Independent Practice Integration into
Large Medical Groups for Sustainable Success;
Options and Considerations

Exploratory Paper

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Introduction

The purpose of this paper is to explore the steps necessary to complete a full practice analysis and to determine viability or the need for integration or merger. Through literature and personal experience, this paper will seek to provide a detailed understanding into the reasons and processes associated with acquisition and integration. The paper will include a background and insight into the decision making, planning, and transitional elements required for integration of an independent practice in order to achieve the organizations’ growth objectives. It will detail the strategies and tactics that prove to be most effective in successfully engaging physician partners from private practice to joining the ranks of shareholders of a large multi-specialty group practice or employees of a healthcare system.

Background Information

The current economic environment and looming regulatory mandates have led small independent practices into considering integration into large, multi-specialty groups, hospitals or health systems in order to acquire costly practice infrastructure, gain negotiating leverage with health plans, promote high-quality care, and benefit from increased professional resource management.¹ Many private practice physicians are faced with the need to determine if joining a large medical group will allow them to meet their personal goals, financial needs, and professional visions.
Hospitals, health systems, and large multispecialty groups are seeking greater alignment by joining forces with independent practices. These organizations view integration as a necessity to withstand increasing expenses, reimbursement changes, decreases in patient volumes and healthcare reform. It is also an increasingly important tool in their recruitment toolkit. Independent practice integration is a viable path toward achieving growth and sustainable success.

As a result, physicians are exploring alternate ways of working with independent practice associations, large multispecialty practices, hospitals and health systems. Since 2000, integration has increased by 32 percent, with 17.3 percent of all physicians now directly employed by hospitals or health systems and 14.7 percent with with large physician groups.²

**Determining the Viability of the Practice**

To determine the viability of the medical practice, it is important to conduct a comprehensive practice analysis to include operations, financial, and administrative assessments. It is also important to look at strategic options in order to identify areas of new volume and income generating venues. These assessments will enable the medical practice to determine the sustainability of the practice.

The value of an assessment or “check-up” of the medical practice has the potential to be substantial. Reviewing the business operations is just as important as a periodic “check-up” of a patient’s overall health. Catching problems early, keeping focused on the “big picture”, and basing strategic decisions on known data are the cornerstones to success.
A complete analysis of the medical practice helps the group to understand the current operations and to realize the need to move the operations from where they are to where they need to be. These steps can assist independent practices determine their value and help to evaluate the option to remain independent or support the decision to integrate.

The decisions on whether and how to integrate should be based on the viability of the practice, an assessment of the market, a comprehensive scope of services, business prospects, and the compatibility of the participants. Physicians thinking about embarking on a practice merger, a financial or clinical integration are strongly encouraged to obtain the advice of private legal counsel experienced in physician-specific legal and reimbursement issues before proceeding.

Understanding the Reasons for Practice Integration

There are many reasons driving physician practice integration. The recent groundbreaking changes in health care policy and reimbursement methodologies are providing new and often compelling reasons for physicians to work in much closer collaboration than in the past. In 2004 in his State of the Union Address, President George W. Bush announced to Americans that most would have access to an Electronic Health Record or EHR by 2014. The potential benefit of having access to an EHR in both inpatient and outpatient settings was projected to result in an annual savings of $88 billion based on a 2007 report by the Commonwealth Fund. As a result, several major federal agencies significantly altered their enforcement policies to facilitate physician
adoption of an EHR. A complicating factor in this projection is that for physicians to acquire, implement and maintain an EHR, extensive financial resources are needed that in turn require a fully merged firm or integrated joint venture.

Another significant motivating factor to integrate is the implementation of quality-based reimbursement mechanisms such as the Physician Quality Reporting System (PQRS) and Meaningful Use. Health insurers, state and federal government and other payers are demanding data on physician performance upon which to base reimbursement and to make informed health care purchases. Integration can enable physicians to finance, develop, implement, and maintain the infrastructure necessary to collect, track and report the types of quality information that these performance-based reimbursement programs require. Closer integration may also be essential to create the collaborative environment needed to make real quality improvements. Without this infrastructure, physicians may not be able to demonstrate the quality outcomes required and ultimately, practices may be precluded to compete in the changing health care market.

In addition to health insurers and employers, consumers are demanding data of physician performance to help them make informed health care purchases. These three entities utilize the quality measure data for a number of factors which include adherence to quality outcome and process measures, patient satisfaction, survey results and to assess the cost of healthcare. Physicians are now ranked by health insurers on quality and cost-related metrics. Insurers disseminate this ranking information to the public to assist them in selecting their physician. The higher the physician “scores” the
higher the reimbursement. Many physicians view integration as an avenue to capture performance data required by third-parties. Integration with a larger group may offer access to costly management information systems used to evaluate performance and promote themselves to third party payers. Many larger integrated groups may be favored by a managed care organization because of the geographic scope of services or mix that patients want.

Creating a larger group practice may provide a way for physicians to not only bare the financial risks associated with purchases but to also bare the expense associated with treating unusually costly and non-insured patients.

**Benefits of the Relationship**

Aside from Health Care Reform, health insurer, expenses and reimbursement changes, additional cost drivers and perhaps more significant motivators among physicians is the desire to aggregate capital for the significant cost of Information and Technology (IT) investments that are involved in health care delivery. Physicians may seek to share the risks they must bare when capital is needed for IT.

Integration may yield not only efficiencies but may offer a competitive edge and market control. It may open avenues to create and expand external relationships, capture additional healthcare dollars through increased size and scope of practice, offer a strong primary care and or specialty care base in order to create a comprehensive scope of services and increase the geographic distribution for the practice.
Quality of life and a pathway to retirement is of great importance to physicians.
Integration can offer stability for retention, recruitment and succession planning.

**Additional Benefits and Considerations**

There are many other forces driving physicians towards integration. In addition to the benefits previously noted, large physician groups or hospital systems can offer economies of scale, including: expert management, financial management, human resources support, information technology, group contracting, physician recruitment, facilities management, billing and coding, credentialing, compliance and risk management, group purchasing, staff training, physician autonomy and governance, and, options for non-clinical or passive income opportunities.

**Considerations for the Best Relationship**

**Practice/Practice Merger or Integration, Physicians at the Precipice**

For many physicians, practicing in a “merger” model environment is ideal. In this model the physician professional is able to remain autonomous, and in most cases, is able to keep the rapid decision making process they’ve become accustomed to. In merger models, consolidation of separate physician practices into one surviving medical group in which participating physicians have a complete unity of interest works very well. The merged entity controls all of the resources of the combined practices so that none of the participating physicians compete with one another. The result is an ability to capture additional healthcare dollars though increased size and scope of practice. In
many cases, the participating physicians are allowed to remain in their local practice setting and oversee the day-to-day practice operations. An additional attractor is that physician owners can choose to be compensated based on individual productivity or if preferred, by employment contracts.

Physicians are realizing that merging multiple practices may offer a more flexible practice model. The stability of this model allows physician groups to remain in control through meaningful decision making and allows for greater retention and recruitment of medical professionals.

There are many reasons driving physicians towards consolidation such as market share, faltering practice economics, complex practice management systems, and the uncertainty around Health Care Reform. Private practice physicians are finding that reimbursement is failing and they may be unable to contain costs. Reorganizing the care delivery model by merging with a large medical group can help them bend the cost curve and improve their financial performance.

The capital investment necessary by independent physicians for mergers may be significant in order to fund the corporate restructuring, consolidation, and the purchase of operational infrastructure. While the capital investment may be substantial, there are many benefits associated with the “buy-in”.

Mergers usually provide greater access to capital and at improved lending rates. It can also provide operational efficiencies by offering economies of scale, including: access to clinical operations such as subspecialty management expertise, expanded scope of
service and geographic reach, a platform for care coordination, diversification and positioning for new payment models.

**Hospital/Physician Integration, Hospital-Physician Partnerships**

Hospital-physician relationships have changed dramatically in recent years, with physicians moving from private practice to hospital employment or partnership in droves. Hospitals are beginning to leverage these relationships in order to increase market share, with the ultimate goal being to help them increase and improve quality because physicians are the ones delivering care directly to the patient.4

Some physicians have been forced into giving up their private practices to join hospitals systems due to the overwhelming bureaucratic red tape, financial realities and the looming prospect of health care reform.5

Hospital systems take away many of the administrative hassles that bog down private practices, while also giving physicians access to capital and technology for a competitive advantage over smaller private and group-owned practices. Quality facilities and state of the art technology available in hospitals and healthcare systems offer physicians the leverage they need to remain competitive and allow for growth and expansion.

Many physicians are making the decision to sell their small business in favor of a steady paycheck and benefits; however, some physicians feel they may lose their sense of autonomy with this decision. Large systems need to take the steps necessary to ensure this does not happen.
An additional factor offered by hospitals and healthcare systems is professional physician leadership. Physician leadership enables those who are interested, involvement in the shared decision of key initiatives and strategic vision. This leadership can span from internal clinical integration to the external regional growth expansion. It provides a venue in which physicians can offer support for clinical care redesign, care continuum, and shared quality goals. All of which provide benefits to the community.

According to Medical Group Management Association (MGMA), hospital/physician integration has accelerated in recent years with the downturn of the economy. MGMA’s hospital membership increased 20 percent between 2003 and 2010. Meanwhile, the number of physicians overall who own their practices dropped 2 percent annually for the past 25 years.  

The demand for hospital employment opportunities is growing quickly amongst physicians. This type of integration allows new generation physicians to enter an employed practice model and helps hospitals meet new growth targets and performance objectives.  

**Other Alternatives**

Management Services Organizations (MSO) or Independent Practice Associations (IPA) may be an alternate option to integration with hospitals, health system and large multispecialty groups, however, physicians may find a lower level of commitment, limited integration options and a financial relationship is not substantial enough to support their needs.
Large Practice, Hospital and Health System Overview and Strategies to Integrate

Shareholders vs. Employment

Physicians have been making the move to mergers and integration for many years. There are many similarities in the integration process however; predominately the difference is ownership vs. employment. Some physicians would argue that there is a difference in autonomy as well.

In both models, medical practices merge or integrate and create a single legal entity, operating under one tax ID and are usually referred to as practice “divisions”. Mergers with large multi-specialty groups are typically physician owned, and may require a capital investment or “buy-in” of the single legal entity. When physicians integrate with a hospital or health system, assets and are purchased from the independent physicians. The physicians and their staff are merged into existing medical groups and become employees of the system.

Governance and Operations

In physician practice mergers and integrations, all governing authority is transferred to the new company or health system. This new entity will have ultimate governing authority over the following: practice assets, liabilities, budgets, compensation, salaries, revenue and cost distribution, the operation of business systems, e.g., billing, collections, accounting, and financial reporting systems; managed care contracting; and general administrative processes and information systems. Staff members become
employees of the new group or system; assets are sold and owned by the new group or system. The new company or health system will also have ultimate authority over the distribution of a physician’s income and expenses, and the tax identification number must be replaced by that of the new company or health system.

In both practice mergers and health system integrations, the physician group will likely promote a new practice name but usually link their prior practice affiliation with the group in order to transfer their goodwill and branding to the combined entity in order to assure patients of equivalent or improved quality.

Merging and integrating groups can normally share technology such electronic medical records and business and information systems to include scheduling and practice management software. There is often sharing of ancillary services which offers added value and convenience for patients.

The Competitive Advantage

Through the support of physician integrations and mergers, collaborative care delivery models are a useful strategy because they formalize the coordination of care and require a level of partnership between hospitals, physicians and payers. These collaborations provide an avenue for large medical groups and hospitals to build a relationship with physicians and community organizations to coordinate care and improve population health.
In addition to partnering with physicians and payers, hospitals are partnering with other organizations in the community such as nursing homes and long-term facilities in order to better coordinate services and manage transitions of care for patients along the continuum of care.

**Understanding the Integration Process, Due Diligence**

Use of a high-level screening tool to assist in making an early determination of “go” or “no go” is recommended. Specific parameters for practice integration should include the following:

- Specific specialties and geographic coverage goals in the context of organizational and service line priorities.

- Existing volumes and potential incremental volumes associated with proposed acquisition.

- Baseline quality metrics used for selection.

- Baseline financial performance requirements.

- Strategic fit and sustainability analysis.

- Cultural fit with the multispecialty group, hospital or health system.

Once the high level determination is complete and favorable, the decision is made to continue to the next step in the process.
Disclosure and Confidentiality Agreement

Perhaps the most valuable tool used to assist in making the decision to integrate or not is the Non-Disclosure Agreement (NDA), also known as a Confidentiality Agreement (CA). This is a legal contract between at least two parties that outlines confidential material, knowledge, or information that the parties wish to share with one another for certain purposes, but wish to restrict access to or by third parties. An NDA creates a confidential relationship between the parties to protect any type of confidential and proprietary information. An NDA protects nonpublic business information.8

NDAs are commonly signed when two companies, individuals, or other entities are considering doing business and need to understand the processes used in each other's business for the purpose of evaluating the potential business relationship. NDAs can be "mutual", meaning both parties are restricted in their use of the materials provided, or they can restrict the use of material by a single party.

Practice Valuation and Evaluation

Understanding the true value of a physician practice is a prerequisite to a successful integration that optimizes financial and operational performance. Valuations provide a comprehensive analysis of both tangible and intangible assets and how they contribute to the fair market value of a physician practice. This includes integrating physician total
compensation assumptions, based on productivity and industry benchmarks, into the value of the new enterprise to ensure a competitive return on investment.\footnote{9}

The valuation will also provide data to evaluate how the practice is doing. This information provides a roadmap to help determine the overall performance of the practice in both financial and non-financial measures.

The following is a list of items most often included in the Disclosure and Confidentiality Agreement put forth by private legal counsel specializing in healthcare.

1. Financial Review to include financial statements for the current and last three years, income statement, balance sheet, cash flow statement and any other pertinent information

2. Tax returns for current year and last three years

3. Fixed asset listings for current year and prior year to include listing and descriptions of all owned properties, schedule and copies of all office and other real estate leases of the group and a listing and description of all owned capital equipment.

4. Notices or communications from any federal, state or local department or agency which may have a material adverse effect on the continued current use of the medical offices

5. Any correspondence or description of any pending audits, investigations or actions to be taken by the Internal Revenue Service concerning the group.
6. Description of any prior Medicare or Medicaid billing refunds, penalties, or investigations.

7. Receivables to include charges, payments and adjustments by provider for the last 3 years, current fee schedule indicating CPT codes, current fees and payer mix.

8. By Physician, the most recent 12-month productivity reports to include frequency (count), charges, and payments by CPT code, and frequency (count), charges, and payments by payer

9. Current accounts receivable aging by third party payer, listing of all third party payer contractual arrangements and any special billing or reimbursement arrangements

10. Any anticipated volume changes (e.g., additional physicians, new services, new sites of service, etc.).

11. Coding, compliance and documentation review to include a copy of the corporate compliance plan, a copy of 10 medical reports per provider for documentation review, charge capture assessment and documentation of which CPT codes were actually billed, and current charge capture forms.

12. Legal name of company to include a listing of all sites of service in which professional services are performed.

13. Staffing Review to include a listing of all owners and ownership positions, listing of all physicians, non-physician providers, administrative personnel, and staff. These listings should include all current wage, salary, benefit and payroll
information, and provide a definition of a full-time physician full time equivalent (FTE) to include the number of weeks and hours worked, vacation, call, etc.

14. Professional liability insurance carrier and a copy of the current malpractice coverage.

15. Litigation information to include a schedule and summary of all disputes and all known threatened civil litigation. A schedule and summary of all consent decrees, judgments, awards, settlements or injunctions within the past five years. A schedule and summary of all pending or concluded within the last 3 years, criminal prosecution, administrative or investigatory proceedings by or before any regulatory authority at the Federal level (OSHA, EPA, FDA, EEOC, OIG or DHHS) and at the State level (DHS, DEP, MHRC) involving the group or any officer, director or employee thereof and related to activities in their capacity as such.

16. Listing and description of all other related businesses to include a listing of all advisors (accountants, attorneys, consultants, benefits brokers, etc.)

17. Service Agreements and obligations to include a schedule and description of all in-force and pending written agreements with hospitals, physicians, service providers, vendors and other third party vendors.


19. Schedule and description of any other clinical and non-clinical (e.g., medical director, teaching, committees, etc.) work activity not summarized above.
If after the valuation and evaluation process is complete and both parties agree to proceed, the Letter of Intent or LOI is the next step in the process.

The Letter of Intent

A Letter of Intent (LOI) is a non-binding agreement in which parties establish the principal business terms and, in most cases, announce transaction plans to the public. The Letter of Agreement (LOA) is a document outlining an agreement between two or more parties before the agreement is finalized. LOIs resemble written contracts, but are usually not binding on the parties in their entirety. Many LOIs, however, contain provisions that are binding, such as non-disclosure agreements, a covenant to negotiate in good faith, or a "stand-still" or "no-shop" provision promising exclusive rights to negotiate.10

Development of a Pro forma

In business, pro forma financial statements are prepared in advance of a planned transaction, such as a merger, an acquisition, a new capital investment, or a change in capital structure such as incurrence of new debt or issuance of equity.11 The pro forma models the anticipated results of the transaction, with particular emphasis on projected cash flows, net revenues and taxes. Consequently, pro forma statements summarize the projected future status of a company, based on the current financial statements. The follow information is typically requested as part of the integration process.
Three year projection of revenues and expenses based on assumptions such as:

- Retiring physicians
- Recruitment and addition of new physicians
- Utilization of Ancillary providers
- Expansion of services and/or locations
- Projected physician productivity
- Projected practice revenue
- Projected physician compensation
- Projected reimbursement (new contracts)
- Additional overhead

The integrating entities will utilize this forecasted information to create the financial statements which will provide insight as to how the actual statement will look if the underlying assumptions hold true.

**Contract Development and Review**

Contract development involves the creation of Purchase and Sale Agreements, Physician Employment Agreements, Asset Purchase Agreement and Professional Services Agreements as needed.
Once the information for the valuation, evaluation, and pro forma is reviewed, both parties’ objectives are considered. It is important to keep in mind that negotiations of this nature may take time. Once negotiations are complete, the result is the development of contracts which are the basis for the offer to move forward with the integration.

**The Planning Stage**

An important part of the process is planning. Obtaining input from all levels within the group leads to buy-in. Physician involvement at all levels of the organization must be supported by executive leadership and the governing board. Clinical and administrative physician leaders should be included in planning and development of new networks, operating models and other integration initiatives. Value-based health care is not possible without physician leadership. Physicians drive the design/redesign of clinical care delivery within this model. Both boards and executive teams should empower physician leaders with the authority to drive change, recognizing their vital role in the value equation. Leading hospitals, health systems and multispecialty groups that are moving to a value-based system consistently mention physician leadership and participation as key differentiating factors.

Currently, most organizations do not have adequate physician representation at the executive leadership and board levels. Physicians comprise less than 30 percent of senior leadership teams (Senior Vice-President and higher) in 88 percent of organizations; 36 percent of organizations report no physicians on the senior leadership team.\(^\text{12}\)
**Transitioning into an Integrated Model**

The transition process requires start-up planning and implementation that is as thorough and seamless as possible. The timing to transition may be several months. Decisions regarding old accounts receivable and staffing must be made. A dedicated transition team proves to be most valuable in a successful integration. A Project Manager would normally lead the transition team. This individual would be responsible for oversight of the transition and would take measures to ensure the projected timeline is met. Additionally, individuals would be assigned to guide the transition in the following areas: Operations, Billing, Human Resources, Communications, Technology and Marketing.

Continuous monitoring of progress toward meeting strategic financial goals and development of plans to address performance shortfalls are critical.

**Post Transition Consideration, Creating Value**

Only post transaction can a group determine if the integration is creating value. Once the structure of the integrated relationship and cultural integration is complete, the entities can truly align and perform as an integrated unit.

Even in a well-orchestrated integration is it evident only after the transition is complete, that integration efforts have been less-than-optimally executed. Cultural integration is often forgotten. Not only do the culture of the large medical group and the practice culture need to integrate, but the cultural integration often includes multiple physician
groups who additionally must integrate with each other. For example, similar specialty
groups are simultaneously integrating; many of whom were direct competitors prior to
the integration.

Creating value and culture into the integration is done by empowering the combined
governance infrastructure with measured and defined authority, responsibility and
accountability to operate, with the charge to improve the quality, operations, financial
and market performance of the combined scope of services.

Successful integrations have taught us that despite the vast differences in the
organizations and the people that run them, the multiple perspectives available in each,
when combined, are a powerful deployment and capable of delivering the promises for
which the integration was initially pursued.13

**Conclusion, Lasting Relationships Take Work**

Achieving a successful and sustainable integration relies heavily upon dedication,
communication, appreciation of partnerships, creation of a common brand,
transparency, a team approach and focus, a health philosophy, relationships based upon
mutual trust and respect, interdependence, a shared vision and shared decision making
with realistic hopes and attainable goals.

Whatever the form of integration, the litmus test for an approach’s effectiveness will be
its ability to align with physician goals related to utilization, cost, service, access and
quality, while maintaining or increasing the level of physician and patient satisfaction.
Ultimately, an organization’s arrangements with independent physicians must provide the platform for organizational growth. Many hospitals, health systems and large multispecialty groups are responding reactively to integration options as they evolve however, a better approach is to proactively identify, evaluate and select physician-integration options that represent a win/win opportunity, meeting physicians’ needs while positioning the overall organization for success.

There is no one integration plan that works for all organizations or all physicians. Service areas and physician needs are diverse, so hospitals, health systems and large multispecialty groups must be prepared to offer multiple engagement options, serving multiple physician constituencies.\textsuperscript{14}

Whichever model is selected, it is necessary to align organizational and physician goals related to improved quality, efficiency and access within the constraints of current organizational capital resources. Finding a sustainable balance of strategic and clinical needs, capital constraints, operation capabilities and management competencies is critical.

The organizations most likely to gain and retain close integration with physicians have common attributes that include in-depth management expertise, shared administrative-physician leadership and a well-developed integration infrastructure. Healthcare executives should be taking purposeful steps to align their organizations with physicians for sustainable success under a very different care and payment system going forward.
As independent physicians continue to integrate with large medical groups and proactively act to build relationships based on solid planning and monitoring, they become poised for sustainable success and understand the need to make care more accessible to patients. Increased access to care can lead to increased market share and an opportunity to better manage population health in their communities.

Endnotes

1 Competing in the Marketplace, AMA February 2009


4 Becker’s Hospital Review, Hospital and Health System Strategy in 2012: 6 Key Initiatives September 2012

5 BDC Advisors, Trends in Physician-Hospital Integration

6 Source: MGMA Physician Compensation and Production Survey


8 Wikipedia.org, Non-Disclosure Agreement

9 Sullivan Cotter, Physician Practice Valuation and Appraisal

10 Wikipedia.org, Letter of Intent

11 Pro Forma explained in the glossary of mergers-acquisitions.org

13 Becker’s Hospital Review, 3 Stages of Hospital and Physician Practice Integration
February 2013

14 hpoe.org Hospitals in Pursuit of Excellence, Accelerating Performance Improvement, September 2012