

Valuing a Medical Practice: *Now Worth More Than Ever!*

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Traditionally, the sales price — or value — of a medical practice depends on the clinical specialty, the operating costs of the enterprise, and certain performance metrics. Likewise, valuation experts generally agree on the valuation model and the pricing. The current systemic changes in the health care environment cause the author to challenge the traditional model and propose a new one. This new valuation model identifies the upside potential of physicians practicing in an accountable care organization (ACO)-type environment that values building long-term patient-physician relationships, more patient interaction, preventive medicine, and better management of the environment where care is given and of testing and treatment protocols.

Among the factors that should be noted in the discussion are:

- Several large group practices have been sold recently at prices that are significantly less than the author's calculation of their value. Most notable of these is Healthcare Partners, which the author believes was undervalued by more than \$700 million.
- Hospitals have been buying physician practices and physician groups at an increased pace over the last two years. The author believes these practices have been undervalued by 20 to 50 percent on average.
- Of the triumvirate of health care (physicians, health insurers, and hospitals), physicians have historically carried the least business clout. And yet in the ACO, medical home, and capitated models of the future of health care, all change the care model in ways that are dependent on the physician.
- More primary care physicians are needed in all of the above models, yet they are and will be in short supply in many markets nationally.

The author believes that physicians are undervaluing their practices in the changing market and need to understand their value as they develop their future business strategies.

Why Are Physicians Selling?

So, why are physicians selling their practices? The principal reasons physicians cite are:

1. They are tired of the business side of health care and want to spend time with patients, not billing, collection, compliance, regulatory issues, etc.;
2. They don't see how they can survive in the changing marketplace without joining forces with major players such as hospitals, payers, or large groups; and
3. They think that they can stabilize their income in these new entities.

CNBC reports that, "A key factor in the consolidation trend is doctors now are willing to work for someone else to get rid of the hassle of paperwork, fighting with insurance companies, increased overhead costs, and other duties that keep them away from patients ... the trend toward doctors working for hospitals is being fueled by middle-age and older doctors who like the idea of spending less time on non-medicine-related work, and younger doctors who place a lot of value on work-life balance."¹ One conclusion of this report on the consolidation of physicians with hospitals and payers is that costs to the patient go up.

Why Are Physicians Undervaluing Their Businesses?

The author believes that the buyers have been "savvier" with advisors and economic analysis than the physicians, and that the traditional selling advisors do not understand practice economics in the new age of health care delivery. In fact, most purchases of physician practices are still based on an RVU earn-out model. In an age when the world is turning to bundled payment, medical homes, capitation, and carve outs, this represents the ultimate lunacy.

¹ Dan Mangan, CNBC, "Patients see higher bills after doctors sell practices," July 25, 2013.

Do the Math!

To get a better idea of the modern-day value of a physician's practice, let's look at the balance sheet of an ACO designed to achieve the "triple aim" of improving quality, reducing cost, and improving patient satisfaction. What we'll find is that the physician can do more than anyone else to make this modern delivery system a success. This, in turn, justifies the new way of valuing a practice.

Whether the ACO is a hospital-driven, payer-driven, or physician-driven model, the core costs to design, build out, and operate the ACO include:

- Increased information technology
- Connectivity between payer, providers, and physicians
- Increased financial management
- Increased actuarial and risk management requirements
- Increased clinical data, analytics, and actionable information
- Increased care management skills
- Increased population health management capabilities
- Increased consumer engagement costs
- Clinical transformation costs
- Developing aligned financial incentives and managing risk

The anticipated opportunities for core cost savings will be different for a hospital-based, payer-driven, or physician-driven ACO model. However, the categories of opportunities are the same:

- Prevent inpatient admissions
- Prevent inpatient readmissions
- Reduce testing
- Reduce surgeries
- Reduce other clinical procedures
- Reduce administrative costs

Let's make the assumption that the ACO group, including the payers, providers, and physicians, do the best they can to manage the design-and-build costs column above. They work together, have aligned incentives, manage the process, etc. (Yes, this is a big assumption, but the math only gets worse if these variables are not aligned.)

What the author did next is research the literature to evaluate the relative opportunities for the savings areas identified above. Clearly, the categories overlap. There is no magic to this, and there are significant differences in the literature as to the opportunities for testing, reductions in surgeries, population health management,

etc. But remember, we are only trying to put a value on the relative opportunity for each category compared to each of the others.

Based on that review, the author places the relative values as follows:

- Prevent inpatient admissions 40%
- Prevent inpatient readmissions 10%
- Reduce testing 10%
- Reduce surgeries 15%
- Reduce other clinical procedures 5%
- Reduce administrative costs 20%

Now, let's examine how the players, especially the physician, can influence each of these opportunities.

Prevent Inpatient Admissions:

The factors that influence an inpatient admission are, in order of timing:

1. Preventing the disease, accident, or medical event in the first place;
2. Identifying factors that influence disease and reducing the occurrence of these factors;
3. Detecting a problem, disease, or potential issue early in its manifestation;
4. Properly treating the problem or disease outside the hospital in a lower cost environment such as the physician's office, outpatient clinic, sub-acute care facility, or the patient's home; and
5. Quickly and effectively responding to accidents or other non-disease-based admissions.

Now let's examine the potential agents that can influence these five factors: the individual consumer, the physician, the hospital, and the payer. While bodies outside the ACO such as EMT response teams, the environment, weather, etc., can influence the inpatient admission, we choose to look at the agents of the ACO itself. Clearly, prevention of the disease is most weighted to the patient. The physician also plays a big role in the "patient activation" category.

Likewise, the payer can influence prevention and early detection, identifying factors that influence a member's likelihood of disease, but the incentives don't align with the opportunity cost. Members of health plans generally change jobs, change payer models, change plans, or for other reasons change the payer. This results in payers having little incentive to influence the long-term cost opportunities of disease prevention.

The hospital's role in preventing inpatient admission is even more at odds with the incentive systems in place. Hospitals get paid for the admission, and without a capitation, bundled payment or other risk-based payment offers little incentive to prevent admission.

After the patient, the physician is the biggest influencer in preventing the inpatient admission. In a medical home, the long-term physician relationship can influence the prevention of disease, the early detection, the test and detection decisions, the choice of treatment regime, the choice of treatment modality, the choice of treatment location, and the coaching of patient and family. Current payment systems, however, do not reward physicians for these activities. As opposed to the incentive gaps with the hospital and the payer, though, the incentives to physicians can be performance-based and tie directly to outcomes and physician cost.

Prevent Inpatient Readmissions:

Approximately one in five Medicare beneficiaries discharged from a hospital is back within 30 days. From Medicare alone, the cost to taxpayers is more than \$17 billion per year. Medicare is addressing the problem in a punitive manner with penalties to the hospital for readmissions (so called "bounce back rates") for heart attacks, heart failure, and pneumonia. It is expected that the list of conditions will be expanded shortly.

How is prevention of inpatient readmission different from preventing admission? Also, do the influencing factors change? The factors that influence an inpatient readmission are, in order of timing:

1. What the hospital does to prepare the patient before the initial discharge;
2. What the hospital does at the time of initial discharge of the patient;
3. What the physician does to prepare the patient at the time of discharge; and
4. What the hospital or payer does in the early days after discharge.

Historically, hospitals have had no incentives to prevent readmission and in fact, were paid more to readmit a patient. More recently, the Centers for Medicare & Medicaid Services (CMS) has implemented penalties for readmission, which have prompted hospitals to evaluate their role in the prevention of readmissions. But again, as with the prevention of the admission in the first place, prevention of readmission strikes at the heart of the hospital's basic economics. The hospital-based ACOs have had limited response to this basic issue.

Studies show that a significant proportion of readmissions are medication-related problems. Likewise, the inclusion of family in discharge planning has a significant impact on readmission rates. Each of these is the primary province of the physician.

Reduce Testing:

All ACOs are counting on reduced testing as a major pathway toward reducing costs and realigning incentives among consumers, physicians, hospitals, and payers. Testing is done in the hospital, in the physician office, and in freestanding facilities. There is substantive evidence in the literature regarding significant over-testing, medically unnecessary testing, and incorrect testing.

Once again, in a hospital-based ACO model, the incentives for reducing testing are often at odds with traditional workflow models and financial incentives, and could easily interfere with the patient-physician relationship. As with the prevention of admissions and with readmissions, the conflict of reducing testing strikes at the heart of the hospital's basic economics. The hospital-based ACOs have not addressed this basic issue.

Physicians, who order, conduct, and evaluate the tests, are in a much better position to effect this change. The potential for financial misalignments exists, but is not as significant as for hospitals.

Reduce Surgeries and Clinical Procedures:

Similar to the economics of reducing testing, all ACOs are counting on the reduction in procedures and surgeries as a major way to reduce medical costs and realign incentives. Procedures and surgeries are performed in the hospital, in the physician's office, and in freestanding surgery centers. There is substantive evidence in the literature regarding excessive, medically unnecessary, and secondary surgeries and procedures.

As with the issue of testing in a hospital-based ACO model, the incentives for reducing procedures and surgeries are often at odds with traditional workflow and financial incentives. They pose the potential for interference with the patient-physician relationship. Here again, as with the prevention of admissions and readmissions, the conflict of reducing procedures and surgeries strikes at the heart of the hospital's basic economics. Payers have monitored the instances of excess procedures and have had some success in managing this activity. However, the payer approach

is a punitive and administratively bureaucratic solution that creates excess administrative responsibility for the consumer, physician, and hospital.

Reduce Administrative Costs:

All parties to the health care system list this as a tremendous opportunity for reducing costs. Unfortunately, the present health care payment system results in many of the following:

- Payers building systems to prevent fraud, inappropriate care, unnecessary care, compliance with contracts, etc.;
- Payers building systems for compliance with state and federal requirements;
- Hospitals and physicians buying and building systems that interact with each other, payers, and patients to get prompt and accurate information to facilitate prompt and accurate payments; and
- Hospitals and physicians buying and building systems to capture demographic, diagnostic, testing, treatment, and procedure information necessary to prepare accurate and compliant invoices for payment.

And you get the point. We are building competing systems to interact with each other (on one side, to prevent *bad* things from happening, and on the other side, to get fair and accurate payment for services rendered).

In addition to these redundant and counter-acting systems, there are literally dozens of compliance agencies, professional societies, licensure agencies, audit requirements, and oversight agencies that exercise limited or substantive authority over hospitals, physicians, and payers. All of these entities require reporting, audits, and significant personnel time to demonstrate compliance. So, yes, there is opportunity to save billions of dollars in administrative overhead. However, each of these entities believes that it adds value to the system, prevents fraud, protects the consumer, or protects the welfare of the population.

So Back to the Math!

While collaborative models (i.e., value-based payment models) are possible, basically, one player (hospital, payer, or physician) is driving most of the ACO models that are being implemented. Most often, it is the hospital. Speaking for hospital leaders, Deborah Bowen, CEO of the American College of Healthcare Executives, says, “Payment reform and missing links in financial

incentives complicate our relationships with physicians and often make it more difficult to see the road ahead.”²

Based on the previous reviews of potential cost reductions, the author has assigned the potential for achieving the full benefit based on which player is driving the ACO: (In general, the author is skeptical of getting anywhere near the full impact under any scenario.)

Probability of Achieving the Full Benefit

	Hospital-Driven ACO	Payer-Driven ACO	Physician-Driven ACO
Prevent Inpatient Admissions	10%	80%	80%
Prevent Inpatient Readmissions	40%	40%	60%
Reduce Testing	40%	60%	80%
Reduce Surgeries	20%	60%	60%
Reduce Clinical Procedures	20%	60%	60%
Reduce Admin. Costs	10%	40%	40%

First of all, the math leads you to the conclusion that physicians and payers are most aligned in an ACO model. Likewise, it is easy to infer that physicians add the most value to an ACO and can achieve the most cost reduction if properly incented. The driver for getting these savings is to align the physician’s payment to these cost savings goals.

However, physicians generally are not organized to drive an ACO, although a few large group practices and IPA-type entities have been successful. In fact, the driver in many ACO-like entities is a hospital(s), which generally has the least probability of success. It appears that a payer and physician collaborative model has the most probability of success.

The success of this model depends on having the payers at the table willing to work with physician organizations to craft innovative payment systems that provide physicians with financial incentives and practical tools to improve care, reduce costs, and enhance patient satisfaction.

If the payers change how physicians are paid so as to emphasize continuity of care for patients, then

² Deborah Bowen, *Healthcare Executive*, “New Conversations to Foster Collaboration,” Sept./Oct. 2013, p. 8.

physicians will be free to act accordingly. The power of the marketplace then will reward those physicians who take proactive steps to prevent unnecessary admissions and readmissions, and reduce testing, surgeries, and other procedures.

Conclusion

The patient-physician relationship is the center for success of any ACO model. Likewise, the clinical team led by the physician is the heart and soul of the health care delivery system. New models of health care delivery must recognize this patient-physician relationship and provide economic incentives to strengthen this relationship. There are hundreds of billions of dollars of waste (including bad consumer habits, excess admissions, excess testing and surgeries, or otherwise) in the health care system. Much of this waste can be recovered by changing the incentives and aligning the players with common goals.

How does this tie back to the issue of physicians undervaluing their practices? It boils down to this:

- No ACO is going to be successful without physicians driving the clinical workflow, especially those segments that are ripe for the essential cost savings. Physicians should value their practices for the central role they play in this change in the delivery system. It is no wonder that hospitals and payers are scooping up physician groups and physician practices. They will pay even more in the future for this right.
- If a physician(s) decides that the right place to practice is in a hospital-based or payer-based model, they should make sure that the contract terms reflect the new reality of capitation, medical home, and bundled payment rather than an RVU-based agreement.
- Physicians who get savvy in the new delivery models will have more to gain than to lose.

Do the math! You will be surprised how valuable your practice is.

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