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Healthcare

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A Newsletter for the Healthcare Industry — Winter 2010

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A Member of the Wolf Financial Group

INTEGRATION OPTIONS

Is There a Hospital in Your Future?

In today's market, more physicians are seeing benefits to integrating with larger practices or hospitals. This article is the second in a series exploring the elements that contribute to a successful practice merger.

The fallout from the acquisition frenzy of the '90s certainly gave hospital/practice integration a bad name. During those heady days, physician practices and local hospitals were linking up at a record pace — through outright sales, financial partnerships or employment contracts.

But many hospitals got caught up in bidding wars, hoping to lock in physicians' patient bases and lucrative referrals. They overpaid for practice "goodwill," provided guaranteed salaries and failed to incentivize productivity.

The result: Productivity fell. Overhead increased as layers of management were added. And cash flow suffered as hospital-based billing offices struggled with collections. Ultimately, bankruptcies soared, and some physicians were paid to take their practices back.

The State of the Union

Today, acquisitions are starting again, albeit with different drivers. Physicians — not hospitals and health systems — are driving the market. The growth is particularly robust in small- to medium-sized markets where physicians are struggling with a declining patient base.

In this new wave of acquisitions, hospitals are typically paying only for a practice's hard assets (i.e., furniture and equipment) and avoiding large base salary guarantees in favor of productivity-based compensation arrangements. Sometimes, a transition base salary and a production-based bonus for the first year are provided. In today's hospital system, medical practice integrations

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Boosting the Bottom Line

Ancillaries Offer Opportunities (and Challenges)

With net income lost to rising overhead and shrinking professional fee reimbursements, many practitioners are tapping their inner entrepreneur and exploring the potential of offering ancillary services. Witness family practices offering vitamins; breast cancer centers selling wigs and prosthetics; and physical therapy centers partnering with chiropractic specialists.

The Money is There

Ancillaries work from a revenue standpoint because they allow physicians to charge for items and services not directly provided by the physician. For many services, there are "technical component" fees that can be billed in addition to professional fees for the physician's direct services. The goal is to find revenue streams that don't require more physician work.

"New services also allow physicians to improve patient care. By bringing services in-house instead of referring them out, doctors can better monitor progress and compliance, as well as expedite lab and imaging results," says Steve Lutz, Partner-in-Charge of ***Healthcare Services Group*** at Wolf & Company LLP.

Due Diligence: Make Sure It's Legal

Stark I, II and III regulations are very complex and apply to many ancillary services covered by government insurance plans. If you want to explore adding ancillary services, you should first determine if the services are "designated health services" under Stark rules. Next, ensure that you will meet the "in-office ancillary service" exemption to the Stark prohibitions, and then make sure your division of ancillary profits will meet the requirements of the exemption. If the ancillary is not a "designated health service" under Stark regulations, you have much more flexibility.

Equal division. Under Stark II, physicians in a group can divvy up ancillary revenue equally. In the case of an orthopedic group, for example, the technical fee portion of the ancillary service can be pooled and divided equally among group physicians. The professional fee portion of the payment then goes directly to the physician who performed the procedure.

Productivity-based compensation. Stark regulations allow physicians to divide ancillary revenue according to personal productivity or predetermined percentages. Using each physician's total relative value units, a group can give a larger portion of ancillary revenue to its full-time physicians and less to part-timers.

Shared arrangements. Under a shared facility arrangement, a large group could partner with smaller practices that have space in the same building and share access to an MRI or CT scanner it owns, providing the smaller practices with some access to imaging revenue. But note that Stark III regulations made some big changes to shared arrangements, and more are on the horizon. Any joint ventures should be carefully structured with the assistance of a qualified healthcare attorney.

Ask Yourself

Ancillaries are not a monetary cure-all. You'll want to devote as much time as possible in the planning and assessment stages. Start with these questions:

Do we have the volume? Don't overestimate your current volume of outside referrals for a service. Get the facts by conducting a feasibility study to determine which services would yield the greatest demand. Look carefully at the age of your patient population and the health risk factors they face. Do we have the space? It's common that physicians underestimate the amount of physical space they'll need to house a new service or procedure.

Can we get paid? Don't make the mistake of thinking, "If I build it, they will pay for it." You certainly won't get paid if your current contracts say that the services you are considering will be paid only through a designated provider the health plan has already contracted with.

Should we buy or lease? Obsolescence is a critical concern when purchasing high-tech equipment. Here, leasing with an upgrade option may make sense. Run the lease-or-buy question by other practices that have already launched the service you're considering.

Are we prepared? What if it takes 18 months for a new piece of equipment to turn a profit? Can practice finances hang in there while that service is sapping practice cash flow or incurring group debt? In addition to a best-case scenario, plot out a worst-case scenario and devise a workable contingency plan/exit strategy.

Is it legal? Finally, have your attorney review your business plan — both from a fiscal and a compliance standpoint.

Branching out into new procedures and services certainly offers the potential for improved revenue and patient care. Just be sure to do your research first. ■

Our accounting professionals can help "run the numbers" to see if ancillaries are right for your practice. For more information contact Steve Lutz at 630-545-4550.

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are closer to a merger than an acquisition. In these deals, incentives for the physicians are aligned with the hospital's goals: Work harder, see more patients, hold expenses down and take home more money.

Who Wins What?

Make no mistake, hospitals benefit from these acquisitions. More doctors mean more negotiating power with managed care contracts, as well as a boost in Medicare and other government payments. For the doctors, hospitals and health systems provide everything from management and billing expertise to cutting-edge information technology. Physicians can also tap into a hospital's often-substantial inpatient and outpatient facilities, as well as a larger referral and coverage network.

Making it Work

Hospitals and physician practices use a variety of models to forge partnerships. Consider these examples:

Direct employment. This is the most straightforward approach. The hospital buys the entire practice and the physicians become employees of the hospital. Physicians give up most control, although hospital committees sometimes allow physicians some power in the governance of their practices.

Captive group. In this situation, a hospital forms a separate physician group. Through participation in a board of directors and/or various committees, physicians can still exert some control over the group's direction. Typically, though, a hospital can wield veto power over the new group's board.

Service-agreement. Here, physicians remain independent but enter into a contract to provide services through the hospital. The physician's old professional corporation or LLC becomes a management services organization that sells services to the newly created hospital subsidiary. Staff remains employed by the same entity with pay and benefits controlled solely by the physician owner(s). The old entity can be converted back to a medical practice if the physician decides to leave hospital employment.

Who's a Good Candidate

If you like control over all operations and the future direction of your practice, you may want to pass on a hospital merger. If not, the change may offer welcome relief. You may wish to consider merging if:

You have sticker shock. Is the thought of next year's malpractice premium causing a sour stomach? Or, how about the rising costs of health insurance and retirement benefits for practice employees? Much of this is covered when you become an employee of the acquiring hospital or health system.

You're technologically behind. If you've been dragging your feet about adopting electronic health records for your practice, you'll benefit by aligning yourself with a hospital that can fund costly EHR systems.

You're feeling "small." If you've been beating your head against the wall trying to get on lucrative provider lists, you'll appreciate a hospital's bargaining power.

You're stressed. If the entrepreneurial nature of private practice has you working harder, worrying more and having less to show for it, you may enjoy handing over much of the business operations to a hospital.

Questions to Answer

Before you make any decisions, do your homework. Ask yourself the following questions:

How much control do I want?
Will you be satisfied as an employee of a hospital? This new role may mean no hiring power and limited autonomy over the direction your practice takes. Are you interested in an arrangement where you have a seat on a governing board, giving you some degree of control?

How much flexibility do I need?
If you're not certain, give yourself an out. Structure the deal to include an opt-out provision that allows you to return to private practice after a stated period if you find hospital life isn't working out. Likewise, seek flexibility in changing payment terms and other features.

How much salary do I require?
Typically, take-home salary remains roughly the same or better, with one critical caveat. Hospital-owned groups often experience substantial cash-flow issues in their first year. Basically, they are starting with zero accounts receivable. At the same time, they may experience delays in credentialing. This all takes its toll on revenue as collections slowly ramp up. Here, a transitional salary can help smooth out the peaks and valleys of first-year cash flow — especially if you are uncertain about how incentives or productivity payment models will work out. ■

Review Your Appraisal

Before buying a practice, a hospital will pay for a rigorous appraisal in part to assure regulators that it's paying fair market value and not buying referrals or violating its nonprofit status. You'll need to hire an expert to review and perhaps challenge the hospital's assumptions about your practice's future profitability, as well as any attempts to normalize your income statement. Ask the hospital to let your expert review its appraisal while it's in draft form and easier to change.

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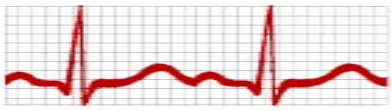
Vital Signs



Why Every Practice Needs a Business Plan

The business of medicine. It's not taught in medical school, which may explain why only about one-third of all medical groups have a business plan, the most fundamental of all business tools.

A business plan isn't just for groups interested in rapid growth. The rise of managed care and increasing economic pressures have created a widespread need for better fiscal management, and a business plan is a big part of smart management.

Creating a business plan is also a disciplinary process that forces you to focus on business principles that can escape a busy physician's attention.

If nothing else, know this about a business plan: Your banker wants to see one. If you foresee any need for capital (e.g., buying an office building or adding capital-intensive technology), you'll need to show a plan.

What Goes In?

At its most basic, a business plan should include:

- Vision/mission/values: What you want your practice to be, where you want it to go, and how you want it to conduct itself.
- Goals: Concrete and specific, with milestones and indicators you can check progress against.
- Market demographics: Statistics about the community you serve.
- Competitive review: Accounting for the competition, which often has the advantage of being already established.
- Financial analysis: A projection of costs and revenue for major projects or services you're considering.

Physician leadership should drive this process, but your accountant can play a critical role in the preparation and review of your business plan. Contact our office today for assistance.