Medical Group Mergers: An Opportunity for Growth

Presented by:

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Introduction

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Outline

- Market Update
- Benefits of Merging
- Costs and Risks
- The Process
- Before the Merger
- Potential Roadblocks
- Making a Decision
- Merger Transition
- Another Option – Divisional Mergers
- “Real Life” Discussion/ Examples

The Health Care Market

Macro Economic Marketplace Influencers

Near-Term Challenges

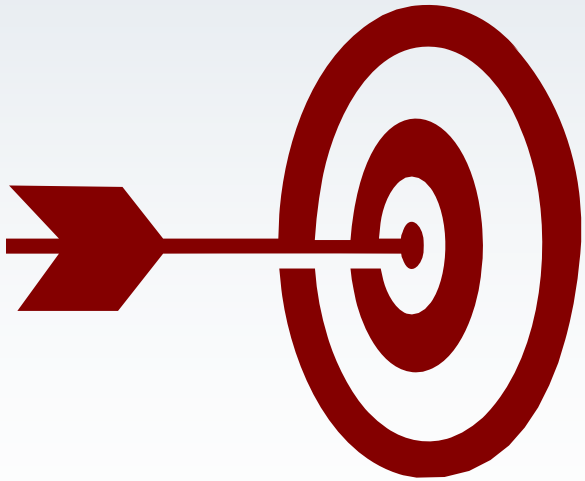
- An unstable and unpredictable political environment
- Volatile investment environment
- Size of National debt
- Consequences of extended recession
- Rising health care costs
- High unemployment rates
- State budget shortfalls

Long-Term Concerns

- Inadequate or inconsistent investment in economic infrastructure
- Rapidly rising medical and pension costs of an aging population
- Sizable trade and budget deficits
- Global economic downturn

Financial Outlook for Medical Groups ?

- Bundling of Services
- Lower Conversion Factor
  - Primary Care
  - Specialists
- Hospital Employment
- Recruiting New Physicians
- Risks of Ownership



Supreme Court Examines Constitutionality

U.S. Supreme Court Ruling: June 28, 2012

Individual Mandate
- Constitutional

Entire Affordable Care Act
- Stands

Medicaid Expansion
-State Option

Response To Challenges: "Health Care Reform"

- Patient Protection and Affordable Care Act
  - A "bend the curve" approach to systemic change
- Commercial Payer, Self-Insured Employer, and CMS payment reform activity
  - Changes to policy design
  - Population health management
- Accountable Care Organizations, Bundling initiatives and Shared Savings programs
  - Re-aligned incentives centered around the "triple aim"
  - Health Systems Selling their own insurance (ex., Kaiser, Steward)

Key Trends Impacting Health Care

1. A volatile political climate will **impact short and long term health care payments**
2. Payment reform focused on **increasing value and lowering total costs.**
3. Systems are making changes in **preparation for different payment models.**
4. Hospitals will experience **significant financial strains** over the next several years.
5. Future customer buying practices will likely **not reflect historical patterns.**
6. **PPAC Act** is creating challenges and opportunities for providers.

The Future Under Health Care Reform

Health care reform is designed to significantly alter:

How We Pay for Care

- Bundled payments
- Payment reductions
- Shared Savings
- Value-based payment
- Independent Payment Advisory Board

How Care is Organized

- Accountable care organizations
- Medical homes
- Episodes of care
- Health information exchange

How Care is Delivered

- Center for Medicare and Medicaid Innovation
- Comparative effectiveness (evidence-based best practices)
- Multi-disciplinary care teams across sites of service
- Electronic Health Records
- Care Transitions
- Improved coordination of care for dual eligibles

What Can We Expect?

We believe seven emerging themes will prevail:

1. Providers will be asked to **accept greater financial risk** for outcomes
2. **Operational efficiency** will be critical
3. Collaboration among **all providers** will be required for survival
4. Significant **investments in technology** will be necessary
5. **Increased quality** expectations, reporting and monitoring
6. Elevated **regulatory risk**
7. Increased focus on **community-based services and care** will result

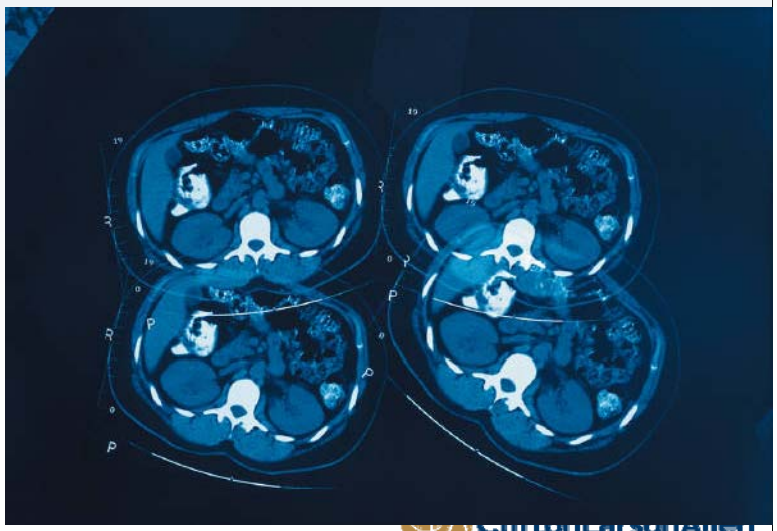
Growth Attitude

Biology:

If a cell is not growing it is decaying

Business:

If you are not growing you are dying



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Benefits of Merging

- Sub specialization
- Contracting
- Diversity of Hospital Systems
- Hospital Relationship Changes
- Business Infrastructure
- Branding
- Economies of Scale

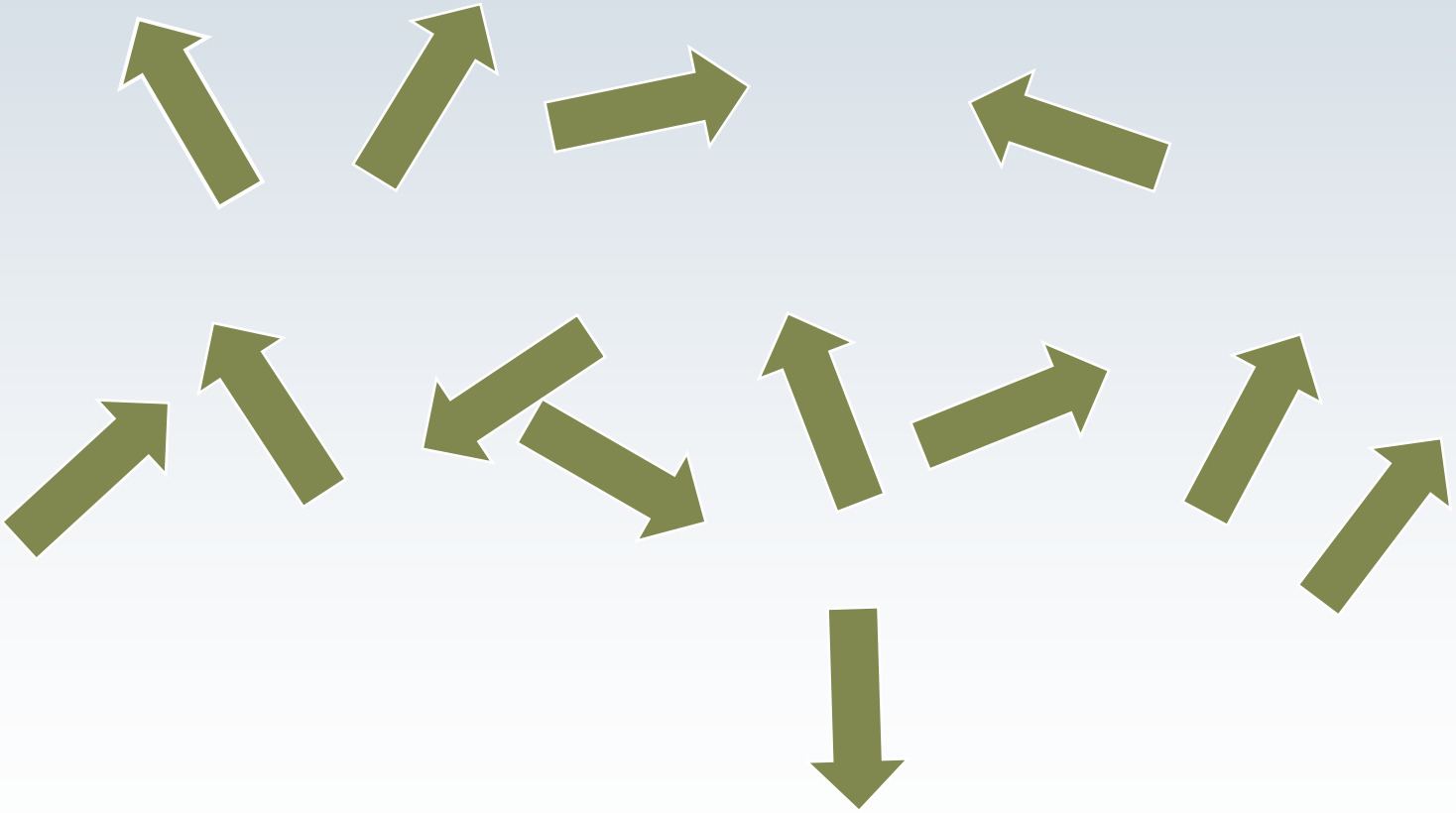
Benefits of Merging

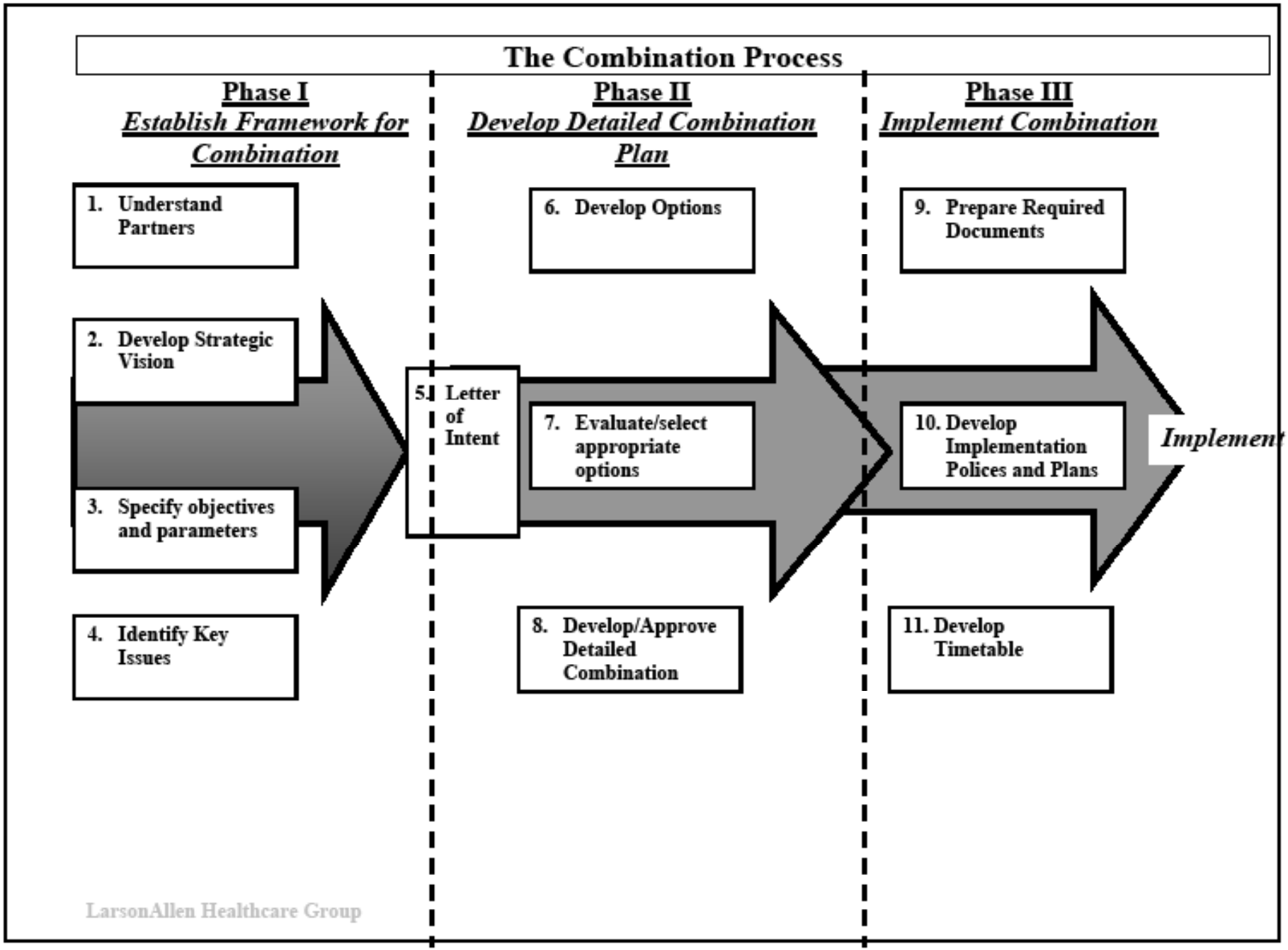
- Job Security
- Income Predictability
- Stabilize Referral Patterns
- Physician Recruiting
- Revitalization of Morale
- Access to Capital
- Others

Costs And Risks Of Merging?

- Time-usually six to twelve months
- Professional costs are high
- Many significant changes will be required-there will have to be compromises by all involved
- It might not work-there is a 50/50 chance
- External stakeholders might be uncomfortable with the merger
- Managing physician expectations
- Distraction - misuse of MAU's

The Process




The Combination Process
Phase I
Establish Framework for Combination
Phase II
Develop Detailed Combination Plan
Phase III
Implement Combination
1. Understand Partners
2. Develop Strategic Vision
3. Specify objectives and parameters
4. Identify Key Issues
5. Letter of Intent
6. Develop Options
7. Evaluate/select appropriate options
8. Develop/Approve Detailed Combination
9. Prepare Required Documents
10. Develop Implementation Polices and Plans
11. Develop Timetable
Implement
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The Process

Merger Committee

- Small practices: typically all physicians
- Larger practices: typically 1 to 3 participants from each group
- Empowered to speak for the group

Group Physicians

- Interviewed individually to identify concerns and key issues
- Attend full group meetings
- Approve final agreements

The Process

Administrative Management

- Heavy involvement in data-gathering
- Often involved in negotiations
- Very involved in operational integration plan

Merger Facilitator

- Organizes process and keeps effort on track
- Sets format and process for analyzing and deciding on issues
- Facilitates meetings

The Process

Attorneys

- Heavily involved once substantive agreements in principle have been reached
- Will advise you on aspects of the merger, help with structural issues to combine the two organizations and provide guidance on legal issues
- If necessary, use for antitrust review

Accountants

- Facilitate analysis of groups to forecast correctly the financial implications of the merger
- Provide guidance on tax and accounting issues
- Prepare financial information needed to close merger

Fair Market Health Care Appraisers

- Depends on the method chosen to value businesses, fixed assets and/or real estate

Before the Merger is Consummated

- Common Vision of Merged Entity
- Range of Legal Structure Options
- Physician Compensation and Benefits
- Impact on Retirement Plans
- Value of Practices/Combination of Assets
- Impact on Management and Employees
- Impact on Patients and Referral Sources

Before the Merger is Consummated

- Effect/Reaction of Hospital/Competition
- Succession Planning and Deferred Compensation Plans
- Assumption of Leases and Debt Obligations
- Tax Ramifications
- Combined Practice Name
- Call/Workload
- Disclosure of Pending Claims and Unrecorded Liabilities

Before the Merger is Consummated

- Involve as many physicians as possible in the "process"- allow them to make the informed decision on the intangible benefits
  - Allow them to interact with the other group members as much as possible
    - ◊ Social/ educational gatherings
    - ◊ Committee format for merger analysis
- Involve high-level employees
  - Identify the high risk positions immediately and have honest discussion and assurances
    - ◊ Nail down roles, responsibilities and working relationships
    - ◊ Surveys

Before the Merger is Consummated

- Strong Communication Plan of a Corporate Vision
  - "We are going to be the dominate medical group in the market"
    - ◊ This will allow us to:
      - Recruit and retain the very best physicians and employees
      - Add additional services so that we can better serve patients and referring physicians
      - Improve Quality through sub specialty reads
      - Create viable internal night hawk service
      - Contract on equal ground with third party payors
      - Less dependent on one hospital system
- Get people to "wave the flag"

Potential Roadblocks

Potential Roadblocks

- Inability of one or both parties to quantify or visualize the benefits of merger
  - In the first 24 months of the merger the costs of the merger maybe equal the benefits of the combination
  - The greatest benefits of the merger are recognized in time (3 to 5 years) when the organization has achieved market dominance and begins to achieve economies of scale greater then diseconomies of scale
- Valuation issues
- Power, Money and Control - usually these are at the core of all issues
  - Mergers of “equals” tend to highlight the control issue

Potential Roadblocks

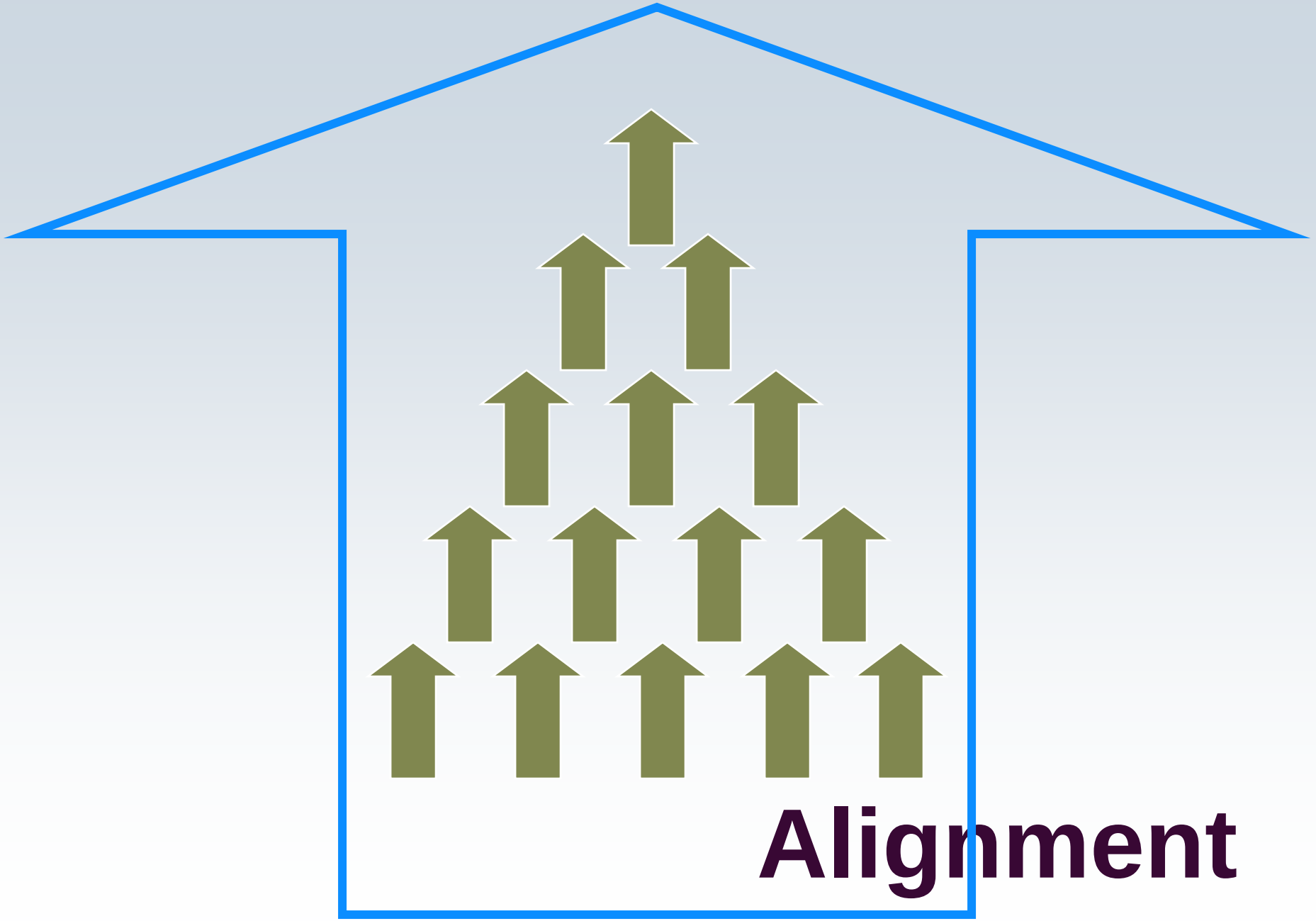
- Cultural differences
- Personnel issues - Administrators
  - Power struggle
- A vocal minority could drive the decision
- History - Years of competition
- Perceptions of differences in quality
- Concern of the reaction from others:
  - Hospitals
  - Referring physicians
  - Third party payors

Making a Decision – Key Questions

- Do we have to do something right now? Is this the best option for us currently? Are we ready?
- Is this the right partner for us?
- Are the long term plans of both partners compatible? Do we have a shared vision?
- What happens if the hospital or health system is taken over by a larger health system?

Making a Decision – Key Questions (con't)

- What relationship model will allow us to accomplish our financial goals while maintaining as much autonomy as possible?
- Will there by any changes in our clinical services, patient demographics, payor mix or referral patterns?
- What is the medical community's vision for health care in our community?
- What would be the conditions for exiting this agreement if need be?



Alignment

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Merger Transition – Leadership's Role

- Share the dreams and celebrate successes
- Have the pulse of the organization and move swiftly to proactively respond to internal and external influences
- Provide character and enthusiasm to the new organization
- Allow new ideas and other leadership styles
- Appear in many forms if received throughout the organization

"You only get paid for risk" *Fritz Wenzel*

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Merger Transition

- Implementation Process
  - Identify Key individuals – Task Force
    - ◊ Lead Physicians
    - ◊ Managers
    - ◊ Internal Finance
    - ◊ Outside Accounting/Tax
    - ◊ Legal
  - Communication Process
    - ◊ Physicians
    - ◊ Staff
    - ◊ Hospitals
    - ◊ Other

Merger Transition

- Management Agreement
- Shareholder/Member Agreements
  - Control Issues – Board Selection
  - Valuation for Buy in/Buy out
  - Profit /loss sharing
  - Capital transactions
  - Debt authorization
- Other Transaction Issues
  - Staffing
  - Practice management software
  - Banking
  - Retirement plan administration
  - Accounting

Merger Transition

- Plan strategically - the journey has just begun
  - New marketing plan
- Over communicate
- Exceed financial goals & objectives (always)
  - Budget
  - Bill it /collect it
- Leadership and governance are critical success factors
- Have the best possible CEO/non-physician leader
- Be sensitive to stress of changes
  - Do not make changes if it is not necessary and you can not win.
  - Retirement plans, Health Insurance

Another Option – Divisional Mergers

- The reasons to pursue a divisional merger should be because of the following reasons:
  - Common vision of the future
    - ◊ Strong belief that status quo is not an option
  - Higher quality care due to ability to sub specialize
  - Internal night time services efficiencies
  - Administration efficiencies
  - Potentially the possibility of lower costs through elimination of duplication of costs that can be passed on to consumers
  - Recruitment of sub specialties
- Benefits have to be seen in opportunities other than contracting due to antitrust concerns

What is it from a professional entity perspective?

Let's discuss the professional entities/services first!

What is it?

Group A and Group B become one legal entity.

Options:

1)New Corp (NewCo) formed and A and B merge into NewCo

2) A “merges” into B

3) B “merges” into A

“Merge” in this case may mean legal merger or it could mean the groups could contribute assets (including cash) and then issue stock

Benefits of Divisional Merger

- A lot of the characteristics of each group can be retained:
  - Separate compensation pools
  - Certain fringe benefits
    - Health insurance, disability, CME methods/amounts
  - Malpractice Carriers and Limits
  - Buy in and buy out methods and valuation approaches
  - Employment agreements
    - Non compete
    - Length to partnership
    - Compensation approach
  - Voting and control of the new entity could be constructed so that neither class of stock has control by itself
  - Scalable –other groups can join and create additional divisions

Board Governance

- Finds and supports excellence in management (directly stays out of operations)
- Represents the organization's "owners"
- Reaffirms and guards the organization's values and supports programs to maintain and enhance quality
- Thinks strategically – Continually…

Board Governance - Sample

- 7 -11 Physicians
  - Proportional Representation
  - Control and Decision-making
- 3 Person Executive Committee
- Administration Time/Compensation
- Committees
  - Financial
  - Practice Management
  - Technology
  - Quality
  - Ad Hoc as needed

Autonomy

- Divisions control their day to day practice
  - Hospital protocols and coverage
  - Have their own internal governance, structure and group meetings
  - Internal compensation,
  - Special calls
  - Nighthawk coverage
- Practice management committee monitors workloads and approves all hires?
- New Locations?
- New Equipment?

Financials

- Income and overhead tracked by division
  - Direct divisional costs allocated to division
    - ◊ Spend money if the choose
  - Minor Issues on “non-deductibles”
- Most overhead expenses covered by billing and management fee paid to MSO
  - Fixed Fee + Variable Fee

How / Where are Decisions Made - sample

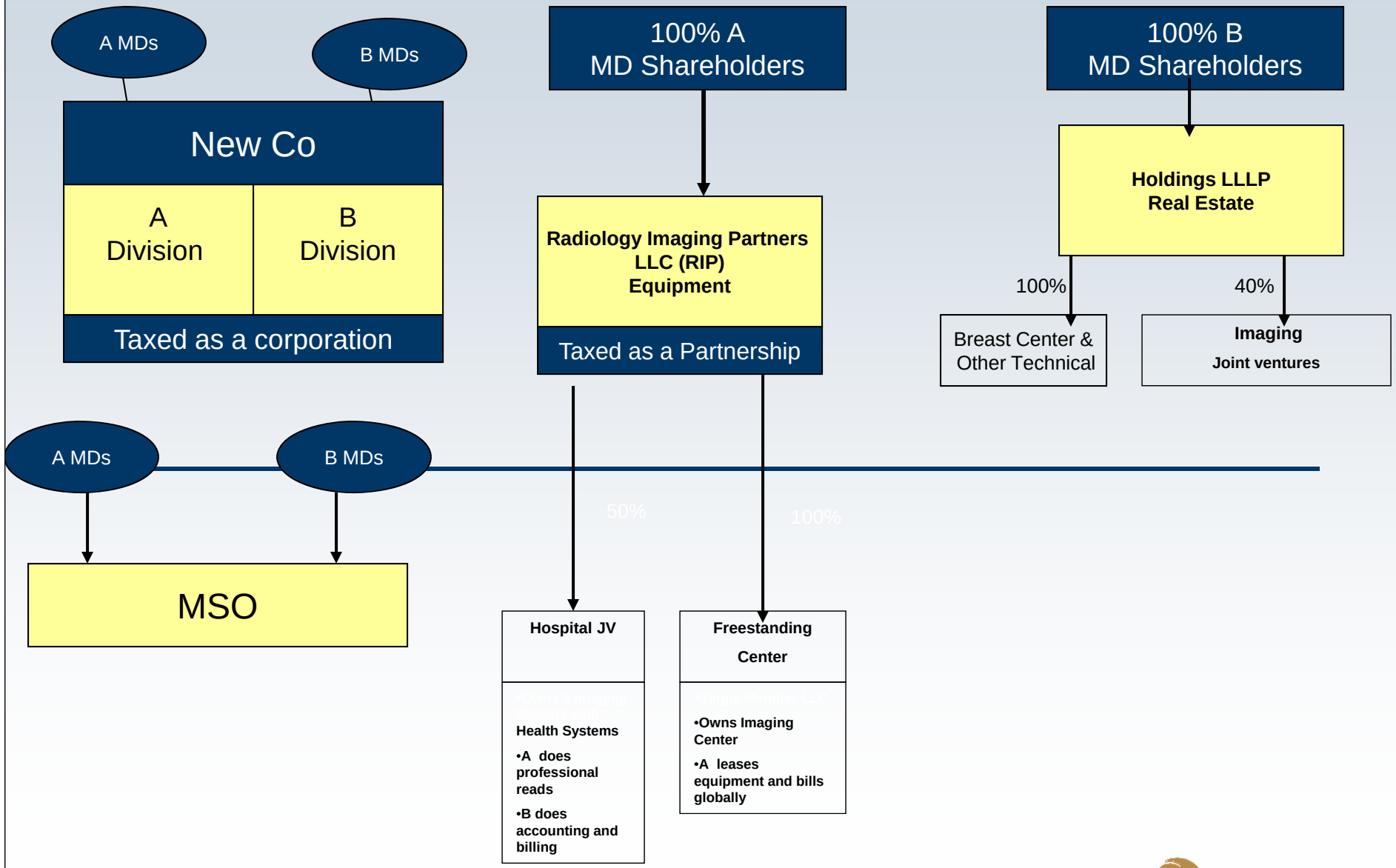
- **Division Specific**
  - **Call**
    - ◊ **System Wide Night Hawk**
  - **Part Time Policies**
  - **Shifts**
  - **Compensation methods**
- **Board Decisions**
  - **Contracting**
  - **General Employee Policies**
  - **Budgeting**

Business Offices

- One of the major components is the combination of business offices. While it is not required there will be a single tax identification and thus a common billing office does make sense
  - This can (and does) create a lot of consternation among the staff
- Often a business office is “spun off” into a separate “Management Service Organization” in order to more easily track costs and to sell services to outside organizations

Steps - Sample

- **Professional Entities "combined"**
- **Management Service Organization – "Business Offices combined"**
  - **Need to**
    - ◊ **Review state and local tax laws – subject to sales tax?**
    - ◊ **Identify the methodology for payment of service.**
    - ◊ **Quantify the value of outside services currently being rendered.**
    - ◊ **Review ownership structure**
      - **Each PA shareholder has ownership or Group A own 50% and Group B own 50%**
    - ◊ **Transfer of "assets" to New MSO company**
    - ◊ **Software issues**
    - ◊ **Establish Management services contract**
- **Imaging Centers and Real Estate remain separate**



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Reach the Summit!

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Some Examples

Today's Agenda

- Introductions
- High Level "Beginning" Financial Review
- Next Steps on Financial Review

2011 Balance Sheets

source documents at M-03b

Balance Sheet	Group B Radiology Assoc. For Year Ended December 31, 2011 Total	Per Rad 30	Group A Radiology For Year Ended December 31, 2011 Total	Per Rad 15
Current Assets	1,500,000	50,000	1,000,000	66,667
Fixed Assets	50,000,000	1,666,667	15,000,000	1,000,000
Less Accumulated Depreciation	(36,000,000)	(1,200,000)	(10,000,000)	(666,667)
Net Property & Equipment	14,000,000	365,535	5,000,000	333,333
Other Assets	1,000,000	33,333		-
Total Assets	**16,500,000**	**448,869**	**6,000,000**	**400,000**
Liabilities				
Current Liabilities	3,000,000	100,000	2,500,000	166,667
Accrued Bonuses	6,000,000	200,000		
Long Term Liabilities				
Notes Payable	5,000,000	130,548	3,000,000	200,000
Total Bank Debt	5,000,000	130,548	3,000,000	200,000
		-		-
Total Liabilities	**8,000,000**	**230,548**	**5,500,000**	**366,667**
Net Book Value (Tax Basis)	**8,500,000**	**218,320**	**500,000**	**33,333**

2011 Income Statement

	Group B Year Ended December 31, 2011		Group A Year Ended December 31, 2011		
	Total	Per Rad 30	Total	Per Rad 15	
Revenue	55,000,000	1,833,333	27,000,000	1,800,000	
Salaries - Office	16,000,000	533,333	10,000,000	666,667	
Operating Expenses	11,000,000	366,667	8,000,000	533,333	
Medical & Disability Insurance	2,000,000	66,667	730,000	48,667	
Pension & Profit Sharing	1,300,000	43,333	113,919	7,595	
Other (Revenue)/Expenses	246,065	8,202	(50,000)	(3,333)	
Depreciation and Amortization	3,000,000	100,000	1,500,000	100,000	
Radiologists' Expenses					
Radiologists' (Non-owner) Salaries	2,500,000	83,333	500,000	33,333	
Radiologists' (Non-owner) Payroll Taxes	300,000	10,000	20,000	1,333	
Owners' Salaries	15,000,000	500,000	5,000,000	333,333	
Owners' Payroll Taxes	1,000,000	33,333	500,000	33,333	
Pension / Profit Sharing	1,000,000	33,333	100,000	6,667	
Radiologist Benefits	750,000	25,000	200,000	13,333	
Malpractice Insurance	1,000,000	33,333	500,000	33,333	
Total Radiologists' Expenses	21,550,000	718,333	6,820,000	454,667	
Taxable Income	(96,065)	(2,508)	(113,919)	(6,701)	
Income Available	21,453,935	715,131	6,706,081	447,966	
Average Shareholder Compensation	17,653,935	882,697	5,686,081	437,391	

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Process

- Compensation differential is a key hurdle that needs to be overcome before the next phase of due diligence proceeds

Long Term Outlook

- As combined organization both *Groups* are better off in the long run.
  - Will your ability to earn income and fund buy outs be stronger under a ***Combined Entity*** as opposed to stay alone or other options?

Benefits to Group B

- Geographic Expansion
- Portfolio Diversification
- More security
- Low cost if synergies are realized
- Greater “pool” to work with
- A more direct & wider market penetration

Benefits to Group A

- Geographic Expansion
- Portfolio Diversification
- More security
- Upside more apparent
- Greater “pool” to work with

Proposed Ramp Up

Group A Shareholders will be merged in and total compensation will be equalized over a 9 year period

Year	% of Average
1	65%
2	65%
3	70%
4	75%
5	80%
6	85%
7	90%
8	95%
9	100%

Group A as a percentage of Group B total compensation

2011 Physician Compensation Comparison

Radiologist Compensation Summary For the year Ended 12/31/2011	**Group A Per Physician** [1]	Group B **Per Physician Owner**
W-2 Compensation (P.A.)	299,651	341,851
Undistributed ABC net income	4,587	
K-1 Income (Please list individually)		
1.)XXY	231,392	
2.) PPP		1,411
3.) FPC		(1,413)
4.) H123		233,375
Buyouts to Former Shareholders	47,938	27,772
401(k) and Profit Sharing Contribution	32,000	32,322
Health Insurance	14,866	17,389
Life and Disability Insurance		410
Meals & Entertainment		2,108
Autos		10,816
Other Physician benefits/expenses (Fringes)		
1.) Education and Prof. Expenses	6,958	3,852
2.) Communications	2,421	1,953
3.) Other "Allowance"	1,793	-
Total Compensation Package	**641,606**	**671,846**

(1)

Support Staffing

Department	Group A FTE	Group A Avg. Wage	Group B FTE	Group B Avg. Wage
Accounting			1.5	27.56
Admin	4.8	27.03	1.5	25.64
Billing			21.8	21.81
Managers			10.0	49.00
Marketing			1.5	32.37
IT	2	31.73	4.0	40.16
Scheduling/Reception	9	18.77	27.8	19.53
Maintenance			1.0	30.00
Medical Records	2	20.62	4.0	17.96
Transcription	3.4	22.88	2.0	23.24
Ultrasound Tech			5.9	40.64
CT Tech			2.8	37.27
Physicist/Dosimetrist			15.0	78.21
X-Ray/Mammo Tech			10.4	32.21
MR Tech			5.4	40.78
Nuclear Tech			2.3	43.28
PA/NP			2.0	57.95
Rad Therapy Tech			3.7	36.52
Radiology Asst			4.0	20.03
Nurse			1.3	40.50
All Techs	20	32.69		
Total	41.2		127.9	

FTE assumed at 2,080 hours/year

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Production Data

	Procedures	wRVUs	wRVU per Procedure	wRVU per FTE
Group A Radiology	58,681	33,255	0.57	11,835
Group B Radiology	249,463	157,362	0.63	8,049

	Hours worked per FTE	wRVU per FTE	wRVU per Hour
Group A Radiology	1,945	11,835	6.09
Group B Radiology	1,660	8,049	4.85

Reimbursement for Top CPT Codes

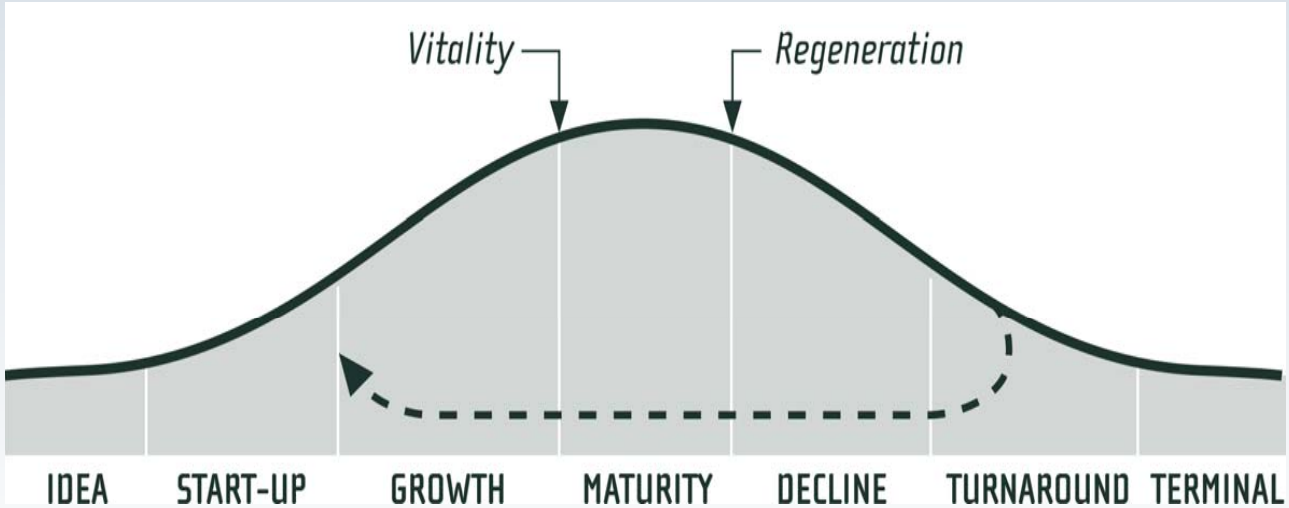
- Does one group have superior reimbursements?
- Will the insurance companies recognize the higher rates?

Tax Structures

- Can get complicated but the transition should be able to be made without a heavy tax burden
- Real Estate

In Conclusion……

Change normally does not occur until the pain of not changing exceeds the pain of changing.



How do you minimize the pain?

Leadership

Resources

- For updated guidance, proposed rules and other information about PPACA implementation issues: http://www.irs.gov/newsroom/article/0,,id=220809,00.html

- Proposed rule on the Health Insurance Premium Tax Credit: http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf

Health Insurance and Penalty (HIP) Calculator

http://www.cliftonlarsonallen.com/HIP/

Per Employee Cost Perspective

Health Reform Employee Dashboard

100% Waived Converted

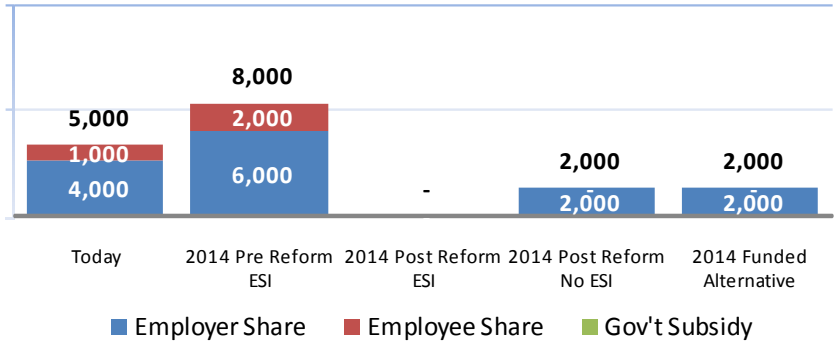
$5,940 Single Silver Exchange Premium (Current Avg)

60% Premium Funded ($30,000-$340,000 Wages)

Total HC Cost - ($000s)	EMPLOYER	EMPLOYEE	SUBSIDY	TOTAL COST
TODAY'S COST	$ 5,826	$ 2,008	$ -	$ 7,834
REFORM ESI	$ 9,651	$ 2,701	$ 736	$ 13,088
REFORM NO ESI	$ 6,700	$ 3,341	$ 6,652	$ 16,693

< 134% FPL

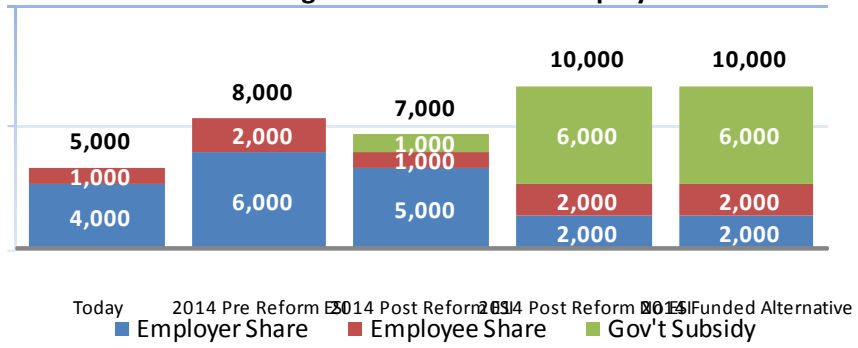
Average Premium Cost Per Employee



206/11% Total (101/8% FT Employees + 105/17% Waived Converted)

134-266% FPL

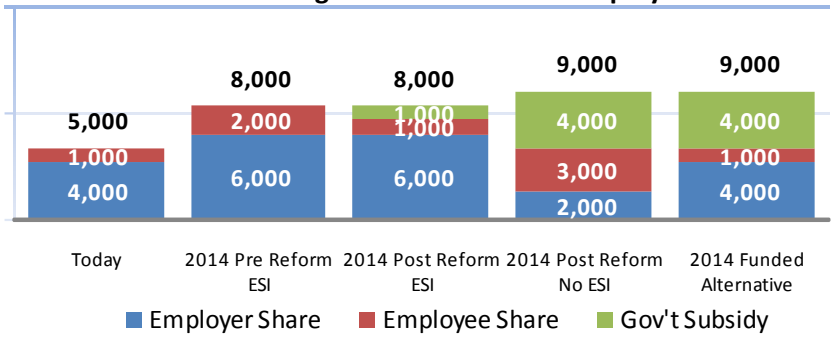
Average Premium Cost Per Employee



821/43% Total (558/42% FT Employees + 263/44% Waived Converted)

267-400% FPL

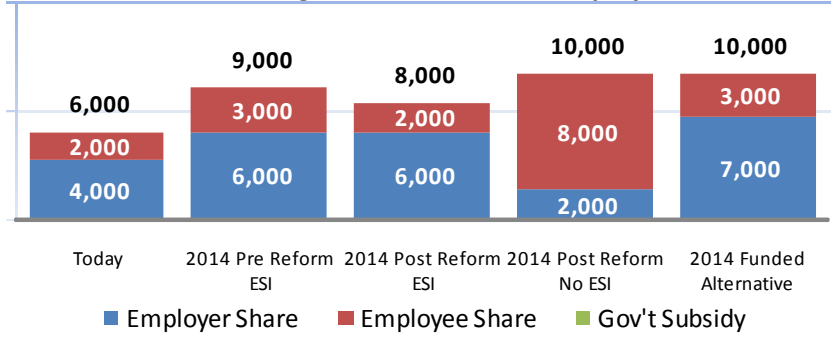
Average Premium Cost Per Employee



467/24% Total (338/26% FT Employees + 129/21% Waived Converted)

400+% FPL

Average Premium Cost Per Employee



427/22% Total (322/24% FT Employees + 105/17% Waived Converted)

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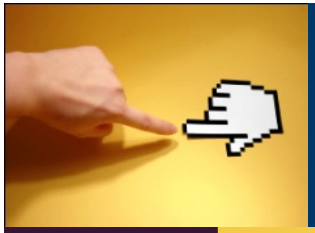

One "Click" Away From Staying Informed

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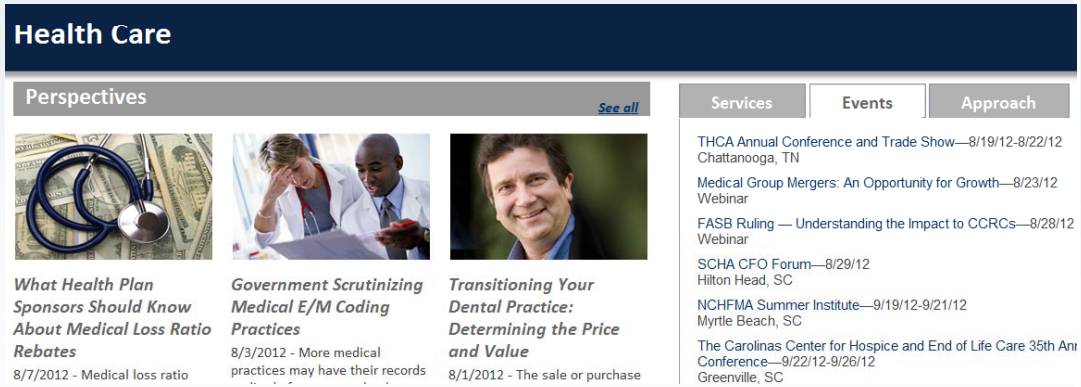

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