



# Back to the Future Part 2? Hospital Acquisition of Physician Practices LHA Annual Conference

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# Introduction

- I. Introduction of speakers and topic

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# Health Care Reform: What does it mean for deals?

- Bundled Payments starting in 2013 pilot programs through 2015
- ACOs
- Reduced payments based on Readmits and acquired conditions starts in 2013
- EMR mandates
- Looming physician shortage
- Restrictions on the “whole hospital exception” – the death of specialty hospitals
- Downward pressure of Medicare reimbursement for docs



# Health Care Reform: What does it mean for deals?

- Physicians Moving Toward Employment:
  - Higher Reimbursement for and demand for EHR
  - PQRI Initiatives (increase .5% till 2011-2014)
  - Increase in malpractice premiums
  - Increased risk/liability for RACs, PPACA Fraud/Abuse, HIPAA/HITECH Penalties etc.
  - Increase patient load without increase pay



# Health Care Reform: What does it mean for deals?

- Physicians Moving Toward Employment:
  - No fix for SGR – cut expires in November 2010.
  - HHS to establish a budget-neutral payment modifier that provides for differential payment to a physician or a group of physicians based upon the quality of care furnished compared to cost
    - Begins for certain physicians/groups as of 1/1/2015
    - Begins for all physicians/groups as of 1/1/2017
  - Quality payment modifier
  - Improvements to Physician Feedback Program
    - Will be expanded to provide individualized by 2012
  - Public reporting of physician performance information



# Groundhog Day?

## Current Trends in Health Care Market

- Nationwide, there is a resurgence of hospital/physician integration activity.
- **“The acquisition of physician practices by hospitals and health systems—once thought to be a thing of the past—has returned with gusto.”** *Healthcare Financial Management Association magazine*, July 2009
- According to this article (and other informed sources) “ [t]oday’s physician practice acquisition deals are bigger, more complex, and riskier than the transactions that took place during the 1990s. It’s important for healthcare organizations to understand this trend: what is occurring, why, and how buyers and sellers can structure, plan for, and execute these deals successfully.”
- Numerous valuation and consulting firms have presented data that indicates that the rate of these transactions is increasing and not likely to subside anytime soon.



# A look at past mistakes

- Employment of PCPs in 80s and 90s
  - Organizations paid too much for practices
  - Compensation structures outpaced revenue streams
  - Organizations were not structured properly
  - Hospitals lost \$
  - Physicians ultimately released into market to compete with hospitals – ASCs
  - Physician drive toward imaging centers that compete with hospitals – resulted in separation



# Current Trends: Will it work this time?

## Avoiding Past Mistakes (what have we learned?)

- Lack of experience with professionals; treated physicians like line-level employees
- No incentives for continuing long hours (flawed compensation models)
- The physicians' loss of control of practices created frustration and dissatisfaction
- Poor management; poor collections



# Drivers for Hospitals

- Physician shortages, including call coverage obligations (EMTLA)
- Focus on quality continues to gain strength
- Reimbursement and payment concerns
- Dealing with regulatory concerns
- Market Share and reducing threat of competition
- Post Acquisition Clinical Integration



# Drivers for Physicians

- Perception of falling reimbursement for professional services
- Limitations on ancillary services
- Desire to reduce stress and pressure of private practice
- Strength in being part of larger team
- PPACA



# Essential components for success!

- Strong physician and administrative leadership
- A group (physician and hospital) culture that supports mission, vision of the organization – not treat Docs as W2s – lack of structure
- A compensation model that rewards administrative time and office staff
- Good negotiations with payors
- Physician inclusion in governance (usually through NewCo)
- Good transition with business office
- Transition team for seamless transition
- Metric based management of outcomes, satisfaction, and expenses



# Where are the pitfalls?

- Adverse selection – some applicants seek employment due to financial hardship
- Productivity decline
- Decrease in on-site emphasis collections – with less physician involvement staff less concerned with operations – payment, billing etc
- Increased expense – no incentive to control costs for practice/doc
- Coding changes – no incentive for coding correctly creates mistakes in proper coding and increases difficulty in educating proper coding



# Incentive Based Compensation

- Key difference in 90's deals and current deals is incentive based compensation
- Focus on incentives through performance, quality and outcomes (quality matrix bonus)
- Usually based upon RVU model
- Base salary plus bonus
- Salary must be at fair market value and must be structured/calculated to comply with the Stark Law and Anti-Kickback Statute
- Separate valuation necessary, apart from asset valuation
- May be helpful to process for parties to identify make or break elements and obtain preliminary valuations prior to proceeding



# Deal Breakers?

- Any initial hurdles (restriction on corporate practice of medicine not an issue in Louisiana)
- Not-for-profit restrictions on employment of physicians or compensation limitations
- Disagreements over valuations
- Governance and control
- CIA limitations



# Ready to proceed?

- If the business interests align, the price is right, and the parties appear to be willing to proceed, what are the next steps?



# Corporate Practice of Medicine

- In many states physicians cannot be employed directly by hospital
- Typically the hospital will acquire the practice through a non-profit health organization to satisfy prohibitions
- Physicians are employed by or structure a Group practice through the non-profit health organization



# Key Initial Legal Considerations to Consider

- a. Employment exceptions (Stark/AKS)
- b. Isolated transaction exception for  
asset purchase
- c. Organization of Group Practice under  
Stark exception?



# Stark Employment Exception

- *Bona Fide* Employment Relationships –
    - Amount of payment is consistent with fair market value and does not take into account value or value of referrals
    - Compensation is commercially reasonable even if no referrals are made
    - Productivity bonuses permissible for personally provided services
- 42 C.F.R. § 411.357(c)



# Anti-Kickback Protection for Employment

- Statutory Exception: any amount paid by an employer to an employee with a *bona fide* employment relationship for employment in provision of covered items or services
- IRS definition of “bona fide employee”
- No explicit requirement of fair market value

42 U.S.C. § 1320a-7b(b)(3)(B); 42 C.F.R. § 1001.952(i)



# “Isolated Transaction” Exception

- A one-time sale of a medical practice will not violate the Stark Law if
- (1) the purchase price is consistent with fair market value and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the target physician or other business generated between the parties,
- (2) the transaction would be commercially reasonable even if the physician whose practice was acquired made no referrals, and
- (3) there are no additional financial relationships between the parties for six months either before or after the sale unless the other relationships meet another Stark exception.

42 CFR . § 411.357(f)



# Qualify as a Group Practice?

- Hospital cannot form a “group practice” of its employed physicians without organizing a separate entity
- Upside – greater flexibility in how physicians are compensated than using employment exception
- Downsides – possibly no longer qualify for the direct compensation exceptions under Stark; Group Practice exception is complex



# Basic structures generally used

- a. Asset purchase
- b. Co-management of service lines
- c. Others



# Key Business Decisions

- Valuation of assets -- multiple methodologies; concerns over "goodwill" and going concern valuations; assets used in ancillaries and hospital based services; keeping focus on present value, not on future values or expected revenues
- Compensation expectations -- RVUs; medical directorships; service line management; medical staff expectations
- Control of day-to-day management -- setting realistic achievable budgets, who has control; can Hospital live with Physician control; can Physicians live with some Hospital controls and bureaucracy; hiring of former Practice administrator, chief accounting personnel, billing personnel



# Asset Purchase Model

- Letter of Intent -- focus on key issues
- Preliminary Valuations/Final Valuations -- need to focus on how to stage getting preliminary valuation prior to getting too far down the line; if the money is not right, either for the assets and particularly for the compensation, the deal is dead in the water
- Asset Purchase Agreement – this is the road map to accomplishing a deal
- Employment Agreements – this may be the only document that the physician actually reads
- NewCo Organizational matters -- who controls; how to have reserve powers; annual budgets and other matters that arise after the initial year of closing; who hires and fires



# Valuations

- Get them started early; helpful to have preliminary valuations to temper expectations
- They take time and are not cheap, but they will be valuable
- It is critical that the hospital purchasing pays a price that does not exceed fair market value.



# Fair Market Value: How is it Determined -- assets

- Usually, the practice retains cash and A/R
- Hard assets and “goodwill” are acquired
- “Goodwill” includes the name of the practice, the medical records, patient data, value of non-competes and other protective provisions
- OIG guidance can be found; OIG has been very skeptical of amounts in excess of hard values as payments for referrals
- Most reputable valuation firms are very well acquainted with the legal restrictions
- FMV analysis usually involves a blend of methods: income (discounted cash flow), market, and cost




# Examples -- LOI

- A good LOI helps avoid future shock!
- Deal with expected governance post-closing
- Practice employees; administrator
- Key terms of employment agreements




# Examples – Asset Purchase Agreement

- Threshold issues; purchase price; hold out doctors; assets purchased and retained; liabilities retained or assumed
- Representations and warranties of Seller and selling shareholder/physicians
  - Joint and several?
  - Limitations on knowledge; whose knowledge?



# Examples – Asset Purchase Agreement (continued)

- Ability of Purchaser to consummate
- Guaranty if shell subsidiary
- Key conditions to closing – receipt of FMV appraisal; receipt of any governmental approvals
- Post closing covenants; employment of staff; maintenance of support to enable practice to continue uninhibited
- Tail insurance; non-compete and other protective provisions; unwind provision
- Indemnification issues – basket; limitations to amount each Shareholder receives




# Examples – Employment Agreements

- No-cut by hospital without cause (5 year)
- Call coverage
- Outside activities
- Conflict of interest policies
- Compensation plan
- Non-compete and other restrictive covenants
- Guarantee of NewCo obligations by hospital



# Examples – NewCo Organizational and Operational Matters

- Bylaws limit ability of hospital member to change terms post closing
- Have a board controlled by physicians except for certain matters, such as termination of the administrator, etc.
- If the hospital has any “reserve power” or override power, this is where to document
- Perhaps consider a contract between NewCo and hospital where hospital commits to fund the approved budget to NewCo in return for NewCo’s provision of certain services



# Post-Closing Issues (how long will the honeymoon last?)

- billing issues;
- registration process;
- co-payments, etc.



# ACOs – the missing link?

- What are ACOs?
  - Groups of providers and suppliers who work together to manage and coordinate care
  - Must meet quality performance standards established by HHS to be eligible for shared savings
- What is the benefit of an ACO under PPACA?
  - Able to participate in a shared savings program to promote accountability for a patient population, coordination of Medicare items or services, and encouragement of investment in infrastructure and redesigned care processes for quality and efficient service delivery
  - Providers in ACOs are rewarded with a share of the savings program relative to a spending benchmark
- Exact structure of various ACO models is still to be determined



# ACOs – who can participate?

- Physicians and other practitioners in group practices
- Networks of individual physician practices and other clinical practices
- Partnerships or joint venture arrangements between hospitals and physicians and other practitioners
- Hospitals employing physicians and/or other practitioners
- Other groups of providers of services and suppliers as the Secretary determines to be appropriate
  - HHS is being urged to consider an all payor model ACO



# ACOs – Requirements under PPACA?

- Must agree to be accountable for the quality, cost, and overall care of Medicare fee-for-service beneficiaries
- Must agree to participate for a 3 year period
- Have a formal legal structure allowing them to receive and distribute payments
- Include enough PCPs for at 5000 beneficiaries
- Provide the Secretary with requested information on the ACO professionals
- Have leadership and management in place to support clinical and administrative systems
- Have defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care through the use of telehealth, remote patient monitoring, and other enabling technologies
- Show the secretary that they meet patient-centeredness criteria, such as patient and caregiver assessments and individualized care plans



# ACO Reimbursement

- ACOs will be reimbursed in same manner as other Part A and Part B providers but will receive an additional payment if they meet quality performance standards, the savings requirement and the benchmark.
- The benchmark is determined us the three most recent available years of per-beneficiary expenditures for Parts A and B services assigned to the ACO
  - Adjusted by beneficiary characteristics
- HHS may adopt other payment models for the shared savings program such as partial capitation
- Shared savings program to be created by HHS by January 1, 2012



# Questions?

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