11 critical questions to ask when buying a physician practice

Before acquiring a physician practice, hospital leaders should ask themselves 11 questions about keys to strategic and financial success that will help them make rational, evidence-based decisions.

The increase in acquisitions of physician practices by hospitals and health systems is a widely publicized trend today. And a report issued earlier this year by Moody’s Investors Services suggests that this trend is likely to continue (Goldstein, L., “New Forces Driving Rise in Not-for-Profit Hospital Consolidation,” March 8, 2012).

The growing calls for delivery system and payment reform are pushing hospitals and health systems to find ways of offering more highly integrated services. For most institutions, this translates to growing pressures for physician practice acquisition, physician employment, and the integration of physician services into the overall enterprise. According to a recent survey, nearly 80 percent of healthcare executives are undertaking or will be exploring acquisitions within the next 18 months (Tocknell, M.D., “M&A: Hospitals Take Control,” HealthLeaders Media, January 2012).

Meanwhile, physicians, squeezed by static or falling payment rates and rising operating expenses, are increasingly looking to hospitals to buy their practices. Yet many institutions that have acquired physician practices have faced several challenges in truly integrating those practices into their organizations. The signs of dysfunctional hospital–physician practice relationships include:

> Lack of clarity and agreement on strategic goals
> Medical staff opposition to hospital-employed physicians
> Low practice productivity related to compensation plan design
> Different values and culture among owned practices and the hospital
> Lack of agreement on how to measure financial performance
> Sharp decline in a practice’s margin
> High operating costs among employed physicians and owned practices
> Practice revenues below expectations
> Lack of executive financial incentives for physician integration
> Lack of board oversight of physician compensation

To minimize problems after an acquisition has closed, several key pieces of information should be acquired and critical questions answered before inking the deal.

The Questions
Answering the following 11 questions in advance of a practice purchase can help hospital and health system leaders make rational, evidence-based decisions about specific opportunities, thereby helping to ensure that the acquired practices are a strategic and financial success. These questions are not intended as a guide for leaders’ necessary comprehensive due diligence, but simply to stimulate thoughtful analysis before entering into a practice acquisition. The questions also do not delve into issues of practice valuation because these issues require fair-market value determinations and third-party assessments of hard and soft assets.

Moreover, no single answer to these questions should be considered definitive in the final decision-making process. Taken collectively, however the answers can help leaders make an informed decision, thereby helping to avoid unfortunate surprises after the deal closes. (See the sidebar below for additional questions addressing cultural, operational, and performance issues.)

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Additional Questions for a Well-Rounded Discussion

Thoughtful discussions prior to acquiring a physician practice should never be one-dimensional. Although the questions that lay the groundwork for such discussions should focus primarily on the keys to strategic and financial success with such an acquisition, hospital and health system leaders should also possess a broad awareness of many other physician practice-related concerns. In particular, these leaders also should be well versed in the cultural, operational, and performance issues surrounding physician practices.

Here are 11 questions that can help hospital and health system leaders gain essential insight into these areas:

> What is the culture of the practice?
> How will the culture of the newly acquired practice blend with the cultures of other practices that you already own and with physicians that you currently employ?
> Is there any pending litigation involving the practice or any of its members (including professional liability, landlord-tenant disputes, employment issues, equipment leases, indebtedness, contractual issues, etc.)?
> Have there been any previous litigation issues, and how were they resolved?
> Does the practice, or do any of its members, have an ownership interest in a pharmacy, durable medical equipment supplier, laboratory, imaging center, or other health services provider?
> Has the practice received Medicare or Medicaid incentive monies for electronic health records and attested-to “meaningful use”?
> How does the coding profile for evaluation and management codes for each practitioner compare with benchmarks for the same specialty or same diagnoses?
> Has the practice been reporting Physician Quality Reporting System measures to the Centers for Medicare & Medicaid Services?
> Has the practice been recognized by any payers for its quality, through patient steerage, or received public recognition?
> Has the practice completed a Physician Practice Patient Safety Assessment for each practice site?
> How do patient satisfaction scores for the practice and for each physician compare with benchmarks?
What is the strategic objective driving this acquisition?

Too often, a hospital or health system acquires a practice “because the physicians want to sell” or “because if we don’t buy it, our competitor will.” Practice purchases that become problematic are often entered into without a clear strategic objective in mind. Ideally, hospitals and health systems should develop a clear strategy and strategic goals for their physician integration activities well before they acquire any practices or employ any physicians. But even if your organization is already in the business of owning practices and employing physicians, it is never too late to develop a strategic plan.

The strategic plan’s objectives should include consideration of whether to:

- Grow or maintain market share
- Develop a new service line
- Grow or maintain specialist referral base
- Expand geographic market area
- Prepare for creation of an accountable care organization (ACO) or health plan

A strategic plan can be immensely valuable in deciding what additional practices might be desirable, as well as which ones may be candidates for divestiture. Devoting time to clearly defining why you want to own a particular practice, why you wish to employ these specific physicians, and what strategic need the acquisition will meet before entering into negotiations with the practice’s owners can help avoid adverse events down the road.

Is there clear support for this strategic objective from the board, management team, and physician leaders (both employed and voluntary)? One of the most common causes for failure in a practice purchase is lack of support from one or more key constituencies. Achieving alignment of objectives from the board, the management team, and physician leaders is an essential prerequisite to a successful transaction. If there is not such alignment, or if there are different expectations about the transaction among the key parties, problems are likely to occur once the transaction is completed.

In addition to the organization’s leadership, it is equally important that there be clarity and buy-in from the physician owners of the practice. If they are not clear about what the hospital hopes to achieve from purchasing their practice, or if they do not agree with the objectives that are set, it is likely expectations will fail on both sides of the transaction.

How does this practice, and each physician in it, compare with industry benchmarks on key physician performance metrics? Important metrics to consider are total collected revenues, total operating expenses before physician compensation, total relative value units (RVUs) and work RVUs per physician and advanced practice clinician, and physician compensation. It is rare for a practice to generate more revenues after being acquired by a hospital than it did under physician ownership, or for its physicians to bill for more RVUs than they did prior to the acquisition. Any pro forma projections for the financial performance of the practice after it is acquired should be based primarily on its performance before the acquisition. There may be opportunities to improve a practice’s financial performance after the deal is done, but any estimates of improvement should be conservative.

Some hospitals expect that any lowered productivity from employed physicians will be offset by the opportunity for increased revenues from provider-based billing for physician services. Although many insurers, including Medicare, currently make separate payments for professional services and facility costs in provider-based clinics, those differentials are unlikely to continue.

What is the payer mix for the practice as a whole and for each physician? A clear understanding of payer mix can help in projecting not only the financial performance of the practice, but also the impact of the acquisition on hospital revenues. A practice with a high proportion of Medicare, Medicaid, or uninsured patients should probably generate additional hospital admissions from those payers. Conversely, if the practice’s patients are represented by significant numbers of private payers with whom the hospital has a positive working relationship, there may be opportunities to negotiate with those payers for more favorable contract terms for the practice, once the practice is acquired.
What is the mix of forms of payment (e.g., discounted fee for service, capitation, bonus payments) in the practice’s insurer contracts? One of the most difficult practice management challenges is dealing with a mix of payment mechanisms that creates unclear incentives for physicians. Pure fee for service is easy, and so is pure capitation. But a blend of different payment methods can be challenging, and experience has shown that physicians generate less income when they are subject to a mix of payment methods.

What is the relationship between RVU production (percentile) and revenue production (percentile) for the practice as a whole and for each physician? The distribution of RVU production and revenue production for a specialty should generally be at similar points on the curve for the practice and its physicians. For example, if a physician is producing RVUs at the 60th percentile for his or her specialty, one would expect the physician’s gross revenues to also be around the 60th percentile. However, if the physician is producing RVUs at the 75th percentile for his or her specialty and the physician’s revenue production is only at the 25th percentile, then the physician is being paid at significantly lower rates per RVU than his or her peers. Conversely, revenues at the 70th percentile, with RVU production at the 40th percentile, is a sign of very favorable contracts with payers—an indication that the practice manager is able to negotiate higher payment rates and could be a valuable asset in the acquisition.

Benchmark data on RVU production and revenue generation can be obtained from several sources, including the Medical Group Management Association’s annual survey of practice costs and revenues for single-specialty and multispecialty practices.

If the physician admits, what percentage of admissions is currently to your facility? Admissions are driven by a variety of factors other than physician preference. Geographic location, patient preference, payer steerage, and several other issues come into play. Accordingly, if most of the practice’s admissions are to other hospitals, don’t expect that pattern to change immediately. Changes in admitting patterns can be made, but they do not occur quickly. Issues related to geographic location and patient origin are unlikely to be affected unless the practice is relocated.

If the physician admits, how does the physician’s total cost per case compare with that of others for the same diagnosis or procedure? If necessary, the physician’s total cost per case can be estimated from the cost-to-charges ratio. Ideally, physicians who are employed by the hospital, or whose practices are owned by the hospital, should be the most efficient, cost-effective members of a hospital’s medical staff. The more prudent they are in using inpatient resources, the lower their cost per case, and the higher the margin. Before purchasing a practice, hospital leaders should determine the cost-effectiveness of the practice’s physicians. If their cost per case (usually driven significantly by physician choice of drugs, supplies, devices, etc.) is higher than the hospital’s revenue for those cases, the additional admissions volume they may generate could make the problem worse. For procedures, it is important to look at supply costs, lab costs, pharmacy costs, and length of stay.

If the physician does not admit, what is the specialist referral pattern, and what percentage of referrals is to specialists who are high-volume users of your facility? This question is particularly important for primary care practices, because physicians are generally reluctant to change their specialist referral patterns. If most of the physicians’ referrals are to specialists who primarily admit to a competing facility, the hospital’s leaders should discuss this issue with the physicians in advance and explore their willingness to refer to specialists who primarily use the hospital’s facility. Similar to hospital admission patterns, specialist referral patterns can be difficult to change.

What is the current formula for determining the compensation of physicians and other practitioners in the practice? Most practices use some form of production-related (work RVUs or gross revenues) formula for determining physician compensation, but few currently factor in metrics for quality,
safety, and patient satisfaction. Early discussions about expectations for physician performance, the metrics to be used to assess performance, and the relationship of those metrics to compensation can help avoid major problems associated with misaligned expectations. This issue becomes particularly important in markets where insurers are moving toward alternative “pay-for-value” payment methods or where the hospital’s strategic objective for the practice purchase is the formation of an ACO.

Is employee compensation related in any way to measures of practice profitability, quality, and patient satisfaction? To increase the likelihood that a practice will meet organizational goals, it is important that compensation for all employees be aligned with those goals. This alignment should start with the executive staff responsible for owned practices and extend through mid-level managers to the front-line clinical and support staff. Early discussion of this concern can help avoid later problems and provide key information in designing employee compensation and benefits and rational financial performance projections.

The Winning Formula
The adage that “an ounce of prevention is worth a pound of cure” certainly applies to hospitals that intend to purchase physician practices and employ their physicians. Asking these 11 questions in advance of a purchase decision can help minimize financial performance problems after the deal is done. Success depends on having a clear game plan and spending the time necessary to make sure that all players—board, management, physician leaders, and the physicians who will be employees—understand and support the plan. With the game plan in place, the focus can turn to flawless execution. And a well-executed game plan is a winning formula. ●