

# From Primary Care Physician Employment to Private Practice: Easing the Transition

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IN THE 1990s, HOSPITALS and health systems took an aggressive approach to purchasing practice assets and employing primary care physicians. Their rationale usually included a desire to:

- Protect core markets
- Maintain market share
- Ward off competitors (i.e., defensive strategy)
- Secure the referral base for hospital or system services
- Add a key component (i.e., primary care) to an integrated delivery system
- Improve their negotiation position with managed care payers

However, the reality was that as the feeding frenzy of physician acquisition was underway, hospitals and systems were essentially concerned about their historical referral base and sought to secure an adequate cadre of loyal, primary care physicians. Practice acquisition and physician employment,

## KEY CONCEPTS

- **Physician Practice Acquisition**
- **Employing Primary Care Physicians**
- **Restructuring Ties with Acquired Physicians**
- **Practice Divestiture**
- **Developing Transition Packages**

*In most cases, the practice acquisition and employment strategy of the 1990s has backfired, with acquired physician practices losing in the range of \$50,000 to \$100,000 or more per physician annually. There are two alternatives for addressing the operating deficits incurred from practice ownership and physician employment: (1) restructuring through the implementation of network-wide and practice-specific initiatives to improve financial performance; or (2) wholesale (i.e., all practices) or selective practice divestiture, depending on the individual practice financial performance and "fit" with the physician network strategic priorities. Unraveling a decade's worth of physician-health system relationships that are grounded by the notion of acquisition and employment is going to be a complex process for both parties. But given the magnitude of financial losses on acquired practices and the inability of health care providers to sustain future losses, there simply are not options beyond restructuring or divesting these relationships.*

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Nationally, practice purchase prices have exhibited much variability depending on the region of the country, specialty, competitors, mindset of physicians and hospital leadership, and other factors. At the peak of practice acquisition, multiples of earnings (e.g., two to three times the net medical revenue of a practice) were paid to acquire practice assets.

In most cases, the practice acquisition and employment strategy has backfired, with acquired physician practices losing in the range of \$50,000 to \$100,000 or more per physician annually in the late 1990s. A study by Coopers & Lybrand found that hospitals lose, on average, \$97,000 per physician per year for acquired practices, much of which results from inferior performance in volume, revenues, and costs.<sup>1</sup>

As recently as two to three years ago, these losses could be offset by surpluses from other components of

hospital operations, but the Balanced Budget Act (BBA) of 1997 has curbed this practice. The BBA has severely reduced reimbursement to health care providers. As a result, many hospitals and systems are facing operating budget deficits that must be funded from non-operating revenue. Financial deficits from the acquisition and employment of physicians have become intolerable for most health care organizations because financial performance from operations no longer serves as a cushion. The immediate need to reduce or eliminate these deficits has become imperative.

### Addressing the black hole

With substantial financial losses from employed physicians or acquired practices showing no signs of abating, not being aggressive enough in addressing the black hole of practice acquisition can lead to insurmountable financial losses.

Most industry analysts agree that the substantial financial losses attributed to the employed physician practices were a major contributor to the bankruptcy by the Allegheny Health and Education Research Foundation (AHERF) in the Philadelphia area. The 1998 bankruptcy filing, for protection of more than \$1.3 billion in debt, remains the largest bankruptcy filing by a non-profit health care organization.<sup>2</sup>

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### Restructuring ties with acquired physicians

The core of the restructuring process is the financial performance improvement plan. Some of the highest return initiatives that have been used successfully in the industry include:

- Revising physician employment contracts to incentive-based arrangements that link compensation to productivity as measured by collection performance or other measures of productivity
- Reducing or eliminating administrative overhead costs and the overly burdensome "tax" on practices to cover excessive corporate infrastructure
- Improving charge, receipt, and production capture
- Rightsizing practice support staff to provider levels and workload
- Consolidating practices to achieve economies of scale

Once the financial improvement plan is in place, hospitals and health systems must consider how acquired practices and employed physicians fit into the overall financial improvement scheme.

A number of relationships, many of which will be evolutionary in nature, can be considered as viable options for restructuring ties with acquired physicians:

- **Joint venture equity partnerships.** In these relationships, hospital, system, and physician participants are co-owners of a business entity, with the level of risk and reward commensurate with the level of investment. A number of these partnerships are emerging in ambulatory services.

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- **Guaranteed lines of credit.** This approach enables physicians to return to private practice with the health system serving as a guarantor for a line of credit for practice start-up, recruitment, practice expansion, and other business purposes. The lines of credit financially link the hospital or system with physicians and encourage the hospital to be vested in and supportive of the overall success of the practice, while falling short of practice acquisition and its inevitable financially draining aftermath.

- **Provision of practice management services.** To help ease the transition back to private practice, the hospital or health system may provide practice management services to the physicians, often on an à la carte basis. Instead of an employment relationship, the physicians enter into a contractual relationship with the health care organization for the provision of services that the practice selects.
- **Information systems linkages.** Joint development of information systems holds great promise as an opportunity for hospitals and physicians to work together toward developing integrated clinical and financial data that can benefit both parties. While hospitals and systems must take the lead with information systems, physicians as the most important end users need to be active participants in the development and rollout of information technology.
- **Joint operating agreements (JOAs).** JOAs are emerging as viable economic alignment strategies. By formally dividing responsibility for clinical or operational initiatives between hospitals or systems and physicians, JOAs secure physician participation in these initiatives, such as developing a service line or recruiting new physicians.

- **Real estate partnerships.** Joint real estate partnerships enable hospitals or systems and physicians to establish long-term commitments to each other through ownership, lease, or management of medical office buildings or ambulatory care centers.

## Practice divestiture

The second approach for addressing the financial drain of employed physicians is divesting practices. Divestiture is not inherently a harsh and painful process that leaves physicians resentful of any further relationship with the hospital's or system's programs and services. If approached thoughtfully with a thorough understanding of all components of the divestiture process, both sides can exit the employer-employee relationship with a better understanding of their future roles as partners in providing medical care.

When divestiture becomes inevitable, the process for determining which practices must be released should be objective and use measurable (rather than subjective) criteria to evaluate performance. The practice evaluation process should also be completed in the context of a target level of financial performance so that the degree of improvement is established.

Evaluation criteria often include:

- Magnitude of individual practice operating losses
- Productivity and financial performance trends
- Remaining years on the employment contract
- Terms and conditions of the employment contract
- The competitive vulnerability of referral relationships
- Practice location in relation to strategic and geographic priorities of the hospital or system

Next, the hospital or system should conduct an assessment of practice needs to determine the goals and expectations of individual physicians. Determining practice needs will serve as the foundation for developing transition packages.

Practice needs can be categorized as:

- **Tangible and operational factors.**

Examples include information systems maintenance, accounts receivable funding, arranging a line of credit for salary continuation, benefits transition, securing a new provider number and transitioning payer credentials under this new provider number, and other necessities in the transition to private practice.

- **Intangible and emotional factors.**

A common example is tolerance for risk. If the physician is intolerant of risk (e.g., the young physician who has never been in a self-employed practice environment), the transition package will be quite different from one offered to the entrepreneurial physician with extensive experience in practice start-up and management.

Once a full understanding of physician needs is achieved, the hospital or system and the physicians can move toward developing and agreeing upon a transition process and the actual transition package. Practice-specific transition packages address a number of complex issues. Lengthy and sometimes arduous negotiation processes may be needed to achieve consensus.

In some cases, transition need not be immediate and may be structured to include an interim period (commonly six to 12 months). During this period, the physician may choose

to continue to use practice management services, such as billing and collections, staffing, medical records, information systems, scheduling, and other functions.

Transition packages address a number of issues, but the financial

terms and conditions typically dominate discussions. There are two key components of financial terms and conditions that must be addressed to determine the purchase price

between the willing seller and the willing buyer. The first is the repurchase of practice assets (e.g., equipment and furniture, real estate, telephone number, practice name, patient lists, and medical records) at fair market value, less amortized depreciation. The fair market value in most markets is generally substantially lower (due to fewer interested purchasers) than the original purchase price.

The second component is the buyout of the employment contract value. To determine an appropriate value, hospitals or systems often compare the calculations of various methodologies. Alternative methodologies to determine the buyout amount include:

- A percentage of losses projected on the remaining term of the employment agreement
- A percentage of losses incurred, typically a calculation based on a negotiated percentage of the prior year's financial performance
- A percentage of potential future contract earnings (to be paid to the physician) based on the present value of future employment
- A negotiated fee that has no relationship to the practice's value or future earnings/losses, but is generally a percentage of the loss-

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es on the remaining years specified in the employment contract

Other terms and conditions of the transition package may include:

- Restriction on the sale of the practice to another party (especially a competitor) for a defined period and, in some markets, a right of first refusal period after a restriction on the sale of the practice
- Agreement to assist with the transition process including managing payer and vendor contracts, leases and service agreements, staff employment and benefits, patient and business records, accounting systems, print and electronic communications, insurances (malpractice, liability, and health), and provider numbers
- Continued inclusion in provider panels and directories and other practice promotion initiatives
- A moratorium on disparaging comments by either party and solicitation of patients from system-affiliated practices

## Conclusion

Unraveling a decade's worth of physician-health system relationships that are grounded by the notion of acquisition and employment is going to be a complex, rigorous, and, at times, strained process for both parties. But given the magnitude of financial losses on acquired practices and the inability of health care providers to sustain future losses, there simply are not options beyond restructuring or divesting these relationships. It is critical that we move toward new physician-health systems affiliations that prove to be more beneficial for physicians, health care organizations, and patients. ●



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