Physician Mergers and Acquisitions: What are the Options and What are the Pitfalls?

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Drivers of Consolidation in the Emerging Landscape

• Reduced profitability for some providers
• Potentially lower demand
  – Reduced use created by higher co-pays, deductibles and retail clinics
• Downward pressure on prices
  – Transparency for shoppers
  – Risk/bundled payments
  – Growth of Medicaid population (with lower cost reimbursement ratio)
  – Reduction in DSH
Drivers of Consolidation

• Lack of physician negotiating leverage
  – Requires integration and size
• Limits on revenue diversification
• Regulatory pressure/ACOs and other new delivery models
• Cultural change in physicians
• Lack of capital
• Environmental uncertainty
Drivers of Consolidation

• Hospital Realities
  – Need to capture and retain patients
  – Patients can’t be captured without physicians who are loyal to the hospital system
  – New payment structures demand fully cooperative doctors clinically integrated with the hospital; e.g. quality payments, bundled payments, readmits, hospital acquired conditions
Drivers of Consolidation

Physician payments changes

- Reduction in ancillary income options
- Pilot projects for bundled payments and quality rewards
- SGR reform
  - Provides a .5% annual increase from 2014 to 2018
  - Freezes Medicare payments from 2018 to 2023
  - Starting in 2018 payments would be adjusted based on doctors' quality performance and meaningful use of EHR
  - Physicians who accept 2-sided risk or participate in alternative delivery structures such as ACOs and family medical homes that utilize quality measurements get a 5% bonus starting 2018
  - By 2018, for those doctors participating in the program, 25% of their income would come from non-volume based performance measures.
Potential Impacts from Consolidation

- Staff and facility reductions
- Increased use of non-physician professionals
- Fewer specialists/more primary care
- Focus on chronic disease
- Curbing waste in health care
Industry Trends: Provider Consolidation

- Predicted that in 2013 over 2/3rds of all physicians will be employed by hospitals or large groups
- Number of independent physicians will decline by 5% per year starting in 2013 (Accenture Health 2012)
- Hospitals now employ 25% of doctors
- 2/3rds of doctors signing employment agreements in 2009 are employees of hospitals

Impact:
- Argued that this will allow for better efficiency and quality
- More capital for investment in systems
- Productivity?
- No evidence of any impact on costs or quality
- Fear that consolidation will allow greater leverage to drive prices up
The Consolidators: Chose Your Partner Well

- Large clinically-integrated practice associations
- Consolidating physician groups
- Hospital–Physician Consolidation — antitrust pushback
- Health Plan–Provider Consolidation
  - Changing economic model?
  - Payer role in integrated delivery models
  - Improved leverage
  - Back to Kaiser model?
- Venture capital/investment banking
- Non-traditional consolidations (e.g., DaVita/HCPs)
What are Options for Consolidation?

• Seek employment by a hospital
• Partner with the hospital in some other fashion
  – Sell or merge
  – Professional Service Agreement
  – Management relationship
  – Service line agreements
• Build Multi-Specialty Practice through mergers and acquisitions
• Form Clinically Integrated Independent Practice Associations
• Join or build an ACO
• Participate in a medical home
• Partner with insurers
• Partner with venture capital owned provider groups owned and/or built by investment banks, venture capital or publicly traded companies
• Consider an insurance co-op
Issues Common to All Acquisitions or Collaborations

• Non-disclosure/Letter of Intent
• Due Diligence
• Provider numbers
  – Medicare change of ownership (CHOW)
  – Payor provider numbers
• Other government licenses
• Indemnity for problems undisclosed or undiscovered at closing
Diligence Issues

• Checklist
  – Corporate Records
  – Affiliated Entities
  – Financial Information
  – Tax
  – Payor Contracts
  – Litigation
  – Insurance
  – Employment
  – Employee Benefits
  – Physician Contracts with hospitals or other providers
Diligence Issues (cont.)

• Checklist
  – Real Estate
  – Environmental
  – Creditors
  – IP
  – Risk Management
  – Contracts
  – Regulatory Compliance
Healthcare Regulatory Checklist

• Fraud & Abuse
  – Space and equipment leases
  – Personal services & management contracts
    • Medical directorships
    • Call arrangements
    • Co-management agreements and other incentive based compensation
  – Physician employment contracts
  – Unwritten financial relationships
  – Ownership interests
  – Relationships with referral sources
Healthcare Regulatory Checklist (cont.)

• Reimbursement issues
  – Overpayments/Repayments
  – Audits
  – Investigations
  – Disclosures
  – Subpoenas
  – CIDS
  – CIAs
  – Litigation
Transaction Documents

• General Terms
  – Reps & Warranties
    • Included
    • Survivability
    • Knowledge qualifiers
    • Ongoing duties to update
  – Indemnifications
    • Caps & Baskets
    • Escrow
    • Time limits/statute of limitations
    • Insurance or other financial guarantee
Physician to Physician Mergers

• Common Issues
  – Governance
  – Compensation differences
  – Different methodologies for distributing ancillary income
  – Benefit plan differences
  – Real estate ownership
  – Debt differences
  – Value differences between groups
  – Different practice software mergers
  – Antitrust concerns
  – Culture differences
  – Staffing issues
  – Payor contracts
  – Regulatory history and liability for unknown regulatory violations
Physician Hospital Consolidation

• Merger or acquisition
  – Benefits
    • More certain environment for compensation—but this may be somewhat ephemeral because of DOJ position on commercially reasonable requirement for Stark and valuation requirements for fair market value
    • Greater access to capital for growth and data infrastructure
    • Increased leverage in payor negotiations unless the DOJ or FTC step in because of antitrust restrictions
    • Administrative assistance to navigate the new delivery models.
Physician Hospital Consolidation

• Cautions:
  – Purchase prices are highly limited—Stark restrictions result in little of any payment based on profitability. Often the only payment is for value of furniture, fixtures and equipment
  – Lack of participation in governance of hospital medical group
  – Hospital revenues are generated by hospital admissions; consequently, their interest or ability to focus on physician operations, management and reimbursement is limited. This may change as hospital payments change to emphasize costs and quality, but much is dependent on the hospitals ability to adjust to changes
  – Hospitals can sell or change ownership and management and are also financially vulnerable in today’s industry.
  – Hospitals do not manage physicians well.
  – Hospital ownership of physicians failed once before
Physician Hospital Consolidation

• The compensation payable by hospitals is highly regulated
  – Valuators are king
  – Hospitals have to rely on valuations and cannot wisely reject a valuation no matter how bad
  – The fair market value of the doctors’ compensation must be tested periodically—every 2 or 3 years which is dictated by the valuers
  – Recent cases and position taken by DOJ raise the distinct risk that hospitals cannot engage in a physician enterprise that costs more than the revenue generated by the physician enterprise—Toumey, Halifax and Bradford
Options for Physician/Hospital Consolidation

Physician Services Agreement (PSA)

Hospital

Physician Medical Group

Ownership

PSA

Hospital Medical Group

Payors
Physician Services Agreement

• **Advantages**
  – Doctors retain governance and hospitals don’t have to become involved with group internal issues
  – Physicians can often have governance input into hospital medical group
  – Doctors can be rewarded for quality performance and efficiency
  – Doctors can be compensated for all of the administrative services they have provided before at no cost
  – System can be rewarded for quality improvements
  – The relationship can be terminated more easily and the physician group can remain intact afterwards. This gives the doctors alternatives if the relationship doesn’t work.
Physician Services Agreements

• Problems
  ▪ Compensation models are still limited by valuation and commercially reasonable requirements
  ▪ Hospitals are wary of lack of control
  ▪ Creates multiple medical “groups” for the hospital
  ▪ Leasing creates more complex legal issues
  ▪ Who bills for ancillary services?
  ▪ Does not solve the concerns about the hospitals ability to manage and future success in the industry although the ease of termination ameliorates the issue to some degree.
Management Company
Collaboration
Other Collaboration Options: Management of Medical Group

Management (1) Can be owned by hospital or co-owned with medical group.
Other Physician Collaboration Options: Physician Management

- Partner (hospital or other)
  - Medical Practice
    - Doctors
    - Management Company
  - Management
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- Management Company
  - Doctors
- Ownership
  - PSA
  - Management
Health Plan Partnerships

- Hospitals and Doctors
  - Humana: Concentra and Norton health care system
  - Cigna purchased large group in Phoenix
  - Wellpoint buys CareMore in California
  - United’s Optum Health plans acquires Monarch—500 doctors in California, Texas, Florida and Arizona
  - Highmark and West Penn Allegheny in Pennsylvania
  - Group Health and Providence in Spokane
  - Aetna: Carillon Clinic and Heartland Healthcare – ACOs
  - Some plans are developing organizations to manage ACOs or clinically integrated networks
Health Plan Partnerships

• Motivations
  • End of the present plan economic model with profit controls?
  • Belief that the insurers have to control the integrated delivery models such as ACOs and medical homes
  • Improves leverage over hospitals
  • Back to Kaiser model?
Health Plan Partnerships: Advantages

- Fewer regulatory concerns regarding fair market value and commercial reasonableness since doctors don’t commonly refer patients to health plans
Health Plan Partnerships: Cautions

• Health Plans make money by cutting medical costs. They will likely try to reduce costs by lowering provider payments. However, doctors are less expensive than hospitals, so physicians may fare better under this pressure.

• Health Plans change their strategies as fads and shareholder pressure dictate. They may decide to jettison the physician groups at some point.
Investment Bankers/ Venture Capital

• Have tended to acquire hospital-based physicians
• Much like the physician practice management companies with the focus being on growing revenue by acquiring new physicians and achieving a liquidation event for the owners
• The focus is not necessarily on effective management of the physicians
• Probable loss of any real governance
• Big advantage is lack of concern regarding limits on compensation from stark and antikickback laws
Clinically Integrated Associations and ACOs

• Don’t necessarily require merger or acquisition
• Can be effectuated through contracts so you can retain much of the group’s independence
• However, they have their own set of issues