MAY 2007

healthcare financial management

healthcare financial management association www.hfma.org

FEATURE STORY

Daniel M. Grauman
J. David Robeson

acquiring physician-owned ambulatory businesses traversing the minefield

Hospitals can gain substantial strategic benefits from purchasing physician-owned ventures, but they should understand the dangers.

AT A GLANCE

- A hospital can acquire a physician-owned facility's assets or buy equity in the facility.
- The purchase price must fall within the bounds of fair market value.
- A professional services agreement also must reflect FMV.
- The purchasing hospital should determine whether the freestanding center should become a hospital outpatient department.

Imagine an opportunity comes along for a hospital to acquire a freestanding, physician-owned imaging center. The hospital sees a compelling strategic opportunity from converting the center into a hospital outpatient department, and it forges ahead with the acquisition. After months of negotiations and planning, the deal is closed, and the hospital begins preparations to transition the center to HOPD status. But not so fast! The hospital is informed that state regulations will not allow the center to operate as an HOPD.

Hospitals interested in acquiring physician-owned facilities obviously need to approach such transactions with care. Entering into such a transaction without the necessary foreknowledge and due diligence can be like stumbling blindly into a minefield, with similar results.

An Opportunity for Hospitals

For some time, physicians have been developing and operating various outpatient facilities and services, including diagnostic imaging centers, ambulatory surgery centers, radiation therapy facilities, cardiac diagnostic services and vascular labs, and the like. Their goals have been to capture a greater share of the healthcare provider dollar, preserve or grow personal income, and increase clinical control over the delivery of these services. However, these physician forays into the ambulatory business world have met with varied success. And changing competitive and payment landscapes for these facilities have, on occasion, caused previously successful ventures to quickly head south.

The proliferation of these ambulatory facilities, with their varied fortunes, has created many acquisition opportunities for hospitals. Typically, hospitals are interested in acquiring such facilities for strategic reasons, revolving around service-line consolidation or alignment of physician relationships deemed beneficial to the hospital.

Regardless of the reason for the acquisition, however, the success of the transaction will depend on its structure and the operational plans set forth for the facility. Although each potential acquisition has its own unique features, certain "critical path"

issues must be addressed in every case. Among the most challenging of these issues are:

> The question of whether the acquisition involves buying assets or equity
> The conformance of the acquisition with fair market value
> The role of the physicians and the professional services agreement
> Third-party payment considerations of ownership change
> "Under arrangement" considerations

What Are You Buying? Assets or Equity?

The first step is to identify exactly what the hospital will be buying. Obviously, when Dr. Jones suggests that a hospital consider purchasing his diagnostic imaging center, the acquisition will revolve around the business. But will the hospital be purchasing the assets of Dr. Jones' business, or will it buy all or a portion of the equity of the existing business?

In general, acquiring assets is more straightforward than purchasing equity. Nonetheless, with each approach, specific issues must be addressed.

Buying assets. Most frequently, acquisitions of this nature involve the purchase of the assets related to the business. Assets are typically categorized as tangible and intangible assets (the latter including the license and a noncompete provision), and they often exclude the net working capital of the business.

The first issue in an asset purchase is determining *which* assets to purchase. Generally, the assets to be purchased are those that drive the economic benefits generated by the business. Identifying these assets is not always simple. Clearly, the issue of intangible assets will be addressed in the determination of the acquisition's fair market value. But before the FMV opinion can be rendered, the assets to be accounted for in the FMV need to be clearly defined. Does the asset purchase include patient charts, telephone numbers, and the employee workforce in place? Is there a distinction between enterprise and personal goodwill? Does there need to be? Is it necessary to acquire and value the business name?

Among the more problematic assets are those associated with noncompete provisions. Typically, a noncompete provision prohibits the seller from engaging in anything that would be regarded as a competing business within certain specified geographic limits. Of course, the sticky points can revolve around everything from the definitions of "geographic limits" to "competing business" to "engaging in." Another issue is the provision's time limits. Most important are the elements that give the noncompete its teeth—that is, what happens if the seller should violate the provision.

If the acquisition does not include a noncompete provision, intangible assets would be of little value, given that in the absence of such a provision, the seller has the ability to transfer his or her business and related revenue stream to wherever he or she wants. In fact, absent such a provision, even tangible assets may have questionable value under a going-concern premise should the seller's hold on the market be such that competition stands little chance of generating a reasonable return on any investment in the assets required to drive the business.

The challenge is to impose an effective noncompete provision that is nonthreatening to the selling physician or physicians with whom the hospital presumably wishes to maintain an effective working relationship.

Structuring noncompete provisions can be challenging, as state laws and regulations come into play. Depending on the state, enforceability of these provisions may vary. Thus, while guidance from hospital legal counsel is crucial in all elements of acquisition structuring, it is particularly important with respect to noncompete provisions.

Finally, with asset purchases, it is advisable to exclude the seller's net working capital. Implicit in this exclusion is the notion that the hospital will need to fund its own working capital.

Although this exclusion creates a need for cash outside of the acquisition, the alternative is more challenging because it requires determining a value of the existing business net working capital and including it in the transaction. The latter approach places the hospital at risk for the collection of the seller's accounts receivable and payment of outstanding accounts payable.

Buying equity. Under certain circumstances, hospitals may find it preferable to purchase equity in a physician venture, rather than purchase its assets. Suppose, for example, that Dr. Jones and his partners represent a unique physician alignment opportunity, or that maintaining the existing investor group would be beneficial to all parties. In this instance, the hospital would likely prefer to buy into the existing entity, essentially transitioning it to a joint venture.

A complete equity purchase usually is subject to the buy-sell provisions contained in the existing entity's governing documents. The hospital should understand these provisions thoroughly because, in essence, they define what the hospital is buying. Hospitals should consider the potential limitations on liquidity, marketability, and control that these terms impose on the investment. Although these limitations must eventually be considered in the determination of FMV, the acquirer should gain a complete understanding of them early in the evaluation process to avoid problems that could arise among existing shareholders.

Liabilities also should be understood and considered in an equity purchase. Physician-owned freestanding outpatient businesses often do not have audited financial statements. In many instances, the only available financial information is compiled by a local accountant. It is challenging enough to accurately estimate historical income, expense, and cash flow, but hospitals also run the risk of overlooking hidden or unrecognized liabilities that they could assume when purchasing equity.

Due diligence should focus on the entity's governance provisions and all existing, potential, and contingent liabilities. Depending on the findings, it may be necessary to restructure governance provisions as part of the transaction, to better suit the hospital's needs and requirements.

If restructuring is not possible, but the hospital wants to preserve the existing physicians' equity position, the hospital might find it worthwhile to establish a new entity to which its initial capital contribution would be the assets purchased from the existing entity. Then, after the hospital has purchased the existing entity's assets and established and capitalized the new entity, the equity holders of the existing entity could reinvest in the new entity, thereby retaining the physician investor group while disposing of the troublesome old entity.

Fair Market Value

Whether the hospital is acquiring assets or equity, the price paid must be within the boundaries of fair market value. Paying such a price not only is prudent business practice, but also is necessary to comply with various laws and regulations requiring that hospital acquisitions and business relationships be at FMV and commercially reasonable. Failure to comply with these laws and regulations could invoke legal challenges involving anti-kickback statutes, fraud and abuse laws, and related Stark II legislation, and, for not-for-profits, private inurement.

A major challenge for the sellers is the "hypothetical buyer" concept implicit in the FMV standard. The typical transaction is one in which a physician or group of physicians sells their business to a local hospital. In such situations, the physicians see significant upside potential for the hospital as the purchaser, given either the strategic gains associated with the acquisition or the favorable payer contracts that can enhance the business revenue stream.

FMV is defined as: *The amount at which property would change hands between a willing seller and a willing buyer when neither is acting under compulsion and when both have reasonable knowledge of the relevant facts.*

The notion of a hypothetical buyer is part and parcel of this definition. In the case of a freestanding physician-owned facility, that "willing," knowledgeable, uncompelled buyer is not necessarily the hospital. In fact, the hypothetical buyer should reflect the most likely purchaser of the specific type of business under consideration—in this case, a freestanding facility. And for this reason, the FMV conclusion is developed with assumption that the facility will continue to operate as a freestanding facility.

A valuation from any other perspective—particularly one that includes the upside potential for a hospital as buyer—is problematic, especially from the perspective of the applicable regulatory and government agencies such as the IRS and the Department of Health and Human Services Office of Inspector General.

The challenge is that the seller often sees the hospital's upside economic potential as at least one of the motivations for selling to the hospital. Therefore, the hospital should make the meaning of FMV, from its perspective as a buyer, clear from the outset.

If the hospital is to purchase equity, the FMV conclusion must also address lack of marketability and control issues. As previously noted, an equity purchase is subject to the buy-sell provisions of the existing entity. The degree to which those provisions impede the ability of an investor to remarket its ownership interest must be reflected in the valuation.

The same is true of control—or, more specifically, relative control. A minority equity interest, associated with little ability to impact governance and operational decisions, must reflect this lack of control.

Should negotiations continue beyond this point, other considerations have significant implications for the valuation process, including the fair market nature of the various agreements that will constitute the structure of the outpatient business operations going forward. Most notable among these agreements is the professional services agreement.

Role of the Physicians and the PSA

To illustrate the role of the PSA in a hospital's acquisition of a physician-owned entity, let's assume that the hospital is purchasing a freestanding imaging center. The sellers of such a center are typically radiologists who have been paid a global rate under the Medicare physician fee schedule that covers both the technical and professional fees. It is likely that these radiologists collected that revenue, paid facility operating expenses, and retained the remainder as their "net income."

As noted previously, the FMV standard assumes that the business will continue as a freestanding entity. It must do so, however, within an Independent Treatment and Diagnostic Facility configuration, whereby it is assumed that the business will purchase professional radiologist services under the terms of a PSA. The PSA defines the compensation paid to the radiologists for professional interpretation services out of the global revenue stream.

The PSA is critical to ongoing facility operations. Consequently, the economic terms of this PSA must reflect FMV. In fact, application of the terms of a fair market PSA on the center could potentially result in net income that is not supportive of the underlying assets.

Also, if the sellers are to retain the real estate associated with the business and lease it to the buyers, the same FMV requirement applies to the terms of any anticipated lease agreement.

Third-Party Payment Considerations of Ownership Change

Although the determination of FMV is developed under the assumption of continued freestanding operations, this does not mean that the hospital must operate the business as such after acquiring it. In fact, given the impact of recently introduced provisions of the Deficit Reduction Act of 2005, transition of a freestanding imaging center to a

hospital outpatient department may prove advantageous. Similarly, the impact of the 2007 outpatient prospective payment final rule on ambulatory surgery center payment makes a shift to HOPD operations desirable.

Many questions need to be considered when choosing the ongoing operational structure.

Will state licensing regulations permit HOPD status? The ability to relicense the facility as an HOPD depends on each state's licensure regulations. Typically, the proximity of the outpatient business to the hospital and the degree to which the business operations are to be integrated into the general hospital operations are important considerations.

What are the timing considerations associated with the acquisition and related startup and licensure? Unless the hospital is purchasing only equity, licensure raises a timing issue. Even with an equity transaction, the business will likely be required to notify state licensure agencies of the significant change in ownership. This notification should not affect billings and payment. However, depending on the state and the ultimate operational structure of the business, a relicensure may be required in the case of asset acquisitions, which can considerably extend the timing of the transaction and result in lost revenue.

How will the "same-store" revenue be affected? Measuring the same-store revenue impact is often challenging. Freestanding outpatient providers typically bill using Current Procedural Terminology. HOPD billing, particularly for Medicare, is based on ambulatory payment classifications. The primary challenge is in converting CPT coding to APC coding. Sometimes, there are direct bridges available to aid in this conversion. Often, there are not.

The revenue impact of "repricing" from freestanding status to the HOPD designation is at best an estimate. Different factors prevent a precise repricing exercise to various degrees. Either detailed analysis for a direct conversion is impossible due to insufficient data on an individual patient account basis, which are required to reprice radiation oncology revenue, or available data preclude a determination of primary versus secondary procedure, as is often the case with ambulatory surgery. Ultimately, even if a direct bridge were available to reprice the business for Medicare, the same exercise would necessarily be less specific for commercial and contracted payers.

Further complicating the repricing exercise are the effects of recent legislation such as the DRA on imaging center revenue and the impact of the 2007 OPPS final rule on freestanding ambulatory surgery center payments. Essentially, such payment schedule changes reflect the "moving target" nature of Medicare outpatient payment. The likelihood of additional changes to contracted payer payment structures adds yet another layer of complexity.

Nonetheless, repricing estimates are possible with reasonable known margins of error, and such estimates can provide a basis for hospital management's decisions regarding the ultimate operational structure of the acquired business.

Will the acquired business be more easily included under favorable hospital payer contracts as an HOPD? Should the acquired business be operated under separate licensure, with a separate provider number, billing for it under existing hospital payer contracts would likely not be possible until after the contracts are renegotiated to specifically include the freestanding provider. Should the hospital have a joint-venture interest in the freestanding provider of less than 50 percent, payers may be unwilling to include the provider under the hospital contracts at all.

"Under Arrangements" Considerations

If the hospital is pursuing physician alignment strategies, it may wish to consider structuring the acquisition as a joint venture. A traditional joint venture structure remains an option if the decision is to retain the acquisition's freestanding operations. *Traditional* refers to joint ventures in which the hospital and physician investors share

ownership of the entity—typically on an equal or nearly equal basis. Such ventures require considerable time and effort on the part of both hospital management and physician investor representatives to structure the governance, operations, and management of the venture, and set the terms under which investment opportunities are offered to the physician investors. A full discussion of the elements of equity joint venture development would be beyond the scope of this article.

As an alternative, a hospital that intends to transition the business to an HOPD, while still including physician investors in the business, may wish to consider an "under arrangements" joint venture model. As an HOPD, all assets associated with the business become assets of the hospital. And more important, patients and the related billings become hospital patients and billings. Under this model, the hospital and physician investors establish a service provider entity.

Using outpatient surgery as an example, the hospital would contract with the joint-ventured service provider entity to provide the outpatient surgery technical services to hospital patients. As such, the service provider entity would be responsible for employing, managing, and supervising the outpatient surgery department staff; procuring supplies; and providing all the other services that an outsourced service provider ordinarily would deliver. Often, the joint-ventured service provider entity would purchase the tangible assets that support the operation from the hospital. For such service provision, the joint-ventured entity would be paid a prenegotiated rate per patient.

The key to defining the "under arrangements" contracted rates is that they be documented as representing FMV. The differential between fair market rate structure and the HOPD rates can often be a divisive issue. Equally as divisive can be the notion that the patients are not those of the joint-ventured entity, but those of the hospital. The implicit lack of control associated with such a structure often runs counter to the objectives of physicians in a joint business arrangement.

Another possible joint-venturing model involves forming a management company and real estate investment companies around the acquired business. With the general caveat that whenever money changes hands between the entity and the hospital or affiliate, it must do so under an FMV arrangement, starting a management company with real estate investment entities may provide the keys to establishing the needed blend of control and/or economic interest.

De-Mining the Environment

Acquiring physician-owned ambulatory businesses can be fraught with challenges. Yet the most perilous aspects of such a transaction can be circumvented with appropriate diligence and education. Setting political sensitivities aside, hospitals should be diligent in understanding numerous legal, regulatory, and payment issues, and they should seek to educate the physician sellers about the deal parameters and constraints that hospitals face as buyers.

Acquisition and possible joint-venturing opportunities involving physicians present sound strategic and physician alignment opportunities for hospitals. And as long as hospitals approach these ventures with appropriate caution and foresight, they will find a clear and open field for exploring new opportunities for financial success.

About the authors

Daniel M. Grauman
is president and CEO, DGA Partners, Philadelphia, and a member of HFMA's Metropolitan Philadelphia Chapter.

J. David Robeson
is a director, DGA Partners, San Francisco.

Reprinted from the May 2007 issue of *Healthcare Financial Management.*
Copyright 2007 by Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154.
For more information, call 1-800-252-HFMA or visit www.hfma.org.