

Health system sponsored physician employment: keys to success

Part 6: Getting started: building the enterprise through acquisitions and recruitment

Acquisition and recruitment strategies

The building blocks of the health system sponsored physician employment enterprise include acquisitions of existing private physician practices and new physicians recruited to the local community. While this

paper focuses mainly on acquisition processes and activities, many of the keys to success described are also applicable to physicians recruited into employment without the acquisition of a practice.



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Building a plan for acquisition and recruitment

Whether the enterprise is growing through recruitment or through acquisitions, it should be supported by a solid business plan. An effective and detailed business plan includes realistic appraisals of an appropriately sized practice management infrastructure. This appraisal should include an evaluation of the corporate structure and governance, physician leadership, professional management, information technology, effective revenue cycle process and financials as well as operational performance reporting.

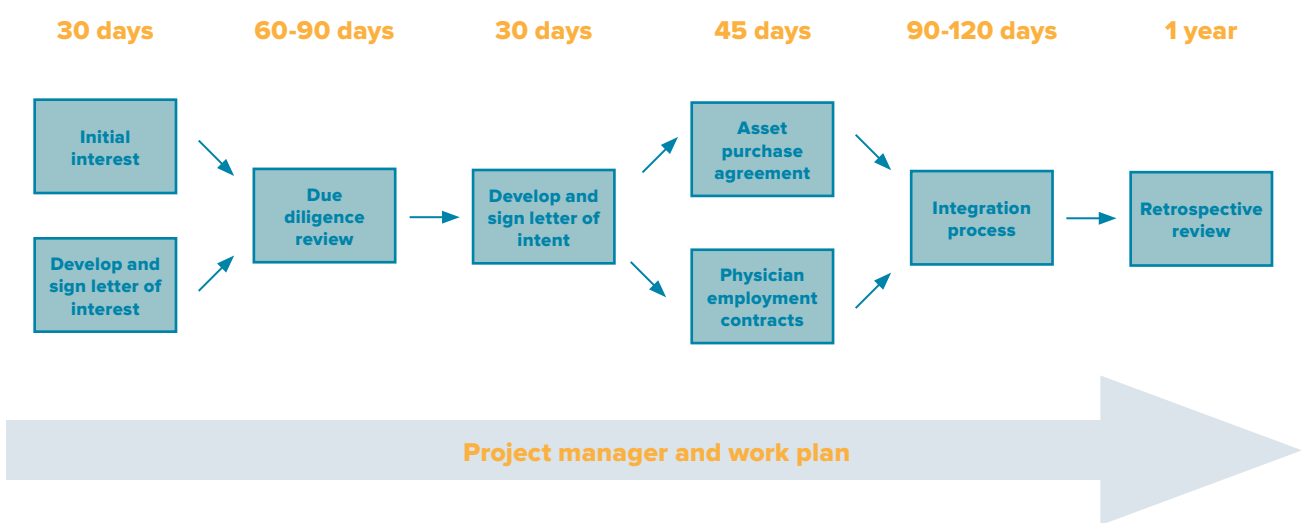
This paper will provide a detailed description of the major steps to successfully implement acquisition and recruitment strategies.

1. Setting the right expectations
2. Assembling an interdisciplinary acquisition team
3. Paying the appropriate price
4. Legal considerations

5. Conducting acquisition due diligence
6. Preparing letters of intent and definitive agreements
7. Developing a standard employment agreement
8. Applicability to new physician recruitment
9. Seven essentials principals
10. Conclusion

The acquisition process map below outlines the significant deliverables and timeframe associated with an acquisition. One of the keys to a successful process is good project management. A well-defined project plan is one with defined tasks, accountable parties assigned to each task and associated deliverable dates at a detailed, task-specific level. The plan should be communicated, regularly monitored and modified accordingly.

Table 1: Timeline and acquisition process map



An average timeline to complete the above process above can range from 8 to 11 months, while for solo or small group practice, it could only take as little as 60 to 90 days to complete.

Setting the right expectations

The first key to success is setting appropriate and realistic expectations with physicians regarding the nature of the potential employment relationship. These expectations should be clearly delineated early in the acquisition or the recruitment process. Because belatedly resolving unrealistic or inappropriate expectations represents a serious and potentially expensive problem, it is best to engage physicians in an employment offer only after the hospital has thought through every detail of a well-designed employment arrangement.

Key questions to be considered in advance of making an employment offer include:

- What is the vision for the physician employment enterprise? How do the employed physician practices fit within the integrated health system structure?
- What is the expected process from the time of first discussion until the closing date of the transaction? What is the nature of formal agreements and other commitments the physician will be asked to sign throughout the process?
- What will the physician be paid in consideration for acquiring the practice? How will this value be determined?
- How will the physician enterprise be governed? What role will physicians have in decision making as well as management and oversight of the practice?
- Who is responsible for the cost of professional liability tail insurance as the physician leaves private

practice and becomes an employee?

- What changes, if any, will occur for the practice's current support staff?
- How will the physician be compensated in the new employment relationship?
- What information technology will the practice use – both practice management system and electronic health record system? When will the practice transition onto new information systems?

With a standardized employment agreement, well thought out practice pro forma that includes physician compensation and appropriate third party valuations, the health system is in a good position to communicate the parameters within which a transaction or recruitment process can be consummated and compensation negotiated. In this context, it is easier to discuss the expectations of both parties. Additionally, the reasons why certain expectations may or may not be achievable will have ample support in the regulatory framework, employer policies or in the underlying economics of the transaction and ongoing employment arrangement.

It may be that certain expectations cannot be met. In such cases, declining to continue with the transaction may be more favorable than entering into an economically unsustainable arrangement, one that subjects both parties to regulatory risk, or one that risks violating parity with other employed physicians.

One way to ensure appropriate expectations is to clarify in writing in a letter of interest that commits both parties to proceed with due diligence that may lead to a letter of intent.

Assembling an interdisciplinary acquisition team

Successful physician practice acquisitions and recruitment to employment processes require an interdisciplinary team. Key members of the acquisition team include:

- **Physician leadership** The best point person in acquiring physician practices or recruiting new physicians is a physician leader, someone who can relate to the prospective employed physician(s) as a professional colleague, as well as someone with the leadership characteristics required to effect a transaction that involves multiple stakeholders.
- **Dedicated health system executive** Because the business of acquiring and recruiting physicians represents a major strategy for the health system, it is important to have a dedicated executive within the health system physician enterprise that owns the process and has the responsibility and flexibility to accomplish key tasks in a timely manner.
- **Consultants** Experienced, operationally oriented consultants can be invaluable, especially for institutions that are either undertaking a physician acquisition or recruitment to employment strategy for the first time, or if the acquisition target is a large medical group. One key criterion for consultant selection is demonstrated experience with similar practice acquisitions and – just as importantly – an understanding of the practice’s operational issues and needs that will follow. Use of consultants should primarily focus on:
 - First time acquirers of physician practices
 - Acquisition of a large, single specialty group practice or large, multi-specialty group
 - A time limited period when a significant number of acquisitions are planned and existing resources will likely be insufficient to get the job done

In each of these scenarios, the best consultants will equip the local management team to execute future practice acquisitions and recruitment processes at normal volume with minimal outside consulting assistance.

- **Legal counsel** Obtaining advice from legal counsel is an imperative component of any physician practice acquisition. As it is for consulting assistance, it is often a good idea to retain outside legal counsel when engaging in practice acquisitions for the first time, when engaged in a potential acquisition of a large single or multi-specialty group practice or when the volume of acquisitions, however small, warrants.
- **Independent third-party valuation firm** In recognition that federal laws and regulations prohibit transactions between hospitals and physicians that compensate physicians at a level higher than fair market value, it is a valuable practice to obtain a third-party valuation firm for the purpose of rendering fair market value opinions on both the acquisition purchase price as well as physician compensation.

It is best if one person, typically a member of the health system sponsored physician practice management team, is designated as the project team leader responsible for coordinating the efforts of each of the individuals described above.

Time is the enemy of a deal

It has often been said that time is the enemy of the deal. Health systems that are not organized for executive follow-through and reasonably timed decision making will struggle in acquiring physician practices. In many health systems, approval to make an acquisition proposal and offer of employment requires the consent of multiple stakeholders on the health system management team such as the CEO, CFO and vice president of business development. If so, these key leaders must make themselves available to the acquisition team and be prepared to make informed decisions within a reasonable time frame.

Paying the appropriate price

In the early and mid-1990s many hospitals and health systems rushed to acquire physician practices with attractive financial offers that included a significant upfront purchase price. This approach was often the result of defensive acquisitions by hospitals in markets where competing institutions or physician practice management firms were acquiring the practices of members of the hospital's loyal medical staff.

Several important lessons were learned from this earlier generation of physician practice acquisitions by hospitals:

- **Physician perception of practice valuation often exceeds reality** Physicians were not able to conceive that their practice had little investment value when all of the earnings of the practice are paid to the physician in the form of compensation.
- **Excessive purchase price became a drag on financial performance** In many cases post transaction physician compensation level was at the same level or higher than prior to the transaction. In the absence of retained earnings, there was no source of cash flow with which to amortize the excessive purchase price. The result was often a write-down by the hospital of practice acquisition good will.
- **At divestiture, physicians place little value on the practice** When many of the unsuccessful acquisitions made in the 1990s became unwound, physicians' perception of the value of their practice plummeted.

Because the vast majority of physician practices do not retain earnings (i.e. all earnings associated with the physician practice are paid out to physicians as compensation), most acquisitions of physician practices by health systems today are asset acquisitions. In asset acquisitions, the physician is paid fair market value for tangible and intangible assets.

Table 2: Typical components of physician practice asset acquisition

Tangible assets	Intangible assets	Excluded assets
Furniture	Medical records	Cash
Fixtures	Work force replacement	Accounts receivable
Equipment	Telephone number(s)	
	Professional insurance tail	

Tangible assets

Nearly every transaction involves the purchase of tangible assets, including furniture, fixtures and equipment at fair market value. If the value of the tangible assets exceeds a certain threshold, such as \$5,000, a third party appraisal should be obtained.

Intangible assets

Whether to offer physicians any payment for intangible assets as part of the purchase price is a business decision that must stay within reasonable fair market value boundaries. Many institutions offer to acquire tangible assets only. However, in competitive markets a more aggressive acquisition strategy may call for a somewhat higher purchase price. This approach can be justified on the basis of the value of active medical records being acquired (typically up to \$6.00 or \$8.00 per chart for patients seen during the past two years) and/or a value for work force replacement.

Work force replacement refers to the inherent value in acquiring a ready work force, such as front desk and back-office clinical and administrative support staff.

The upper limit of work force replacement value is typically \$3,000 - \$4,000 per support staff employee and somewhat higher for physician extenders (up to \$10,000 - \$15,000 per employee). In addition, a work force replacement value as a signing bonus of up to 20% of first year's cash compensation may be established for the physician.

If feasible, it is always preferable to defer upfront payments contingent upon the physician remaining employed for a specified time period in the form of a retention bonus.

A reputable third party valuation firm should be used to determine the upper limit of fair market value associated with the intangible purchase price, including payments for medical records and work force replacement.

Independent ancillary enterprise

In the event the physicians to be acquired are owners of an independent ancillary service enterprise such as a cardiac catheterization lab, ambulatory surgery center or freestanding imaging facility, it is often desirable for the health system to acquire this business enterprise at the same time the practice is acquired. Unlike the acquisition of the physician practice, which is an asset-based transaction, the valuation of an independent ancillary service enterprise is typically performed on a discounted cash flow basis.

Excluded assets

Also of importance during the purchase transaction is the handling of cash and accounts receivable. Accounts receivable may represent a significant value that the physician will realize as a part of the transaction, because the health system sponsored physician employment enterprise will be responsible for recapitalizing receivables following the acquisition. To avoid an argument over the value of accounts receivables, it is recommended that the physician simply retain the receivables with the option of having the new physician enterprise collect them on behalf of the physician at a market competitive rate in the range of 5%.

Indebtedness

A key variable in any physician practice acquisition is the level of indebtedness of the practice in relation to purchase price. Many practices, for example, have chosen to monetize their accounts receivable as a way either to fund capital projects (building expansion, new equipment, new physician development and electronic health record installation are typical examples) or as a way to cover current operating deficits. In some cases, physicians must be asked to come to the closing table prepared to write a check for indebtedness and/or to cover the cost of federal income tax on the purchase price where a significant portion of the purchase price is required to extinguish debt.

In summary, it has become a leading practice to limit the purchase price associated with physician acquisitions to tangible assets only, or in some cases, tangible assets and limited intangibles such as medical records and work force replacement. This means that in the latest generation of practice acquisitions, upfront purchase price is rarely a key driver in motivating the physician to join the health system sponsored physician enterprise.

It is best to suppress purchase price expectations as early as possible in discussions with physicians regarding interest in practice acquisition. The key motivations for moving forward with a transaction should be tied to the terms and conditions of the physician employment agreement. Most important is the opportunity for an attractive compensation plan that aligns incentives of the physician with the health system for financial sustainability and clinical quality improvement.

Legal considerations

Any transaction purchase price and post transaction physician compensation must be within fair market value and also be “commercially reasonable.” Given today’s regulatory environment it is advisable that health systems secure fair market value opinions from an independent third party valuation firm experienced in physician practice valuation and compensation.

Fair market value for both the practice purchase and for physician compensation should be determined in accordance with the definitions found in the Stark legislation and regulations. Note that both definitions explicitly state the value should not be determined in a manner that takes into account, directly or indirectly, the volume or value of any Medicare/Medicaid-designated health service (a Stark legislation defined term) referrals or other business generated by the selling physicians.

Similarly, the Stark regulations define “commercially reasonable” and states that valuations should be performed in accordance with that definition. This means that the purchase price must be reasonable for a commercial enterprise even if the seller makes no Medicare- or Medicaid-designated health service referrals to the employing entity or affiliated entities. Similar language is contained within Stark’s provisions related to physician compensation.

As part of the buyer’s acquisition and employment due diligence, a detailed, five-year pro forma should be developed that incorporates the physician compensation projection. The pro forma can be modeled with and without Medicare- or Medicaid-designated health services so that a “commercially reasonable” determination can be performed. To help mitigate the loss of the Medicare/Medicaid business the buyer may consider making reasonable assumptions relating to the growth of its commercial business.

Conducting acquisition due diligence

Acquisition due diligence is research conducted by the buyer, with the cooperation and assistance of the seller, to understand the seller's financial and operational condition. The process is focused on determining the practice's capacity to be successful in the post transaction business environment. The acquisition due diligence process has several components that are discussed in this section:

- Organizational structure, governance and management
- Practice demographics
- Physician employment agreements and compensation plan
- Practice financial performance
- Revenue cycle performance
- Information technology

Organizational structure, governance and management

Examining the organizational, governance and management structure of the physician practice gives the health system insight into how well the practice will mesh into the health system's own organizational and management structure. It enables the parties to design an effective integration of the practice into the existing physician employment enterprise and to measure the likely impact on practice performance post acquisition.

Some issues that are examined during this process include:

- What will be the management infrastructure need post transaction?
- Can the current infrastructure be used to support the health system's growing physician enterprise?

- Will physicians continue to manage the practice through a physician-only executive committee or through a joint policy board that includes health system administration?¹

In most cases from the physicians' perspective, governance of the employment enterprise is a threshold issue that will be a key item of discussion with physician leaders early on.

Practice demographics

It is important to understand the composition of the practice's clinical staff composition, including age, subspecialties and practice styles. Due diligence should incorporate an understanding of the urgency of succession planning, the practice's capacity for growth and the specific locations where growth could occur.

In addition to practitioner and clinic staff demographics it is important to also understand the patient demographic, payer mix, key market areas and services offered. Key issues to explore include:

- Will transitioning to an employed model impact payer mix by introducing a greater level of indigent care?
- Will the health system want to expand certain services or in certain markets pursuant to an existing strategic plan?
- Will changes to Medicare payments have a disproportionate impact on practice economics due to the percentage of Medicare patients in the practice?

These are business considerations that need to be taken into account. They might impact the financial pro forma and the projected and actual financial performance. They may require modifications to the final agreement and may even impact the decision to proceed.

Physician employment agreements and compensation plan

Negotiations will be aided by an understanding of the physicians' current employment and compensation terms. Key areas of inquiry include restrictive covenants, call requirements, employee benefits provided, professional liability insurance and compensation methodologies.

Practice financial performance

Understanding the financial performance of the physician requires reviewing past and current financial statements, and projecting the annual performance of each physician. Through a practice benchmarking process, the health system gains comparisons of the practice's current performance with industry best practice as well as insights into expected future performance. Key items that are examined during the benchmarking process include:²

- Support staff salaries and benefits as a percentage of net revenue and support staff full time equivalents per physician FTE
- Supplies, transcription, professional liability insurance and occupancy costs as a percentage of net revenue and per physician FTE
- Total operating expenses as a percentage of net revenue
- Operating profit/loss per physician FTE

Once this financial analysis is complete, a financial pro forma is developed for the new physician or practice. The pro forma must take into account the changes that will occur moving from one financial operating platform to another. The pro forma should include a consolidated profit and loss statement, a balance sheet and a statement of cash flow.

The pro forma will also enable the health system to produce financial models testing various operating scenarios.

Examples are:

- Segregating baseline ancillary revenues by current procedure terminology (CPT) and expenses, and by specialty and location
- Analyzing the impact, if any, from migrating in-office ancillary services to hospital-based or provider-based services
- Examining physician compensation approaches
- Examining infrastructure investment options to support administrative and revenue cycle needs
- Evaluating the top 20 CPT codes for key payers to determine the reimbursement impact of converting the practice to new payer contracts
- Modeling transaction-related costs, and future operational, strategic and capital investments

Revenue cycle performance

Critically important to the sustained cash flow is the revenue cycle process³. A due diligence assessment of the revenue cycle process should include a comprehensive review of physician practice site operations and a hands-on review of the entire professional fee revenue cycle processes including the central business office if one exists. This analysis will determine whether practice operational procedures and policies – and the technology used to support them – are able to effectively collect cash and payer remittances. It will also determine whether any significant issues exist that would have a negative financial or operational impact on the health system's physician enterprise, post transaction, and/or whether there exists the opportunity to improve professional fee cash collections.

The following are some of the major elements of an operations and revenue cycle assessment required during a due diligence process:

- Practice site assessments to review patient flow, information capture, coding practices, charge processing and time of service collections

- Revenue cycle front-end operations review to determine performance and communication flow between the practice site and central business office
- Management structure and staff competencies assessment relating to core revenue cycle processes
- Information system evaluation of the tools utilized by billing office personnel to manage core central business office tasks
- Policies and procedures accuracy and adequacy analysis
- An assessment of key revenue cycle performance metrics within the practice against industry standards and best practice

Information technology

Information technology is a core operational tool of a successful practice. More important is determining whether the tools available are put to optimal use by management. The due diligence process should

include a review of current information systems and a well thought out plan for whether and how to integrate existing systems into the health system's information technology platform. Due diligence should begin with a review of seller's information systems' capabilities and level of functionality being utilized. This should be followed by a detailed review of file structures and other key elements of the system's performance. Due diligence should culminate with an information transition plan that addresses operational and financial impacts.

It is best to avoid the temptation to maintain multiple legacy information system platforms following practice acquisitions. Even the best revenue cycle management teams will underperform if saddled with multiple platforms.

Following practice acquisition, strategic decisions will also need to be made whether to maintain legacy clinical information systems platforms or convert acquired practices to a common systemwide clinical information system.

Preparing letters of intent and definitive agreements

Negotiating and communicating key terms during the acquisition or recruitment process helps set expectations for the future employment relationship.

Due diligence enables the parties to translate expectations into an agreement on the terms and conditions related to the acquisition and the ongoing employment relationship. These terms and conditions should be memorialized in a letter of intent to provide the physician and health system the ability to move more quickly to the definitive agreements.

What is the letter of intent?

The LOI is a reasonably detailed, laymen's description of major terms and conditions discussed above. It should include a binding confidentiality agreement, a binding exclusivity agreement preventing the parties from negotiating with competing parties for a set period of time and a non-binding commitment to enter into acquisition due diligence process and negotiations toward a definitive agreement. The LOI consists of two components:

- The first is the letter itself defining the letter's purpose and key terms including its non-binding nature, length of time it is in effect and incorporation of any previous confidentiality agreements.
- The second component of the LOI is the term sheet that sets forth the details of the asset purchase agreement and the employment agreement. Included in this component of the letter of intent are the purchase price, a list of included and excluded assets and liabilities, and a summary of the material terms to be included in the employment agreement. A draft of a standard employment agreement and

compensation plan already in use by the health system, but not specific to this transaction, may also be attached.

Definitive agreements

Typically there are two forms of definitive agreement: the asset purchase agreement and the physician employment agreement. If the LOI is reasonably comprehensive (and if generic forms of the APA and PEA are provided as attachments to the LOI), it will provide guidance to the legal counsel to draft straightforward agreements and allow each party to signed both definitive agreements in a timely fashion.

Developing a standard employment agreement

The development of a standard employment agreement is a necessary component of managing a successful physician enterprise and should be a key component of any physician transaction. A standardized agreement ensures consistency across the physician enterprise for most contract terms. Negotiable terms should be limited to a handful of items that are unique to the transaction such as compensation levels. Standardized agreements prevent the temptation to negotiate terms falling outside of health system-established parameters, ease administration across a growing physician enterprise and create parity among employed physicians.

The employment agreement term defines the life of the agreement and is often divided into two periods — an initial term and renewal term. The initial term varies in length between three to five years, which provides for greater security against termination. For example, the parties may agree during the initial term that neither party may terminate the agreement without cause. This restrictive period allows each party time to transition into their new relationship and encourages constructive resolution of issues without the threat of withdrawal.

In addition, limiting the initial term to three to five years affords each party the opportunity to reassess the relationship after a reasonable period of time.

After the initial period, renewal terms provide for successive and automatic annual renew unless otherwise terminated in accordance with the agreement's termination provisions or upon delivery by the non-renewing party of a written notice of non-renewal 90 to 120 days prior to the end of current renewal term. This "evergreen" approach to renewal eliminates the need to renegotiate the agreement at the end of each term.

Term of initial compensation guarantee

It is customary in physician practice acquisitions as well as in new physician recruitment for the sponsoring institution to offer a cash compensation guarantee for a limited time. Leading practice is for the physician to be placed on the physician compensation plan beginning day one, but with a minimum guarantee or "floor" of cash compensation for one, two or three years, depending upon the circumstances. The length of the cash compensation guarantee period should be a function of the risk associated with building and/or maintaining practice volume. It should be as short as possible in order for the physician compensation plan to quickly align the physician's and hospital's incentives for financial performance and quality improvement.⁴

Termination provisions

Termination provisions define the circumstances under which the physician or health system may terminate the employment agreement before the end of its current term. Termination provisions can be categorized as "for cause" or "without cause." Circumstances triggering a for cause termination include, but are not limited to:

- Temporary or permanent disqualification, from practicing medicine, including revocation or suspension of physician's license to practice medicine or to dispense medication
- Loss of privileges at employer's or any hospital
- Death
- Inability to participate in or loss of participation in any federal, state or commercial insurance plans in which the health system participates
- Inability to secure, or loss of professional liability insurance

- Disruptive personal behavior as defined by employer or personal behavior toward patients or staff that violates employer’s policies and procedures, such as sexual harassment or inappropriate use of controlled substances or alcohol
- A judicial or governmental finding of a violation of a civil or criminal statute raising to the level of a non-traffic related misdemeanor or higher
- A material breach of the employment agreement

For circumstances that may be addressed and the behavior brought into compliance, the reaching or non-compliant party should be given written notice of non-compliance and provide a 30-day cure period prior to termination. In other circumstances, including death or in the event that quality and patient safety may be compromised, termination or suspension should be immediate.

“Without cause” termination provisions enable the parties to terminate their relationship based upon a unilateral decision independent of the need to satisfy any circumstance. The ability to terminate without cause should be accompanied with a 60 to 120 day written notice provision that allows the recipient adequate time to respond. Despite the notice requirement, employers may elect to negotiate the ability to transition the physician out of the employment relationship at an earlier time, while compensating the physician through the end of the notice period.

Indigent and charity care

The requirement that physicians provide indigent and charity care is tied directly to a not-for-profit health system’s mission and tax exempt qualification criteria. The amount of indigent and charity care provided by the physician practice should be regulated to a degree that does not interfere with the overall practice operations and financial sustainability. Setting expectations regarding the amount of indigent and charity care provided by the practice should be addressed during the acquisition or recruitment process.

Without a contractual stipulation regarding charity or indigent care, physicians on a net income or other collections dependent compensation model may focus their care on other payer categories. Conversely, a newly employed physician may experience an unanticipated demand for care from this charity or indigent patients merely as a result of physician’s new affiliation. Not serving this population may not only be in conflict with hospital’s mission, but could collectively place the physician enterprise’s or health system’s tax exempt status in jeopardy. The economic impact of caring for a portion of the indigent population and providing some charity should be mitigated through the compensation plan.

Outside activities

Often independent physicians are involved in outside activities with third parties to augment income or pursue personal interests. Third parties can include pharmaceutical companies, ambulatory centers, device and medical equipment companies, research firms, and affiliated diagnostic or clinical entities. Involvement typically includes ownership, personal services or endorsements. Once employed, these activities can become in conflict or competition with the activities of the physician’s new employer.

To avoid future conflicts, the employment agreement should require full disclosure of all relationships and a resolution of any conflicts during the acquisition or recruitment process. Thereafter, physicians should be required to disclose and seek written approval prior to engaging in any outside activity to ensure conflicts are not created. The ability to engage in such activities may be granted if such participation does not prevent a physician from fulfilling employment related duties and responsibilities, is not a conflict of interest, nor a violation of the employer’s policies and procedures governing outside activities. In many instances, such activities may be encouraged by the employer, but in all cases the circumstances should be transparent.

In those situations where a physician is permitted to work outside the scope of the employment arrangement it is important to clarify that such activities are not covered by the employer’s professional liability insurance policy and separate professional liability insurance coverage must be arranged.

Restrictive covenants

To protect the employer's investment in the physician enterprise, as well as the interests of other employed physicians, a restrictive covenant prohibiting the physician from practicing medicine within a defined geographic area for a specified period of time should be standard term.

The enforcement of a restrictive covenant is dependent upon state law. To be enforceable a restrictive covenant must be reasonable in terms of its geographic limitation, temporary restrictive period and breadth of restriction. States that have enforced restrictive covenants have generally held that specialists can be restricted from a larger geographic area than primary care physicians. Temporarily, restrictive periods range between one to two years. The scope of the restriction is often limited to those activities the physician was engaged in during employment that would be competitive to the employer and include employment, a management relationship or other economic arrangement with a competing health system.

If any one of the following: geographic limitation, temporal restriction or restrictive scope are found by the court to be outside legal parameters, the court may find the entire contract invalid or modify the individual section dealing with the restrictive covenant so it falls within legal parameters.

Another key issue is whether the employment agreement should exclude a physician from returning to private practice if he or she leaves the health system. The potential loss of a physician from the community usually outweighs any perceived competitive threat from the physicians returning to an independent status. In resolving this issue the employer should ensure that physicians returning to private practice are precluded from receiving management services or other economic consideration from a competitor as a means of circumventing an otherwise enforceable restrictive covenant.

Call coverage

Call coverage is an increasing challenge for health systems and physicians to navigate. The issues have grown more intense as physicians demand a more balanced lifestyle and physician shortages place pressure on the number of physicians available to cover a specific service. Addressing the frequency of and when and how call responsibilities would be altered, for example if call drops below a certain frequency, should be clearly spelled out in the employment agreement. Unlike practice call, emergency department call responsibilities may be governed by the physician's medical staff relationship and hospital bylaws. Any additional call responsibilities may be specifically addressed in the employment agreement, but caution should be taken to remain consistent with the medical staff bylaws.

Specify duties resulting in incremental compensation

Any additional duties such as administrative roles and responsibilities, committee assignments and medical directorships resulting in incremental compensation beyond that earned for the provision of professional services should be specifically delineated within an attachment incorporated into the employment agreement. Duties should be clearly specified as well as any additional time, attendance, documentation or other requirements necessary to support incremental compensation. The incremental compensation should be included as part of any independent fair market value review and fall between regulatory acceptable parameters.

Compensation

Physician compensation⁵ should be clearly defined in the employment agreement. Compensation should be defined in terms of amount during the initial or renewal terms and include a detailed narrative of the compensation plan formula with an example calculation. Also, any specific circumstances that may trigger a review or revision of the compensation plan should be included, most importantly a periodic review to ensure compensation remains within fair market value. In anticipation of future revisions, the compensation plan can be referenced in the employment agreement as an attachment.

Professional liability insurance

It is not unusual for employers to provide professional liability tail coverage upon termination. This type of liability coverage covers the risk associated with claims relating to the period of employment that may be reported in subsequent periods following termination of employment. The employment agreement should address the level of professional liability insurance that will be provided to the physician and how tail coverage will be addressed upon the termination of employment. Employers will need to address how to handle professional liability for coverage of claims relating to physician's prior practice if the physician is not independently securing tail coverage for that period.

The employer has several options to consider:

- The physician can remain with the physician pre-employment carrier. If this alternative is chosen the employer should consider the impact of insuring different components of its physician enterprise through multiple carriers who may not work cooperatively to resolve a dispute including the different components within a dispute, such as physicians, mid-level providers and the hospital.
- The physician can transition into the health system's commercial or self-insured captive coverage arrangements. Current carriers can provide retroactive coverage for pre-employment claims. Physicians can share the cost of tail coverage with the health system should the physician terminate within the initial term of the agreement or be terminated for cause. The physician's share of the tail insurance premium can decrease over the period in order to recognize the decreasing risk to the institution.
- Sometimes health systems with a self-insured captive may decide to provide commercial liability coverage to the physician during an initial period. This can be achieved by either retaining the physician's existing policy or securing a separate policy from the health system's captive excess carrier or other commercial carrier. This gives the health system the opportunity to allow pre-employment related claims risk to diminish before transferring coverage to its self-insured captive.

Tail insurance coverage can cost between 1.2 and 2 times the costs of a typical annual premium. The decision to provide tail coverage is the buyer's; however, the need to maintain coverage remains an obligation of the seller. Thus, if the employer assumes the cost of tail coverage as part of the acquisition it should include this expense in the calculation of the practice's fair market value and deduct the value from the purchase price.

Soft Close

In as much as there are multiple notifications to third-party payers and other credentialing requirements when on-boarding a new physician, it is leading practice to finalize definitive agreements a month or two ahead of the actual closing date. This provides for a predetermined closing date and the opportunity to provide required notifications to third parties in advance that will significantly enhance cash flow once the physician comes on board. Signing definitive agreements in advance of the effective date of closing is often referred to as a "soft close."

Applicability to new physician recruitment

While much of this white paper focuses on acquisition of existing physician practices, many of the same lessons learned also apply to new physician recruitment. Key among the common best practices are:

- Establish appropriate expectations regarding physician compensation, other employment terms and conditions and the time table for recruitment and on-boarding
- Develop a prospective assessment of the financial implications of the ongoing employment arrangement for both the enterprise and the individual physician
- Communicate a clear vision of the relationship and the organization the new physician is joining

In either scenario – physician practice acquisition or new physician recruitment – planning for the on-boarding, orientation and initial year's practice experience for the newly employed physician is essential.

Seven essential principles

Whether adding new physicians to an employment enterprise through acquisition or recruitment, there are principles of success that are important to apply.

1. Articulate and **communicate a clear vision** early in the process. This enables physicians and other stakeholders to understand the context of the ongoing relationship and whether it is a good fit for both parties. With a vision in hand, garnering early physician leadership support will help manage expectations and keep stakeholders focused.
2. **Think integration** from day one. The direction of health care demands early consideration of an integration strategy that can be supported and driven by aligned incentives. Don't overlook the need to assimilate different cultures and include cultural integration activities into the project plan.
3. **Establish reasonable expectations** regarding the transaction and future sustainability. Once established, manage the process in accordance with sound project management principles, including communicating status, results and changes to stakeholders, physician leaders and at appropriate intervals the entire physician group. This approach requires that momentum be maintained.
4. Use the acquisition or recruitment process to **build and strengthen trust** between the parties. This foundation of trust will carry the relationship forward and enable parties to work through the inevitable challenges they will face in the transaction and in the post transaction employment relationship.
5. Work with the right **multidisciplinary team** of professionals including some with physician practice site operational experience. A practical operational focus is essential to success. Advisors should meet regularly and keep pace with each other's activities and stay within advisor provider constraints whether they are legal, operational, financial or strategic.
6. **Understand the financial implications** related to transactional and future operational and strategic capital needs as early in the process as possible. Setting the right expectation requires the parties to understand the financial implications of the transaction and future relationship. Capital needs can mount quickly and should be quantified early in the process and committed to by the appropriate parties.
7. Treat the relationship like a **partnership**. A partnership implies mutual cooperation toward the achievement of a common vision with each partner accepting responsibility for their contributions and being held accountable by the other parties for outcomes. Upon success, all parties that have contributed to the financial outcome should share in the reward.

Conclusion

Attention to key principles and a disciplined process will increase the opportunities for successful and sustainable acquisitions and recruitment that add value to the physicians' practices, the health system and the community.

Building the medical group through acquisitions and recruitment is core to the long term success of the health system sponsored physician enterprise. This paper has presented and discussed the strategy, data gathering process, team of people, negotiations, legal considerations and attentiveness required for success. Focus on the outlined essential principles will increase the opportunities for successful and sustainable acquisitions and recruitment that add value to the physicians' practices, the health system and the community.

Health system sponsored physician employment: keys to success

- Part 1 Why health systems employ physicians
- Part 2 Aligning incentives through physician compensation
- Part 3 Organizational structure, governance and management
- Part 4 Optimizing the physician revenue cycle
- Part 5 Metrics and reporting for the physician enterprise
- Part 6 Getting started: building the enterprise through acquisitions and recruitment**
- Part 7 Putting it all together

Case Study



Getting started: building the enterprise through acquisition and recruitment

**Phoebe Putney Memorial Hospital
Albany, Georgia**

Bob LaGesse has 34 years of health care industry experience in both hospitals and physician practice. He joined Phoebe Putney Health System in December 2008 as senior vice president for physicians practices. Mr. LaGesse coordinates the strategic planning, business and clinic operations of the health system's employed physician group.



Bob LaGesse

Senior Vice President, Physicians Practices
Phoebe Putney Health System

About Phoebe Physician Group

The Phoebe Physician Group started in 1997 when physicians were hired to service the needs of rural health clinics. Initially, the only common element in the physician group was that the medical service organization provided a billing function and a shared tax ID number with the hospital. Primary care physicians were later joined by specialty practices to fill gaps in coverage such as neurosurgery, maternal fetal medicine and neonatology or to protect market share.

In 12 months, 30 physicians were added to the group through acquisition and recruitment. Given the current environment, the group is expected to grow from 85 to 116 physicians and to add four new mid-level providers from August 2009 to the end of 2010.

Defining goals and processes upfront

PPG has developed a systemic approach to defining its objectives and designing specific processes to optimize its acquisition and recruitment strategies.

Goals for a sustainable recruitment, acquisition and retention strategy include:

- Identifying local and regional specialty gaps so that decisions are not made on a knee-jerk basis
- Meeting critical system needs
- Seizing opportunities to move volume
- Strengthening physician ties regionally by offering a health care and hospital system where physicians want to bring their patients

Building a comprehensive and strategic planning process

The strategic planning process requires a well designed and thoughtful approach. The following chart outlines the critical steps in the planning process that will be discussed in more detail in this case study.

Table 1: Acquisition and recruitment planning process				
Step 1: Horizon assessment	Step 2: Organizational fit assessment (filter)	Step 3: Viability assessment (filter)	Step 4: Planning documentation	Step 5: Implementation
General industry assessment	Vision	Financial sustainability	Recruitment plan (See sample plan - table 2)	Recruitment (See sample plan - table 3)
Physician community needs assessment	Mission	Capital availability	Budget plan	On-boarding
Medical staff risk assessment (preventing gaps)	Expertise	Facility	Market plan	Acquisition
Market assessment (New services, potential acquisitions, competitor activities)		Staffing	Operational implementation	Marketing
				Facility planning
				Operational Retention

Working the plan, one step at a time

The five-step plan as displayed in the chart on page 21 has successfully been used by PPG and is detailed below:

STEP 1: HORIZON ASSESSMENT

- **General industry assessment** Compile from experience and literature an understanding of the general state of the health care industry, physician practice, technology trends, revenue and payer realities and public expectations.
- **Physician community needs assessment** Complete a physician community needs assessment. The realities of the marketplace are an important additional consideration. The formal needs assessment is based on population and morbidity factors to meet federal policies on physician recruitment assistance. Special considerations need to be made with market place factors to ensure not to over or under saturate a market with a given physician specialty
- **Medical staff risks assessment** Assess the risk of potential loss of physicians on the medical staffs of all the system hospitals being evaluated for risk of loss. Those risks might include the following:
 - Identification of call coverage needs
 - Potential risks of retirement and slowing of practice, such as physician dissatisfaction with the community or hospital, as well as the physician, spouse or family wanting to live in another region or state
 - Practices fragmenting or in difficulty
 - Plans or actions of a local competitor such as opening of urgent care centers that will attract members away from the medical staff
- **Market assessment** Evaluate all physician practices in the system market area not currently on the facilities' medical staffs. Based on experience, PPG considers opportunities for practice acquisition from partners impacted by retirements or health issues as well as potential acquisitions of new service lines. It

is preferable to not recruit a physician if the system already gets 70% to 80% of his/her patients and instead look at “splitters” with the highest potential gain. Focus is given on physicians known to be dissatisfied with competing hospitals and that might leave the local community. Those physicians are then prioritized based on their greatest potential gain or opportunity to improve volume. This target list provides a list of physicians with whom PPG schedules conversations.

STEP 2: ORGANIZATIONAL FIT ASSESSMENT

Develop decision criteria to determine risk or opportunity to the organization. The overarching initial decision is that any action fit within the vision and mission of the organization. The mission includes both service considerations and financial considerations.



It is critical to define clear acquisition principles and address the following questions:

- Does the practice fulfill a strategic or tactical need?
- Does it bring new volume or services; prevent loss of market share; increase leverage with payers?
- Is there sufficient capital available to sustain the planned acquisition?
- Will the physicians fit into an employed model culture?
- Does the system have the infrastructure to support the acquisition?
- Does the model fit the organization and is it sustainable?

STEP 5: IMPLEMENTATION

Recruitment

The recruitment process and recruitment tools must be continually re-evaluated. Financial realities, regulatory changes and lifestyle expectations are in constant flux, and each affects the success of the recruitment process. The following chart displays the process and tools.

Table 3: Retooling the traditional recruitment process

Recruitment plan	Recruitment sourcing	Recruitment	Onboarding	Retention	Tools
Specialty	Outside recruiters	Screening	Mentoring Sponsoring	Communication	Marketing materials
Timing	Website	Scheduling	Orientation	Problem resolution	Stipends
Locations	Direct mailing	Interview	Enrollment	Involvement	Student loan repayment (a)
	Sponsor and regional residency programs	Site visit	Marketing		Physician champions (b)
	“Home grown”	Contracting	Practice operations Planning		Loyal real estate agents [©]
			Practice opening		

(a) Student loan repayment is increasingly more appealing as a tool with more physicians having nearly \$200,000 in student loans. The loan repayment must fit within the fair market evaluations and cannot be stacked on top of a high compensation agreement without careful analysis. Note that student loans are taxable.

(b) Physician champions is a “home-grown” Phoebe Putney program where physicians keep in touch with gifted home town students as they progress through the educational process to become physicians. Christmas cards, dinner invitations and other personal contacts keep the medical students connected to return to practice locally.

(c) Loyal real estate agents or community persons can serve as information sources, as well as assist in that personal connection helping recruitment.

Acquisition

Tips for conducting acquisition due diligence

It is critical to be patient, diligent and obtain all the information needed as early as possible in the process. Some example of information that will need to be collected are:

- Audited profit and loss statements
- Liabilities and assets
- Outstanding contracts and leases
- Billing and collection data
- Practice payment policies
- Coding data and agreement for advanced documentation audit
- Ancillary income sources
- Physicians' W-2 information
- Historic and outstanding risk management and malpractice issues

Conducting skillful pre-acquisition negotiations

Consider legal and consulting assistance needs in advance, especially with sophisticated and large (more than 30 or so) medical groups. Negotiate with an end in mind. Have the following questions answered and considerations made:

- Know what the system is unwilling or unable to "give on" before entering into negotiations
- Consider shared and reserved authority, decision making and structural control
- Think about the compensation models that you are willing to consider
- Consider staff assimilations (paid time off, compensation range, benefits, training, human resources and management policy differences)
- Be ready to deal with old accounts receivables. Phoebe Putney does not purchase A/R. Old A/R is left to the physicians

- Have the asset purchase and fair market valuation performed by outside independent firms
- Make decisions about legacy practice management and electronic medical records. PPG has found that one of their first big mistakes was to retain legacy systems for a while with the intent to change later.
- Always be very clear in contract language and during negotiations. Spend time on the contract language before getting into the numbers because language is as important as the money
- Keep detailed notes -- even from telephone calls -- and share key points with both parties

Post acquisition critical success factors

The time period early after an acquisition sets the stage for how the participating parties judge the success of the effort. The early experience of each party can color the perception of the viability of the strategy itself. An early failure or problem can be difficult to overcome. Planful attentiveness can pay large later dividends.

- Be patient
- Identify what the physicians will want to see about their new practices.
- Use a cross-functional team (HR, accounting, information technology, marketing, etc.) to make the acquisition go smoothly
- Recognize there will be "speed bumps" and adjustments to be made
- Expect change anxiety, a certain level of distrust, some "buyer's remorse" and "seller's remorse" is not uncommon

Plan re-assessment schedule

The strategic planning process outlined above also requires ongoing and recurring activities and monitoring with a defined plan re-assessment schedule.

- Continuously or monthly
 - Recruitment plan
 - Medical staff risk assessment
 - Opportunities
 - Gap assessments
 - Market assessments
- Quarterly
 - A more formal market assessment
- Annually
 - Reassessment and review of current document

A formal community needs assessment is required every two years to assist in the strategic planning process and to meet regulatory requirements.

Lessons learned

Successfully conducting acquisition and recruitment strategies requires a well thought out approach supported by a comprehensive and carefully designed strategic planning process. While the design of the plan and well-managed project management principles are instrumental to the ultimate success of the venture, the ability to carefully execute the plan and conduct ongoing re-evaluation and monitoring of its various critical components will ultimately determine the final outcome and sustainability over time.

This case study is summarized from comments by Bob LaGessee on Nov. 17, 2009, as part of the 2009 VHA CEO Affinity Group teleconference series.



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End notes

1. *Health system sponsored physician employment: keys to success: Part 3 – Organizational structure, governance and management*, Southwind Health Partners, LLC and VHA Inc., 2009.
2. *Health system sponsored physician employment: keys to success: Part 5 – Metrics and reporting*, Southwind Health Partners, LLC and VHA Inc., 2009.
3. *Health system sponsored physician employment: keys to success Part 4 – Optimizing the physician revenue cycle*, Southwind Health Partners, LLC and VHA Inc., 2009.
4. For a more complete description, see *Health system sponsored physician employment: keys to success: Part 2 – Aligning financial incentives through physician compensation*, Southwind Health Partners, LLC and VHA Inc., 2009.
5. *Health system sponsored physician employment: keys to success: Part 2 – Aligning incentives through physician compensation*, Southwind Health Partners, LLC and VHA Inc., 2009.