



Considering a Sale? What You Should Know

By Elias N. Matsakis, J.D.

As was expressed in “Assessing Current Practice Management Issues in a Challenging Environment” in the July issue, cardiologists, other specialists and hospitals are showing a keen interest in creating new types of working relationships.

Although a number of hospital and physician group practice integration approaches are being explored ranging from least-integrated (gain-sharing, service line management or practice management agreements) to most-integrated (sale of the practice with employment), this article addresses the principal areas of concern with respect to a sale of the group practice assets to a health system. Issues under consideration fall into three basic categories: valuation, compensation and governance.

Valuation: How Will Practice Assets Be Valued?

Both for-profit and not-for-profit health systems require that a practice's fair market value be independently appraised. For-profit third-party buyers not affiliated with a hospital do not have this constraint as there is no risk that the sales price was intended to compensate the group for referrals. Good appraisers will meet collectively and separately with all parties in a transaction to make sure they fully understand all parties' short-term, mid-term and long-term goals prior to beginning the valuation process.

Appraisers use three methods of valuation:

Income Approach — Determines a value indication for a group practice using methods that convert anticipated future economic benefits of ownership into a single present value. Generally, appraisers applying the income approach to cardiology practices use the Discounted Cash Flow (DCF)

Method, where future cash flows of the practice as a standalone entity are projected and together with a terminal value as of the end of that period are discounted to their present value using a discount rate commensurate with the risk of realizing the projected cash flows.

Market Approach — Determines a value indication of the practice by comparing sale prices of cardiology practices with similar attributes. Typically, the appraisers have a database of private — and occasionally public — transactions. They look to multiples of income or per physician pricing and attempt to correlate higher or lower risk factors with the appraised practice to the practices that were actually sold to estimate value.

Asset Approach — Determines a value indication of the practice based on the value of the assets net of liabilities as a viable business, not as a liquidation. The resulting equity value is considered to be the practice's fair market value on a controlling, marketable basis. In using the asset approach, appraisers will often look to the replacement cost method as a method for determining value — in other words, the cost of replacing the assets, recruiting physicians, work force, etc.

Appraisers most often use multiple methods to test the value determined by the predominant method they choose to use. Also, higher values typically can be obtained where the group practice revenue from ancillary services is profitable and can be separately valued using market or discounted cash flow methodologies as if sold as a separate asset, rather than just the supply and equipment values of such ancillaries.

Health systems are showing increased reluctance to pay for physician goodwill; however, they are paying for medical records, the business value of ancillaries and trained workforce in place when the payments can be supported by independent

valuations. Similarly, appraisers may select the market approach either directly or as a test for their other valuation methodology.

The key to reaching a fair value is to insist on an appraiser who will explore all methods and provide an independent valuation that represents a true “viable business” value rather than default to a book value on the unsubstantiated — and often wrong — assumption that all practice income is converted into compensation.

Physician Employment Structures

Cardiac group practices have focused increased attention on future compensation methodologies in evaluating the merits of any practice sale proposal. The trend in physician employment is strongly focused on compensation based on individual and group productivity rather than salary guarantees. Many systems are prepared to guarantee salaries for a few years based on productivity assumptions but subject to fair market value appraisals.

In assessing sale of their practice, physicians need to ensure that the transaction is structured such that these “integration benefits” are designed, implemented and evaluated in a manner that includes and values physician input. In other words, purchase price and employment income are not the sole determinants of the “right deal.”

Governance, What You Live with Every Day

To cite the original Whitepaper, “[Governance] is the most important aspect of a potential integration negotiation. Frankly, if a transaction is consummated, cardiologists will remember how much money they make once every two weeks, but how the practice runs will affect them every day.”

Three basic models are used in connection with the operation of a group practice after any sale —

- direct employment
- employment through a hospital- or buyer-controlled

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Some valuation firms structure the employment as a formula (net receipts minus net expenses) with physicians benefiting from the retention of their existing receivables with compensation paid on an accrual basis as to their future services. Other employment models use relative value units so as to make the physician compensation neutral regardless of the payer. Often, the system support for new physician recruiting, electronic medical records, improved top-line reimbursement or realization and certain economies of scale in the cost side of the practice are captured in Management Service Organization (MSO) arrangements that offer physicians a lower overhead.

What Drives Value?

The key drivers of value are excellent clinical reputation, strong physician leadership, leading market position, group loyalty, clinical innovation and positive partnering between the institutions. Other value drivers include strong administrative leadership, practice infrastructure, broad geographic coverage, efficient and clinically appropriate ancillary services and favorable managed care contracts. Strategic objectives include preserving operating margins or securing greater reimbursement from governmental and third-party payers. The objective of this alignment is more cost-effective and higher-quality care through more rapid implementation of best practices, demonstrable quality and outcomes, economies of scale and efficiencies and IT compatibility.

physician group practice

- employment through a system-controlled physician division entity with separate administration and governance that reports directly to a system board with oversight over both hospital and physician operations

Often these structures are complemented with an MSO with independent or physician ownership to provide strong physician control over the practice site. Ancillary activities are maintained in the group practice or incorporated into the hospital's service offering.

When physician group practices are left administratively intact, have strong autonomy at the office level and physician leadership at all levels with administrators accountable to a system board rather than to other hospital administrators, cardiologists will be able to exercise appropriate control in delivering care in the inpatient and outpatient settings.

In more integrated systems, physicians are involved in numerous physician-led committees with the authority to create the initiatives necessary to ensure that the practice is adequately supported with capital investment, clinical personnel, tools and protocols to coordinate patient care among all providers.

Other key terms in employment agreements include the initial term, the standard for termination, specific governance rights, overhead charge limits, other bonus pools, ability

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to maintain group practice ancillaries, treatment of legacy investments in competing providers, benefits and professional liability responsibility, continuing education, compliance with quality and peer review requirements and other practice support. In states where they are enforceable, virtually all employment agreements have non-compete agreements with significant penalties.

What Issues Provide The Greatest Challenges?

Integrating cultures represents the greatest challenge to any merger or sale. Integrating into larger organizations inevitably results in some loss of autonomy and includes increased

Pending changes in health policy will probably mandate or compel all providers who care for patients with chronic and acute cardiac conditions to collaborate and communicate more effectively. The possibility exists that providers could be receiving a single global payment that will rise or fall on their collective effectiveness.

CV Professionals in Unique Position

Cardiovascular professionals are in a unique position to lead that effort. Some may choose to integrate their practices into a larger health system. Any sale of a cardiology practice should provide fair value for what is being transferred but should also



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oversight, stricter compliance expectations, more bureaucracy and decreased flexibility in staffing of support personnel.

Unwinding existing arrangements, establishing a governance grid that ensures physicians the requisite control of their practice, integrating IT systems and human resource policies — all are challenging to resolve. The acquired practice is expected to work with system- or hospital-employed physicians without disturbing their existing referral relationships with independent medical staff. Cardiologists with medical staff memberships at multiple, competing hospitals face additional challenges.

contain employment agreements and governance structures that enhance — not diminish — physician control over care delivery. Cardiologists also might consider other partnering arrangements with a hospital or other physicians that preserve autonomy but achieve some alignment, such as service line joint ventures, MSO arrangements and other hospital management arrangements as an alternative to or as a first step towards fuller integration.

Matsakis, who is with Holland & Knight LLP, is one of the authors of “Assessing Current Practice Management Issues in a Challenging Environment.”



Letter to the Editor

Recognizing the Whole Working Group

The article “Are Doctors Shackled by Malpractice Insurance? Where It’s Going, What We Can Do” in the July 2009 issue of *Cardiology* presents a brief, accurate summary of the issues being addressed by the ACC Working Group (WG) on Malpractice Insurance.

However, it did not credit the additional members of the WG who, besides Dr. Rodgers and us, are working hard to ameliorate the problem of medical malpractice. These members are **Joseph G. Cacchione, M.D., F.A.C.C.**; **Paul N. Casale, M.D., F.A.C.C.**; **James T. Dove, M.D., M.A.C.C.**, and **Suzette E.G. Jaske**. Excellent staff support and

direction are provided by Brenda Hindle (bhindle@acc.org).

We encourage you to send your suggestions and ideas to assist us in achieving our goals.

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