Avoiding the Lose/Lose — Large Physician Group Acquisitions Gone Bad and How to Avoid Potential Traps

Randy Bauman
Delta Health Care
rb@deltahealthcare.com

Gerry Hinkley
Pillsbury Winthrop Shaw Pittman LLP
gerry.hinkley@pillsburylaw.com

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Case Study

The Players

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physician Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 bed sole community hospital - NFP</td>
<td>50 physician multi-specialty 60% PCP</td>
</tr>
<tr>
<td>In business over 50 years</td>
<td>“Legacy” group in business over 50 years</td>
</tr>
</tbody>
</table>
| Small but growing employed PCP base | Full complement of ancillary services - major competitor of the hospital:  
  • Outpatient imaging (including CT/MRI)  
  • Nuclear cardiology  
  • Outpatient surgery (hospital minority partner with outside physicians) |
| Small but stable profit margins | Physician production (wRVUs) below the median |
| | Ancillaries support physician incomes in excess of productivity levels |
| | Coming off a “bad year” financially |
## Case Study

### Deal Drivers

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physician Group</th>
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<tbody>
<tr>
<td>Eliminate group as major competitor</td>
<td>Stabilize (and increase) physician incomes</td>
</tr>
<tr>
<td>Eliminate duplicate services</td>
<td>Help in recruiting and retention</td>
</tr>
<tr>
<td>Provider-based billing upside</td>
<td>Physician risk-averseness - Debt levels</td>
</tr>
<tr>
<td>ACA/ACO Strategy</td>
<td>PCP/Specialty tension on compensation</td>
</tr>
<tr>
<td></td>
<td>Eliminate ACA/ACO uncertainty</td>
</tr>
</tbody>
</table>
Case Study

Management and Advisors

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physician Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-standing and respected CEO – consensus management style</td>
<td>Long-standing CEO nearing retirement lacking respect from physician leaders</td>
</tr>
<tr>
<td>External counsel limited experience in large physician transactions and multi-specialty groups</td>
<td>External counsel experienced solely in specialty group transactions. Brought in by specialists to represent the group</td>
</tr>
<tr>
<td>Experienced transaction advisory firm</td>
<td>No transaction advisory firm - local CPA with limited experience and objectivity (standing to lose a large client)</td>
</tr>
<tr>
<td>Separate appraisers for business valuation, compensation and real estate (jointly agreed upon with physician group)</td>
<td>No appraisers</td>
</tr>
</tbody>
</table>
## Case Study

### Operational and Cultural Integration Issues

<table>
<thead>
<tr>
<th>Multi-specialty Group (50 physicians)</th>
<th>Hospital Employed PCP Group (&lt; 10 physicians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established successful billing platform</td>
<td>In process of choosing new system</td>
</tr>
<tr>
<td>Established EHR system</td>
<td>New system being implemented (different from multi-specialty group’s)</td>
</tr>
<tr>
<td>Seasoned management team (CEO/CFO/COO)</td>
<td>Group “administrator” with office management experience</td>
</tr>
<tr>
<td>Full payor contracting and credentialing department</td>
<td>Hospital CFO responsible for payor contracting. Credentialing sub-contracted.</td>
</tr>
<tr>
<td>Robust practice accounting system</td>
<td>Piggybacked on hospital accounting system</td>
</tr>
</tbody>
</table>

Hospital unwilling to recognize the potential “value” of the operating platform being acquired.
Antitrust Issues

Elimination of competition *ALWAYS* has potential antitrust considerations

- Large physician-owned groups command market power and higher fees from payors that directly impact compensation - neither is likely true at hospital

Major Issue: Payor contracts and fee schedules

- Normally not a material issue. Small groups likely have standard (non-negotiated) fee schedules
- Large multi-specialty groups often have significantly higher fee schedules than the hospital because:
  - Hospital physician networks are often small with little initial focus on fees
  - Hospital often trade-off IP/OP and per diem fees for physician fees

Pre-closing sharing of information on payor contracts, fee schedules and employees
**Antitrust Issues (Continued)**

### Which Contracts are Better? Which Survive? Impact on Deal:
- Physician approval driven primarily by increased compensation
  - “Affordability” of increased compensation driven by post-acquisition proforma
  - Proforma uncertainty driven by unknown impact of payor contract fee schedules

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<th>Hospital</th>
<th>Physician Group</th>
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<tbody>
<tr>
<td>We have better contracts</td>
<td>We have better contracts</td>
</tr>
<tr>
<td>Our better contracts will increase group revenue</td>
<td>Our better contracts will increase hospital group revenue</td>
</tr>
</tbody>
</table>
Antitrust Issues (Continued)

- When is transaction far enough along to assuage antitrust concerns and allow sharing of payor contracts and fee schedules?
  - Antitrust/price fixing
  - Confidentiality provisions in payor contracts
  - Which fees schedules survive? TPID# – implications on deal structure
  - Implications if deal collapses

- Options
  - “Black box” analysis
  - Drive blind
  - Contract contingency
  - Guess
Practice Valuation Issues

- Large groups often engage their own valuation firm for comparative purposes.
- Since the parties jointly chose the firms, neither had the benefit of advocacy although the physicians felt the firms advocated for the hospital.
- Medical records:
  - Disparate philosophies of valuation firms absent an earnings stream.
  - Wide range of values per chart - 4X in some cases.
- Trained workforce:
  - Disparate philosophies of valuation firms absent an earnings stream.
  - Disparate philosophies of valuation firms with respect to including physician owners.
Practice Valuation Issues (Continued)

Business unit carve-outs and joint ventures

- Separate valuation of group owned imaging centers and other ancillaries are often demanded and must be carefully examined to assure “double-dipping” is eliminated

- ASC jointly owned by group with minority hospital ownership and outside physicians gave rise to minority interest valuation considerations
  - Control and collapse of ASC was essential from hospital standpoint
Compensation

Issues unique to multi-specialty groups

- Frequent changes to compensation plan
- Complexity “baked in” over many years
- Ancillary profits yield physician income levels in excess of what is supported by personal productivity (wRVUs)
- Generally specialists "subsidize" PCP and therefore would earn more under wRVU model
- Generally PCP would earn less under wRVU model
- Moving to wRVU model creates disparity in percent increases
Compensation (Continued)

- All of the above have to fit within the confines of fair market value and commercial reasonableness in terms over both individual and overall increases.

- Shareholder supermajority vote thresholds create the need to make everyone happy often including:
  - Floors to protect PCP from downside by “baking in” increases
  - Caps to limit increases for specialists
  - Transitional models
  - Result: Complexity and uncertainty in out years
Operational Consolidation

- Post-transaction systems
  - Practice management
  - Billing
  - Accounting
  - Other

- Role of physician group management team

- Employee benefits

- Seniority grandfathering

- Employment policies

- Indemnities, compliance and contingent liabilities
Opening the Door for the White Knight

Asset valuation and compensation appraisal disparities:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Competing Hospital System</th>
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<tbody>
<tr>
<td>Individuals capped at 75th percentile</td>
<td>No individual cap</td>
</tr>
<tr>
<td>Aggregate increase capped at 30%</td>
<td>Aggregate increase 43% (not capped)</td>
</tr>
<tr>
<td>Productivity standards +/- 5% of historical</td>
<td>No productivity standards</td>
</tr>
<tr>
<td>Low ($3-$4) chart value resulting from lack of earnings stream</td>
<td>Chart value $15 (3-5X)</td>
</tr>
<tr>
<td>No value for physician owner workforce</td>
<td>Some value assigned to physician owner workforce through non-compete</td>
</tr>
<tr>
<td>No valuation premium for “on campus” MOB</td>
<td>Premium assigned to “on campus” MOB</td>
</tr>
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Opening the Door for the White Knight (Continued)

How did the competing hospital and its appraisers do it?

- No simple resolution of disparate valuation philosophies
  - Example: Ignored aggregate increase metric (comparison of the proposed comp to historical). Comp model proposed was simply the greater of median comp or wRVUs multiplied by median comp per wRVU based on weighted average of regional surveys.

- Different perspectives of different appraisers can make or break deals
- Hard “rules” can box you in.
- Justification to match 11th hour competing offer judged too risky

Sometimes the best deals are the ones you don't close.
Seeds of Demise are Often Sown Early – What Could Have Been Done Differently?

### Hospital
- Agreement to jointly choose appraisers (to be paid for by the hospital)
- Legal counsel inexperienced in multi-specialty group dynamics
- Lack of direct communication to group's board and/or shareholders
- Unwillingness (or failure) to recognize the value of the group as an operating platform
- Continued negotiation after LOI expired (along with blackout and no-shop) despite significant investment in transaction
- Took hard line on operational consolidation and minor governance issues - physicians questioning “collaboration”

### Physician Group
- Sought cost savings by sharing appraisers (paid for by the hospital) - lacked experienced 2nd opinion and advocate
- Sought costs savings by not engaging an experienced financial advisory firm
- Legal counsel inexperienced in multi-specialty group dynamics
- “Steering committee” of three specialists – limited communication to shareholders
- Long-standing PCP/Specialty tension on compensation and impact on supermajority vote requirements
- Unaddressed productivity issues with PCP being subsidized by ancillary profits and specialists