

## **Are You Merging With Another Practice? Here are Issues and Terms to Discuss for Success.**

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Practice mergers--the economic integration of Practice A and Practice B into a new and larger group--are fueled by one of three core incentives: anxiety, avarice or ambition. Although practice merger activity has been relatively quiescent since the early- to mid-90s, when practice consolidation was driven in the main by health reform worries, I believe than in the coming years, as calls for new variations on health reform grow louder, we'll see a resurgence in such transactions.

The incentives are more varied today, and not just fear-based. These incentives include:

- Sharing increasingly expensive testing and treatment equipment
- Paying for marketing costs that have risen steeply in recent years
- Providing patients with a deeper team of subspecialists
- Pooling case volumes sufficient to support the development of an ASC or laser center
- Preparing for an anticipated tougher reimbursement environment, where you may have open access to patients (unlike the last era of pre-paid health plan development) but be obliged to be markedly more efficient in using fixed-cost resources to thrive
- Responding to the formation of *other* large groups in town

Practice-to-practice marriages present at least as many social nuances and intrigues as two single parents merging households, with the added complexities borne of scale, regulatory burden and financial intricacy.

The long run-up to any merger transaction includes a series of meetings between the principals (and eventually the senior lay staff) of each side. When I moderate these merger conferences, the agenda commonly focuses on the discussion and resolution of numerous open issues. I've listed the most important of these issues below--generically in this case. If you're contemplating a merger in your local market, a review of this list may help you decide, even before the first formal meeting, if you're ready to take the next step.

1. Is a "merger" even the appropriate transaction, or should this deal be something else? An acquisition? A strategic alliance? Or a narrower partnership to develop a surgery center or shared satellite?
2. What are the drivers for your merger transaction? Here are a few common examples:
  - Succession planning
  - Admiration of the target practice or practitioner
  - Geographic benefits (covering service area gaps in your regional market)
  - Improved contract access
  - Expense sharing (eg: developing a central billing office, or combining marketing staff)
  - Cooperative ancillary facility development
  - Supporting, as a group, a retinal or glaucoma subspecialist you can't support on your own

- Building to a scale allowing effective competition with a dominant practice (the second and third largest practices may merge to eclipse the largest market player)
3. What issues are potentially retarding a transaction? Some retardants include:
    - Excessive near-term transaction or consolidation costs, pushing gains well off into the future
    - Difficulty identifying equal and reciprocal benefits
    - Clinical or business philosophies that differ
    - Interpersonal conflicts between principals or key management staff
    - Simply, the passage of too much time...early interest in an iffy-but-worthy transaction can yield to boredom and then antipathy if pace and momentum are not maintained. Time is generally not a friend of prospective merger transactions.
  4. What are the details of the post-transaction strategic plan? Is there an agreed, common vision? Are the principals hot to pursue this, or merely lukewarm? What is the desired endpoint practice and how fast will we get there? What is everyone's tolerance for risk or deferment of income? If merging will lead to the acquisition of new facilities or costly equipment, is everyone prepared personally to take on debt?
  5. Are there other local practices we should consider as subsequent consolidation targets? Your prospective merger may be just the first move in a real-life chess game. If this is the case, do the original merger parties agree on who the subsequent tuck-in targets should be?
  6. How long will each provider continue to practice, what will be their retirement trajectory (abrupt or gradual?), and are there successors in line to take their place?
  7. Who is going to be the administrator of the new practice--an existing manager, or someone new and neutral? Which staff will advance in their careers? Which staff will be redundant and terminated? How will these staff be treated most fairly?
  8. Are we going to immediately collapse lay staff wage and benefit differentials, phase changes in over time, or even grandfather in existing staff? How soon will we change staff policies, uniforms, operational details, training protocols, etc.
  9. What will be the name of the converged practice? Will we pursue a re-positioning and the creative design work associated with this? How can we leverage the market strengths of each respective party in the new practice?
  10. Who will own what post-merger? How will the values of the respective practices (and the equity owned by each constituent partner) be derived? Will the by-doctor ownership of the newly merged practice be equal (eg: each of 4 partners owns 25%) or unequal? Will there be proportional or disproportional ownership in all practice segments (the core practice, ASC, optical, equipment leasing company, real estate entity, etc.)
  11. What will be the form of business? (Partnership, LLC, PC, etc.)
  12. How will practice governance change? What will be the chain of command and what will the organization chart look like? How often will the board meet? What future conflict resolution procedures will be used? What will be the financial performance reporting intervals? What agreed normative benchmarks will prevail?

13. Will any policies limit the outside business activities of partners? (eg: In unaffiliated optical or ASC entities in the market)
14. Who will be the initial managing partner or medical director? What will his or her term of office be? What authorities will be granted? Will the managing partner be paid a stipend for this important work?
15. What provider compensation methodology will be used initially, and how will this be reviewed from time to time? What about benefits and officer entitlements? What maximum vacation and education time off will be permitted to partners? If excessive time is taken off by a partner, what penalty will this trigger?
16. How and for what offenses can an inappropriate partner be bumped to associate or removed from the practice? Will founding partners be in a special category and somehow shielded from removal? How will non-compete issues be handled? Will competitive prohibitions be absolute or will we take a liquidated damages approach?
17. Who will remain on the end-point practice's advisory team: lawyers, accountants, compliance advisors, various other consultants?

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