Why Merge Medical Practices?

Somewhere in a physician's professional career in private medical practice, there will likely be the opportunity to merge, acquire and/or sell his/her medical practice with another entity. In fact, most physicians in private medical practice will encounter numerous opportunities for some type of merger or acquisition in the course of their careers. The unstable and rapidly changing environment of health care has again intensified the interest of physicians to merge with other physicians who might share a common vision (Remember the merger activity of the mid to late 90's?). This is again leading to a resurgence of consolidation activity.

However, with this activity has also come the many examples of group disagreements, improperly planned mergers physician distrust, incompatibility, poor communication, lack of physician leadership, and contrasting visions, which in turn have led to demergers. Most of these pitfalls and eventual demergers are the result of inadequate due diligence by the groups prior to merging operations, management and leadership.

A demerger is one of the most expensive propositions a medical group can be involved in – at least twice to three times more expensive than a well-planned merger, and that is without considering the impact of lost revenues from decreased production and inefficient operations.

With horror stories like this, why should physicians even consider merging at all?

Actually, there are many benefits to a merger for all of the participants. A well-planned merger can not only improve the financial performance of a group of physicians; it can also help secure its future in the market place. Let's examine some of the benefits that can be derived from a well-planned and executed merger.

One of the greatest benefits derived from a merger of independent medical practices is the **increase in negotiating leverage.** One of the best types of leverage with insurers, payors, hospitals and suppliers is size. As medical practices increase in size (and many times in geographic locations), their ability to utilize this network to their advantage in negotiations becomes quite evident.

The larger medical practice will generally find more opportunities for joint ventures, partnerships and affiliations. In fact, many times hospitals and other organizations that did not formerly do business with the practice will come knocking on the door as new suitors. As payors try to meet the consumer's demand broader provider choices; larger clinics will be early targets for enrollment and will generally have the ability to negotiate more favorable contractual terms with the payor.

Another benefit to consider for a merger is the barrier it may present to competition for entry into the market. Smaller groups and solo practitioners will think twice before opening a medical practice in a market that is already adequately covered by a larger group of physicians.

The most frequently discussed benefit of a medical practice merger by physicians is economies of scale. The theory is that the combined groups can reduce duplicative expenses by using their size as leverage – for instance, negotiating larger volume discounts from supply and equipment vendors because of their anticipated higher usage. Professional fees also are generally less per physician when shared in a larger group.

Additionally, many merger plans include the intention of eliminating redundancy and the costs associated with duplication of facilities, equipment and staff training. Typically included is a

plan to eliminate some of their full-time equivalent (FTE) employees once the merger is completed. **However, keep this in mind** – It has been my experience that, due to the cost of a merger and the complexity of actually combining cultures and operations of two or more practices, even a well-planned merger might not realize significant economies of scale in the first year.

As patients (consumers) have more and more choices about their physicians and the related health care they receive, **marketing has returned to importance for medical groups.** A larger group can usually afford a more comprehensive and extensive marketing campaign, which generally results in a greater return on its invested dollars if done well.

Although raising capital has not traditionally been a big issue for physicians, it is a pressing need for medical groups today. Progressive medical groups need capital to invest in new partners, new markets, new revenue streams, medical practice management systems, sophisticated clinical equipment or new facilities (i.e. ambulatory surgery center or medical office building). Simply put, to be successful today, medical practices need access to more money. Larger groups obviously can pool their resources to be more effective at these and other strategic but capital-intensive activities.

In today's business environment, medical practices must have strong physician leadership. Quite often medical groups will reach a point in their lifecycles when their internal physician leadership wanes. A merger offers the opportunity for a group in this position to merge with a group of similar culture can provide good strong physician leadership to the new entity. And not only do medical groups need strong physician leadership but they also need **a strong qualified management team.** Mergers allow groups the opportunity to attract talented management teams and place them into challenging areas where they can perform to the best of their abilities.

Good medical practice management and EMR systems clearly are the lifeblood for cash flow and strong financial operations of a physician practice. An increasingly complex business environment requires medical practices to invest in medical practice management systems that will provide continuing functionality to meet the demands of this volatile marketplace.

For larger groups, purchasing and upgrading these systems is more cost effective on a per doctor basis, since the total cost can be spread over more investors. Also, as technology continues to evolve, larger medical groups will have the advantage over smaller groups in researching, investing in and implementing these state-of-the-art practice management systems, as they become available.

The following are other advantages to a physician practice merger:

1. As physicians are able to move into larger groups and share that call coverage, their quality of life improves
2. When the practices merge, the combined entity is able to utilize physician extenders to their maximum capacities
3. A successful merger generally infuses new synergy into the entire group, typically leading to a stronger united group practice that is better equipped to deal with the competitive pressures in today's health care business environment
4. Practice mergers provide the participating physicians with new partners whom they can count on to assist them personally, financially and probably most importantly, clinically. A strong partnership has the ability to share knowledge and experiences and to learn from one another while on a mission with the same purpose.

I firmly believe there will continue to be an explosion of group practice consolidation with mergers of small and larger practices on a regular basis. It is very evident that physicians who

want to survive and be successful in health care in upcoming years must make structural and cultural changes that allow them to incorporate with other physicians.

Physicians will need to adapt, manage and even lead the transition in health care. I believe that many groups will meet these new challenges by committing to the required due diligence and then successfully implementing medical practice mergers to secure their future in the market place. Assuming a medical professional already has addressed the clinical aspects of a merger and has agreed on an appropriate compensation arrangement for all parties involved, the following represents an informal checklist intended to provide a road map of issues key to a successful practice merger.

• **Management.** A basic financial rationale for a merger is to achieve operational cost savings by consolidating the management function of a medical practice. However, such a consolidation is often at the expense of individual physician's autonomy and control. The parties must decide who is ultimately responsible for running the new practice and the extent of that authority. This is especially critical when the new practice has multiple locations, which often makes it cumbersome to meet and discuss day-to-day management issues.

• **Accounting.** Who will be responsible for keeping the books? It is often said that "the person with the checkbook holds the power." If the practice decides to mitigate this power by maintaining separate checkbooks at each location, for example, the cost savings of consolidated operations are lost. As a compromise, a practice administrator is often hired to maintain the accounting records of the practice and to provide systematic financial reporting to the physician-owners.

• **Structure.** Will the new practice operate as a P.C., LLC or as an affiliation? Most practices are formed today as LLCs to take advantage of the numerous favorable tax provisions afforded these entities. However, entities switching from P.C.s to LLCs need to plan carefully to avoid tax traps associated with the former P.C. accounts receivable and depreciable assets.

• **Location.** Will the new practice merge offices? If so, any existing lease arrangements will need to be resolved. In many instances, the practice's office is owned by the physician or physicians and leased back to the practice at favorable rental rates. Obviously, these lease arrangements will need to be incorporated into the overall financial arrangements between the physicians. This concept also applies to any equipment transferred into the new practice.

• **Retirement and benefit plans.** An often-overlooked area is the effect of practice consolidations on any existing retirement or benefit plans. Rarely do two practices maintain identical benefit plans that can be easily merged. Typically, one of the old practice's plans emerges as the survivor, one of the plans may be terminated, or entirely new plans are established. In any of these instances, planning and guidance is essential to avoid adverse account vesting, or even state Department of Labor or Employee Retirement Income Security Act violations.

• **Banking relationships.** A significant financial benefit to practice consolidations is the ability to negotiate more favorable banking and lending terms due to the added financial strength of a larger medical practice. Banks are more interested in competing for your business. Take advantage of this. Early on in the consolidation process, invite several lenders to bid for your business. Remember to include individual banking needs such as home equity and mortgage loans in addition to the standard working capital and term financing needs of the medical practice in their proposals.

• **Individual tax issues.** In general, medical practices do not pay income taxes. Rather, the taxes end up being paid on the respective physician's personal income tax returns. Proper tax planning for a practice merger or consolidation must include an analysis of the tax burden to be

paid by the physician. This issue is especially important with the number of physicians practicing as LLCs, since the physician will need to remit income and self-employment taxes via quarterly estimates. If these amounts are not properly calculated, a tax "surprise" will likely be the outcome on April 15.

INTEGRATION OPTIONS

The following document describes several different integration options which may be considered by physicians looking to strengthen their position in their local markets. In general, the level of integration present in the models increases as the list progresses.

Network Affiliation or Association

These models resemble a club with a general purpose. They are useful for communication, education and camaraderie. The primary benefit of these models revolves around the creation of a forum for supportive dialogue, communication and commiseration. They can usually be developed quickly without significant costs. They are, however, not functional for contracting or for implementation activities.

Joint Ventures

Joint Ventures are usually designed for developing specific capital projects (buildings, for example). They are usually project driven and generally have a defined primary goal. In most cases, profit or loss distribution is on some basis which is closely related to the amount of capital or risk assumed by the investors. They can involve physicians and non-physicians and their success is defined by a particular balance sheet and income statement related to the project.

Independent Provider Association (IPA) or Provider Organizations (PO)

These models are generally used to organize independent practices into contracting entities. The independent provider association contracts with HMO's, direct purchasers, or other vendor groups. They should not be confused with preferred provider organizations which can be formed by providers, purchasers or intermediaries. The key distinction between the IPA and the PO revolves around the independence of the individual physician or practice. Provider Organizations usually lack a specific hospital affiliation.

Management Services Organization (MSO)

Under this model, the MSO actually does services for member, client or subscriber practices. It can be formed as an equity (for profit) business or as a cooperative (cost sharing entity). It is normally capitalized in conjunction with a healthcare system, its owners, a PO or by loans.

It can be as simple as a billing service or it can actually combine the assets of practices (much like a foundation model). Some MSOs provide staff resources to IPA's or to networks to assist with contracting activities. Some MSO's own and manage buildings and have a full complement of staff for practice support. Sometimes, if it is set up to gain outside investors, it is termed a PMC or physician management company.

Physician/Hospital Organization (PHO)

This model is generally nonspecific and encompasses all joint ventures. Usually, the medical staff and hospital form an IPA or a PO and it becomes a partner with a hospital in a variety of medical delivery related ventures. Exclusivity usually becomes an issue since there is generally some selection process to qualify doctors. In small communities, the entire medical staff may be invited to participate.

Group Practice Without Walls

The Group Practice Without Walls usually includes a single billing number, combined pension programs and benefits package and a central fee schedule (unless there is wide geographic diversity). This model is not a true group practice, however, since individual sites (or units or groups) can still manage themselves and make determinations about their own staff, and equipment. Generally, this type of organization is used by a group which seeks the structure to address anti-trust or Stark hazards but who wishes very minimal integration.

Single Specialty Group Practice

This model includes only physicians of the same specialty. The group uses one billing number, one fee schedule, one benefit package, and usually relies on a formal group governance structure and some kind of collaborative income determination methodology. This model, unlike the ones described before it *can* represent a significant level of integration.

Single Discipline Group Practice

This model is similar to the Single Specialty Group Practice but made up of only one *discipline* such as primary care, vision care, surgery, cardiology and cardiothoracic, etc. The grouping must not be confused with the more general categories of "specialists, non-primary care" or "everyone left out of the hospital deal".

Multispecialty Group Practice

Multispecialty Group Practices are defined by the same criteria as the other true group practices but include multiple specialties and disciplines. The inclusion and integration of the various specialties should be done in a managed fashion to ensure that the group includes the right mix of specialties and the appropriate proportions to allow for a symbiotic coexistence.

A Purposeful Combination of any of the Above

Examples might include:

1. An MSO with hospital sponsorship.
2. A group practice sponsored by an IPA.
3. A single specialty practice supported by an HMO.

Any number of these organizations could be supported or connected with any other with only common sense, financial integrity and regulatory parameters limiting the choices.

INTEGRATION ALTERNATIVES

The following table highlights the advantages and disadvantages of the models described above.

Alternatives	***Pro***	***Con***
Loosely Affiliated Networks		
Network Affiliation or Alliances Joint Ventures IPAs/Physician Organizations MSOs PHOs *Contracting only, little business integration*	Inexpensive Non-Threatening Maintains Group Autonomy	Unpredictable Loose and ineffective No economies of scale No ability to do case management

Group Practice w/o Walls	*Pro*	*Con*
Individual site autonomy, one billing number with separate site control and accounting	Simulates site independence Low political cost Easily achieved from a functional perspective Solid contracting platform	Little or no economies of scale No group planning or benefit from critical mass Minimal ability to participate in capitation or case management

Practice Merger	*Pro*	*Con*
Single Specialty Group Single Discipline Group Multi Specialty Group *Negotiated integration as a group practice*	Ability to accept capitation Potential economies of scale Solid contracting base Positive environment for physician discussion and exchange of ideas Group planning	Threatening to existing autonomy More costly than other options Functionally challenging

Practice Acquisition	*Pro*	*Con*
Single Specialty Group Single Discipline Group Multi Specialty Group *Establishment of a process for others to join the main practice with full integration under existing rules*	Preserves existing culture and autonomy Established decision making structure preserved Functional order is preserved	Threatening to target groups