

PRACTICE MANAGEMENT

Buying and selling physician practices: Haven't we seen this before?

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The acquisition of physician practices by hospitals and health systems – once thought to be a thing of the past – has returned with vigor. Hospitals, with cash and a desire to recapture lost revenues and lock in future referral streams, are expressing renewed interest in such acquisitions, while physicians – often strapped for capital, overleveraged and facing declining incomes due to pricing pressures and reduced prospects for ancillary revenue – are, again, strongly considering hospital employment.

Is this “*déjà vu* all over again?” Maybe. Maybe not. Unlike the practice acquisitions that took place in the 1990s, today's deals are bigger, more complex and riskier. It is important for today's physicians to understand what is happening, why and how physicians and hospitals should plan for, structure and execute these deals successfully.

What is going on out there?

A recent survey by the American Hospital Association indicates that by March of this year, almost 40 percent of physicians surveyed were considering sales of their practices.¹ This figure is up from approximately 30 percent a year ago.² These numbers follow a significant number of large physician practice acquisition deals that have made headlines in the past couple of years:

- In the summer of 2007, Aurora Health Care of Milwaukee announced its affiliation with Advanced Health Care, a 250-plus physician multispecialty group practice, with locations throughout Milwaukee and southeastern Wisconsin.
- Also in the summer of 2007, Banner Health acquired Arizona Medical Clinic, an 80-person multispecialty group near Phoenix.
- In January 2008, Fairview Health Services in Minneapolis acquired the 87-physician Columbia Park Medical Group.
- Also in January 2008, Medical Associates, a specialist-heavy group in suburban Milwaukee, agreed to affiliate with Pro Health Care, a suburban Milwaukee-based system.
- In addition to the above, over the past year vast numbers of smaller practices have been acquired by hospital systems.

Big or small, what did these deals have in common? While the nonpublic nature of the transactions often makes details difficult to analyze, all likely shared some of the following characteristics:

- The physicians likely were offered employment arrangements that included production-based compensation formulas and incentives to align physician and hospital interests.
- The practices may have been valued by one or more independent, third-party valuation firms to support or determine purchase price.
- Certain value likely was derived from ancillary services, such as imaging, laboratories, ambulatory surgery, sleep studies and clinical research.
- In some instances, intangibles, such as assembled work forces, may have contributed value.
- The physicians and the hospitals may have agreed to structures that will provide the physicians with an ongoing role in group governance and management of the physician group.
- The size of the groups, the profitability of the ancillary business lines and the value of the tangible and intangible assets most likely represented material investments by the hospital buyers with significant strategic implications for their businesses.

What has been driving this trend?

No single reason accounts for this transaction volume. Rather, a confluence of economic and regulatory circumstances has dramatically changed the business environment, making these deals attractive for sellers and buyers.

Reimbursement pressures and healthcare reform. Changes in Medicare are driving down the profitability of physician practices and other services (such as imaging and ambulatory surgery, including reimbursement for endoscopy and

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¹American Medical News (Sept. 7, 2009).

²*Id.*

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colonoscopy procedures in an Ambulatory Surgical Center [ASC] setting), while managed-care companies continue to take advantage of the market consolidation over the past decade. In many markets, payers have used the bargaining leverage gained from consolidation to extract significant concessions from physicians. We have seen an increasing number of gastroenterologists consider hospital employment due to, among other things, declining reimbursement for ASC-based GI procedures. For example, in 2009, Medicare reimbursement for upper GI endoscopy biopsy (CPT Code 43239) decreased by 7 percent over the 2008 rate, and diagnostic colonoscopies (CPT Code 45378) dropped by 6 percent.

Now, with the specter of healthcare reform looming, many physicians and hospitals are wondering who will be the winners and who will be the losers. Some physicians believe that these reforms, if they come, will result in “bundled” Part A and Part B Medicare payments and will drive physicians into the arms of hospitals. Most agree that, whatever happens, the economics of the practice of medicine may never be the same. Those with strong enough convictions have decided that being “first movers” will result in higher purchase prices and better employment arrangements.

Changes in law. Changes in the federal and state regulatory environment clearly have had an impact on this trend. In the 1990s, joint ventures, such as shared services facilities, block leases, turn-key management structures and “under arrangements” deals, had become commonplace. These arrangements allowed physicians and hospitals to share in, rather than compete for, ancillary income streams.

Beginning in late 2007, however, the Centers for Medicare and Medicaid Services and the Office of Inspector General made sweeping changes to the Stark law and other rules – changes that not only stemmed the tide of new deals, but also required the restructuring or termination of joint ventures already in place. As a result, physicians and hospitals once again find themselves competing for revenue from ancillary income streams.

Capital constraints. The past decade saw physicians spending considerable capital on equipment and facilities that, in many markets, created excess capacity. As years passed, equipment and facilities became outdated, and many physician groups – bereft of capital and highly leveraged – delayed reinvestment, resulting in reductions of cash flow from previously profitable businesses. The recent credit crunch has only exacerbated the need for capital and the lack thereof.

Physician shortages. The acquisition of physician practices has become a strategic imperative for many hospital systems to address medical staff shortages. The Bureau of Labor Statistics predicts that there will be 212,000 physician openings by 2014 – a number equal to more than 25 percent of the current physician work force. In some states with high numbers of retirees, such as Arizona and Florida, acute physician shortages are already the norm.

Past practices and how things have changed

The acquisition craze of the 1990s was unsuccessful for many hospitals, and the resulting employment arrangements were unsatisfying for many physicians. Hospitals typically overpaid for practices, put physicians on salary guarantees and then failed to actively and carefully manage the acquired practices.

These failures typically resulted in huge investment losses, poor patient care and service and, ultimately, unproductive and unhappy physicians. In many instances, the practices were re-sold to their original physician owners, usually at a substantial discount to the original acquisition price.

It is important that physicians understand that hospital leaders today are taking a much more strategic approach to practice acquisitions. Likewise, physician executives are well advised to be equally strategic. By this, we mean that physicians should attempt to ensure that any acquisition structure provides fair market value payments for practice assets, thoughtfully aligns incentives through compensation, allows a certain level of physician practice autonomy and, to the extent possible, provides a voice for physicians in governance and management. By doing so, we believe that physicians and hospitals have the best chance of successfully merging their respective businesses.

Practice values and purchase price

Physicians often have high expectations relative to the value of their practices. They recognize, and would like to be paid for, not only the value of the professional fees they generate, but also the technical and facility fees (imaging, laboratory, surgical fees, etc.) that they will bring to their hospital partner. In the past, hospital buyers – anxious to placate their physicians – overpaid for practices, paid for things they really could not buy and rarely sought independent support for the price paid. This is no longer the case.

The question of value is more closely scrutinized today than it was a decade ago. Hospital leaders are much more price conscious and, further, are acutely aware of the duties they owe to their bond holders and the boards, as well as the need to comply with the federal and state anti-referral laws (such as the so-called anti-kickback statute and

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the Stark law). Hospitals really cannot, and generally will not, pay more than fair market value for a physician practice, no matter how important the practice (and its physicians) are to the hospital.

Moreover, although the value that a physician practice generates for its hospital partner – in the form of technical and facility fees – is unquestionable, the price paid for the practice can only take into account the business the practice generates for itself, not what it generates for the hospital. Paying too much or paying for the wrong thing could be deemed a breach of fiduciary duty or can be found to violate laws that can lead to significant fines, penalties, suspension or expulsion from Medicare or, worse yet, criminal convictions. The latter risks are shared by physicians, who can face severe penalties and even jail time for accepting illegal payments.

So, how do hospitals and physicians stay inside the lines when structuring purchase price? Competent legal advice and credible third-party valuations are essential. Time and energy should be spent determining the assets that can be purchased and in formulating assumptions that will be used by valuation experts. Good lawyers and competent valuation experts take guess work and risk out of this process and can help manage the expectations of both physician sellers and hospital buyers.

Compensation and expectations

Physician practice acquisitions are as much about emotions and expectations as they are about deal points. No deal point is more emotional, nor creates higher expectations, than does the issue of compensation. One of the main reasons that physicians join hospital systems is to provide themselves with greater certainty and security around compensation.

Historically, physician employees were put on salary guarantees that often led to unproductive – and ultimately unhappy – physicians. Over time, hospitals and physicians learned that divorcing physician compensation from productivity and hospital objectives was a prescription for failure. Physician leaders and hospital executives are well advised to spend time and money up front to structure compensation arrangements that link compensation with productivity, quality and other objectives important to the hospital. Today's compensation structures reflect these elements. For example, well-designed structures often compensate physicians relative to:

- Productivity (either through resource-based relative value units or net revenue generation)
- Collections
- Clinical efficiency
- Integration efforts
- Quality, safety and patient satisfaction
- Income from ancillary activities
- Good citizenship

As is the case with purchase price, it is critical that physician compensation be consistent with the fair market value of the services provided by the physician. Both the federal Stark law and the rules governing tax-exempt organizations prohibit physician-employee compensation from exceeding fair market value levels. Paying compensation in excess of fair market value can subject the hospital and the physician to significant penalties.

This concept was illustrated in a recent settlement between a hospital system and the United States Department of Justice (DOJ). In August of this year, Covenant Health System of Waterloo, Iowa, paid a reported \$4.5 million fine to settle allegations that compensation paid to certain of its physician employees, one of whom was a gastroenterologist, exceeded the fair market value of the services provided by the physicians.

While specific details of the compensation plan are private, published reports indicate that the physicians in question were paid on a production-based model. Although, reportedly, the physicians in question were highly productive, the DOJ took the position that their compensation exceeded fair market value and that payments to them violated the federal Stark law.

Based on this position, the DOJ further contended that the hospital system violated the federal False Claims Act each time it billed for a procedure ordered by one of the physicians in question. The settlement sets a significant precedent and should alert all hospitals and physician employees to the importance of setting compensation levels consistent with market value.

Terms of employment

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It is hard to divorce compensation from terms of employment. Physicians involved in an acquisition transaction should request their proposed physician-employment agreement early in the deal process. The employment contract provides each physician with an outline of what his or her professional life is going to be like post-transaction. In many cases, the contract will likely be longer, more detailed and, sometimes, more heavy handed than that to which the physician is accustomed. Physicians should pay careful attention to items such as:

- Hours of practice.
- The level of administrative and clinical control that can be exercised by the hospital over the physician's practice.
- The ability of the hospital to relocate the physician's practice. This can have an effect on compensation, especially when it is production based.
- Compensation formulas (see discussion above)
- Benefits, such as paid continuing medical education and vacation.
- Covenants not to compete. Physicians are often required to sign covenants not to compete that will require them to relocate from the community, for a period of time, should they leave the employ of the hospital.

Physicians and governance

Among the more difficult elements to structure in a practice acquisition are the terms under which physicians retain a voice in how they govern and manage themselves. Many physicians who become hospital employees have never worked for anyone other than physicians; some of them will have had governance and leadership positions within their organizations. These physicians may balk at the idea that they no longer have a voice in governance and management.

Failure to allow physicians a meaningful voice in governance can kill a deal or eventually lead to significant dissatisfaction among valuable group members. That said, physicians need to understand that the decision to allow physicians a voice in governance must be balanced with the need of the hospital to protect and maintain its tax-exempt status and run its operations efficiently.

Areas where physicians are likely to have significant input regarding governance typically involve clinical issues, such as quality, utilization review, patient satisfaction and research; physician and clinical employee discipline (including, in certain instances, hiring and firing decisions); compensation allocation (within legal constraints); capital prioritization; and resource utilization, such as supplies, staff and equipment.

Legal Issues

Both the acquisition of physician practices and the employment of physicians are fraught with legal issues. Among key elements that must be considered are:

- **Transaction structure** (*e.g.*, equity versus asset purchases). Physician transactions are often structured as asset purchases, which allows the hospital to avoid certain liabilities, but leaves those liabilities with the selling physicians. In this regard, doctors are well advised to understand the potential liabilities inherent in their practices before approaching a transaction with a hospital.
- **Physician tax considerations** (*i.e.*, single versus double taxation). Physicians pay taxes, and hospitals do not. Careful analysis must be made as to how a transaction will affect the physicians who are selling.
- **Structuring purchase price.**
- **Regulatory approvals.** Poorly timed approvals can slow down a transaction.
- **Due diligence.** Physicians should be aware that hospitals are likely to scrutinize the practice to be acquired closely to ensure that any compliance issues are caught and addressed, early in the process.
- **Market terms.** In today's transactions, physicians are generally required to represent and warrant the condition of the practice.
- **Escrows and indemnities.** Depending on the size and complexity of the transaction, physician sellers likely will be required to indemnify the hospital buyer for any problems that crop up later with the practice. The physicians may be required to place into escrow certain amounts of the purchase price to support those indemnities.

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Careful structuring protects value

Acquisitions of physician groups are a significant trend that will accelerate as changes in law, reimbursement pressures, physician shortages and structural changes in how care is delivered force hospitals to rethink their traditional physician integration strategies. These complex transactions require identification and consideration of a multitude of variables. Managing these variables effectively will ensure the successful conclusion of a transaction. Structured correctly, these deals can ensure that long-term value is created from an acquisition effort.

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