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Issues to Consider in Selling or Leasing a Medical Practice to a Hospital

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August 08, 2011

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Historical Trends

While the focus of this article is not on the history of hospitals purchasing medical practices, some brief historical discussion is appropriate. Approximate fifteen years ago hospitals we purchasing medical practice, often for very significant prices. Then, approximately ten years ago, the hospitals gave them back to the physicians for free, primarily because the hospita had not realized the financial benefits they had expected. Today, it is déjà vu all over again with hospitals in the market to purchase or lease medical practices, particularly cardiology a primary care.

Often these practices are geographically of some significant distance from the hospital's primary location. It appears that the major motivation for these purchases is to enlarge the geographic area from which the hospital draws its patient base in order to increase admissions and other utilization of the hospital's facilities/services. The establishment of accountabl care organizations under the Healthcare Reform Act, with their potential for enhanced levels of reimbursement, appears to be another motivating factor.

The motivations for physicians to sell their practices are the higher reimbursement rates the hospitals can command for the same services the physicians performed in their practices (assuming that any of it trickles-down to the physicians); and the financial, staffing and other assistance the hospitals can provide the practices to cope with their ever increasing administrative burdens.

There are quite a number of distinctions in how hospitals are currently purchasing medical practices as compared to fifteen years ago. However, there are three major differences. Firs hospitals are not offering to pay significant purchase prices, even in those situations where they are purchasing all the practice's assets out-right. Instead, the hospital may offer some additional enhancement in employment compensation to the physicians for a number of years as, in essence, the additional purchase price for the practice. (As discussed below, this may be problematic from a regulatory perspective.)

Secondly, the practices are no longer being totally absorbed into the hospital's administration and bureaucracy for purposes of their operations. Rather, the physician owners and the practice managers/administrators are left in place to operate the practice, subject to only general guidelines and oversight by the hospital administration.

Third, during the prior cycle of practice acquisitions the physicians were paid a fixed salary which was unrelated to their productivity and the fees generated by the practice for the hospital. In the current acquisitions, and in the leasing arrangements discussed below, physician compensation is based totally on productivity, generally based on RVUs.

To Sell or Lease

The sale of a practice to a hospital can be accomplished through a number of different models. The hospital can acquire the practice's hard assets with the physicians and staff remaining employees of the practice and with the practice retaining its identity as a separate entity. In the second form the hospital acquires the assets, the physicians and staff becom employees of the hospital, and the practice ceases to exist. In a hybrid model, the staff becomes employees of the hospital, but the physicians remain in the practice which retains its separate existence as an entity. While the issues with each model are somewhat different, there are certain common concerns with any form of sale.

This article does not address the fundamental, and somewhat philosophical, question of whether a medical practice should affiliate, in some business form, with a hospital. Instead, on the physicians have made this decision, this article provides some guidance on what should be the form of this affiliation and the terms the physicians should attempt to negotiate with the hospital. In our opinion, absent unusual circumstances, we do not recommend an outright sale of the practice; rather, we prefer a lease arrangement.

While there are many variations in each practice's situation, there are a number of major considerations which dictate against an outright sale. The primary consideration is that the hospital is not going to, and in any event cannot, legally pay the physicians the true value of their practice. The true value to the hospital is the referrals the physicians can generate to

Under the various federal anti-kickback laws the hospital cannot pay the physicians more than the fair market value of their practice. Any payment beyond this amount could be considered as a kickback for the physicians' referrals to the hospital. Also, while there are various methodologies which accountants use to value practices, they are all based on the tangible and intangible assets of the practice itself (i.e. within the four corners of the practice). Consequently, the revenue generated by other physicians to whom the practice refers patients is not, and cannot be, considered in determining the practice's fair market value.

Another negative is that, as previously discussed, under the current methodology for these acquisitions the physicians, in the main, are not relieved of the responsibilities for administering and managing the practice. This is particularly true for the practice's managing physician, should he or she continue in this management role after the acquisition.

Further, after the acquisition the practice is still considered as a separate operating division or profit center of the hospital. Consequently, the physicians' compensation is still tied-to th profitability of what was their prior medical practice. Admittedly, there is access to the higher reimbursement rates the hospital can command for the same services the physicians previously provided in their independent practice. However, the real question is how much of that enhanced reimbursement will trickle down to the physicians. This is a particularly troublesome concern as time progresses, given that once the practice is purchased the physicians become a captive audience of the hospital with little bargaining power.

Finally on negatives, a purchase is for all intents and purposes irrevocable. The practice's patients now become those of the hospital's affiliated practice. In essence the hospital now owns all the patient lists and records. If not immediately, then probably within a few years, the name of the practice ceases to exist. And the physicians are subjected to intense restrict covenant and non-solicitation provisions.

Leasing Is Preferable

By comparison, a properly negotiated lease arrangement, with correctly drafted supporting contracts, can avoid all the pitfalls of an outright purchase. Moreover, it enhances the

probability that going forward the practice will continue to realize its appropriate portion of the expected enhanced revenue. This is primarily because, with a proper lease arrangement the practice is not a captive of the hospital. Further, as discussed below, there is at least one avenue for a further revenue stream with the practice, through a separate entity, acting as the management company in this lease arrangement.

Lease Agreements

There are generally two agreements in a leasing arrangement between a hospital and a medical practice. The Facility and Services Leasing Agreement generally provides for the hospital affiliated medical practice to sublease the office space and to lease all the medical and office equipment and non-physician staff from the practice. The Leased Provider Agreement is for the hospital affiliated medical practice to lease all the physicians from the practice as independent contractors of this affiliated practice.

The medical practice, as an entity, continues to exist, at least on paper, but it is actually only a shell in that all its assets, both human and otherwise, are leased to the hospital affiliated medical practice. Nevertheless, for the reasons discussed below, there are many advantages for physicians in maintaining the existence of their practice entity, only one of which is the opportunity to establish a management services company.

Establishing a Management Services Company

The Facility and Services Leasing Agreement(s) which we have reviewed to date provide that the medical practice lessor will act as the manager for the lessee hospital affiliated practi There is a potential regulatory issue with this arrangement. Because the medical practice continues to exist as a business entity, albeit just a shell, it is providing management services for another separate entity, the hospital affiliated lessee practice.

Under both the Board of Medical Examiner Regulations, and the Professional Corporations Act, the only business a medical practice can engage-in, as a professional entity, is the practice of this profession. Obviously, a medical practice can manage itself, but there may be legal issues with the practice providing management services for another, separate pract entity.

Given this concern, and in the interests of creating another revenue stream for the physicians, we recommend that they create a separate management services company. This compa would then separately contract with the hospital affiliated medical practice to provide management services. These services can include the leasing of all medical and office equipment and all non-physician clinical and administrative/support staff. The physician owners of the medical practice are permitted to also separately own this company and to charge a fair market rate for its services to the hospital affiliated practice.

In addition, there is a statute and New Jersey Department of Labor regulations for employee leasing companies which provide that such companies must, in essence, be licensed by th Department. Accordingly, this is another regulatory concern which dictates that the physicians create a separate management services company. This company will then employ all the practice's support and other non-physician staff and lease them to the hospital affiliated medical practice.

If the physicians' medical practice was previously performing its own billing, in-house with its own employees, then the lease arrangements should provide that the management servic company will perform the billing for the hospital affiliated practice. Even though billing has become a physician's worst nightmare, we still recommend this lease arrangement for a number of reasons.

First, obviously, it allows the physicians to maintain a significant amount of financial oversight. Secondly, it eliminates the potential for a gap in billing and reimbursement with a conversion to the hospital performing the billing function. Third, it provides the physician owners with immediately available and reliable financial information on whether, as discussed below, to reopen the Leased Provider Agreement to negotiate increases in compensation for the leased physicians.

Another consideration is that under the Department of Banking and Insurance regulations, any entity which provides medical billing for another entity must be registered with the Department. Accordingly, we recommend that the management services company also obtain such registration because it will be providing billing services for the hospital affiliated medical practice, as another separate entity. Most importantly, this creates another revenue stream for the physician owners of the company because, here again, it can charge the fai market rate for the billing services it is providing. So what was previously a nightmare now becomes a dream.

It is not particularly difficult nor costly to file with, and obtain the necessary approvals from, both the Department of Labor and the Department of Banking and Insurance to become an employee leasing and medical billing services company. After obtaining such approvals, yearly filings with both Departments are required. But, here again, these are not particularly burdensome regulatory requirements.

Financial Terms of Lease

The Leased Provider Agreement will probably compensate the leased physicians based upon a fixed dollar amount for each RVU of medical services they provide. Initially, it is extrem important that the physicians retain an outside expert to assist them in insuring that this formula is fair and reasonable.

Most medical practices do not calculate physician compensation on an RVU basis. Before beginning any negotiations with a hospital, the practice must take the services it performs, (e office visit, procedures), and assign each of them an RVU. Then the productivity of each physician, and the practice as a whole, has to be evaluated in terms of RVUs. Once the practi has estimated the amount of income it generates per RVU, it is then in a position to begin negotiating with the hospital.

There are regulatory limits on this method of compensation in that the hospital cannot compensate a physician more than the fair market value of a comparable physician in that particular market. Any excess compensation beyond fair market could be considered as a kickback for the physician's referrals to the hospital. This consideration does place an upper limit on any compensation arrangement based on RVUs.

We recommend that the Leased Provider Agreement include a yearly reopener provision only for purposes of renegotiating this compensation formula. We appreciate that this is a double-edged sword, and no one has a crystal ball. However, hospitals are establishing or otherwise entering into accountable care organizations which afford the possibility of enhanc reimbursement levels. Accordingly, the expectation is that the dollar value of the services provided by the leased physicians will increase. (Obviously, this expectation is dependant on the physicians' evaluation of the hospital's competency to improve quality of care and efficiency in providing integrated medical services, in order to qualify for enhanced reimbursemer under the Healthcare Reform Act.)

In addition, we recommend that the physicians obtain an outside consultant to determine the fair market value for the leased space, equipment and employees, and for the management/administrative and billing services, which the physician-owned management services company will provide to the hospital affiliated medical practice. A report and certification, that the fees being charged are fair market, should be obtained from this consultant, who is preferably a healthcare accountant or economist. Unquestionably, the compan services and lease agreement with the hospital affiliated practice should include a yearly reopener provision for fees.

Additional Lease Terms

There are quite a number of additional terms which need to be included in any leasing agreements to: (1) insure the maximum possible benefits for the lessor medical practice; (2) protect its continued existence and independence as much as possible; and (3) afford the practice the real ability to terminate the lease and continue in existence as a viable business detailed description of all these terms is beyond the scope of this article. Accordingly, what follows is a laundry list, not necessarily in the order of importance, of the essential additiona terms:

1. Maintaining the name of the physicians' practice in front of the patients;

2. Insuring in the Leased Provider Agreement that the patients are those of the individual leased physicians and not the hospital affiliated practice;

3. Since the physicians are independent contractors and not employees of the hospital or the affiliated practice, they should not be subject to any non-compete or non- solicitation provisions, only confidentiality;

4. An escape clause which permits the practice to terminate the lease agreements during the first year or two on short notice of thirty to sixty days;

5. After the escape clause period, the lease agreements should be for limited terms, perhaps two or three years at most, and with the reopeners previously discussed. (Terms 1 throug 5 are to insure that the practice does not become a captive of the hospital.);

6. The practice, obviously, retains its accounts receivable because, as an entity, it continues to exist;

7. Should the hospital insist on performing the billing, then it must provide the practice with, in essence, a line of credit with an extended payback period on very favorable terms. (This provision is to address the contingency of a gap in collecting fees with the conversion to the hospital's billing department.); and

8. If at all possible these arrangements should not be exclusive. (This permits the management services company to provide such services for other medical practices. It permits the practice, itself, to enter into other arrangements; for example, merging with a larger practice or into a multi-specialty practice, in addition to providing the leased physicians to the hospi affiliated practice.)

Conclusion

What we have suggested in this article is, obviously, the optimum leasing arrangements from the medical practice's perspective. The ability of any particular practice to negotiate this optimum depends on its bargaining power in relationship to the hospital.

Physicians need to appreciate that they have more bargaining clout in these negotiations than they might otherwise think. Under the Healthcare Reform Act hospitals are under enormous pressure to participate in larger accountable care organizations. Also, hospitals are in keen competition to expand their patient bases in order to increase admissions and ot uses of their facilities. These factors afford physicians more leverage in negotiations on lease arrangements with hospitals, particularly for those practices with a high volume of patient and referrals.

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