

Value Your Practice

Use caution when trying to put a dollar amount on group's market worth



The issue of practice valuation is a sensitive one. Some hospitalist practices might have significant monetary value, which could make it reasonable to ask new doctors to buy in or enable selling the practice for a profit. Still, it's risky to assume this is the case for your practice.

Let's examine the issue using a pair of situations I encountered not long ago. I have changed some details of the practices to more clearly illustrate a point and conceal which practices I'm describing. Both situations would have gone smoother if it was clear what the hospitalist practice was worth. But how do you assess that value?

Case No. 1

During a couple of days in 2006, I consulted with a high-performing private practice hospitalist group on the East Coast. The group was led by one of the most energetic and thoughtful leaders I've encountered.

Maybe your practice really does have significant value over and above the salaries the doctors earn. Perhaps you have developed proprietary operational processes that are particularly valuable and would be difficult for others to replicate without knowing your "trade secrets."

Like many other private practice groups, they divided physician members of the practice into partners and non-partners (sometimes referred to as shareholder and non-shareholders in the corporation). A hospitalist who had been a full-time member of the practice for a specified period of time (two years in this case) was eligible to become partner.

This entailed a "buy-in" requiring the doctor to pay money to the practice (usually the doctor would pay using a loan from the practice, which was repaid through deductions from his/her paycheck).

For this practice, the principal benefits of partner status were having a vote in group decisions (non-partners couldn't vote) and receiving a portion of the distribution of all corporate profits each year. These profits came from two sources:

- Money remaining after all salaries and overhead were paid; and
- Buy-in money received by the practice.

Because the partners had this "upside potential" they agreed they

would cover any staff shortages by working extra shifts instead of the non-partners.

Setting things up with a buy-in to achieve partner/shareholder status seemed to make a lot of sense. After all, it is the way nearly all private-practice medical groups in other specialties are structured.

Problems soon arose when they realized there wasn't significant "profit" available unless there happened to be two or three doctors buying into the practice in a given year.

So, the partners became disenchanted because they shouldered the burden of covering any extra shifts but didn't get a significant profit distribution in most years. Non-partners who became eligible for partnership were choosing not to buy in because it seemed like more responsibility without more income. The group's system began breaking down.

Keep in mind they had a terrific practice. The docs liked each other and were pleased with the group leader, were highly regarded by hospital executives and other doctors, and had a growing patient volume.

Yet, the partners were unhappy they weren't seeing extra compensation as a reward for buying into the practice with the money, time, and effort they invested.

Despite being a desirable practice in nearly every respect, new doctors were choosing to forgo partnership status. These things were creating significant morale issues that threatened the ongoing success of the group.

So why did these problems arise?

Case No. 2

Later in 2006, I worked with a different private-practice hospitalist group out West. Their practice had been started by, and was still owned by, a "parent" medical group. As the hospitalist practice grew, everyone (hospitalists and non-hospitalist doctors in the group) agreed it made sense to have the hospitalist practice separate into its own distinct corporation. Like the practice in the first case, all parties had high regard for one another.

The problem was the non-hospitalists who invested the time and energy to start the hospitalist practice wanted the departing hospitalists to compensate the larger group.

The hospitalists could understand why the other doctors proposed a buy-out but wondered what the hospitalists would get in return for paying it. The answer seemed to be not much. They weren't confident they could recoup

their investment by having future hospitalists buy in to the practice (proposing this had scared off more than one recruit), or by selling the practice to another party.

Assess Your Value

The problems faced by both these practices are a result of uncertainty about what their practices are worth.

In the first case, doctors who had the opportunity to buy into the practice were choosing not to because they believed they weren't going to get anything in return (and had the added burden of putting themselves on the schedule more often to cover open shifts).

Likewise, in the second case the hospitalists agreed it seemed reasonable to pay the other doctors in the parent group to go out on their own. But the hospitalists worried they would never be able to recoup that money by selling shares of the practice to new partner hospitalists or selling the whole group to another entity.

It's tricky to value any medical practice. A common approach is to put a price on tangible assets owned by the practice (e.g., buildings and equipment like computers and lab apparatus, and the accounts receivable), and the patient base (or good will) the practice has developed.

It isn't too difficult to come up with a value for tangible assets, and most hospitalist practices have little or nothing in this category (the only hard assets I can think of that I own are my pager, stethoscope, and a couple of lab coats I never wear). Patient lists and good will are particularly difficult to place a value on. Even for a primary care practice with thousands of patient charts, there is no guarantee patients will agree to transfer their care to a purchasing doctor.

For most any kind of medical practice, including a hospitalist group, good will mainly is a function of the referral relationships doctors have developed that ensure a steady flow of patients. Since a steady flow of patients is not a problem for most hospitalist practices (too many patients is more common than too few) the value of that referral stream may not be much.

Another asset many hospitalist practices own is their contract(s) with sponsoring organizations (usually hospitals, but sometimes health plans). They provide for supplemental payments over and above professional fees the practice collects.

This is often a hospitalist practice's most valuable asset, and it may be

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worth investing money to acquire. It's the primary reason large hospitalist staffing companies are willing to pay to acquire local hospitalist practices.

Usually these contracts cannot automatically be assigned to another party without the hospital's consent. Most hospitals' loyalty lies with the hospitalists who provide their coverage, not with the company that may hold the contract. For example, with the hospitalists in the second case, their hospital would have been willing to immediately sign a new contract with their spin-off group to maintain their existing hospitalist coverage. The parent group's hospital contract wasn't worth acquiring.

All this suggests hospitalist practices may not have much monetary value. That is, an outside party probably wouldn't pay much to buy your practice. I think this is true for the two practices I describe above. For practices like these, it is probably best to avoid having a buy-in to achieve partner status, and not diverting some practice revenue that would otherwise be used to pay salaries into a "profit" pool from which distributions are made to partners/owners periodically.

Practices Worth A Lot

I'm aware my comments might seem insulting to a group of hospitalists who have worked long and hard for several years to build what they think is a great practice. Surely it's worth something.

Maybe your practice really does have significant value over and above the salaries the doctors earn. Perhaps you have developed proprietary operational processes that are particularly valuable and would be difficult for others to replicate without knowing your "trade secrets." These could include things such as particularly effective ways to document, code, and collect professional fees; methods to enhance hospitalist efficiency and/or quality; unusually effective recruitment strategies; or even the ability to negotiate highly favorable contracts with payers.

Even if your practice does have remarkably effective proprietary components, you still would have to convince a buyer these valuable assets would persist after the change in ownership and the departure of key individuals. For example, you might have the best practice in the country because you've been able to recruit the best doctors. If I buy your practice and those excellent doctors leave, I've lost the unique asset that was key to the practice's value.

Clearly there is room for a lot of debate about hospitalist practice valuation. (Search the Internet for "medical practice valuation" for a number of good articles about this.) There are many practice management companies that rely on the notion that their ideas and operations provide greater value than other practices. One such company, IPC, had a successful initial public offering of stock that found a marketplace willing to pay for its perceived value. But keep in mind that this company has many practices in many states, and much of the value may lie in the fact that the value of the whole is greater than the sum of its parts. So, unless your

practice is huge and has sites in many states, I don't think you can assume IPC's public offering means your prac-

tice might have a similar value.

Think critically about your practice. Challenge yourself to think about what

you would pay for your practice and what you would get in return. If you have a hard time coming up with clear reasons your practice has significant intangible value, you should probably avoid structuring a buy-in for new doctors or a buy-out for departing doctors. **TH**

Dr. Nelson has been a practicing hospitalist since 1988 and is co-founder and past president of SHM. He is a principal in Nelson/Flores Associates, a national hospitalist practice management consulting firm. He is also part of the faculty for SHM's "Best Practices in Managing a Hospital Medicine Program" course. This column represents his views and is not intended to reflect an official position of SHM.

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Geoff Giordano, editor, ggiordan@wiley.com, (201) 748-5839,

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