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* How insurance companies, hospitals, government, etc. Slice Costs And Maintain Quality

When Is “Not A Tax” a “Tax?”

By Richard J. Gimpelson, MD

The Patient Protection and Affordable Care Act (PPACA) is now the law of the land. If you were for it, you are happy now. If you were against it, you are happy now. Why are all of you happy? – because it will be part of your guide for the November elections.

Being the impartial observer that I am, I will not comment on the value or lack of value of the PPACA. I am merely going to enlighten all of you on the areas of the PPACA in which you and the rest of America will have to interact with the IRS.

First, some quotes from those who have given us the PPACA:

1. Candidate for President Obama – “If you are a family making less than $250,000 per year, you will not see your taxes go up.” (2008)
2. President Obama – “Absolutely not a tax”. (9/20/2009)
3. Nancy Pelosi – “It is a penalty, not a tax” (7/1/2012)
4. White House Chief of Staff Jack Lew – “Health Care Law not a tax, it’s a penalty.” (7/1/2012)

The Congressional Budget Office predicts that by 2016, four million Americans will pay the PPACA tax. Some 75% will make less than $120,000 per year. It is interesting that when the White House solicitor general argued for the PPACA before the Supreme Court, he referred to the Mandate as a “tax” according to an article in *Forbes* from the Washington Legal Foundation (6/28/2012).

Most importantly, when the Supreme Court ruled on the PPACA, Chief Justice John Roberts, who wrote the majority opinion, said that the “Mandate” could not be supported by the “Commerce” clause, but that it must be a “Tax,” because the Constitution requirements cannot be skirted simply because Congress wishes it so. Thus, whether a provision is valid under the Constitution depends on how that provision functions, not Congress’ intent.

Since the Supreme Court (the highest court of appeals in the United States) ruled the “Mandate is a Tax,” there is no debate any longer and the Mandate is a Tax!

As the song goes, “One is a Lonely Number,” so do not worry as many new taxes are included in the PPACA:

1. Individual Mandate Tax – A couple pays the higher of $1,360 per new taxes are included in the PPACA: the Mandate is a Tax!
2. President Obama – “Absolutely not a tax”. (9/20/2009)
3. Nancy Pelosi – “It is a penalty, not a tax” (7/1/2012)
4. White House Chief of Staff Jack Lew – “Health Care Law not a tax, it’s a penalty.” (7/1/2012)

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As the song goes, “One is a Lonely Number,” so do not worry as many new taxes are included in the PPACA:

1. Individual Mandate Tax – A couple pays the higher of $1,360 per year or 2.5% of adjusted gross income.
2. Medicine Cabinet Tax – Prohibits reimbursement for over-the-counter medications from pre-tax dollar funded Health Savings Accounts, Flexible Spending Accounts, or Health Reimbursement Accounts.
3. Flexible Spending Account Cap – Imposes a cap of $2,500 per year (presently unlimited). This is especially hurtful to those who pay for special needs education that often exceeds $10,000 annually.
4. Medical Itemized Deduction – Currently 7.5% of adjusted gross income, but will be raised to 10% of adjusted gross income.
5. Health Savings Account Withdrawal Tax – Increases from 10% penalty to 20% if money is taken out for non-medical early withdrawal.
6. Indoor Tanning Services Tax – Places a 10% excise tax on people using tanning salons.
7. “Cadillac” Health Income Tax – Will impose a 40% excise tax for employer-paid premiums on taxpayers covered by such plans. Most interesting about this tax is that it does not begin until 2018 because most unionized members are covered by this type of plan and the deferral gives an adjustment period to devise other methods of coverage for union members. There are 13 other taxes that apply to businesses and other high income earners. Some of these taxes may result in reduced employment or an employer’s decision to pay the tax penalty rather than provide insurance for employees.

A 2.3% excise tax on all medical devices costing more than $100 will help drive up the cost of medical care.

A surtax on investment income for households earning more than $250,000 per year will raise the capital gains tax from 15% to 23.8% and taxes on dividends from 15% to 43.4%. Subchapter S Corporation tax will rise from 35% to 43.4%.

Therefore, “Not a Tax” became a tax after the Supreme Court ruling on the PPACA. It appears that some people in Washington, D.C., are not aware of the saying “if you hear hoofbeats, think of horses, not zebras.” However, the Masai Mara Game Reserve and Nairobi National Park are both located in Kenya, so this may be where the horses/zebras confusion comes from.

Don’t forget to vote on November 6!

Dr. Gimpelson, a past SLMMMS president, is now co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

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Harry’s Homilies®
Harry L. S. Knopf, MD

ON AGING
The best mirror is an old friend.
(G. Herbert: *Jacula Prudentum*)

Dr. Knopf is editor of Harry’s Homilies.© He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.
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Hospital Employment of Physicians and Acquisition of Practices Increase

The advertisements, articles, and “Letters” appearing in *St. Louis Metropolitan Medicine*, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. *SLMM* reserves the right to make the final decision on all content and advertisements.
I look forward to the articles on hospital ownership of medical practices in this issue. Hospital ownership seems to be the default paradigm for Accountable Care Organization (ACO) formation. I am not sure if governmental incentives favor hospitals due to political reasons, or the traditional role of hospitals as “centers of care” clouds perceptions of the future.

Economic and governmental change is leading many physicians to explore alternatives to independent private practice. Many residents finishing training are turning to employment by a hospital or hospital-aligned practice as well.

Hospitals can be the most intensive cost centers for many services, particularly outpatient services. Many hospitals are positioned well for developing networks or ACOs because of favorable not-for-profit tax treatment, access to capital through bond issue or existing institutional wealth, and their traditional role as centers for care.

Hospitals tend to be bureaucratic and traditional. Innovation and agility are desirable aspects of entrepreneurial enterprise. New approaches to lowering costs and improving efficiency in health care may come from non-hospital enterprises. A favorable regulatory environment is necessary for physicians to be involved in innovative approaches to care.

Physician ownership of hospitals or other care agencies is severely limited by regulation. Hospitals are not necessarily the best model for the future. Alternative organizations may develop around physicians, insurers or managed service organizations, which could contract with hospitals only for the services that hospitals uniquely provide (e.g., inpatient care). Hospitals may be bypassed by more efficient options in the future.

For convenience of description, *hospital-physician relationship* is the term used to describe the relationship between physicians and whatever entity that ultimately acts as the center of care.

Clearly, fear and uncertainty are stimulants of change, however, opportunity and potential rewards are motives for choice. Physician ownership of practices is decreasing while hospital employment or practice acquisition is increasing.

Often-cited motives for physicians choosing hospital employment include:

- Predictable income
- Predictable coverage, and
- Predictable time off

Decreasing patient revenues, increasing practice expenses and decreasing access to capital—as required for EMR and eRX projects among other things—are factors. Decreasing negotiation strength with respect to commercial payers and flat or decreasing reimbursement for Medicare services have a major impact. Decreasing ownership of ancillary services due to the regulatory environment affects physician income and independence.

In contrast, some leaders welcome the current situation as an opportunity to deliver health care in a more efficient and rewarding manner. The future dictates risk-based payment as costs of care exceed available financial resources. Unlike the previous “gatekeeper” primary care physician model of the 1980s, access to lowest-cost resources at the earliest point in care is a concept of ACOs.

Specialists or specialty services may have their own risk-based contracts and outcome measurements. In theory, greater efficiency and less waste in care should result in higher incentives for risk-based providers.
Information technology promises data dashboards, quality and outcome reporting, and the like. Compliance with guidelines and evidence-based medicine are sure to be heavily promoted as markers of care and efficiency. Hospitals have momentum in information technology, and the small physician practice is disadvantaged.

Hospital ownership of medical practices is only one approach to physician “alignment.” The hospital-physician contractual relationship is limited only by ingenuity of lawyers and the regulatory and economic context. Payment for referrals (or use of facility) is prohibited.

Alignment may include outright employment or employment by a hospital group; or a hospital may employ and manage staff, pay administrative costs, provide a global payment rate, or provide management alone. Fair market value must be present to comply with self-referral and anti-kickback constraints. Good communication and periodic review of the contractual relationship is advised. On-call agreements, medical directorships, joint or full management of practice employees, and joint business ventures may provide economic alignment.

Nurturing relationships with providers and realizing a common purpose are important for long-term success. Providing the patient with good clinical services, as measured by predictable outcomes, is a foundational precept of effective alignment.

Additional sources for articles on hospital-physician relationships:

www.ama-assn.org (Go to “AMA News archives”)  
www.beckershospitalreview.com  
www.msma.org  
St. Louis Metropolitan Medicine, January 1998 issue

**Tort Reform Cap Struck Down:** On July 31, the Missouri Supreme Court struck down the $350,000 cap on noneconomic damages in medical malpractice (negligence) that was set by the 2005 Missouri tort reform legislation. The court majority overturned a two-decade precedent holding caps constitutional. In Watts v. Cox Medical Center, the court ruled that a damage award made by a Greene County jury should stand and statutory non-economic limits would not be imposed. The court stated that the cap violated the plaintiff’s state constitutional right to a jury trial. The earlier ruling in Sanders v. Ahmed applying limits in a statutory cause of action (wrongful death) was not affected.

The MSMA has issued a public statement regarding the Watts decision and outlining probable adverse effects for the physicians and residents of Missouri (available at www.msma.org). These effects are availability of physician services and malpractice coverage. It is more important than ever for physicians to become members of local and state medical societies to analyze and report these effects and communicate with a clear, unified voice.

**PPACA Upheld:** On June 28, the U.S. Supreme Court upheld the constitutionality of the PPACA in a 5-4 decision. The precise future impact of this legislation remains uncertain. It is certain to be at the center of federal election campaign debate. Further legislative modification may be in store. The support and opinions of the Medical Society membership are greatly appreciated.

For more information: Twitter @mcmahonjmd #slmms #lawsuitreform

**Editor’s Note:** In the June/July President’s Column, the text omitted the reference numbers corresponding to the references listed at the end of the article. The numbers were part of the author’s original text but were omitted in the production process. We apologize for the error.

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**Donald Palmisano, MD, JD, to Speak at Hippocrates Lecture**

Past AMA president Donald Palmisano, MD, JD, will be the featured speaker at the annual SLMMS Hippocrates Lecture on Tuesday, Oct. 16, at 6 p.m. at Ces & Judy’s Catering, 10405 Clayton Rd. His topic will be “National Perspectives on Medical Liability Reform.”

Dr. Palmisano is founder and president of Intrepid Resources of Metairie, La., which provides complete independent risk management and claims review services for physicians and hospitals. He served on the AMA board of trustees from 1996 to 2005 and was 2003-04 president. He is a member of the board of governors of The Doctors Company, a medical liability insurance company for physicians. He is a member of the board of governors of the National Patient Safety Foundation and from 1999 to 2003 was a commissioner on the board of the Joint Commission on Accreditation of Healthcare Organizations.

Dr. Palmisano was a key participant in the passage of Louisiana’s Medical Malpractice Act which mandates medical review panels prior to suit and sets a $500,000 cap on total recovery except for medical expenses as incurred.
Health care has many challenges. They without a doubt include our aging population, increasing costs for delivery of services, uncertainties of health care reform and the chronic shortage of providers—not to mention the growing demand for state-of-the-art, technologically advanced care. Yet with all these obstacles, as physicians it is our duty and desire to provide the best quality of care to our patients with excellent service and compassion. We in the health care industry must have a true calling—a real dedication to these principles—for our patients to have the best possible outcomes and for us to have any chance of long-term success and financial survival.

Mercy has realized that with meaningful physician leadership at all levels, we can provide excellent service and compassion. In what has been a formerly hospital-centric system, Mercy is now a ministry innovating how health care is delivered by involving physicians in decision making at all levels. The patient experience is at the center of every goal and objective. Our model is not one of simple physician employment but rather of true integration.

Mercy Clinic is Mercy’s provider/physician organization. It is separate and parallel to the hospital and is truly empowered and accountable with its own management and governance structure. Clinic physicians are intimately involved with clinical and business strategies to improve efficiency, reduce redundancy and share in the ultimate health outcomes for all of our communities. The management structure includes physician and administrative partners with an appointed medical director and senior vice president overseeing the operations of each of our clinical divisions (i.e., adult primary care, adult specialties, hospital based services and pediatrics). Another separate clinic division is quality. While quality is and has to be imbedded in every facet of our organization, this division oversees quality initiatives monitored for all providers.

The Clinic board for Mercy East communities (including St. Louis and Washington, Mo., and the surrounding metro area), currently has 15 members—12 of whom are elected by the physician members of the group. The other three include the Clinic president, chief operating officer and the Mercy regional president. Our Clinic board is parallel to and does not report to the hospital board but rather reports to an overarching Mercy ministry board.

The physician board members are very engaged, and more involved as a strategic and visionary group, rather than with operational/management concerns. In this way, we strive to be truly physician-led with outstanding professional management, all with aligned incentives. Subcommittees of the board are charged with initiatives including:

- Physician satisfaction and engagement
- Co-worker satisfaction to make us a desirable place to work in this very competitive environment
- Patient satisfaction with emphasis on compassionate service
- Best business practice
- Physician compensation
- Optimal use of our electronic health record

Patient-centered care is at the heart of every conversation. However, only with physicians and co-workers engaged and satisfied—with very competitive compensation, professional satisfaction and lifestyle balance—is there any hope of achieving an outstanding, best-in-class health care experience for our patients. Each of these board subcommittees is provided with measurement tools that can be used for internal monitoring and provide the basis for tactical plans for long-term improvement. Each is charged to exceed community and national benchmarks and to make Mercy Clinic physicians recognized regionally, nationally and internationally for quality health care.

Through this structure we fully believe we have the best chance to approach the complex challenges of high quality and compassionate care. These include challenges such as engaged physician leadership, delineation and management of those with chronic illness, best business practices as far as expenditures and costs, best utilization of human and capital resources (physician, other provider, the complex array of other co-workers), addressing the challenges of consumerism, health care reform, financing as well as strategic planning.

We recognize the need to deliver care in the right setting, preventing inpatient and high-cost care whenever possible. We must assure that care is effective, efficient, patient-centered, equitable, safe and timely—consistent with all of the imperatives of the Institute of Medicine. While the Clinic and hospital structures are somewhat in-
dependent, there is continual effort to coordinate clinical care and process, involving both integrated and independent physicians to achieve the highest quality care for our patients. We believe that Accountable Care, including changes in health care financing, is coming no matter what the impact of the Supreme Court decision regarding recent legislation. We must develop high levels of coordination across all levels of care and be facile to innovate and constantly change as needed.

This is an exciting time for health care delivery. The old Chinese curse of living in interesting times is upon us. Yet there is unlimited opportunity to improve our current systems of health care delivery, bettering access for patients throughout our community and assuring they have the best health outcomes with the greatest utilization of resources. I believe our model of a fully integrated health care delivery system with physicians, hospitals and a robust administrative group of leaders partnering at all levels has the best chance for long-term success.

It has been my tremendous honor and privilege to serve as president of Mercy Clinic East Communities since the inception of the Clinic in our area about 18 months ago. We are about growth. It is our goal to unite with local communities and focus on the unique needs we serve. Local health care delivery (when possible), development of centers of excellence, use of technology, growth of telemedicine to meet the needs of communities with more limited resources, and expansion of health, wellness and preventative services are among our concerns.

Sitting on the sidelines in these turbulent times and simply trying to preserve what is in place, I believe, is a strategy bound to fail. What will distinguish successful organizations will be physicians and administrative leaders joining forces with unified goals and incentives. Simple employment of physicians by hospitals is not a solution. True acknowledgement and development of physician leadership and full integration is the only answer to arrive at a sustainable world-class organization.

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John W. Hubert, MD, is an SLMMS member and president of Mercy Clinic East Communities. Mercy is the sixth largest Catholic health care system in the U.S. and serves more than 3 million people annually. It includes 31 hospitals, more than 200 outpatient facilities, 38,000 co-workers and 1,600 integrated physicians in Arkansas, Kansas, Missouri and Oklahoma.

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**Mercy Clinic – East Communities: Growth in Numbers**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2012</th>
<th>Difference</th>
<th>% Change</th>
</tr>
</thead>
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<tr>
<td>Physicians</td>
<td>345</td>
<td>537</td>
<td>+192</td>
<td>56%</td>
</tr>
<tr>
<td>Practices</td>
<td>100</td>
<td>195</td>
<td>+95</td>
<td>95%</td>
</tr>
<tr>
<td>Advanced Practitioners</td>
<td>60</td>
<td>131</td>
<td>+71</td>
<td>118%</td>
</tr>
<tr>
<td>Co-Workers</td>
<td>800</td>
<td>1453</td>
<td>+653</td>
<td>82%</td>
</tr>
<tr>
<td>Patient Encounters</td>
<td>1.1 mil</td>
<td>1.9 mil</td>
<td>+800K</td>
<td>73%</td>
</tr>
</tbody>
</table>
Doctors are becoming hospital employees. Private practice, which has been the dominant way physicians have practiced since the country was founded, may be a thing of the past. Doctors are closing their offices for the simple reason that the hospitals give them a hefty signing bonus for the first year or two, and then the government and insurance companies reimburse them at higher levels as hospital employees than they can obtain in private practice. Hospitals buy doctors’ practices in order to lock in referral sources for inpatient and outpatient services. How long can this costly state of affairs last?

The Pressure Is On

The government is under tremendous pressure to reduce Medicare costs. Over the past 30 years health care expenditures have increased from 7 to 16 percent of the GNP. The number of uninsured has increased from 30 to 50 million.¹ For a family of four the cost of health care has increased to $20,000 annually according to a recent report from the Milliman Medical Index.² And the public is asking if all these expenditures are worthwhile. The health of the U.S. population is no better than the health of citizens of many countries that spend far less on health care than does the U.S.

Hospitals comprise the nation’s largest single health care expenditure at about 30 percent of the total. Both the government and employers are finding it more and more difficult to pay for skyrocketing health care costs. And they are finally beginning to scrutinize hospital costs.

A recent article in the St. Louis Post Dispatch listed the costs of MRI imaging at various hospitals and outpatient imaging centers. There was at least a three-fold difference in pricing. A private for-profit hospital was the least expensive. The largest hospital system in the area refused to even reveal its prices for MRIs.³ Competition is supposed to be the hallmark of managed care, under which our current health system operates and which was supposed to reduce health care costs. How can there be competition when there is no price transparency? Why does this marked disparity in hospital pricing exist?

MRIs aren’t the only overpriced hospital service. Hospitals strongly urge their employed physicians to refer their patients to hospital imaging centers for other types of X-rays and to high-priced hospital-owned clinical laboratories and outpatient surgical centers.

Reimbursements Vary

The influential governmental non-partisan Medicare Payment Advisory Commission (MedPAC) has recommended cuts in hospital reimbursement. One major cut would be in primary care services. Currently a mid-level office visit for a hospital-owned doctor is $124.40. The same visit in a private physician’s office is $69.97 or 44.6% less. MedPAC has recommended the elimination of this disparity. MedPAC has recommended uniform pricing for identical treatments, regardless of whether they are administered by doctors who own their own practices or doctors who work for hospital-based clinics. It is estimated that this change alone would save Medicare about $1 billion per year.⁴ If implemented it would also severely hamper hospitals’ ability to attract physician employees.

How did it come about that the government...
and insurance companies pay doctors in private practice so little but pay hospital-based doctors so generously? Both the Federal Trade Commission and corporate managed care organizations have encouraged hospitals and health plans to employ physicians. 7 Policymakers hold as an article of faith that conflicts of interest inherent in fee-for-service private practice are the root cause of high health care costs.

The “experts” contend that cost savings can be realized when physicians practice as employees in vertically integrated systems like the Mayo Clinic, the Cleveland Clinic, Kaiser Permanente, and other hospital systems. There are no studies to support this assumption. In fact the data, some of which is cited above, support the opposite conclusion.

What percent of the GNP does health care have to consume before the policymakers start making changes in hospital reimbursement? When will hospitals be held accountable for their lavish spending on massive unnecessary building programs, huge administrative salaries, advertising, and yes, even subsidies to physicians? And when will the so-called experts in health care admit that multi-hospital mergers and the ownership of physician practices function as monopolies that raise not lower costs?

The average physician rushing to sell his or her practice to a hospital doesn’t have time to think about these questions. There are bills to pay, children to send to college, mortgage payments to meet, and savings to put away for retirement.

Possibilities for Change
But sooner or later the good times for hospitals will have to end. The hospitals will of course vigorously oppose any changes in the current system. Congress is not bound to accept the recommendations of MedPAC. Hospitals constitute a very powerful lobby and will use all of their vast resources to maintain the status quo. Economic reality may nevertheless force them to cut back on non-essential expenses.

If third-party payers and the government decide to pay physicians owned by hospitals at the same rate that they pay physicians in private practice (as MedPAC recommends), physicians may find becoming a hospital employee less attractive. And hospitals might be forced to lay off many of their employed physicians. If such a scenario plays out, private practice could make a comeback.

Dr. Gale is a past president of SLMMS and frequent contributor to St. Louis Metropolitan Medicine.

In line with the substantial amount of integration occurring in health-care markets, there is a significant and increasing trend of hospitals purchasing physician practices and consequently directly employing the former practice physicians. In light of the Supreme Court’s decision to uphold health care reform, we will likely see this acquisition trend continue. In part, the mode of consolidation is due to tougher economic conditions for independent practices; additionally, payment methodology changes under new government initiatives, such as accountable care organizations and bundled payments, are motivating physicians to consider hospital relationships. This article addresses considerations for physicians encountering the opportunity to sell to a hospital or health system.

Benefits

Under the right circumstances, physicians can enjoy great benefits from selling to hospitals, including less personal financial risk and greater income predictability. Hospital employment can reduce uncertainties concerning government program changes related to health care reform, including reimbursement uncertainty. Physicians can also avoid the increasing expenses required to operate a private practice, including necessary investments in electronic health records and other sophisticated medical equipment. Furthermore, physicians are increasingly demanding better quality of life in terms of time off, the inherent stress of running a business and management of patient volume.

Hospitals also enjoy significant benefits from the purchase of a physician practice. For example, an integrated hospital-physician organization can give greater leverage in negotiation with commercial payors. Additionally, employing physicians can improve a hospital’s market position in comparison to other hospitals and to ambulatory surgery centers. Employment of physicians also allows a hospital a greater ability to implement quality initiatives in compliance with fraud and abuse requirements.

Regardless of the individual reasons both physicians and hospitals may entertain integration, physicians should approach such an opportunity with significant planning and a full understanding of the process of acquisition and the employment relationship following integration. There are several important aspects on which to focus if considering a sale. The physicians in the selling practice should take the time to understand and invest in creating the best deal for themselves, both with regard to the practice sale and their future employment arrangements. This endeavor should involve utilization of the practice administrator as well as appropriate external consulting, tax, financial and legal advisors.

Requiring the potential buyer to sign a confidentiality agreement is one of the first steps a practice should take when considering a sale. Not doing so can become problematic for a variety of reasons, for example, if perhaps your practice is not ready for the fact of the potential sale to become public news to its competitors, its employees or other potential buyers. The confidentiality agreement should be clear as to the information you need to protect. If too specific, the agreement may miss something important and leave a dangerous gap. If your language is too broad, it may leave room for the buyer not to act as cautiously as it should. Confidential information may include financial information, business and marketing strategies, employee information, policies and procedures, compliance with standards from accreditation and certifying boards, and Medicare correspondence.

Overall, physicians should consider the following matters as they enter into any potential practice sale:

- Value of the practice
- Structure of the deal
- Employment relationship
- Covenants not to compete
- Federal fraud and abuse laws
Valuation

Determining the value of your practice will be one of the first steps both the practice and the hospital must consider. There are a number of approaches to valuation. Most methodologies will take into account the practice’s tangible property (personal and real), cash, debt and goodwill. Some valuations also consider the practice’s accounts receivable although its value is generally excluded from the purchase price. Regardless of the approach ultimately used, the hospital will certainly engage a professional valuation firm to appraise these items. Often, a valuation expert will employ multiple methods of valuation for comparison purposes. The hospital may or may not share the appraisal with the practice, but in any event, the practice should consider investing in its own appraisal to ensure a counterpoint to the hospital’s appraisal.

In the valuation and price negotiation process, it is important to note that hospitals, which are typically tax-exempt organizations (as well as restrained by the fraud and abuse laws, as discussed below), will be restrained from offering greater than reasonable or fair market value for the practice. That being said, it is important to obtain an appraisal from an experienced, reputable firm that specializes in health-care valuations. This will serve you well by ensuring the appraiser understands and appreciates all the assets associated with your practice.

Understanding and Structuring The Deal

The hospital will almost certainly want to structure the deal as an asset purchase, rather than an acquisition of the practice’s actual legal entity. An asset purchase allows the hospital to protect itself, to some extent, from a practice’s prior liabilities. For example, buying the practice’s “stuff,” rather than continuing the practice in its current legal entity, will to some degree insulate the hospital from responsibility for any malpractice claims accruing prior to the purchase. Typically, the hospital will acquire the practice through a subsidiary for purposes of insulation from liability and to ensure the hospital is compliant with legal and ethical rules concerning physicians’ independence of judgment.

Although the asset purchase structure reduces the hospital’s concerns with respect to liability, the hospital will want to conduct a thorough process of reviewing the state of the practice’s operations, referred to as “due diligence.” The due diligence process is designed to identify and evaluate information about the status of the practice in order to inform the parties as to how to negotiate the sale and for purposes of allocating risks between the parties. Physicians should be prepared to open practice operational information to the hospital, including financial and tax records, malpractice and other insurance claims data, debt, payor arrangements (though sharing this data is somewhat limited by anti-trust law), employee matters and physician productivity.

Employment

The negotiation of employment and compensation arrangements will be critical to a successful sale because this will be the ongoing relationship far beyond the sale period. Structuring physician employment terms, conditions and compensation must be considered as a major component of the deal and physicians are well-served to scrutinize suggested arrangements. Often hospitals will require, as a condition of the sale, that a majority of the practice physicians, including key physicians, must sign employment agreements with the hospital at the time the deal is finalized.

Compensation models vary widely, from a straight salary model to production-only compensation. In recent years, complex formulas are often developed to reward physician productivity while still achieving compliance with fraud and abuse laws (see below for further discussion on fraud and abuse). This may often be difficult because the method by which physicians may have been compensated in private practice may not pass legal muster in a hospital-employment model. For these reasons, negotiation of compensation can become the most complex and contentious part of a practice sale.

Many commonly used productivity arrangements are based on objective measures, usually relative value units (RVUs), under which physicians are paid based on personal performed services. Overall, physicians should strive for

(continued on page 16)
Practical and Legal Considerations of Selling a Medical Practice to a Hospital
(continued)

transparent and specific compensation methodology, clear job expectations surrounding productivity, call coverage, office hours, time off and covenants not to compete.

Physicians should be aware that tax-exempt hospitals are further restrained as to compensation practices. Tax-exempt organizations are prohibited from paying beyond reasonable compensation, referred to as for “private inurement.” Hospitals with tax-exempt status have few, if any, more important concerns than protecting their tax-exempt status. Therefore, physicians should be prepared to encounter this issue in their compensation discussions.

Covenants Not to Compete
A hospital will most likely require covenants not to compete (CNCs) in both the purchase documents and in the physician employment agreements. Both are generally enforceable in Missouri as long as they are considered reasonable as to time, scope and geography. Missouri generally views CNCs differently in the context of the sale of a business in comparison to a non-sale employment relationship. Typically, Missouri gives greater flexibility in terms of time, scope and geography in the context of the sale of a physician practice. The tendency to broader enforcement is based on the concept that part of what the hospital has paid for is the business’s goodwill, name and reputation. Most often, CNCs will be written to restrict the selling physician’s ability to have an ownership interest in or develop a competing business for a certain time period following the sale and within a certain geographic area.

When a physician’s ability to practice medicine is restricted, Missouri courts generally have several options to address the CNC if it is not considered “reasonable.” The court may strike completely a patently unreasonable CNC. However, Missouri courts may “blue pencil” (rewrite) the CNC to remove or revise unreasonable terms. Ultimately, Missouri courts take a balanced approach to CNC enforcement against the seller of a business, considering the sale as a whole, including what protection a buyer should be able to expect from its purchase.

Fraud and Abuse Laws
When a hospital acquires a physician practice the federal Stark Law must be considered. The Stark Law prohibits, in the absence of a statutory or regulatory exception, a physician from referring a patient to an entity with which the physician (or his/her immediate family) has a “financial relationship,” if that referral is for “designated health services” which generally include many services reimbursable by government programs, and include both inpatient and outpatient services. Failure to comply with the Stark Law can result, for all parties, in enormous consequences, including significant financial penalties and exclusion from participating in federal health-care programs.

One of the few exceptions available under the federal Stark Law for the sale of a physician practice is the “isolated transaction” exception. Under this exception, a one-time sale of property or a medical practice will not violate the Stark Law if (i) the purchase price is consistent with fair market value and is not related to the volume or value of any referrals by the physician or other business generated between the parties, (ii) the transaction would be commercially reasonable (even if the physician made no referrals), and (iii) there are no additional transactions between the parties for six months unless such additional transactions can meet another exception under the Stark Law.

Additionally, physician employment arrangements must meet an exception to the Stark Law for purposes of legal compliance. Generally, this will mean compliance with the Stark Law’s “employment” exception, which requires that compensation is consistent with fair market value for the services being provided and cannot be related to the volume or value of referrals or other business generated between the parties.

The second very important federal law for purposes of fighting fraud and abuse is the Anti-Kickback Statute (AKS). AKS makes it a criminal offense to offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable in whole or in part by federal or state health-care programs. AKS, similar to the Stark Law “exception” concept, offers specific “safe harbors” such that if the parties structure the transactions to strictly comply with one of AKS’s regulatory safe harbors, this will avoid any criminal prosecution. However, strict compliance with an AKS safe harbor is often difficult to accomplish. Thus, for transactions that cannot strictly meet the elements of an AKS safe harbor, the intent of the parties, based on the facts and circumstances of the arrangement, is the relevant question. Generally, the approach taken is that even if strict compliance with a safe harbor is not accomplished, the transactions should be structured as close as possible to a safe harbor.

Conclusion
Selling a practice is a complex transaction requiring thorough analysis of all the issues and a commitment of the time and energy necessary to conduct the transaction appropriately to attain the desired objectives. Although these deals are considered friendly and all parties desire the same end result, physicians must protect themselves for purposes of the sale and future employment arrangements. Ultimately, physicians entering into any practice transaction should follow several general rules: (i) take your time, don’t rush, (ii) carefully analyze each aspect of the transaction, and (iii) engage competent advisors to guide you.

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Large Group Private Practice – The Best of Both Worlds

Alternative to hospital employment offers clinical autonomy with the benefits of a large organization

Signature Medical Group (SMG), founded in 2001, now has a compliment of more than 100 board physicians, rendering more than 420,000 patient visits per year, in the St. Louis, Kansas City and Southwest Missouri areas. Specialties include: orthopedics, women’s services, gastroenterology, dermatology, pediatrics, colorectal surgery, allergy/immunology and primary care. SMG also provides imaging, laboratory and other ancillary services. For private-practice physicians, including those with Signature Medical Group, this practice model offers a viable alternative to hospital employment and the best opportunity for reducing cost and improving quality for the community.

One of the largest private practice physician groups in Missouri, Signature Medical Group provides a level of clinical autonomy for its physicians while maintaining the clout of a large organization. SMG has the resources to assist its physicians with all aspects of their practice. The medical staff has developed clinical guidelines, outcomes studies and cost review mechanisms to continually find the most cost effective continuum of care.

Fred Williams, MD, of Signature practice Gateway Gastroenterology, said, “It’s the best of both worlds in that we are still an independent group. We’re an eight-physician group which today is actually relatively small compared to large multi-specialty groups. To be part of Signature, with over 100 physicians, this gives us increasing clout.”

Adding to this large group concept, Todd Glass, MD, of OB/GYN Health Partners explains, “We’ve certainly seen better reimbursements across the board for almost everything that we’re doing. It’s nice to have a group that’s really working toward managing the business for you and is being run in essence, by you.”

Signature Medical Group practices range in size from a single physician to groups with more than 15 doctors. Hamsa Subramanian, MD, of Signature Allergy & Immunology, said, “For all practical purposes this is my office and I am a solo practitioner under the umbrella of Signature. I have a lot of independence to run my practice. I’m not worried about the administrative aspect. They do that part for me and I can practice my medicine without any problems.”

There is a cost advantage passed along to patients who see private practice physicians, who enjoy significant choice in referring their patients to other health care providers, taking quality and cost into account. In contrast, physicians employed by a health system are required to select other providers within the same health system, leading to a lack of competition and restraint of trade that encourages higher cost. This lack of choice can impact and increase the cost of each episode of care.

SMG physicians believe that the implementation of free market principles can promote quality and cost transparency as well as competition in the marketplace. SMG physicians advocate for employers and patients – the primary payors of health care costs – who can assist a transformation of the health care system by carefully choosing health care providers, like SMG or other private-practice physicians.

For more information or to watch a recent video production with comments from 12 SMG physicians, go to www.signaturemedicalgroup.com.

By John Marshall, Communications Director, Signature Medical Group