven years practicing.

Jason Greis:

Exactly.

David Mandell:

I was going to ask you that and I think that's right. I mean, my guess is the increase in outside investment, private equity, is kind of forcing some of this formalization because they want to see it. And if I'm investing in a business, I want to see that the practice has thought this through, and then we're not going to get into disputes when every doc retires. Are you seeing that? Is that something that the investors want to see? They come in, they say, "Hey, do you have an exiting plan? Do you have a sunsetting plan? And if not, this is something we want to see before we close the deal."

Jason Greis:

They haven't specifically asked for it. It's interesting because I think what happens oftentimes is they take a look at the practice's organizational documents, they kind of nod and they put in place whatever they want to throw on top as their organizational structure. But in all of those instances, there are gating mechanisms for physicians who are coming into the platform in terms of how many physicians can retire at any given time.

David Mandell:

I see.

Jason Greis:

What's the order of payment when you join one of these conglomerated physician practices as part of the platform? And so I think, no matter what, if you're thinking about doing a healthcare private equity deal, having these conversations, if it's two, three, five years out, it's still helpful to think through these issues because you're going to have the same conversations again if you ever decide to go the healthcare private equity route.

David Mandell:

So let's say you're one of the docs listening to this, "We don't have anything in place. We're a ten-person orthopedic practice." Or, "We're an eight-person gastro practice," whatever it is. What should considerations should if physician sun setting policy include and what's involved in developing that kind of policy?

Jason Greis:

And it varies. Maybe a 40-person physician practice might have something that's more robust or a 100-person physician practice or clinic versus something that's say two or three person physician practice and where maybe quite frankly, that's just more of a discussion you have among the partners in terms of what your expectations are going to be. But when we're helping our physicians to think through these issues and create the policies, we'll talk about things like coming up with retirement based upon age or a certain amount of tenure. What is the length of the wind down period? Oftentimes it's somewhere between one and three years. The policy oftentimes addresses things like mental and physical disabilities, and how do you deal with them.

Call coverage requirements, because one of the benefits that oftentimes the exiting physicians are looking for is to slow down and not provide call coverage. And obviously you have to have a group that's big enough in order to accommodate that sort of request. Decrease the phase,

productivity requirements usually come up, which also goes to, "What does it mean? Are you rounding at the hospitals or skilled nursing facilities or your surgery centers? Are you just doing clinic a few days a week? If you're a practice that has medical directorship fees, what does it mean for that physician shares of MDA fees?"

And then another key point is as you're winding down and retiring, if the practices ancillary investments like surgery centers, dialysis, real estate, are you going to use retirement or the wind down as some sort of mechanism to exit the physician from those ancillary investments? And the answer may be very different depending upon the type of ancillary investment. For real estate for example, oftentimes physician practices allow physicians to maintain their real estate investment well into retirement versus call it surgery center or dialysis where the intent there is to use those sorts of investments as an extension of your physician practice and to care for your patients.

And so oftentimes, both for practical as well as for potential compliance reasons, it's always smart to exit the physicians out of those investments and quite frankly, help to keep the joint venture healthy by then hopefully bringing in some of the younger generations. The policy oftentimes will deal with things who's going to pay for the malpractice tail? What does life insurance, if anything, look like? And then again, just having some sort of discussion or reminder about what the covenants are going to be when you leave, whether it's none compete, none solicit? So there's a lot to cover potentially formalize either in a policy or policy combined with maybe some changes to some of the other documents of practice has in place.

David Mandell:

I want to ask about the documents in a second, but I want to go back to one of the things you mentioned that stood out to me. So you mentioned mental and physical disability. And I think that's something that is, I think, can be the most difficult and is why it's so important to have something in place before because I'm sure there are partners. I mean, the numbers just have to be thus that there are folks who are dealing with somebody who maybe is having cognitive issues or physical disabilities where they can't do what they used to do either in full or in part. And again, trying to deal with that in a way to be fair because let's just assume all good intentions. "Hey, this is a guy who was a partner of mine for 20 years, but we're not a charity also. This is a business and we want to do the right thing. Well, on the other hand, we can't overextend ourselves and we can't set a precedent to everybody else."

It's hard to do that. So it seems to me that would be one that really is important. And especially as we've just said before to do this before there's an issue, right? And I mean, to me, that's as important for a three person practice as it is for a fifty person practice. Because if you're a three and one of your docs, one of your partners gets disabled or has a cognitive issue where they can't do what... Really in a hard place, if you don't have anything thought through

because you want to do the right thing. And yet it's not going to be easy to do it right. I mean, no matter what the good intentions are, if it's not put down in place earlier. So what do you see? Do you agree with that? And what do you see in terms of those provisions that maybe someone here could listen to and get some kind of the motivation about?

Jason Greis:

It's much easier. I totally agree with you too. Become a little bit more disconnected and say, "Hey, we thought about this ten years ago or when we were doing our wind down policy. And here's how we decided that we were going to deal with it instead of dealing with it on a one off basis where everyone's feeling like they're getting the short end of the stick." So again, I agree with that. And then in terms of how to do it, quite frankly, I've seen different practices deal with it in different ways. Some practices key it off of their long term or short term disability policies and say, "Hey, if you're disabled is determined by our insurer," then that's the trigger mechanism. Others will say, kind of use the approach of, "We're doctors. We know a lot of doctors. Let's go out and hire someone who we think is independent to make the determination." And it's not only an area where there can be hard feelings. It's an area where you have to be careful legally because of age discrimination and disability discrimination claims as well. So objectivity becomes that much more important.

David Mandell:

On n the other side, you can't have someone in your practice continuing to see patients if we don't think they're cognitively able to do it. So you kind of have risks on all side. That's why I think it's so important to work this thing out beforehand because if you're doing it on the fly, there's just pitfalls everywhere. I mean, it's almost amazing that people could do it frankly on the fly and have it not turn into something that is disputed. I mean, just talking about this now, I mean, between the family that is perhaps the doctor's getting exited, but the concerns about liability. But there's also, like you said, disability or age based claims. I mean a lot of mine fields there.

Jason Greis:

Yeah, for sure. And you're seeing it in the hospitals too that hospitals and surgery centers are adding to their bylaws that if you're a physician of a senior age, you actually have to go in for competency exams either on a yearly basis or as part of a credentialing cycle. It's kind of similar to, I guess, the DMV requiring you to go in and have an exam every year for your motor vehicle test.

David Mandell:

Yeah. Yeah. That makes sense. I mean, they're obviously thinking about these things. So just a couple more questions. So you mentioned the practice's organizational documents. Does it tie into their articles or organization they're an LLC or their bylaws or how do you do it? Just don't want to get too much in the weeds because we don't have a lot of lawyers listening, but is it a contract? Does it involve the actual corporate documents? How do you guys usually create that?

Jason Greis:

Yeah. Usually it starts with a sit down with the partners to start thinking through these issues, and we'll give them kind of the agenda that I just gave you. And sometimes we're involved and sometimes we're not involved, and they get back to us in terms of how they want to deal with it. And then we help them to put together policies. And then we just need to make sure that those policies dovetail correctly with employment agreements or if they do have ancillary investments and they want to use the wind down policies of trigger in the ancillary investments that they're synced up with the ancillary investments. And so it can sometimes be a good opportunity if you've got an organizational plan, organizational documents that are 20, 30 years sitting on the shelf, accumulating dust and dust that was often think through those issues again. And then also it's a good opportunity to reconnect with your life insurer and your 401k folks and just make sure that everything is working together.

David Mandell:

That's often how we get connected in is, "Hey, I'm doing this. Do I have enough insurance life insurance? Should I look re-look at my disability? Do I have long term care insurance?" Because typically even the best practices, the group policies, while they're good and they're helpful, you're going to need your own policies. I know that with disability, and they get that usually early on in their training, but long term care, et cetera, which often these days can kind of spin off of a life policy, which is great because if you don't use the long term get benefit then you get it as a death benefit. And if you want to use it during your life, you can. So it gives you kind of two bites of the apple. Any last sort big picture thoughts on this issue? And then tell us how you typically work with practices.

Jason Greis:

I think that we've used the term lost opportunity a few different times. And I think that all practices are trying to differentiate themselves right now from the guide down the road. And it's so difficult to recruit physicians with the staffing shortage and the physician shortage. This can be a differentiator if you do it right in terms of coming up with a buy-in formula, buyout

formula, retirement formula, something that really shows physicians that you've thought through it. And it can be another key differentiator in recruiting.

David Mandell:

Yeah. I think that's right. Whether the terms are ideal or not, and they're... What does ideal even mean? But I think it's more the fact that, "Hey, this is a practice that's thought this through." They're not doing this on the fly. They actually think about the business issues, the financial issues, the things that make being a partner easy because whether you love it or not, it's done. You don't have to think about it, right? That doesn't mean you couldn't influence it or there's review and kind changes over time, but versus a practice where it's like, "No, we never really thought about that before." Then you know there's headaches coming.

Jason Greis:

Right.

David Mandell:

Especially a young doc coming in. It's like you're going to be the one having to figure it out for the docs who are already there and that's stress. So I do agree. I mean, I don't know if fellows or docs would see it, but certainly physicians moving one practice to another, I think, would see it is a real value these people have thought through some of these internal issues that can keep things peaceful and moving forward in the right direction. That makes sense. So last thing, if any of the docs listening are interested, they can email you. What's the best way to start a discussion with you?

Jason Greis:

You know what? I appreciate it. I'll send you a brief slide show of talking through and walking through some of these issues as I've spoken on this many times at conferences. And then doctors can feel free to reach out. My cell is always a good way to reach me, and it'll be in the presentation, but it's 847 977 4383. And then my email, Dave, if you don't mind putting on your website.

David Mandell:

Yeah. We'll put that in the show notes, both your bio, which obviously if they go to your site though, it has there in your email there. So Jason, thank you for so much for being on. I know this is a topic that makes sense, that it's important. And frankly, I haven't heard people speaking about it. So I think it's doing folks a favor and hopefully some of them get ahold of you.

Jason Greis:

Hey, now I appreciate it. And thank you for having me as a repeat guest.

David Mandell:

Yeah. The first one. So that's great. So for all the listeners, thank you for tuning in, and every two weeks we'll have another episode. If you have an idea of somebody, including yourself as a doc who's listening saying, "Hey, there's some things that I think I could impart to my fellow docs." Feel free to contact me. We're early in season three and I'm lining up guests for the rest of the season. And with that, thank you and tell your friends about us.