Unwinding Hospital-Physician Acquisitions
When the Honeymoon Ends
by Daniel B. Frier and Timothy D. Norton

In the past several years, many hospitals have been in a feeding frenzy, purchasing one medical practice after the other. Primary-care physicians, cardiologists, OB/GYNs and other specialists have been the targets of these acquisitions. With increasing costs and sideways or dropping reimbursement rates, hospital offers to purchase physician practices have been too tempting for some physicians to reject. Many physicians have made the choice to sell their practice assets and become hospital employees.

Now that many of the initial contract terms for these acquisitions are expiring, hospitals have begun to renegotiate the terms of the employment agreements for acquired practices, or have elected not to renew the agreements. Consequently, the first wave of physicians seeking to unwind their relationships with hospitals, or being forced to do so, is underway.

For physicians who have placed their practice entities in mothballs for several years, and have become accustomed to being a hospital employee, the prospect of an unwind can be daunting. This article discusses some of the legal issues counsel should focus on when representing physicians who are unwinding a hospital acquisition.

Why are Some Hospital-Physician Transactions Unwinding?
The vast majority of hospitals lose money on the professional fees generated by acquired practices. Sometimes the hospitals lose a great deal of money. The reason why is easy to understand. Hospitals induce physicians to sell their practice assets in exchange for a lump-sum purchase price, plus a salary that is 10 percent to more than 25 percent greater than what the physicians were previously earning, assuming their patient volume remains roughly the same. Hospitals are generally no better (and often worse) at billing and collecting professional fees than the average physician-owned medical practice. Therefore, hospital-owned practices incur greater costs (higher salaries) and frequently collect less money than their physician-owned counterparts. Since most medical practices do not have a year-end surplus (i.e., all profits are distributed as income to the physicians), there is really no extra ‘fat’ that enables the hospital-acquirer to offset the loss. A medical practice’s balance sheet turns red, and usually stays red, from the moment the practice is bought by a hospital.

To offset the loss of professional fees, many hospital-physician transactions rely upon the higher reimbursement that inures to a hospital outpatient department (HOPD), as compared with the reimbursement to a private medical practice. However, most experts agree these higher reimbursements will not last, and the rules around HOPDs are already tightening, curtailing the development of new HOPDs. If these HOPD reimbursements decline, more practice unwinds are likely.

If a hospital consistently loses money on a practice, it is likely to either renegotiate the relationship or terminate it altogether. This is especially true in the case of hospitals whose administrations have substantially changed since the original acquisition. The new personnel may be inclined to clean house, and this inclination may be enhanced by the presence of strong non-competition provisions preventing the physicians whose employment contracts are not renewed from rushing to a competing hospital. All of these factors make it extremely important for attorneys representing physicians who have sold or are considering selling their practices to hospitals to consider the possibility of an unwind at the start of the transaction, and be prepared to guide their clients through the unwind process should it occur down the road.

Key Unwind Provisions in the Sale Documents
A number of factors must be considered by attorneys in evaluating the rights and responsibilities of their physician-clients when unwinding a hospital acquisition. These rights
and responsibilities will depend, in large part, on how the acquisition documents were negotiated at the outset of the transaction.

**Exercising the Right to Unwind.** The asset-purchase agreement should provide a physician with an option to unwind the transaction if either party elects not to renew the relationship for any reason. To the extent the medical practice is comprised of two or more physicians, the option to unwind may require the approval of a certain percentage of the physicians to be effective. A process for this and other inter-practice decisions should be delineated in the sale documents, or through a separate document signed by the physician partners.

**Repurchasing Assets.** A right to repurchase allows the physicians to buy back practice assets necessary to reconstitute their medical practice. Physicians should be permitted to repurchase the practice assets at fair market value. This may be tricky if, after several years, the hospital replaces or adds onto a practice’s assets. For example, if the hospital purchases an expensive electronic health records (EHR) system, it may be very costly for the practice to purchase the system. Thus, counsel should be careful to permit physicians to carve out from the repurchase certain newly acquired assets.

**Re-Assignment of Leases.** Space and equipment leases must be reassigned back to the physician’s practice entity, assuming the space and equipment continue to meet the needs, and budget, of the practice.

**Practice Employees.** Former practice employees, who have been employed by the hospital, must be re-employed by the practice. This can be challenging because, unlike hard assets, people have free will, and may not want to return to the practice due to a number of factors, including improved benefits offered by the hospital. Purchase documents must make it clear that the hospital is prohibited from soliciting practice employees following an unwind.

**Billing.** As part of the initial negotiation, the physicians may have request ed the right to continue to bill claims through the medical practice to the minimum extent necessary to remain credentialed with third-party payors. The existence, or absence, of such a provision will dictate whether the practice will have the ability to immediately continue billing through the practice in the event of an unwind, or will need to be re-credentialed with third-party payors.

**Restrictive Covenants.** Hospitals traditionally insist that the acquisition documents contain both a non-compete and non-solicitation provision that applies to the former owners of the medical practice. The non-compete will typically last for a period of two years, and will prohibit the physicians from affiliating with another hospital system and, in some cases, a large medical practice (e.g., a medical practice with 20 or more physicians) within a certain geographic area. Ideally, this restriction will not apply under certain circumstances, such as termination by the practice for cause, termination by the hospital without cause, and decreases in compensation offered by the hospital after the initial term. Hospitals may be reluctant to carve out the non-compete simply due to decreases in compensation, if the decreases are the result of the hospital’s regulatory need to maintain the compensation at fair market value.

**Developing a Transition Plan**

The process of unwinding a hospital acquisition can be quite complex, and must be evaluated on a case-by-case basis. Counsel for the medical practice is well advised to carefully review the acquisition documents to determine the client’s rights and responsibilities. Additionally, unwinding a hospital acquisition may have a variety of hidden costs beyond the purchase of the practice’s assets. It is critical the physicians fully understand the costs involved in returning to private practice. These costs may include re-establishing an office location, re-hiring staff and implementing an employee benefits plan, re-acquiring practice assets, re-credentialing with certain payors, establishing a line of credit, and incurring legal and accounting fees, etc. Therefore, counsel should help the practice establish a comprehensive written plan in conjunction with the practice’s accountant in order to effectuate a smooth transition back into private practice.

With increasing overhead expenses, declining reimbursements and a shift into non-fee-for-service reimbursement, simply returning to the status quo may not be a viable option for the physicians. Counsel should also evaluate consolidation and integration strategies with other practices that do not run afoul of restrictive covenants with the hospital. Alternatively, the practice may also consider entering into an employment relationship or a professional service arrangement with another hospital. As distinct from an employment relationship, a professional service arrangement will allow the practice to remain independent while being reimbursed at optimal levels by a hospital partner. Moreover, a professional service arrangement may provide the practice with financial stability with respect to income while the hospital bears the risk of reimbursement reductions and non-payment from patients and payors.

**A Word about Non-Compete Provisions**

A non-compete provision can be the most difficult hurdle for a practice seeking to transition away from a hospital. Many clients ask whether their non-compete is enforceable, and the likely answer is—it depends. Clearly, the spe-
pecific facts and circumstances of the employment arrangement and the separation and unwind play important roles in whether a non-compete is enforceable. A hospital that is in breach of its obligations, or that has terminated an employment relationship without cause, may be at a disadvantage in terms of enforcing a non-compete. Unfortunately, most agreements with hospitals have fee-shifting provisions that may require physicians to pay for the hospital’s legal costs if they violate the non-compete, and it is difficult to predict how a judge will handle a particular case. Defending non-compete litigation can be very expensive, even when successful. Here are a few things to consider if physician clients are considering undertaking the risk of a non-compete violation:

1. Try to negotiate a carve-out with the hospital. Sometimes, if a hospital believes the clients will still be in a position to support the hospital, it is not in the hospital’s best interest to enforce the non-compete and further damage the relationship with the practice.
2. Try to persuade another party (hospital or practice) to reimburse the physicians for legal defense costs arising from any prospective non-compete litigation.
3. Have physician clients move their practice as close to the outskirts of the non-compete radius as possible (e.g., nine miles away for a 10-mile non-compete).

Unwinding a physician-hospital purchase transaction is fraught with complexity and risk to physician clients. At the onset of a representation, it can be helpful to create a detailed checklist of to-do items, and carefully warn clients, in writing, of the potential downside of the various choices they make.

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