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# IS YOUR PRACTICE MERGER DOOMED TO FAIL?

*Before you partner with another practice,  
make sure you've addressed these four questions.*

**P**icture this: Your successful three-physician practice is about to merge with an equally successful two-physician group next door. Everyone is excited about the potential benefits of the merger, which include added services, decreased overhead and an increased patient base. But a number of key issues have yet to be settled, such as the legal and organizational structure of the new practice and the methods for allocating costs and determining compensation within the group. If these issues are not resolved ahead of time, the merger could spell disaster.

## What not to do

When I began my career as a family physician, I returned to my hometown to work in a rural primary care clinic. One internist, one general surgeon and I, one family physician, comprised our clinic. Because my colleagues and I wanted to focus mainly on seeing patients, our office administrator functioned as the key decision-maker over the business side of the practice. Next door was a husband and wife physician group (a general surgeon and a pediatrician) who had worked in the community for more than 25 years. The couple approached our administrator to assess the possibility of merging with our practice. Both were more than 60 years old, and they felt the merger would help them transition into retirement within a few years. We viewed it as a way to increase

services, redistribute costs and eventually inherit their patients. As an added bonus, their proximity to our office would limit merger costs since only one wall would have to be torn down to connect the two practices. It seemed like a win-win situation ... until the problems began.

During negotiations, our administrator was so determined to go through with the merger that he conceded on almost every point. We merged as a "general partnership," but it was anything but a partnership. For starters, the other physicians were allowed seven weeks off from work annually, nearly double that of our physicians. The new partners were also afforded additional nursing staff. They refused to combine their medical records with ours or use our clinic protocols. In addition, they expected their compensation to increase.

Unfortunately, our merger ended disastrously. It was doomed from the beginning because of poor negotiations that failed to address essential issues. On the plus side, our situation presents an excellent lesson on what *not* to do when merging practices.

## Four key questions

Practice mergers fail for a variety of reasons, but chief among them are personality clashes and competing interests. If these factors are not sufficiently aligned from the beginning, it matters little what agreements or contracts you develop with the other party. However, even if person-

alities and interests are in sync, practices need to carefully answer the following questions before moving forward.

**1. What legal structure should you choose for the new practice?** The options are a general partnership, a limited liability corporation (LLC), a limited liability partnership (LLP) or a professional corporation (PC). Our group opted for a general partnership, which was a mistake, given that one of the physicians had been sued several times and the rest of us would have been held personally liable in the event of another lawsuit. An important benefit of LLCs, LLPs and PCs is that they protect the individual physicians from personal liability for another partner's negligence. In addition, PCs (C corporations and S corporations) provide personal liability protection from both creditors and claims against the practice. The downside to these entities is that they require a new employer identification number (EIN) from the Internal Revenue Service. Once this EIN is processed, the practice needs to apply for a new Medicare assignment account, which could delay claims processing for several months. (For more information, see "Choosing the Right Practice Entity," *FPM*, November/December 2005, page 42.)

**2. How should you structure the day-to-day operations?** Merging practices need to be restructured to share key functions, such as medical records, a billing office and other administrative functions. In our merger, the other practice joined with us to offset their costs but wanted to continue to operate independently. They refused to share clinical staff and medical records, and their nursing staff wanted to chart, file paperwork and

process patients "the way they had always done it." This fostered territorial behavior and undermined unity within the new group. The best approach for our merged practices would have been to share all personnel, including clinical staff. This would have decreased the total number of staff needed and facilitated a team mentality.

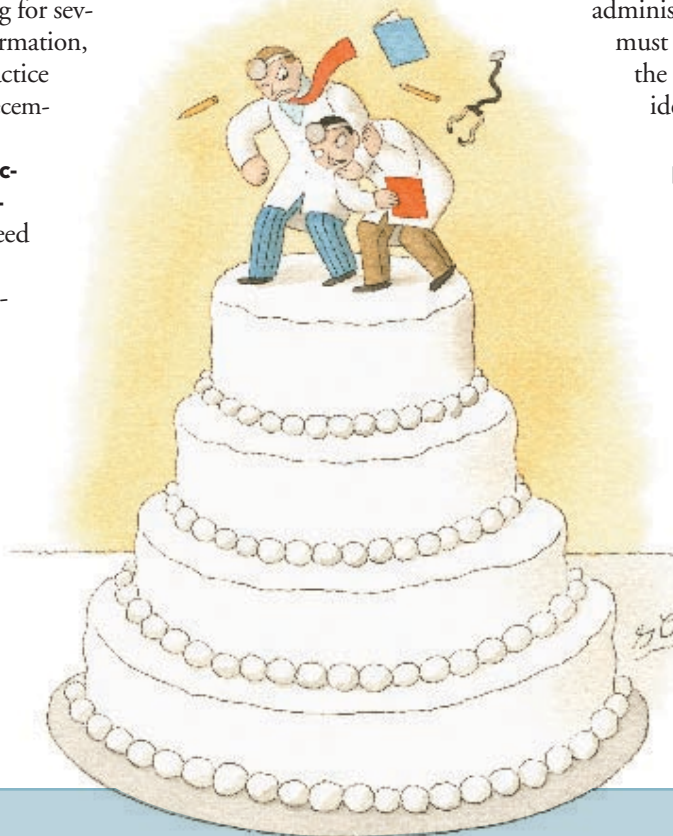
Implementing standard policies and procedures in areas such as charting, rooming patients, filing paperwork and handling prescription refills is also essential. Having consistent protocols throughout the practice creates order and helps staff cover for one another. To help ensure buy-in, practices can involve key employees in establishing these policies.

Most importantly, all office staff should answer to one main administrator, either a physician or an office manager who oversees day-to-day operations of the practice. It can also be helpful to appoint a supervisor for each department (e.g., front desk, business office and nursing) who answers to the office administrator. The office administrator must schedule regular meetings with the staff to encourage input and identify problem areas.

**3. How should you allocate practice expenses?**

Cost allocation involves spreading overhead expenses equitably among providers. There are three main types of costs: fixed, variable and personal. Fixed costs remain the same regardless of the number of patients seen. Variable costs are dependent on the number of patients or procedures performed. Personal costs apply to each provider individually.

At the time of our merger, we did not have a clear



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understanding of variable and personal costs. We chose to divide both fixed costs and variable costs evenly among the physicians with personal costs being assigned to the individual physician. Items included in the fixed costs were administration, building, equipment and leases, marketing, office supplies, payroll, telephone and utilities. Our variable costs included lab supplies, surgical supplies and X-ray supplies. Personal expenses included CME, liability insurance, professional membership dues and vacations.

One of the problems with this allocation method was that the new surgeon consumed a significant portion of variable costs in the form of medical supplies but was not penalized financially. As a result, he had no incentive to contain supply costs because they did not directly affect his income. Another problem was that our business office costs (billing, filing insurance and collection of accounts) were included under fixed costs and divided evenly among physicians. However, precertification and billing for our procedure-focused surgeon tended to be more time-intensive than for the primary care physicians. A better approach might have been to allocate these expenses based on each physician's net revenue as a percentage of total net revenue, or to divide these costs based on relative value units (RVUs).

Something else to keep in mind is that if the payroll is divided evenly among providers, all providers should have input when deciding pay raises. In addition, it's a good idea to delineate a "general staff fund" under fixed

costs. This fund can be used for lunches during staff meetings, clinic parties and employee rewards, which help enhance job satisfaction for employees. Having this fund avoids the situation of one or two physicians always paying for these items out of their own pocket.

**4. What method should you use to determine physician compensation?** Like most groups, we based physician compensation on productivity. Common methods used to measure physician productivity include gross revenue, net revenue, patient encounters and RVUs. Although RVUs seemed to be the most appropriate measure of productivity, we lacked the accounting procedures needed to measure them. As a result, we used net revenue (gross physician charges less contractual discounts and bad debts) to measure productivity.

To determine the net production for each physician, we deducted the physician's monthly practice costs from his or her monthly net revenue. We then divided this amount by the practice's available monthly cash to determine the physician's monthly compensation. For example, let's say Dr. Smith's monthly net production is \$10,000 (or \$20,000 in net revenue minus \$10,000 in practice costs). If the group's available monthly cash is \$55,000, Dr. Smith's share would be as follows:  $\$10,000 \div \$55,000 = 18$  percent, or \$9,900.

In addition, profits from ancillary services were distributed based on the percentage used by each physician. For example, let's say Dr. Smith provided 20 percent of the group's ancillary services, which generated \$30,000 in monthly profits. Dr. Smith's share would be \$6,000, for a total of \$15,900 in income for the month.

Since two of the physicians were new to our group, we lacked the data to calculate a running average (normally 6 to 12 months) of each physician's net revenue. So, we had several months with a drop in net revenue – and,

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therefore, a drop in take-home pay – because physicians were on vacation or attending CME conferences. The new physicians could not understand this concept and often vocalized their discontent with any variance in their take-home pay. In addition, their extra time off bred discontent among the other providers who had to review their labs, refill their patients’ medications and provide call coverage, essentially without getting paid for it.

In retrospect, the compensation should have been based on each physician’s previous financial data (i.e., a rolling average of each physician’s net revenue over 6 to 12 months). A pre-merger evaluation of the two physicians’ productivity would have provided useful information for our group. Once all financial statements had been reviewed, a pro forma document should have been developed estimating each provider’s pay.

### Lessons learned

Some of the biggest conflicts in health care facilities today involve poorly planned partnerships with unrealistic goals. Keep in mind

that merging practices is an investment in patience. It may take months before you reap the benefits of a new partnership. The following tips will help to ensure your success:

- Never exclude yourself from key decisions regarding your practice.
- Always seek advice from an attorney as well as an accountant when negotiating contracts; even in small towns, a handshake is not always the best way of doing business.
- Sound cost-accounting methods can have a profound impact on a physician’s bottom line.
- Always have a way out (a buy-out clause) if the partnership is not working.

In the end, our partnership failed because it was not structured well from the outset and many of the physicians’ personalities were not amenable to change. For me, the experience revealed my deficiency in business knowledge and motivated me to earn an MBA, which helped me land an administrative position in academia. From time to time, I do miss practicing rural medicine, but I do not miss the “partnership” I once had. **FPM**

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