

Anatomy of an Acquisition Alternative: Leasing the Practice

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The default position of many healthcare systems seeking physician alignment is to acquire the practice and employ the physicians, but there is another approach that poses far less financial risk to both parties and is far easier to undo if necessary: leasing the practice. The group stays as it is, but renders services for which the hospital receives the reimbursement and commits to paying the group a fixed amount for a stable quantum of work. Additional alignment features can be added, including medical directorships, comanagement, quality bonuses, and more. Potential problem areas include post-termination restrictive covenants and dispute resolution. Planning in advance for both fair market value disputes and addition of new practitioners is useful.

KEY WORDS: Alignment; compensation; restrictive covenants; acquisition; provider-based compensation; fair market value; business confidentiality.

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The pace and volume of the acquisition of medical practices by healthcare systems has been trumpeted far and wide.¹ Today's motivation to own or be owned is somewhat different from the last consolidation wave of the mid-1990s. For the healthcare system, there is a primary fantasy of control of referrals and solidification of market share. For the physicians, there is the fantasy of financial security with little change in behavior. In fact, the data show that there have been few economies of scale realized, and an increase in prices and costs charged for the same services, with little improvement in value.² In some instances, courts have upheld the antitrust regulators' insistence on unwinds.³ One of the major problems with acquisition, however, is that unwinding is not so easy. Once the healthcare system has the hard assets and personnel of the practice, reconstructing it is not so simple. There is an alternative that has the capacity to be easily terminated, with the potential to create greater value, if constructed properly. It is called *leasing the practice* because the group stays in its original configuration, but deploys itself to the healthcare system for the term of the arrangement.

THE FUNDAMENTALS

The basic premise of the arrangement is that the medical group stays in exactly the same corporate configuration

it has always been, whether a professional corporation or a limited liability company. It retains its own assets and personnel. The physicians and nonphysician practitioners for whom claims may be submitted reassign their right to payment to the healthcare system, which then bills for their services on the system tax identification number. The system leases the space in which the practice operates, whether from the group or a third party, or the space leases are assigned to the system. The healthcare system agrees to pay to the group a fixed amount of money on an annual basis over whatever term is negotiated. I have done five-year rollovers, three-year rollovers, and one transaction that was structured to be revalued at four years, after the following four years, and then after two years.

An explicit focus on the features of clinical integration to produce better value enhances the way additional dollars can be generated.

In today's world, establishment of the compensation amount is critical. I routinely recommend that the group about to be leased engage its own valuator. After all, the

healthcare system will have theirs. The financial commitment usually is for an annual sum to be paid to the group, parceled out to them in monthly installments. Quantification of the amount is made taking into account payer mix and group productivity. It is typically stated in terms of the volume of work relative value units (wRVUs) the healthcare system is obtaining under the practice lease, fashioned as a professional services agreement. In most of the arrangements I have structured, the group negotiates a corridor of productivity—for example, 8%—above which they are paid additional compensation on a wRVU basis, provided that quality targets are met. The link to quality blunts an incentive to churn out work for more money. A bottom threshold equal to the upside threshold also is established, so that if productivity falls off over some sustained period of time (e.g., more than a quarter), the compensation is revalued so as to reflect fair market value, which is a range and not a fixed number.

Other sources of revenue based on alignment activities also typically are included, with additional yet different compensation for them. These can include medical directorships, comanagement arrangements, payment for quality performance, and additional bonuses for quality. I have done several transactions where, if the group meets quality targets for three consecutive quarters, they can be paid an additional once-a-year quality bonus, which we have colloquially referred to as the “super-duper quality bonus.” An explicit focus on the features of clinical integration to produce better value enhances the way these additional dollars can be generated.^{4,5}

With new payment models emerging, the contract establishing the arrangement also should confront what happens with earned quality/value bonuses, meaningful use payments for as long as they last, and other pay-for-performance reimbursement the healthcare system will receive because of the physicians’ performance. In addition, because it is hard to predict what new payment models will be available, an inclusionary process whereby the group and system together determine how the new contracts and new dollars will be handled has to be established. A joint operating committee can be useful in this regard.

Paying for the overhead of the practice often is handled through a negotiated budget with a process in place to make decisions in case of the need for significant deviations. I have done transactions where overhead was a direct pass-through. I have also done transactions where the overhead was factored into the wRVU payments. Often the group is paid a management fee, as a stipend, for the administration and management of the group, which is now operating on behalf of the hospital. In the more successful of these ventures I have been involved with, the group also is paid to functionally create the billing for the healthcare system, most of which are notoriously unskilled and inefficient at performing the physician billing.

SOME HOT SPOTS

The biggest hot spot probably is a post-termination restrictive covenant, including nonsolicitation clauses. There is an argument that the patients are and remain the physicians’ patients and not the system’s, unlike the assertions healthcare systems typically make when they acquire the assets of a practice and employ its physicians. Because the patients remain the patients of the practice, there should not be a post-termination antisolicitation clause.

Similarly, the system is not committing major capital to one of these transactions, nor is most of the business generated by the healthcare system. I have done several of these transactions with no post-termination geographical or facility-specific restrictive covenants. This makes life immeasurably easier if things do not work out. I had one transaction of that nature where the original healthcare system, to which my clients did not really refer anyway, did not appreciate the value of the relationship. My clients let the lease agreement expire, and simply reassigned to a new system for the initiation of the next term. Space and equipment leases and other contracts had to be assigned and assumed, but without the covenant it was a significantly easier transition.

Even where a system insists on a post-termination restrictive covenant, it typically is time limited to one year, restricts only for reaffiliating with another system, and allows the group or any combination of members of the group to go back into private practice, even during the covenant period.

Easy termination does not force the parties to find a way to resolve issues.

Dispute resolution can present some thorny issues. The goal of these relationships is to make the affiliation closer than if the physicians remained completely independent. Therefore, easy termination does not force the parties to find a way to resolve issues. When they cannot be resolved, generally mediation or arbitration is the way to go for issues other than fair market value. A system sometimes will use the issue of fair market valuation to try to lower the amount of compensation it is paying to the group during a term. Or something will change in the overall payer environment so the physicians believe they are not being paid enough. Without having to go through a full arbitration, in many of the transactions I have done we have set up a separate dispute resolution mechanism for fair market value alone. The system names its valuator and the physicians name theirs. The parties agree on the question to be posed, which is identical for both valutors. The valutors then produce their valuation reports. If their answers are

essentially within 5% of each other, the parties split the difference and accept the result. If the difference is more than 5%, then the two valuers or the parties name a third valuator. If either party cannot accept the figure offered, the party can terminate, but the physicians will not be held to any post-termination restrictions. None of the transactions I have worked on has had to utilize this mechanism, although for some of the older ones, new valuations have been negotiated.

Finally, another issue that is worth addressing in the agreement is the addition of new practitioners. Replacing a practitioner should not present major difficulties, since the new practitioner would step into the shoes of the departing one. Sometimes it is worthwhile to establish a mechanism to determine when an additional practitioner is needed, and sometimes it is worth stating that threshold in terms of RVUs. Because the hospital is billing for the services, it can participate in recruiting the practitioner to the physicians' group without the necessity for income guarantees and loans. It is much more like recruiting a physician directly, except the payment goes into the group's compensation. The key is to agree in advance on what stipend will be made available for the new recruit and for what period of time. In addition, that stipend should be based on assumptions pertaining to that individual's productivity. If he or she exceeds that productivity in terms of wRVUs, then the new practitioner's services should also be compensated by an additional conversion factor per wRVU, but not as high as the rest of the group, because the system is already paying the stipend.

TWO BARRIERS TO OPTIMIZATION

When physicians begin to contemplate these transactions, they often focus on the disparate payment the hospital receives for provider-based services, where Medicare and some commercial payers pay a premium facility fee for services that are precisely the same as those the physicians bill in their offices with no facility fee. In these lease transactions, sometimes the hospital will propose that the arrangement be established as provider-based, to obtain the additional dollars that help subsidize its payment to the physicians. The problem with taking that path, however, is that the patients come to see the same physicians, in the same location, with the same personnel, performing the same services, but now they have a hospital copay to confront. It does not make the patients happy. We routinely put into these agreements a provision that says the hospital cannot make the practice provider-based unless the physicians agree. This issue will diminish with site-neutral fee schedules.

In one transaction I handled, the physician group was being contracted to perform the billing for the hospital.

In the early drafts of the agreements, the lawyers for the hospital inserted a confidentiality provision that said that if the hospital's rates became known outside the transaction, whether intentionally or not, whoever had revealed them, whether negligently or not, would be assessed a \$1 million penalty! We suspected this was a "French general" provision, meaning that the hospital had had some bad experience previously and was going to make sure that never happened again. Eventually we negotiated it away, but the issue of confidentiality of rates is intensely sensitive to hospitals, and strong and broad confidentiality provisions are not uncommon. The barrier such provisions create, however, is that if they are too broadly drafted, if the group needs to negotiate a different relationship, they cannot provide information about their current wRVUs, or productivity, or other essential aspects of their ongoing performance to their potential partner. In one transaction, despite my efforts, a very broad confidentiality clause prevented disclosure of current productivity; however, the group was stable and its workload was stable, so we were able to provide prior data along with a representation that it was an accurate statement of the group's productivity.

CONCLUSION

Leasing the practice to the hospital or healthcare system is a strong alternative to selling the practice. It can fulfill both the physicians' needs for some financial stability and the hospital's needs for better alignment. When the transaction is conducted with explicit attention to how it will improve the value of care, it can produce better financial results for both parties. Many hospitals and systems have not yet tried these arrangements, but once they understand how they are at far lower financial risk operating this way, and that the physicians maintain the power and cohesion of their group, it makes for a far stronger relationship between the two. ■

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