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

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Case Study

The Players

Hospital	Physician Group
200 bed sole community hospital - NFP	50 physician multi-specialty 60% PCP
In business over 50 years	“Legacy” group in business over 50 years
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

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Deal Drivers

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

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Management and Advisors

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

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Operational and Cultural Integration Issues

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

Hospital unwilling to recognize the potential "value" of the operating platform being acquired.

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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

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Antitrust Issues (Continued)

Hospital	Physician Group
We have better contracts	We have better contracts
Our better contracts will increase group revenue	Our better contracts will increase hospital group revenue

- 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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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

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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

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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

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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

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Opening the Door for the White Knight

Asset valuation and compensation appraisal disparities:

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

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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 match11th hour competing offer judged too risky

Sometimes the best deals are the ones you don't close.

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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

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